



GUIDE FOR PARTICIPATORY LOCAL ASSESSMENT

COMMUNITY
COMPONENT OF
THE IMCI STRATEGY





Integrated Management of
Childhood Illness - IMCI

GUIDE FOR PARTICIPATORY LOCAL ASSESSMENT

[COMMUNITY COMPONENT OF THE IMCI STRATEGY]

Child and Adolescent Health Unit (CA)
Family and Community Health Area (FCH)

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PREFACE

Recent decades have witnessed substantial improvements in the health status of the population in general and of children in particular. Life expectancy has increased in most countries as a result of the decrease in deaths from infectious and respiratory diseases during the first years of life. Some diseases that just decades ago seriously affected the health of thousands of boys and girls worldwide have gradually lost their importance as a cause of morbidity and mortality, thanks to the sustained mass vaccination efforts of all the countries.

Improvements in global health have been closely allied with the development of knowledge and technology. Hand in hand with the results of many of these advances, new discoveries and scientific developments have astonished humanity, paving the way for optimism about the future control and prevention of many diseases.

Within this context, the inevitable questions arise, which have acquired a new sense of urgency in the global and national arena: Why do millions of boys and girls die each year before the age of 5? Why are the vast majority of these deaths from diseases and health problems that are easily and economically preventable or treatable?

For several decades, international cooperation agencies have been actively seeking the causes of this situation, and while many factors are behind the persistence of certain diseases as a cause of childhood morbidity and mortality, a constant in their fatal outcome is the lack of access by many families to the resources and information that would permit the prevention and timely and adequate treatment of these diseases.

A basic set of behaviors can prevent children from getting sick, or when they do, help ensure that they get better and that families make the decision to seek outside help early. A series of simple, inexpensive interventions put within the reach of families through the health services and health workers can also prevent disease and provide effective treatment for the majority of them. Finally, a few family and community practices may not only offer tools to protect against disease but the most appropriate conditions for the survival, growth, and development of children.

Putting these practices and interventions within the reach of all families has been the main objective of governments, especially in recent decades. As part of the international commitments assumed at the World Summit for Children in 1990 and the Millennium Summit in 2000, all the governments have committed to a sustained effort to achieve a series of goals and targets that will contribute to an improvement in the health and well-being of the population. Although great strides have been made, the persistence of high infant mortality and morbidity rates in many countries suggests that efforts should not only be increased, but targeted especially toward the areas of greatest vulnerability. It is precisely here that children's survival and healthy growth and development are still not a reality, revealing the inequitable distribution of the benefits that knowledge and technology have brought to humanity.

Expanding the IMCI strategy to the whole primary health care network and transferring its educational contents to all families is therefore key to ensuring that the children of Americas, especially those from areas and population groups with higher morbidity and mortality indexes, gain access to interventions that will guarantee their survival and healthy growth and development.

Disseminating and promoting this knowledge is therefore an ethical imperative for all. The role of health workers in this effort is fundamental, as they labor in areas devoted to providing care and protecting the health of the population, who periodically seek them out not only for treatment, but to prevent disease.

Also part of this effort are all the people involved in the design of public policies, whose application can help to guarantee that the basic measures to protect life and promote the health and development of children are within the reach of families and communities.

Integrated Management of Childhood Illness (IMCI) is an effective strategy that gives families and the general population access to the key interventions for child survival and healthy growth and development. Through its community component, IMCI has helped to reinforce the most beneficial practices in the care and treatment of children in the home and to discourage those that are potentially harmful.

This contribution has been made possible by active family and community participation, which, through intersectoral work coordinated at the local level, has made it possible to reach the most vulnerable population groups. This work has also enriched the analysis of the child health situation, incorporating a community vision and perceptions, which has resulted in better identification of priorities and the adaptation

of responses to the particular characteristics of each place.

In recent years, thousands of people have joined forces in the effort to extend the benefits of practices that can promote health in children and improve their nutritional status and development in the early years of life. More and more children have been reached, especially the most vulnerable, helping the countries to move toward the attainment of the

Millennium Development Goals (MDG) to which all the governments have committed themselves, giving boys and girls the world over a better opportunity in adolescence and adulthood.

Dr. Yehuda Benguigui
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PRESENTATION

The philosophy that inspires the working methodology may be summed up in three consistent attitudes: bringing together, participating, and building.

These three attitudes characterize the role of the Local Team and, at the same time, they are the values of the Project. For this reason, they are constantly being promoted by the personnel engaged in its activities.

The local coordinator is first and foremost a leader. He or she is always bringing together and mobilizing local capacity in the area, enlisting allies in the commitment to disseminate the key practices for the protection of children under 5 to their mothers, families, and local communities. Those who respond to this call gain the right to take part in the Project's tasks and activities, contributing their talent and at the same time benefiting from the human, social, and cultural rewards that derive from the experience.

Participation should be incorporated as a value in the design of each activity, with an ongoing effort to discover its mobilizing potential and take advantage of it to build communication and interaction—among adults, between adults and children, and among children—aimed at generating awareness, consensus, and social, family, and personal practice in protecting children under 5 and their mothers.

PRESENTATION AND RATIONALE

This document is intended for local personnel in the health services, the Red Cross, and other social players involved in the health area, to support them in carrying out an assessment of their local situation and its health problems, especially those related to children under the age of 5. It also seeks to understand why the situation has occurred, so that a plan of work can finally be developed that will be effective in tackling the problem.

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) promote the world initiative of Integrated Management of Childhood Illness (IMCI), a strategy that has been validated and accepted as one of the primary interventions for improving the health situation of children in the Americas. This strategy is implemented through three operational components:

- Improving the skills of health workers by providing them with the knowledge and practices that will enable them to treat children better and on a timely basis;
- Strengthening the organization of health services so that they can respond to child health problems effectively through networks.
- Incorporate families and communities into the effort to improve family and community practices in protecting and caring for children.

The community component attempts to coordinate health services initiatives with actions that can be carried out in the community, involving all possible actors and sectors at the local level, in order to promote family and community practices for the care and protection of children in the home and community. The family itself, and the family and social networks are the main target of the interventions being developed.

Community participation is both an end and a means of helping to improve family and community practices in child care and protection. However, in order for it to happen, there must be a deliberate and conscious decision to involve all available human resources and organizations in this effort—community health workers, NGOs, municipal governments, grassroots organizations, schools, leaders, and so on. Only then can it have a positive impact on the health of children.

The local Red Cross and the health services that promote the process need to comprehend the social, geographical, and institutional scenario and find their place within it. Situational assessment contributes actively by enlisting the participation of all social actors involved in the local IMCI community undertaking. It is suggested that this Guide be discussed by the local team, made up of personnel from the health services, the Red Cross, and other institutions called upon to become active players in addressing child and maternal health problems at the local level.

This Guide is intended to serve as an instrument to facilitate the process. It should be tailored to local conditions and realities on an ongoing basis, enriched by local experiences and resources.

OBJECTIVES OF PARTICIPATORY LOCAL ASSESSMENT

General Objective

To share a methodological sequence that will make it possible to address the status of child health through the participation of different social actors which, working together, will organize a plan of work.

Specific Objectives

- 1) To collect, organize, and analyze information available at the local level on the health status of children and pregnant women, and to describe and analyze the social actors and their networks.
- 2) To understand family and community practices at the local level.
- 3) To analyze the health problems identified jointly with the people and the social actors, examine the causes and consequences, and propose actions for dealing with them.

CHARACTERISTICS OF PARTICIPATORY LOCAL ASSESSMENT

Participatory local assessment, which is being promoted for the purpose of implementing the community component of the IMCI strategy, has three characteristics, corresponding to its three major phases:

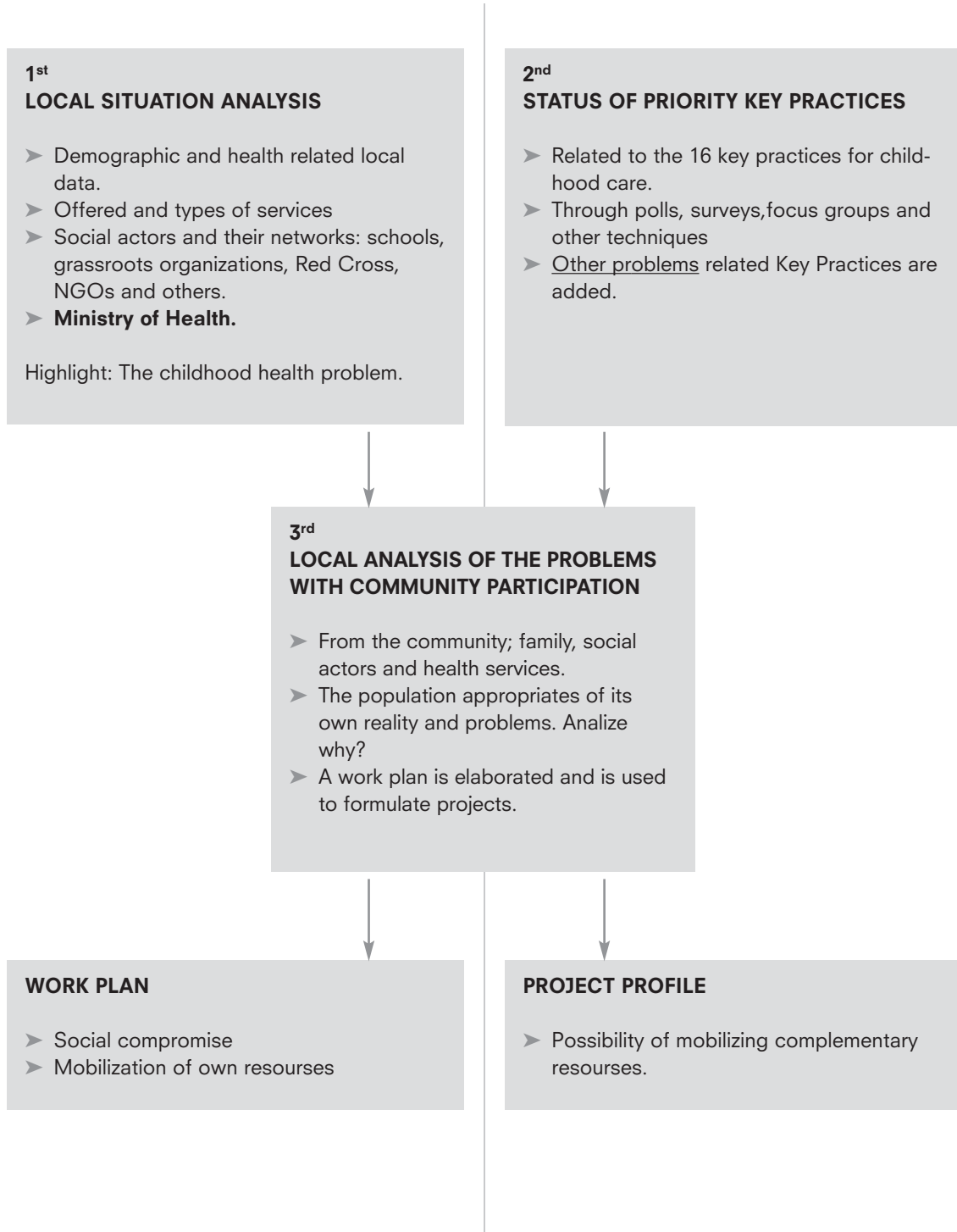
STAGE ONE: This stage corresponds to analysis of the local situation, based on direct information from the local area as it relates to the child and maternal health problem: data about the population, including its distribution, dynamics, and social, economic, and cultural characteristics; data on infant, maternal, and general mortality, including the trends and some of

the factors that account for them; a description of the public, private, and community organizations and the social actors; the number of communities; and information about the health services network, including its organization and problem-solving capacity—in other words, the human resources and institutional bases that exist in the local area.

STAGE TWO: This stage involves situating and characterizing the 16 key family and community practices used in treating and caring for children. The status of family and community knowledge, attitudes, and practices (KAP), as well as those of the social actors, in terms of the key family and community practices. These will be investigated through soundings, opinion polls, KAP surveys, interviews, and/or focus groups.

STAGE THREE: This stage corresponds to joint analysis and a participatory exercise with the community, represented by families, social actors, the health services, and the Red Cross. Based on an analysis of the local situation and identification of the causes and consequences of specific child health problems, actions are proposed that will form the basis of a plan of work and/or project profile.

ENTITIES OF THE PARTICIPATORY LOCAL ASSESSMENT



STAGE ONE

[Analysis Of The Local Situation]

- **ANALYSIS OF THE LOCAL SITUATION
(WITH MAP OR SKETCH)**
- **IDENTIFICATION OF CHILD AND
MATERNAL HEALTH PROBLEMS**
- **IDENTIFICATION OF THE SOCIAL
ACTORS AND THEIR NETWORKS**

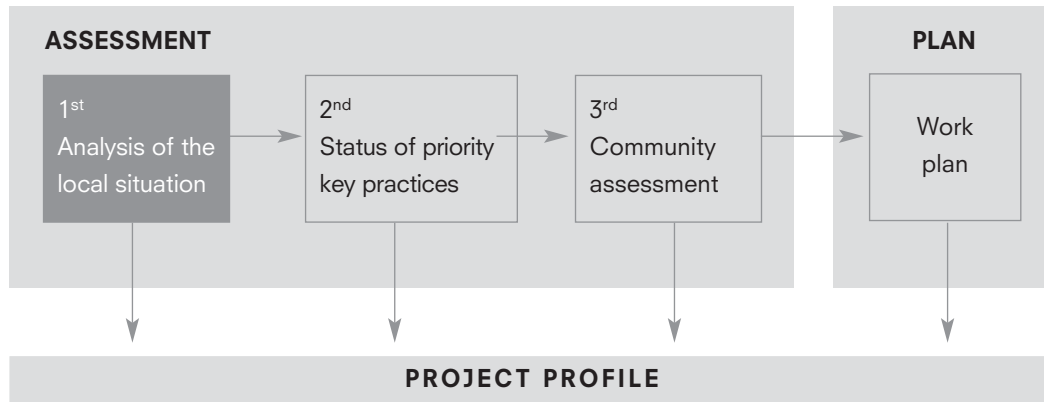
PLAN NACIONAL
DE SUPERVIVENCIA
Y DESARROLLO
INFANTIL
Y
SALUD
MATERNA



6 de
nov.

la unidad nacional
por el binomio
madre-niño





STAGE ONE

[Analysis Of The Local Situation]

During this first stage the team finds its place within the immediate setting—the locality, the environment, the social and geographical space inhabited by the people, as well as the institutions and social actors, which have their own networks—and defines the specific aspects of the child and maternal health problem.

This approach helps to reinforce a sense of identity and belonging, to encourage the recognition that child and maternal health problems do exist, and to create awareness that a wide network of social actors is available to address these problems.

INSTRUCTIONS FOR STAGE ONE: ANALYSIS OF THE LOCAL SITUATION

The local Ministry of Health and the Red Cross, through the Local Coordinator, bring together all the entities in this area of work—universities, NGOs, other State agencies, and teachers—to take part as a team in participatory local assessment.

It is suggested that the team start to prepare a map or sketch of the local area, which will be very useful for:

- Identifying the child and maternal health problem;
- Describing and analyzing the social actors and their networks;
- Presenting the health services network;
- Capturing the social, cultural, productive, and demographic characteristics of the local population;
- Formulating requests for additional national and regional information from the central level, which should be supported by the Ministry of Health and the Red Cross.

This stage brings up a series of questions and requests for information that needs to be reflected in the description of the local situation, especially with regard to the child health problem and the networks of existing social actors.

1) IDENTIFICATION OF THE CHILD AND MATERNAL HEALTH PROBLEM AT THE LOCAL LEVEL

In order to identify child and maternal health problem(s) at the local level, it is first necessary to take a national and subnational perspective. This description and analysis is important to understanding the magnitude of the problem, its trends, and the national programs that currently exist for addressing it.

1.1 National And Subnational Situation

Brief description of:

- Child mortality and trends, based on existing national information;
- Child mortality by cause of death;
- Child morbidity;
- Maternal mortality, trends;
- Ratio of institutional delivery / delivery at home;
- Coverage with prenatal care.

The group's work should be supported by tables or matrixes that display the data. For example:

CHILD AND MATERNAL MORTALITY: NATIONAL AND SUBNATIONAL RATES

CAUSES	NATIONAL	SUBNATIONAL	YEAR
Child mortality	(Rate)	(Rate)	
Maternal mortality	(Rate)	(Rate)	

CHILD MORTALITY BY CAUSE OF DEATH: NATIONAL AND SUBNATIONAL RATES			
CAUSES	NATIONAL	SUBNATIONAL	YEAR
1.	(Rate)	(Rate)	
2.	(Rate)	(Rate)	
3.	(Rate)	(Rate)	
4.	(Rate)	(Rate)	
5.	(Rate)	(Rate)	
6.	(Rate)	(Rate)	

1.2 Local Situation

At this point, the local reality should be described briefly, starting with aspects related to health status, identification of the child and maternal health problem, characteristics of the local population, and the presence and role of the social actors and the health services network.

Brief description of the local health situation:

- Total population of the area;
- Age distribution of the population;
- Child mortality and its trends (preferably expressed in absolute numbers);
- Child mortality by cause of death;
- Child morbidity;
- Maternal mortality and its trends (in absolute numbers);
- Ratio of institutional delivery / delivery at home;
- Coverage with prenatal care.

The group's work should be supported by tables or matrixes that display this information. For example:

CHILD AND MATERNAL DEATHS AT THE LOCAL LEVEL		
ITEM	NUMBER OF DEATHS IN 2000	NUMBER OF DEATHS IN 2001
CHILD DEATHS		
MATERNAL DEATHS		

CAUSES OF CHILD MORTALITY AT THE LOCAL LEVEL

CAUSES	ABSOLUTE NUMBERS
1)	
2)	
3)	
4)	
5)	
6)	

CAUSES OF CHILD MORTALITY AT THE LOCAL LEVEL

CAUSES	ABSOLUTE NUMBERS
1)	
2)	
3)	

The data obtained up to this point make it possible to perceive the “problem situation” of children under 5 and pregnant women in the local area.

Based on the information gleaned, the area’s child and maternal health problem(s) should be stated and characterized. To be stated correctly, the problem should be expressed as a gap between the situation encountered and the one desired, specifying its magnitude, the people it affects, and its location in time and space.

- The situation as it exists in reality
- Manifestation of a gap
- Magnitude of the gap

- People affected
- Manifestation in the local area
- Temporal nature of the problem
- Indicators

2) DESCRIPTION AND ANALYSIS OF THE SOCIAL ACTORS AND THEIR NETWORKS

A map or sketch of the local area is used to identify the social actors, public and private institutions, community organizations, schools, churches, local government, etc. The following questions will help to provide information about the actors, their function, and the networks associated with them:

- What State and private institutions are represented in the community?
- What grassroots organizations are active in the community?
- What media are available for communicating with remote areas (radio, telephone, etc.)?
- What types of mechanisms exist for coordinating with the institutions and organizations identified?
- What health promotion activities are carried out in the community? Who carries them out?
- What lines of action are carried out by the

NGOs in the community? How do these NGOs interact with the health services?

- List the social actors that have been identified (mayor, governor, schools, daycare centers, health promoters, healers, midwives, community health workers, etc.).

All these questions should be considered, along with any others that the team considers relevant, and the answers should be recorded in the following matrix of social actors:

MATRIX OF SOCIAL ACTORS		
SOCIAL ACTORS IDENTIFIED IN THE LOCAL AREA	WHAT DO THEY DO? (Main role in the local area)	NETWORK AT THEIR DISPOSAL (Structure)
Schools		
Grassroots organizations		
Local government		
Red Cross		
Health services		
Community health workers		
Churches		
NGOs		
Others		

The following example shows two actors identified in an area of Bolivia.

MATRIX OF SOCIAL ACTORS		
SOCIAL ACTORS IDENTIFIED	WHAT DO THEY DO? (MAIN ROLE IN THE LOCAL AREA)	NETWORK AT THEIR DISPOSAL (STRUCTURE)
Schools	<ul style="list-style-type: none"> Educate school-age population through formal public education Participate in educating parents. 	<ul style="list-style-type: none"> Eleven educational centers 3,800 children aged 6 to 14 165 teachers Outreach to 2,000 parents
Grassroots organizations: neighborhood councils	<ul style="list-style-type: none"> Serve as a local authority with responsibility for the management and programming of annual operating plans 	<ul style="list-style-type: none"> 52 neighborhood councils, one for each neighborhood in the area Ten members on each council Above the Neighborhood Councils are the District Councils.

Identification of the social actors, including recognition of their role and awareness of the network at their disposal, creates a potential base for the promotion of health care for children and pregnant women.

Describing the role and structure of the social actors in the different local areas makes it possible to see opportunities for getting them involved in reaching out to families as part of the community component of the IMCI strategy.

3) THE LOCAL HEALTH SERVICES NETWORK

The community and the public and private health services are two essential actors in the Comprehensive Care of Childhood Illness (IMCI) area. The previous section dealt with identifying the social actors and their networks; this section looks at the response of the health services.

➤ What local programs are concerned with

improving the local epidemiological health profile of children under 5 and pregnant women?

- How are the local health facilities (health establishments, Red Cross, social security, etc.) organized to take care of common childhood illnesses?
- On the map or sketch indicate distances, hours open to the public, availability of radio, telephone, ambulance, etc.)
- Does the health facility have the capacity to deal with common child health problems on-site? Does it have appropriate remedies? Does it have treatment rooms for delivery, caesarean section, and neonatal care?
- How has the IMCI strategy been incorporated into the work of the health facility? What roles and functions are played by personnel in facilities that have implemented the IMCI strategy? What do they do? Give examples.
- Are health workers trained in the IMCI strate-

gy? How many? Number of personnel assigned to the health facilities in the project area.

- How does the health facility coordinate with other community actors and organizations—for example, community health agents (CHA)? For what purpose?

4) ACTIVITIES CARRIED OUT BY THE RED CROSS

- What activities or projects does the Red Cross carry out in the local area?
- How does the Red Cross articulate and coordinate with the health facility and other community actors and organizations? For what purpose?
- Have Red Cross personnel been trained in the IMCI strategy? How many? Number of workers assigned to Red Cross facilities in the project area.

5) HOUSING AND BASIC SERVICES

HOUSING SECTOR: characteristics of housing as they relate to child health—for example, sheltered/unsheltered.

BASIC SERVICES: water supply system, sewerage, refuse disposal.

6) SOCIOCULTURAL ASPECTS

- Describe the social, organizational, cultural, political, and labor characteristics of the population.
- Identify any cultural characteristics of the population and the health services personnel that might serve as critical links in the care and protection of children and pregnant women?
- Do people in the community have difficulty availing themselves of the health facilities

because of distance, inadequate transportation, geographical terrain? Why?

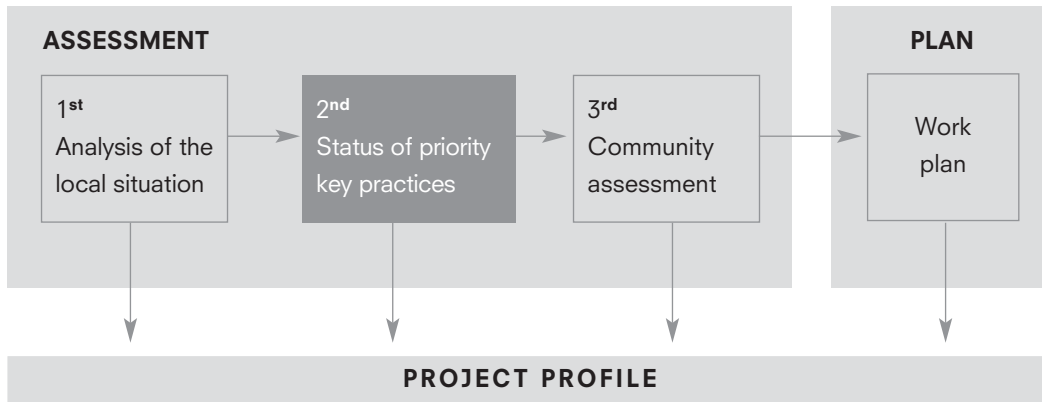
- Does the cost of getting to the health facilities or the cost of the care itself pose a problem for the population seeking help? In what way?
- Explain any aspects of the health services supply that discourage mothers and families from consulting these facilities?

STAGE TWO

[LOCAL STATUS OF THE KEY PRACTICES]

- **STATUS OF THE KEY FAMILY AND COMMUNITY PRACTICES**
- **SEQUENCE DEFINING THE KEY PRACTICES SITUATION**
- **16 WHO/UNICEF KEY PRACTICES**





STAGE TWO

[STATUS OF THE KEY FAMILY AND THE
COMMUNITY PRACTICES]

After the local situation has been analyzed, the social actors and their networks identified, and the local child and maternal health problem characterized, the next step is to learn more about the status of family and community practices for protecting children and pregnant women.

One way to analyze and gain a deeper understanding of the problem (i.e., obtain a local epidemiological profile) is to relate it to the 16 key practices for protecting children and women and find out which practices need to be given priority for direct intervention and which ones are likely make the child and maternal health problem worse.

INSTRUCTIONS FOR STAGE TWO: STATUS OF THE KEY PRACTICES

Since not all the key family and community practices are relevant to the local epidemiological profile outlined in Stage One, it is important to assign priority to certain practices and subject them to qualitative research through focus groups, in-depth interviews, KAP (knowledge, attitudes, and practice) surveys, etc. The following sequence is suggested:

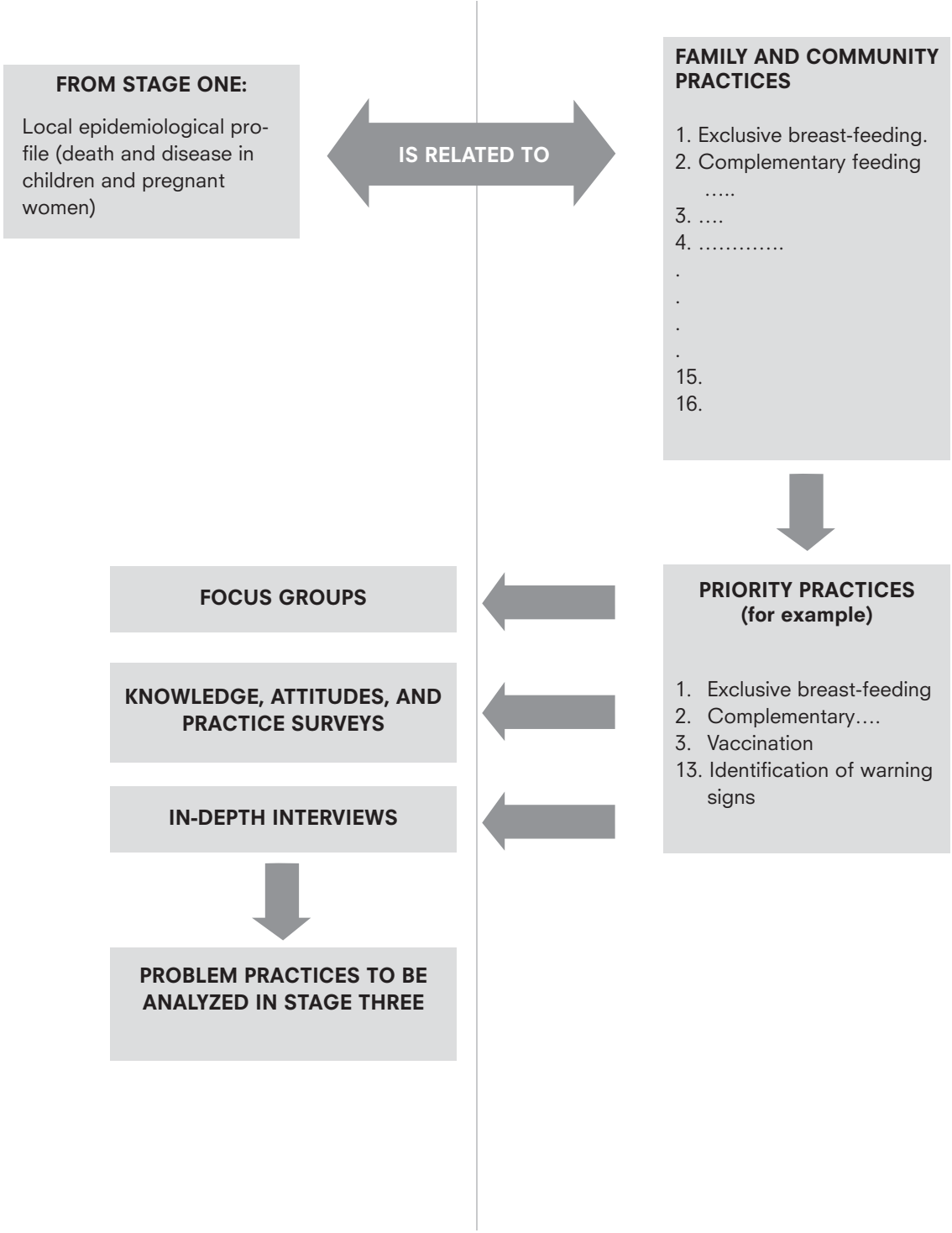
1. Once the leading health problems of children under 5 and pregnant mothers have been identified in Stage One, the next step is to identify and assign priority to those of the 16 key practices that are most directly related to the problem.
2. After the priority practices have been identified, any information should be noted in the key practices matrix.
3. After the information gaps have been noted, the next step is to identify and request technical assistance from one of the institutions or professionals participating in the project that has skill in the use of focus groups and other types of qualitative and quantitative research. If this capacity is not available, other entities in the area that have human resources trained in this type of research should be called upon.

(Annex: Focus Groups)

IMCI community intervention offers the added benefit of being able to enlist universities, NGOs, or individuals as partners in conducting quantitative or qualitative research on knowledge, atti-

tudes, and practices. It is therefore important to approach known experts in these methodologies and to find out about any research that has already been done.

SEQUENCE FOR DEFINING THE STATUS OF THE KEY PRACTICES



Below is a matrix showing the 16 key family and community practices and the information required about them—i.e., the knowledge needed about each practice so that, once the research is done, other prob-

lems that seem capable of being targeted by the IMCI community component can be addressed, and, at the same time, an initial baseline for measuring the results of intervention can be established.

16 KEY PRACTICES FROM WHO/UNICEF

For growth and development	
KEY PRACTICE	WHAT WE NEED TO KNOW
Breastfeed infants exclusively for the first six months of life.	<ul style="list-style-type: none"> • Habits and customs associated with feeding children under six months of age. • Introduce another type of food or liquids other than breast milk before the child reaches six months of age. • Duration of exclusive breast-feeding.
Starting at six months of age, feed children with complementary food of appropriate quality, frequency, and quantity.	<ul style="list-style-type: none"> • Habits and customs associated with feeding children starting at six months of age. • How, when, how frequently, and with what foods is complementary feeding initiated? • Duration of breast-feeding.
Provide children with adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplements.	<ul style="list-style-type: none"> • Availability of local products that are rich in micronutrients (vitamin A and iron). • Access, frequency, quantity, and mode of consumption of these products.
Promote children's mental and social development by being responsive to the child's needs for care and stimulating the child through talking, playing, and a stimulating environment.	<ul style="list-style-type: none"> • Who participates in stimulating the child. • How love and affection are demonstrated in the family and community.

For preventing illnesses

KEY PRACTICE	WHAT WE NEED TO KNOW
Take children to receive a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.	<ul style="list-style-type: none"> Family attitudes regarding the vaccination of children. Health service, community, and family factors that could hinder completion of the child's vaccination schedule.
Dispose of feces (including children's feces) safely, and wash hands after defecation, before preparing food, and before feeding children.	<ul style="list-style-type: none"> Family and community habits regarding personal hygiene, food preservation and hygiene, and excreta and solid waste disposal. Source of water supply, how water is consumed and stored.
Protect children in malaria-endemic areas and ensure that they sleep under insecticide-treated mosquito nets.	<ul style="list-style-type: none"> Anti-malaria control and prevention measures used by the family and community. Measures taken by families to protect their children against malaria.
Adopt and sustain appropriate behavior regarding HIV/AIDS prevention and care for the sick with special attention to orphans.	<ul style="list-style-type: none"> Attitudes toward and preventive measures taken in the presence of an HIV/AIDS-infected person.

For appropriate home care

KEY PRACTICE	WHAT WE NEED TO KNOW
Continue to feed and offer more fluids, especially breast milk, to children when they are sick.	<ul style="list-style-type: none"> Habits and customs associated with feeding sick children. Factors that might keep a sick child from receiving adequate nutrition and fluid intake.
Give sick children appropriate home treatment for infections.	<ul style="list-style-type: none"> Care given to sick children in the home. Factors that affect noncompliance with the treatment.
Avoid abuse and neglect of children and take appropriate action if it has occurred.	<ul style="list-style-type: none"> Whether or not physical or emotional abuse occurs in the home. Whether or not children and women are victims of physical or emotional abuse.

For appropriate home care (cont)	
KEY PRACTICE	WHAT WE NEED TO KNOW
	<ul style="list-style-type: none"> • Family and community attitudes toward child abuse. • Measures taken in the event of any type of abuse.
Ensure that men actively participate in providing child care, and that they are involved the matters affecting family reproductive health.	<ul style="list-style-type: none"> • Participation of men in child care and family reproductive health. • Factors that affect the participation of men in child care.
Take appropriate measures to prevent and control child injuries and accidents.	<ul style="list-style-type: none"> • The most frequent types of child accidents in the home and community. • Attitudes of the family and community regarding children's vulnerability to accidents. • Preventive measures taken at the family and community level.

For seeking assistance	
KEY PRACTICE	WHAT WE NEED TO KNOW
Recognize when sick children need treatment outside the home and take them to appropriate for health care.	<ul style="list-style-type: none"> • Conditions that indicate to the family that the child is at risk. • Attitudes of the family and community regarding these warning signs. • Factors that might prevent at-risk children from receiving proper and timely care.
Follow health workers' recommendations regarding treatment, follow-up, and referral.	<ul style="list-style-type: none"> • Whether or not the family complies with the treatment, follow-up, and the advice of the health worker. • Factors that might stand in the way of compliance.
Ensure that every pregnant woman receives adequate prenatal care, including at least 4 visits with an appropriate health care provider and the recommended doses of tetanus toxoid vaccine, and is supported by family and community in seeking appropriate care at the time of delivery and during the postpartum/breast-feeding period.	<ul style="list-style-type: none"> • Family care and customs at the time of pregnancy, childbirth, and puerperium. • Where and to whom women go for prenatal monitoring and delivery care. • Factors that might prevent pregnant women from going to a health facility for prenatal monitoring and care during delivery and puerperium. • Signs that the family recognizes as indications that a pregnant woman is at risk. • What do they do when they see these signs?

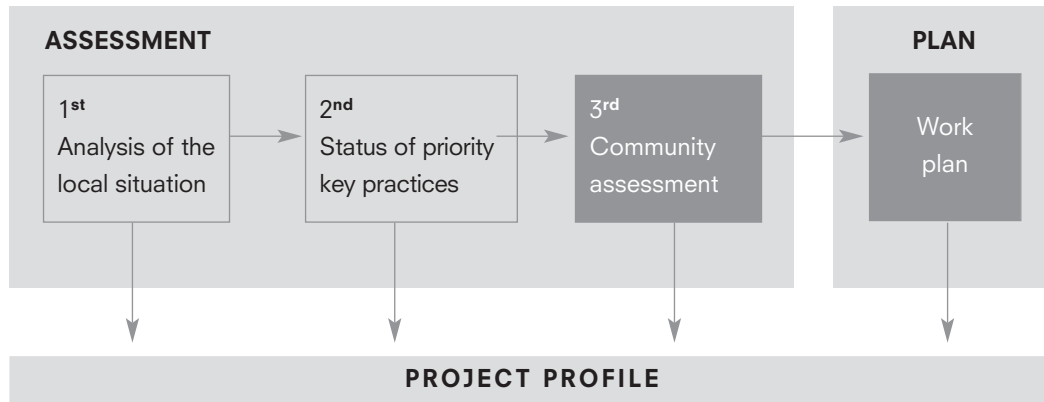
STAGE THREE

[Local Analysis of the Problems with Community Participation]

GRASSROOTS PLANNING WORKSHOP

- **ANALYSIS OF THE LOCAL SITUATION**
- **THE HEALTH PROBLEM**
- **CAUSES AND CONSEQUENCES**
- **ACTIONS**
- **WORK PLAN**





STAGE THREE

[Analysis of Problems with Participation
of the Community and its Actors]

Stage Three takes the form of a local workshop entitled “Grassroots Planning.” This is the methodology that will make it possible, starting with identification of the problem, to finally propose actions for overcoming it. Moreover, the outcome will serve as the local plan of work and as input for the formulation of proposals.

The process of participatory local assessment concludes with this workshop, which will generate a product that serves as a plan of work for the various actors involved.

The notion of a local plan of work for community-based IMCI reflects the capabilities available to each of the actors for dealing with the child and maternal health problem with the same funds,

human resources, and social networks. The outcomes achieved (problem-causes-consequences and actions) constitute a new source of knowledge for formulating project profiles, and thus mobilizing supplementary funds if necessary.

Participatory local assessment concludes with a local plan of work for the different social actors involved. It represents a local mobilization of institutions and human resources that are concerned with the problem, starting with their own resources.

Stage three of participatory local assessment is synonymous with the grassroots planning workshop. Stage Three, the occasion for this workshop, is the stage during which the organized community and existing social actors discuss and analyze the central problem using the grassroots planning methodology.

1) OBJECTIVE OF THE WORKSHOP

- To prepare a plan of work, based on discussion and analysis by the organized population, leaders, and public and private organizations, for addressing the child and maternal health problem using the Grassroots planning methodology.
- To consolidate or create more opportunities for coordination and multi-institutional consensus-building based on active social participation.

2) INPUTS FOR THE LOCAL WORKSHOP

- a) Information from Stage One: quantitative information related to the systematization of local information based on guidelines for the formulation of participatory local assessment. This information should be accompanied by a map or sketch of the local area.
- b) Information from Stage Two: results of qualitative studies on child and maternal health at the local level that will make it possible to visualize the problems related to knowledge and family practices.
- c) The experience and the knowledge of each participant as a social actor; through the working group sessions, these actors will develop the basic actions for the plan of work and the project profile.

3) PARTICIPANTS

Representatives from the following three groups:

- Mothers or child caretakers;
- Social actors: the local government, the local education network, grassroots network organizations, community health workers, community leaders, church leaders, and others.
- The health services network and the Red Cross. About 30 representatives, who first went through a two-day interactive process of coming together and raising awareness.

4) METHODOLOGY

- Working groups
- Plenary sessions

SEQUENCE OF THE WORKSHOP

ANALYSIS OF THE LOCAL SITUATION

- Working groups
- Discussion Guide 1: Analysis of the Local Situation
- Plenary session

THE CHILD AND MATERNAL HEALTH PROBLEM WITHIN THE OVERALL SITUATION

- Plenary session with presentation and discussion of the problem within the local setting
- Reasons for the problem (causes)
- Working groups on the Grassroots planning methodology
Discussion Guide 2: Analysis of Families, the Community, and the Health Services
- Plenary session with presentation of causes at the level of families, the community, and the health services, and analysis of the consequences of the problem

CONSEQUENCES IF THE PROBLEM SHOULD PERSIST

- Discussion in plenary session

WHAT STEPS SHOULD BE TAKEN? Discussion Guide 3: Actions


- Plenary session on actions

ESTABLISHMENT OF AGREEMENTS AND COMMITMENTS

- Social actors and local authorities

Annex: See detailed agenda of the workshop, discussion guides, grassroots planning, and sample outcomes from a workshop.

5) THE GRASSROOTS PLANNING MATRIX.



PROBLEM	CAUSES	CONSEQUENCES	ACTIONS
The central problem (death or disease of child or its mother, or the consequence of an inadequate key practice)	At the level of: <ul style="list-style-type: none"> ➔ The family ➔ The community ➔ The health services 	Consequences envisioned if the problem persists	What to do? How? With what resources? When? Who? How will it be evaluated? At the level of: <ul style="list-style-type: none"> ➔ The family ➔ The community ➔ The health services

When the same population that actually experiences the problems goes through the exercise of identifying them, analyzing the causes and consequences, and assumes responsibility for changing the situation, we can see that this is the closest possible thing to “community participation.”

OUTLINE OF THE ASSESSMENT REPORT

GENERAL DATA

- Country
- Region
- Province
- Locality (political division)
- Health services jurisdiction
- Red Cross jurisdiction
- Date

ANALYSIS OF THE LOCAL SITUATION

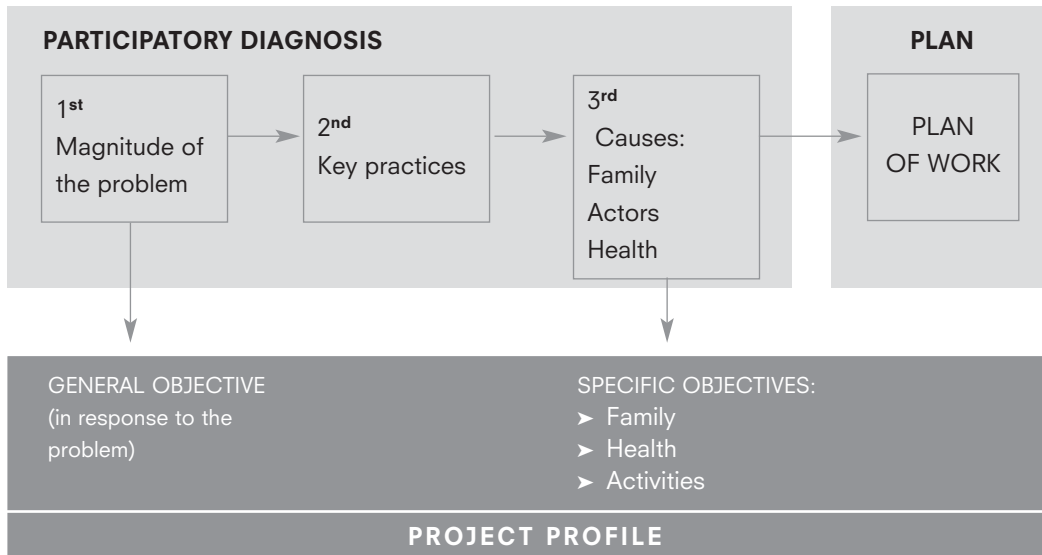
- National and subnational context
- Local context
- Health problems of children under 5 and pregnant women in the local area
- Social actors and their function and networks (structure)
- Status of the health services

STATUS OF KEY PRACTICES AT THE LOCAL LEVEL

- Priority key practices vis-à-vis the local epidemiological profile
- Results of qualitative studies of priority key practices

ANALYSIS OF THE PROBLEMS IDENTIFIED VIS-À-VIS THE COMMUNITY AND ITS ACTORS

- Analysis of causes and consequences
- Actions of:
 - Families
 - Social actors
 - Health services
- Plan of work
- Annex: Grassroots Planning Matrix



COORDINATION OF PARTICIPATORY LOCAL ASSESSMENT WITH THE FORMULATION OF A COMMUNITY IMCI PROJECT

[Project Profile]

Participatory local assessment, concluding with the Grassroots Planning Workshop and preparation of the plan of work for community IMCI, is a powerful tool for defining the job of each actor with respect to the child health problem. These problems range from inadequate care practices to disease and death in children under 5 and pregnant women.

Preparation of the plan of work concludes the process of participatory local assessment.

In those cases in which it is possible to systematize the process of seeking or mobilizing supplementary funds, participatory local assessment and its outcomes will provide the basis for formulating proposals.

The following outline describing how to rapidly draft a project profile for community IMCI.

PROJECT TITLE

1) Executive Summary (half a page)

Summary description of the problem to be addressed, the setting, the target population (geographical and cultural aspects, size) and how the problem will be solved (sustainable critical actions) with the collaboration of all the actors involved: the Red Cross, the Ministry of Health, NGOs, and the organized population. The project will be viewed as an institution-building factor and as an opportunity to promote sustainable critical actions for the protection of children under 5 and pregnant mothers in the localities identified. *(Content drawn from the three stages of the local assessment)*

2) National and Local Situation (one page)

Global data on the country's social, political, and economic context. Local situation: available human resources and institutional base. Demographic and health indicators in general and for children in particular. *(Content drawn from Stage One of the assessment)*

3) Description of the Problem within the Local Context (half page)

Describe the problem, its causes and consequences, and the population affected, as well as the trends and consequences if the project is not carried out. *(Stage One)*

4) Objectives (one page)

Describe in concrete terms the outcome it is hoped to achieve at the end of the project (half page). The general objective should be framed as a response to the central problem identified in Stage One; the specific objectives should respond to the causes of the problem that have been identified in terms of the family, the actors involved, and the health consequences.

5) Expected Results (one page)

Each specific objective should include a reference to the results expected at the end of the operational stage of the project (1 year), based on the profile.

6. Strategy (one page)

Describe how the specific objectives are expected to produce the desired results. This should include the role of the organizations that will be participating in the project and the institutional sustainability of their role (based on their specific objective in each case).

7) Activities (Description) (four pages)

Describe the activities to be carried out in building toward the outcomes (four to seven important, necessary, and sufficient activities for each result).

8) Plan for Monitoring and Evaluation (two pages)

Describe the process of monitoring and evaluation, as well as the indicators of project implementation, progress, and impact. The formats for documenting the methodology, the activities, and the changes that take place should be mentioned and attached in an annex. The data entered in these forms will constitute a systematic record of progress under the project

9) Responsible Individuals, Organizational Structure, and Functions (one page)

State who will be responsible, how the personnel will be organized, and how the teams in charge of project execution will interact. Also, describe the responsibilities of each individual person and those of the local grassroots organizations.

10) Operational Methodology (one and a half pages)

Describe the intended sequence of events for implementation of the project, indicating who will work with whom and what will be done. One of the most effective ways to present this information is to iden-

tify phases of the project corresponding to important specific criteria (stages of project development, detailed aspects of the methodology, or attainment of expected intermediate results).

11) Annexes

- Map of the target area
- Plan for monitoring and evaluation
- Plan of work: timetable, budget, resources from the local area
- Other appropriate supporting documentation
- Forms for systematically recording progress

ANNEX 1

[Focus Groups]



WHAT IS A FOCUS GROUP?

A focus group is a qualitative research methodology in which six to ten people engage in freely structured informal discussion to gather information on a specific subject.

WHO DIRECTS IT?

The discussion is guided by a moderator, who encourages the participants to speak freely and share their ideas and feelings about the subject. Moderators have the following characteristics:

- They can identify easily with the participants, they speak the same language fluently, and they inspire confidence.
- They are familiar with the subject.
- They are flexible, listen well, and take everyone's views into account.
- They never teach or provide information.
- What they do ask questions, they listen and take note of the views expressed.

THE MODERATOR ASKS QUESTIONS, SOUNDS PEOPLE OUT, LISTENS, AND LEARNS.

What Are The Steps For Developing A Focus Group?

STEP I: DECIDE WHAT INFORMATION NEEDS TO BE KNOWN. Identify the subject to be addressed and list the knowledge that will be needed. The following phrases may help to get things started:

WHAT WE NEED TO KNOW

1. What we don't know is the status of breast-feeding.
2. We have doubts about
3. We don't understand

STEP II: DECIDE WHO SHOULD PARTICIPATE IN THE FOCUS GROUP. Think about the people who will be most useful for research purposes and who can provide the information you need in the most

effective way. Describe the characteristics these people should have in common.

CHARACTERISTICS OF THE PARTICIPANTS

1. Rural women from the Chao District.
2. Women with children under 5.
3. Women 15 to 35 years of age.

Once the characteristics of the participants have been decided on, be careful to use impartial channels to recruit and select the members of your focus group. Remember that the number should be 6 to 10 participants, and the ideal number is 8.

STEP III: PREPARE A DISCUSSION GUIDE FOR THE PARTICULAR FOCUS GROUP. Based on the guidelines for the focus group, which should be prepared in advance, you should be able to elicit the necessary information and promote discussion. There are four parts to a focus group meeting.

DISCUSSION GUIDE FOR FOCUS GROUP

1) INTRODUCTION (10 MINUTES)

- Presentation by the moderator.
- Purpose of the focus group: explain the purpose of the meeting. Emphasize that the purpose is not to impart knowledge, that there are no right or wrong answers, and that the participants are free to disagree and change their minds.
- Explanation of the procedure: explain that a person will be taking notes and, in addition, the conversation will be recorded to ensure that no information is lost, and that everything they say will be held in confidence. Emphasize that all are free to participate, but no two people can speak at once. Tell them that the discussion will last about an hour.
- Introduction of the participants: encourage everyone to participate in the discussion.

2) ESTABLISHMENT OF AFFINITY

At this point the moderator asks easy-to-answer questions that encourage the participants to speak up. This should take 10 minutes, as the participants begin to play a more active role. For example, one question might be: "Would someone like to tell about her child's most recent illness?"

3) IN-DEPTH DISCUSSION

Ask 6 to 8 key questions the subject being explored (Stage One).

- Arrange the questions so that they go from the more general to the specific.
- Avoid direct questions that can be answered with a simple “yes” or “no.”
- If necessary, reword the question or try a different approach to elicit more in-depth information.

4) CLOSING

- At this point, the participants should be given the opportunity to clarify their positions regarding any opinion, perception, or practice that was discussed.
- Without making any judgments, briefly summarize what has been heard from the group.
- Thank the participants and emphasize the importance and value of the information collected.

Other recommendations:

- Select a quiet and private venue; be sure there are enough chairs; and arrange them in the form of circle.
- If possible, make arrangements for, or purchase, refreshments or other incentives.
- Tailor the questions; listen carefully to what the participants say; and ask questions that will elicit unexpected information.
- Address the entire group, looking at all the participants. to encourage all of them to respond.

- If necessary, rearrange the order of the questions to reflect the direction the discussion is taking.
- Try not to focus your attention on any one person, because the rest may feel excluded.

STEP IV: DESIGN THE FORMS TO BE USED FOR TAKING NOTES. A person should be taking notes in all the focus group discussions. This person should watch and listen closely, writing down as much as possible about what is said, as well as noting people’s reactions. It is important that he or she be familiar with the guidelines for the moderator.

FORM FOR TAKING NOTES

DATE: TIME: PLACE:

MODERATOR:

NAME OF PERSON TAKING NOTES:

NUMBER OF PARTICIPANTS: DURATION:

Questions	Responses / Comments	Observations/ Interpretations

STEP V: ORGANIZE THE NOTES AND PREPARE A FINAL REPORT FOR THE FOCUS GROUP:

➤ Fill in the gaps

It is important for the moderator and the person taking notes to get together immediately after the focus group meeting to review the notes and recordings and fill anything that is missing in order to complete the report.

➤ Organize the information

- Analyze all the information collected in response to each question.
- Summarize the main points made about each question.
- Support the findings with a few examples of comments that people made.

SUMMARY OF THE RESULTS

COMMUNITY:

MODERATOR: PERSON TAKING NOTES:

TYPE OF PARTICIPANTS:

NUMBER OF PARTICIPANTS:

DISCUSSION QUESTIONS:

Finding 1: The majority of mothers in the Chao District breast-feed exclusively during the infant's first 2 months.

Quotes from participants who corroborate this finding:

I have been breast-feeding my baby for the last month (Rosa Chávez: Chao.)

*Seek out your people.
 Love them.
 Learn from them.
 Plan with them.
 Serve them.
 Begin with what they have.
 Base what you do on what they know.
 With the best leaders,
 When their task is carried out,
 And their work is done,
 The people will say:
 "We did it ourselves!"*

(OLD CHINESE VERSE)

ANNEX 2

[Grassroots Planning]

The operational tool to be used for the group assignments is Grassroots Planning, a methodology that enables a group to identify and define the problem and analyze its causes and outcomes, leading ultimately to a proposed series of actions or tasks for addressing these causes.

As it can be seen, the starting point is for the group is to define the problem and take up the challenge. The group may be composed of health workers, mothers, and members of the community at large, either women or men. What they should have in common is that they are all affected by the same problem.

In a crisis such as a natural disaster, when the urgent need for action and the concrete problem are shared by the entire community, this methodology becomes a tool for keeping abreast of the events that need to be dealt with, since it takes account not only of actions but also of the actors and the timing.

Finally, Grassroots Planning is useful wherever there are common problems shared by a group that has the same interests and the same ideals. If the challenge calls for constructing a local paradigm, the exercise of going through Grassroots Planning will strengthen it. If it involves building consensus, intersubjectivity, or leadership in a group it addresses a problem, the methodology will serve as a coherent organizer.

In the case of health work at the local level, and by extension the work of other sectors such as education and agriculture, this approach will often invoke such phrases as: "with the active participation of the population," "multisectoral action," "starting at the level of the target population," "drafting proposals jointly with the target population." In fact, many of these phrases are used to characterize strategies within a given project or program.

Grassroots Planning is also a methodology that makes it possible to channel social participation, generate multi-institutional action, and strengthen management and leadership.

This document seeks to socialize the process and methodology of Grassroots Planning as it is practiced at the local level in groups that address local problems, as well as the institutions associated with them.

Even though this methodology has been applied primarily at the local level, it can be used by groups to tackle problems at any level (local, regional, or national). Hence, Grassroots Planning is also useful for staff or managers who are willing to address certain problems that may arise at their level of the government or other hierarchy.

Grassroots Planning is a simple, dynamic methodology that enables any group to deal with a problem that affects them directly. Moreover, its logical and participatory analysis can be applied by personnel at

the regional or national level to develop consensus-based coherent, sustainable actions in response to problems that are identified in the course of managing or executing policies or programs.

HOW DO WE USE GRASSROOTS PLANNING?

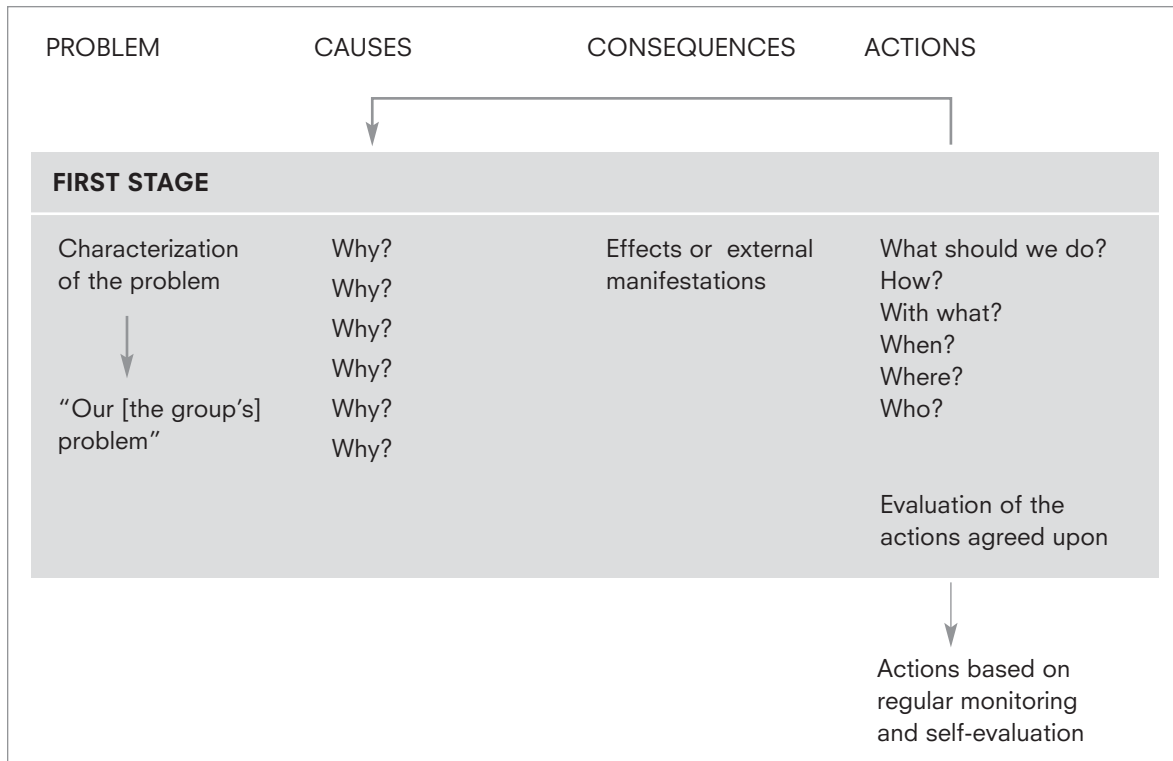
The starting point is the definition of the problem, which will be framed in terms of the group so that it is their problem. This group is composed of the target population plus the social actors involved. For example, it would be impossible to imagine a workshop on problems with trash disposal attended solely by the people affected, because they would be limited in the solutions or actions they could propose. It is essential to include the presence of the municipal government, health agencies, and NGOs or other institutions engaged in related activities.

There are three phases to the methodology of Grassroots Planning:

1. Definition and characterization of the problem.
2. Analysis of the causes and consequences. Why? What happens then?
3. Actions that the group decides it can take.

In developing the Grassroots planning matrix, it is important to bear in mind that the actions are accompanied by a series of questions, each of them designed to address one of the causes that has been described and analyzed.

The actions should always be aimed at addressing each of the causes.



STAGE ONE

The Problem

The process of identification, definition, and prioritization of the problem by the group (the organized community, personnel from the regional or national level, and older adults and adolescents adults, who are the target population in this case) begins once the problem has been isolated. Only if the problem is perceived collectively (i.e., seen as "our problem") can a consensus be reached regarding the actions to be taken. Thus it is absolutely essential that the problem, even if it is not experienced directly by the majority of the community, be perceived as everyone's problem.

STAGE TWO

Causes

Once the problem has been defined, the causes that might be contributing to it are analyzed. The reiterated "Why?"s prompt the workshop participants to express and share their particular knowledge and experience with others in the group at all levels. Because of the dynamics of the workshop, this moment becomes a valuable mutual learning experience. The familiar causes are identified—i.e., those having to do with society, the State, the socio-economic structure, etc. The depth of analysis of the causes will be directly proportional to the participants' experience and knowledge.

Distinguish between those problems that can be dealt with locally and those that cannot. For this purpose, the community needs to determine where or how it is going to request support. For each cause, regardless of the level of the group, the

degree to which it is capable of doing the job needs to be clearly understood. To the extent that the Grassroots Planning process devotes time, carries out studies, and implements actions, the first meetings will almost always succeed in visualizing the immediate causes in such a way that the degree of analytical community development and the degree of resolution through action undertaken will enable the social group to delve more deeply into the analysis. The repeated “Why?”s help to explain the problem. This stage of identifying the causes is important for ensuring that the proposed actions are directed toward dealing with and gradually eliminating each of the causes identified.

Consequences

It is the effect of the problem that appears as its external manifestation and is usually visible—i.e., what the human group knows.

Identification of the consequences makes it possible to demonstrate that actions aimed at dealing with the causes are more sustainable and successful than those directed toward the consequences. (For example, if the cause of a malnutrition episode is due to an epidemic of gastroenteritis, a sustainable intervention will be one aimed at improving water and sanitation, rather than one that emphasizes food supplementation.

STAGE THREE

Actions

After analyzing the various causes and effects of a given problem, it is time for the group to propose actions or tasks to be undertaken. As we said earlier, the group consists of the target population, local institutions, and others concerned with the issue in question.

Each cause analyzed during this stage should elicit the following questions: What should we do? How? With what? Who? When? When do we reassess what we agree on?

What should we do?

Once there is a shared desire to address the causes that have contributed to the problem, the collective consciousness is ready to take concrete action in the community—for example, building a bridge to speed up the delivery of food and the transportation of local products to market. In addition, managerial actions are taken at higher levels in the corresponding sectors that have been called upon to provide technical support—for example, training in the design and construction of a simple water chlorination system, or in the optimized production of carotene-rich native foods.

How?

This question refers to the strategy chosen for carrying out a given task. At this point, the sectors define and sometimes redefine their actions, depending on available technical and human capacity. It would not be unusual, following the analysis, to invite an expert to give a talk on family planning if this were the only human resource available in a given locality.

With what?

At this point consideration is given to the human, natural, and financial resources available to the community itself or their complement (i.e., those managed by the State), or else activities that could finance a given project or program, should such a possibility be under discussion.

When?

The timetable, which is decided on collectively, will depend on the time needed by those involved and on the urgency of solving the problem. Problems resulting from natural disasters require immediate action.

Who?

In this step, responsibilities are decided on for the people or groups involved (for example, child care or construction of a water chlorination system, manually built bridge, etc.). These responsibilities can be assigned to a community leader, an administrative committee, a sectoral representative, mothers' clubs, etc..

Evaluation

The actions taken once the tasks have been identified need to be evaluated by the community, including all its actors. In this exercise, which is more like an evaluation process, the focus is on whether the problem persists or whether its causes have been eliminated and it has disappeared. It is also important to analyze the performance of tasks by the responsible individuals or groups and the utilization of financial resources, as well as human resources if applicable.

This is a tool for working with groups. The only way it can yield value added is when it is actually used in practice, or better yet, when it is used as a means of following up on actions and commitments mandated by the group after it has been applied to addressing any problem that the group decides to work on.

ANNEX 3

Agenda and Group Working Guides for the Grassroots Planning Workshop

I) FOREWORD

The process of community participation is both a means and an end in itself, geared in this case to helping improve family and community practices in child care and protection. In order for it to take place, a deliberate and conscious decision must be made to involve all the social actors of the community in this effort.

The Grassroots Planning Workshop provides an opportunity to come together, interact, and learn, with the various social actors assuming different positions, roles, and functions. Here they address the subjects of child and maternal health, the nature of the local epidemiological profile, the key practices that pose problems, and the causes and consequences of these problems. The participants attempt to discover the underlying reasons and the factors that contribute to the problems in order to gradually develop collective activities that will trans-

late into social practices that encourage families to adopt the key practices.

This workshop is the final stage of participatory local assessment, after the baseline surveys and focus groups have been conducted to learn about the situation and the extent to which the key practices are followed. The Grassroots Planning Workshop examines the causes in depth and proposes actions in the form of a plan of work prepared by the social actors themselves.

2) OBJECTIVES

- Prepare a plan of work that reflects discussion and analysis by the grassroots population, community leaders, and public and private organizations about addressing the child and maternal health problem.
- Consolidate or strengthen opportunities for coordination and multi-institutional consensus-building through active social participation.
- Develop the elements for formulating a project profile based on a plan of work: the problem, the causative factors, the consequences, and the actions that every social actor expects to carry out.

Inputs

- a) Information from Stage One. Discussion Guide for Participatory Local Assessment:
 - Magnitude of the child and maternal health problem
 - Total population and breakdown by strata
 - Network of health services available
 - Network of social actors available
 - A map or sketch of the local area
- b) Information from Stage Two. Discussion Guide

for Participatory Local Assessment:

- Using output from the baseline survey and focus groups, describe the status of the key practices so that the findings can be presented to the Grassroots Planning Workshop, where priorities can be assigned depending on the magnitude of the problem and the vulnerability of the target population. This point is of vital importance, because, based on the results of the baseline survey and the priorities assigned to the practices, the result becomes strategic input (content) for communicating, stepping up, and generating actions to promote the health of children and pregnant women, as well as actions to prevent illness.
- c) The experience and knowledge of each participant, be they mothers and fathers or part of a network of social actors.

3) METHODOLOGY

Working group sessions

Plenary session

Duration of the workshop: one day and a half (12 hours)

4) AGENDA

DAY 1:

Registration 20 minutes
 Opening Session. 20 minutes
 Introduction of the Participants 20 minutes

DEVELOPMENT OF THE WORKSHOP:

- 1) Opening Presentation:
 Objectives, Methodology, and Expected Outcomes30 minutes
- 2) Analysis of the Local Situation120 minutes

Working Group Session
(Discussion Guide 1: Analysis of the Local Situation)
Plenary Session 30 minutes

Objective: To place the participant within the local situation and assess the strength of the social actors and their networks.

3) Plenary Session 30 minutes

4) The Problem of Child and Maternal Health in the Context of the Local Situation30 minutes

Objective: To share findings about child health problems: the epidemiological profile and the results of the baseline survey and focus groups, which show the status of the key and priority practices.

Matrix to be used for the analysis:

PROBLEM	CAUSES	CONSEQUENCES	ACTIONS
The central problem (death or disease in children and their mothers) or a selected practice that becomes a problem.	<ul style="list-style-type: none"> • In the family and its network • In the community and its actors • In the health services 	Effects foreseen if the problem persists	What should we do?, How? With what? When? Who? How do we evaluate the outcome? All these questions regarding the following causes: a) Family members b) Community c) Health services

– Plenary Session: Presentation of Causes Found in the Family, the Community, and the Health Services

Objective: To share the perceptions about the causes cited by each group, creating an opportunity for debate and analysis with the continuing value-added benefit of interaction.

The plenary will also be devoted to analyzing the consequences of the problem.....45 minutes

6) What to do next? Actions
Working Guide 3: Actions to be Taken ..120 min

Objetivo: Define actions to be undertaken by families, social actors, and the health services related to the main causes of the problem being addressed (child mortality or key practice). In the corresponding plenary session, if the initial input was a key practice, information will be shared about key messages.

Plenary Session: Actions to be Taken . . 30 minutes

7) Establishment of Agreements and Commitments.....30 minutes
Local Authorities

8) Closing Session20 minutes

GRASSROOTS PLANNING WORKSHOP

DISCUSSION GUIDES FOR THE WORKING GROUP SESSIONS

DISCUSSION GUIDE 1:

Analysis Of The Local Situation

The first step is to form three working groups:

- a) Mothers or caregivers;
- b) Local actors, organizations, and institutions;
- c) Health services personnel.

A clean map or sketch of the area will be prominently displayed, and each group will help to fill it in.

- a) The group of mothers or caregivers, speaking for families, will place symbols or icons on the map indicating the women's or community organizations to which they belong, and on a

separate flipchart they will describe the main functions of these grassroots organizations. In addition, this group will list the activities in a typical day, week, and year for the women in their family and the community, as well as their role in child care and self-care.

- b) The group of social actors and local institutions will also list the local institutions and public and private organizations that operate in the particular local area, and, on a separate flipchart, they will describe the functions that they perform in their community. For this purpose, it is helpful to use the following matrix:

LOCAL ACTOR	FUNCTION PERFORMED	PERSONNEL STRUCTURE
MAYOR		
TEACHER		
GOVERNOR		

- c) *The health workers* will indicate the local health services network on the map, including other institutions that provide health services. On a separate flipchart, they will list the hours that the services are open to the public, the problem-solving capacity of each service, and the other health facilities to which cases can be referred in the event of child and maternal emergencies. They will also describe the referral and cross-referral process and the network of CHAs that are involved in working for the community. An added value offered by the health workers is that they can reach the whole population and its various strata, based on the local epidemiological profile, which will also be shown on the map or sketch.

The plenary session following the working groups will be devoted to presenting the conclusions of each group and opening up the subject for discussion among all the participants. This interaction will strengthen the conclusions of each group. The process of incorporating (or excluding) these contributions makes the plenary session a valuable step along the road to analyzing the local situation. The participants in the plenary are situated not only within the geosocial space but also within the network of social actors, the health services, and the setting in which the role and function of mothers and fathers in the status of children and pregnant women is being verified.

DISCUSSION GUIDE 2:

Search For The Reasons Behind The Problem

After the participants have shared and analyzed the central problem (death and disease in children and pregnant women in the particular situation), they are again divided into working groups so that the workshop can now focus on understanding the causes of the problem.

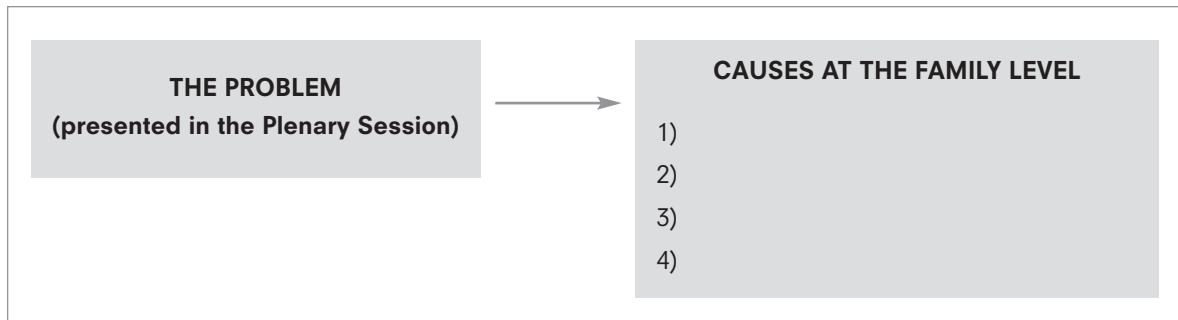
- a) The group of mothers or caregivers, after identifying the problem, will ask, Why does this problem exist? In addition to this general question, they are encouraged to go on and ask specific questions, such as:
- Do mothers believe there are family practices that protect the health of young children?
 - Do they exclusively breast-feed their children?
 - For how many months?
 - Why don't they do so exclusively for six months?
 - At what age do they start to give their children other food besides milk?
 - How often? How much?
 - Do the children, especially those under 1 year of age, get all their vaccinations at a health facility? Why?
 - In malarious areas, does the group believe that children can also be affected? How? Why?
 - Should children continue to be given food when they are sick? Why?
 - When children are treated at the health services, are the recommendations followed? If not, why not?
 - Do you think you know enough about how to play and talk with children to stimulate their language development? Give an example.
 - Do you know how to set limits and get children

to obey you without hitting them or repeatedly shouting at them?

- Do you think that children under 5 or women are physically or psychological abused? If the group wants to answer this question, Why do they think so, and who are most affected by the abuse?
- Do men and boys get involved in the care of younger children?
- Why do you think men don't help with household chores and child care?
- Are children under 5 at risk for accidents? What kinds? Where?
- Do mothers recognize when their children are seriously ill? How do they know?
- Is rapid breathing a sign of danger in an infant under 1 year of age? If so, why?
- Do pregnant women get prenatal checkups? With whom? How often?
- Where do pregnant women deliver their babies?
- If they deliver at home, why don't they go a health center?
- Is the quality of care given to the child better in the hospital or at home? Why?

The questions above correspond to several key practices. If a prioritized list of practices has been produced from the baseline survey, the questions can be targeted more narrowly, focusing in depth on two or three priority practices.

Drawing on the information from the group's responses, identify four or five family causes that account for the role played by the family in child health problems:



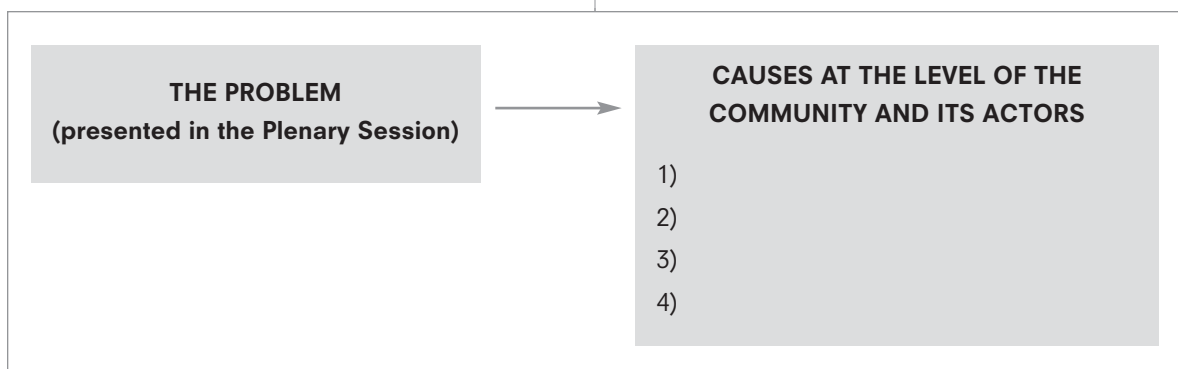
b) The group of local actors and institutions, after identifying the problem, will ask themselves why it exists, and there will be a shower of responses. They will then go on to answer the following questions, incorporating those that the group considers particularly relevant as:

- Is the subject of child and maternal health a priority for local organizations, institutions, and other actors? If so, why? If not, why not?
- If it is a priority, explain how this is manifested at the local level—in other words, what concrete actions show that it has been given importance in the community?
- Does the role to they plan in the community as actors and institutions make it difficult for them, or does it help them, to disseminate health promotion?
- Is child and maternal health a visible agenda in their institutions?
- What coordination and consensus-building mechanisms exist at the local level? Do they work? Give examples. If there are

none, why?

- Which of the NGOs operating in the local area are active in health? What lines of action are they carrying out?
- Do water supply and sewerage systems reach the entire population?
- Do the people drink safe, potable water?
- Is the water contaminated? Is there any correlation between illnesses and the work being done by the local actors?
- Is there an adequate process for solid waste removal and final disposal?
- Are such values as mutual support, reciprocity, and respect for life, especially in the case of children and mothers, expressed through actions? If not, How is it that abandoned children exist who have no hope of being protected by their family, the community, or its actors and institutions?

Based on the responses, the group will assign priority to three or four causes that have direct bearing on the central problem.



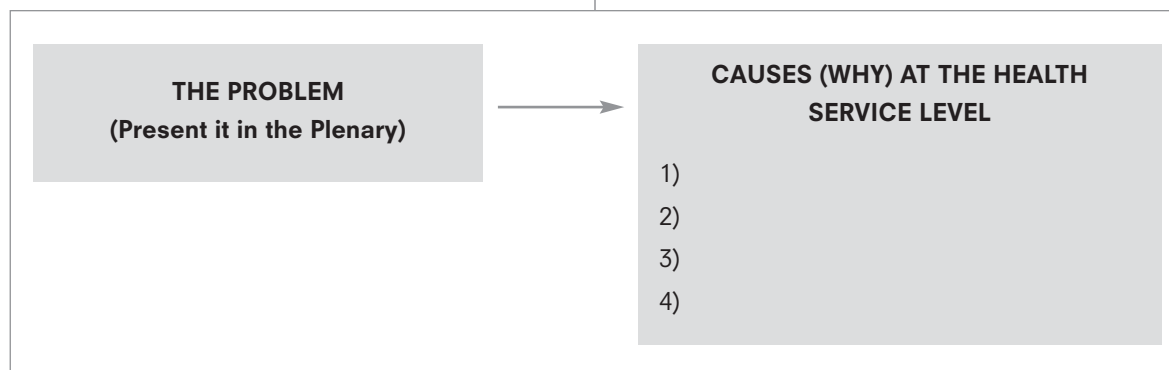
c) The group of health services personnel will consider why the health problem still exists in the local area. Then they will respond to the following questions:

- Is the schedule of service open to the public sufficient? Do they think that the limited availability of health care (in terms of hours) might be regarded as one of the causes? If so, Why?
- Is the way people are treated in the health services a factor that discourages them from going there? If so, Why?
- Are drugs available, especially for children, to treat pneumonia or malaria? Oral rehydration salts? Other supplies? If not, Why not?
- What aspects of care given by the health services discourage mothers and the family from consulting them?
- How are the health services (public health facilities, Red Cross, social security, etc.)

organized in the particular locality in terms of timely and ongoing care for children with common illnesses? How do their referral and cross-referral functions work?

- How are the health facilities in the locality equipped to deal with the common health problems of childhood? Are there intensive care units? Incubators? Operating rooms for performing C- sections?
- How has the IMCI strategy been incorporated into health service operations? What roles and functions are played by the establishment's personnel in those places where the IMCI strategy has been implemented?
- Are there health workers trained in the strategy? Where?

Based on the responses, the group will assign priority to three or four causes related to the health services that it considers important.



La plenaria permitirá que las conclusiones de cada grupo nuevamente se expongan al debate y análisis de los participantes. En este momento, además del inter aprendizaje producto de la opinión de madres, actores sociales y personal de salud, se mejoran las conclusiones y se visibilizan nuevos problemas que los participantes —por su importancia— no habían abordado. La plenaria se constituye en un espacio de generación inicial de valores compartidos con relación al niño y niña y mujer gestante, a partir del consenso y de la interacción.

DISCUSSION GUIDE 3:

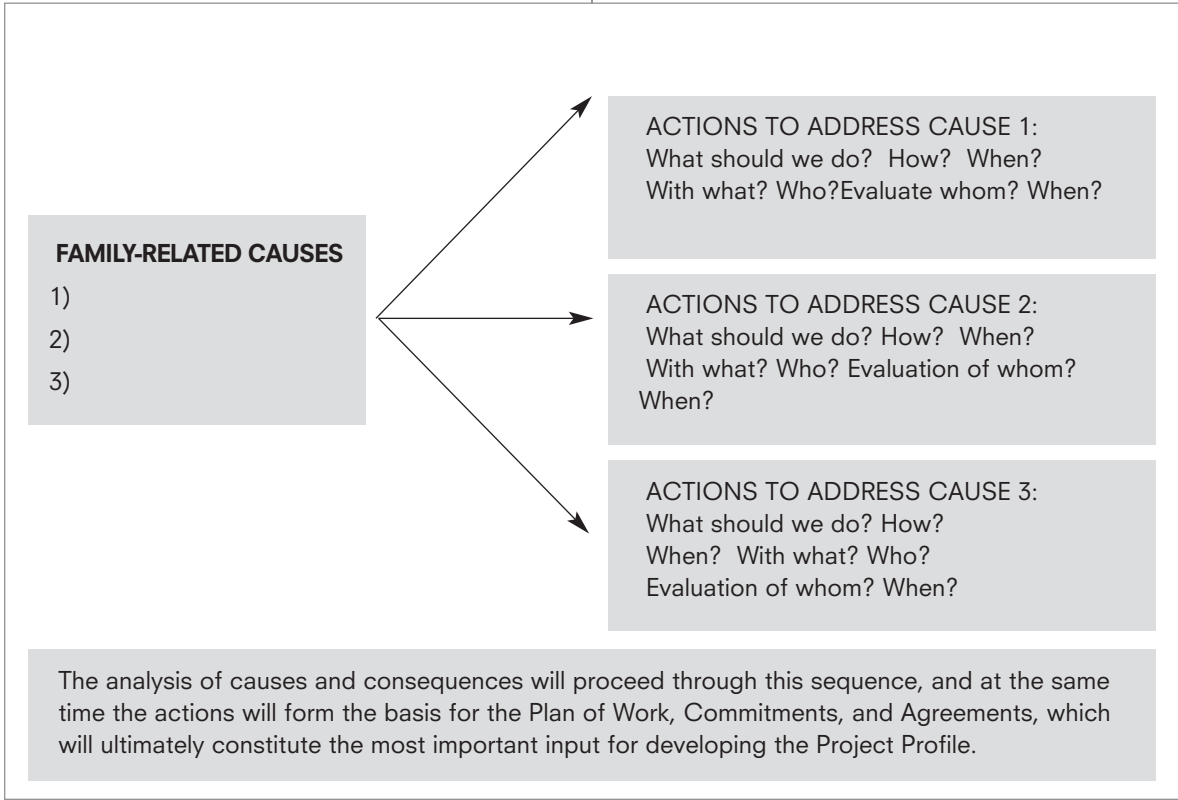
Actions To Address The Problem

After the causes and consequences are understood, the respective groups will look to their own capacity and potential for dealing with the causes that turn the problem into a public health challenge at the local level.

- a) In their working group, the mothers or child caregivers will have assigned priority to four

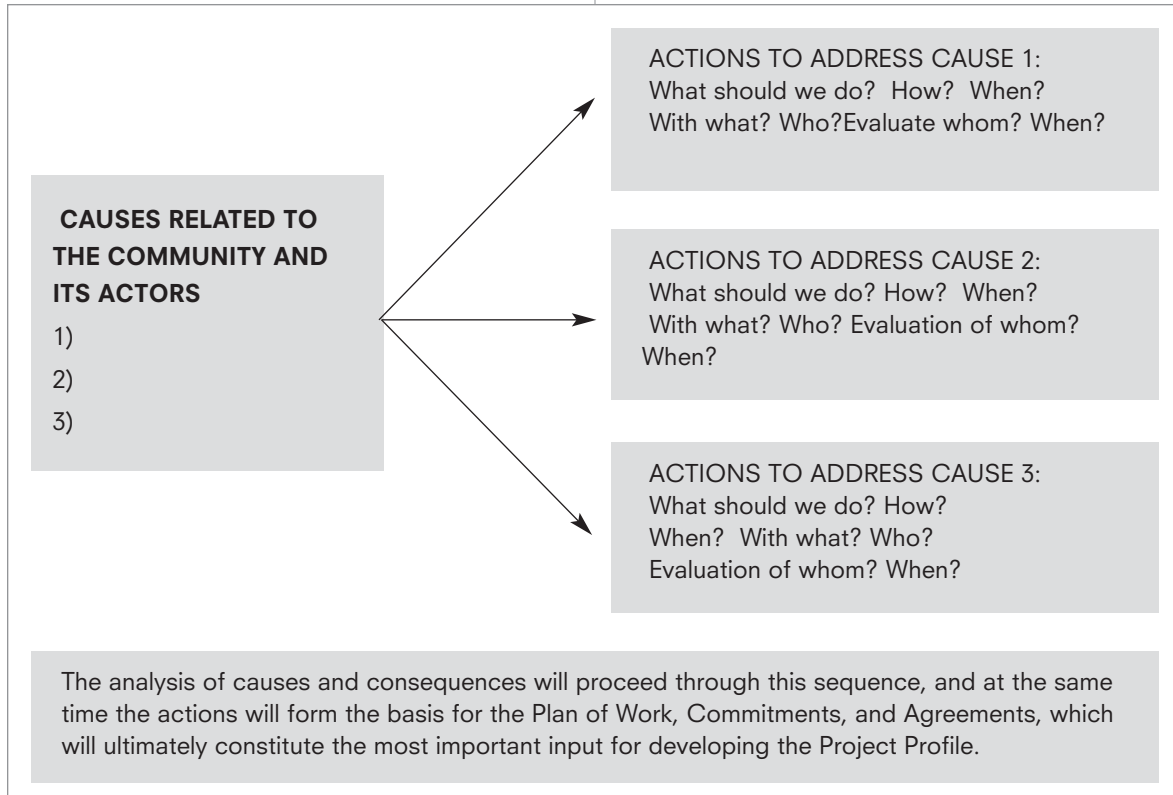
causes that contribute to the central problem in the community; in the plenary session, they will examine the general consequences of this problem and then decide on actions for dealing with the causes.

For each priority family-related cause, the following questions will be asked:
 What should we do? How? With what?,
 When? Who? How do we evaluate it?



b) The group corresponding to the community and its actors will also have identified certain

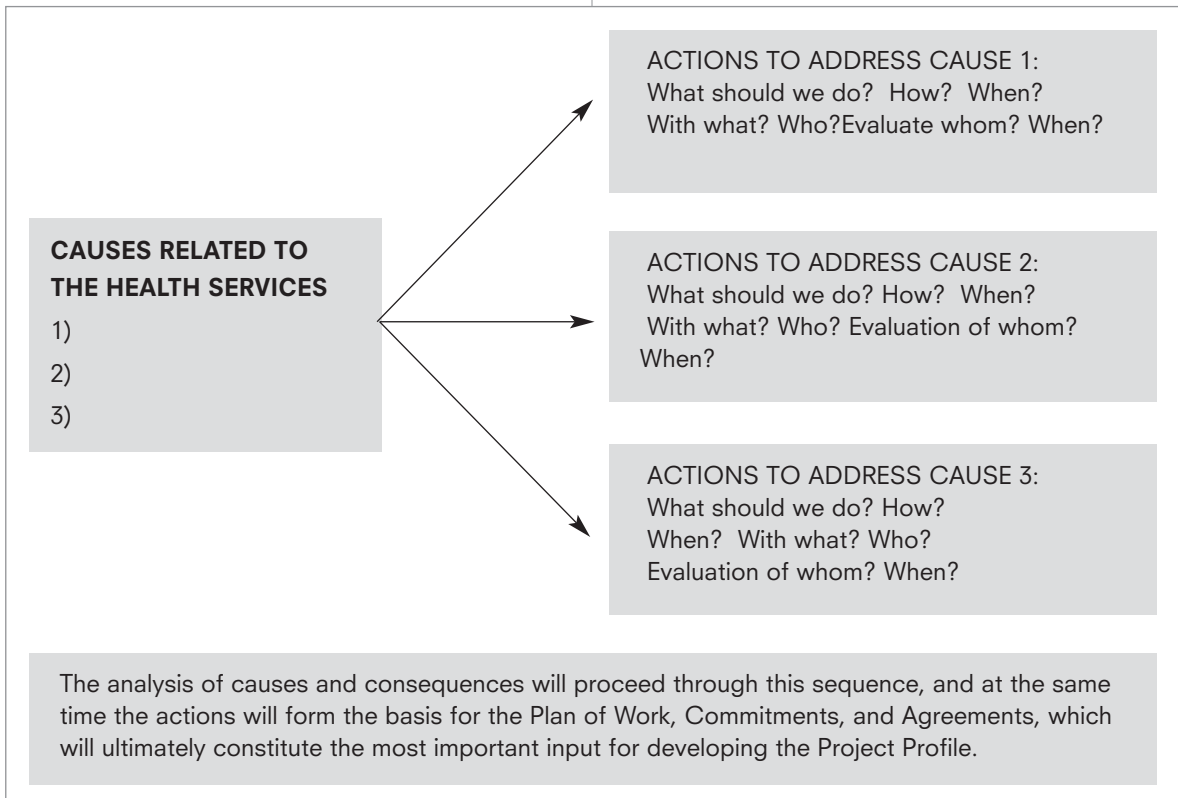
priority causes, which will serve as the basis for actions. How do we evaluate these?



c) For each health-services related cause that has been identified and assigned priority, the group will answer the questions below. By answering them, they will be creating actions to be taken

by the health agencies to reduce the problem:

What should we do? How? With what? When?
Who? How do we evaluate it?



EXAMPLE OF OUTCOME FROM A GRASSROOTS PLANNING WORKSHOP

THE PROBLEM	CAUSES	EFFECTS	ACTIONS
<p>In the Pucarita area, 50* children under 5 died from complications of diarrheal diseases, respiratory infections, and malnutrition in 1999-2000. There are also problems stemming from delivery at home by midwives and others.</p> <p>* Information from the Pucarita civil registries (based on burials at the Pucara Cemetery, the only formal graveyard). The civil registries do not have any information on burials in the 8 clandestine cemeteries in the Pucarita area.</p>	<p>FAMILY-RELATED</p> <ol style="list-style-type: none"> 1. Mothers do not have enough knowledge about how to care for young children or about prenatal care. 2. Mothers who work outside the home leave young children in the care of older children and sometimes lock them up inside the house. 3. Family violence, both parents abusing children and husbands abusing their wives, occurs for various reasons, including the consumption of alcohol. <p>RELATED TO SOCIAL ACTORS</p> <ol style="list-style-type: none"> 1. Neighborhood councils, actors in the health field, and teachers are unaware of the important role they can play in promoting child and maternal health. 2. Appropriate educational methodologies are not being applied to inform, educate, and train all the actors in the community, including those in the health field. 3. Most drinking water comes from wells, and there is insufficient knowledge about water quality. <p>RELATED TO THE HEALTH SERVICES</p> <ol style="list-style-type: none"> 1. The number of hours open to the public (6 h, Monday through Friday) is insufficient. 2. Patients have been mistreated, and the public is afraid to go for prenatal and delivery care. 3. Knowledge about the IMCI community component is limited, and there is no simple model for active community surveillance. 4. There is a shortage of alternative remedies for infectious diarrheal diseases (dysentery) covered by basic health insurance. 	<p>More death</p> <p>More poverty</p> <p>Family breakdown</p>	<p>FAMILIARES BY FAMILY MEMBERS</p> <ol style="list-style-type: none"> 1- a. Workshops and neighborhood Councils. b. Periodic meetings of organized women's groups. 2- a. Promotion of use of day-care centers. b. Information targeted toward caregivers of young children (caregivers older than 12 years of age). c. Periodic meetings of women. 3- a. Research on the causes and effects of family violence. b. Workshop on presentation and discussion of causes and effects of family violence. c. Periodic informal meetings with men and parents to discuss the problem of family violence. <p>BY LOCAL ACTORS</p> <ol style="list-style-type: none"> 1- a. Training for the secretaries of health in the 52 neighborhood councils: child health and risk mapping. b. Training for school boards (2 per board) and the school superintendent (1 adviser per school). 2- Adult education workshops for neighborhood councils, teachers, and health workers. 3- a. Consciousness-raising sessions with neighborhood councils. b. Measures to control water quality. <p>BY THE HEALTH SERVICES</p> <ol style="list-style-type: none"> 1- Meetings, management at the district and headquarters level. 2- a. Self-appraisal meetings. b. User satisfaction surveys. c. Suggestion box. d. Adaptation to local customs related to delivery. e. Workshop on service quality. 3- a. technical Assistance on clinical and community IMCI. b. Model of active community surveillance. 4- Revolving drug fund, including support for less-advantaged families.



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