Working with Individuals, Families and Communities to Improve Maternal and Newborn Health

A Toolkit for Implementation

Module 2:
Facilitator's Guide to the Orientation Workshop on the IFC Framework

World Health Organization

Enfants du Monde

Pan American Health Organization
World Health Organization
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Contents: Module 1: An overview of implementation at national, province and district levels; Module 2: Facilitator's guide to the orientation workshop on the IFC framework; Module 3: Participatory community assessment in maternal and newborn health; Module 4: Training guide for facilitators of the participatory community assessment in maternal and newborn health; Module 5: Finalizing, monitoring and evaluating the IFC action plan.

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ACRONYMS

IFC	Individuals, Families and Communities (In reference to the World Health Organization's framework for Working with Individuals, Families and Communities to Improve Maternal and Newborn Health)
MoH	Ministry of Health
MNH	Maternal and newborn health
NGO	Non-governmental organization
PCA	Participatory community assessment
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Tell us what you think!

All comments on this document are welcome. Please let us know if you find the content useful, your experience in using this guide, if there is any information missing, or if there is anything else you would add to this guide. Please send all comments to the Department of Maternal, Newborn, Child and Adolescent Health (MCA), World Health Organization (WHO), Geneva, to mncah@who.int.

THE STORY OF THE TOOLKIT

In 2003, The World Health Organization (WHO) published a concept and strategy paper entitled *Working with individuals, families and communities to improve maternal and newborn health*,[1] herein referred to as the "IFC framework".

The IFC framework was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries.

Soon after its publication, countries began to ask how to implement the Framework and how to operationalize the key themes of empowerment and community participation. This is where the story of the five modules included in this document, *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, begins.

The work of all five modules was done under the technical supervision of Anayda Portela, WHO/ Department of Maternal, Newborn, Child and Adolescent Health (WHO/MCA) in Geneva. The modules related to the participatory community assessment (PCA) were developed under the guidance of Anayda Portela, Carlo Santarelli of Enfants du Monde and Vicky Camacho, then the Regional Advisor on Maternal Health to the Pan American Health Organization (PAHO). Each module has a series of authors, reviewers and country experiences.

We have attempted to mention all the teams and moments involved below. Some individual names may not be cited, however we wish to convey our gratitude to every person and country team who has contributed, and regret any contributions which may have been overlooked or not specifically mentioned.

The first work on the PCA and the corresponding *Guide to train facilitators* began in 2005. In response to country requests in Latin America, Vicky Camacho proposed an adaptation of earlier MotherCare work and of the Strategic Approach developed by WHO/Department of Reproductive Health and Research. Veronica Kaune, a consultant from Bolivia, developed the first guide for PCA, which was reviewed by an expert group including Fernando Amado, Angela Bayer, Lola Castro, Colleen B. Conroy, Julio Córdova, Luís Gutiérrez, Martha Mejía, Rafael Obregón, and Marcos Paz.

A meeting was held in El Salvador in September 2005 to review the PCA with representatives from Bolivia, El Salvador, Honduras, and Paraguay. After the first pilot experiences in El Salvador and Paraguay, the PCA was modified to simplify the process and reporting to ensure that a country could integrate it into its ongoing planning processes.

Kathryn Church, a consultant supported by funding from Enfants du Monde and PAHO, then went to El Salvador to support the national IFC committee in a next country experience. The MIFC committee included representatives of the Ministerio de Salud Pública y Asistencia Social (MSPAS), Concertación Educativa de El Salvador (CEES), Fundación Maquilishuat (FUMA), CREDHO, and PAHO EL Salvador. The PCA was conducted in Izalco and Nahuizalco with support from local facilitators, the health units and the SIBASI of Sonsonate.

[1] Please see http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/

Special mention is made of the work in El Salvador who was a pioneer in leading the IFC implementation in the Americas Region, and the PCA was subsequently reformulated on the basis of these experiences.

The El Salvador team included: Jeannette Alvarado, Tatiana Arqueros de Chávez, Carlos Enríquez Canizalez, Luís Manuel Cardoza, Virgilio de Jesús Chile Pinto, Hilda Cisneros, Morena Contreras, Jorge Cruz González, William Escamilla, Jessica Escobar, Elsa Marina Gavarrete, Melgan González de Díaz, Edgar Hernández, María Celia Hernández, Pedro Gonzalo Hernández, José David López, José Eduardo Josa, Carmen Medina, Emma Lilian Membreño de Cruz, Ana Dinora Mena Castro, Ana Ligia Molina, Sonia Nolasco, Xiomara Margarita de Orellana, Ever Fabricio Recinos, Guillermo Sánchez Flores, Lluni Santos de Aguilar, Luís and Valencia. Maritza Romero of PAHO was instrumental in supporting the process.

Kathryn Church was subsequently hired by WHO Geneva to work with Anayda Portela to simplify the PCA based on the El Salvador experience; thereafter what are now Modules 1, 3 and 4 were produced.

Carlo Santarelli of Enfants du Monde also provided important input into this work. Subsequent experiences led to further refinement of these Modules: 1) in Moldova and Albania with the support of WHO Europe and Isabelle Cazottes as a consultant, and 2) in Burkina Faso with the support of the Ministry of Health (Minstère de la Santé), Enfants du Monde and UNFPA.

Isabelle Cazottes was then hired by WHO Europe to work with WHO Geneva (Anayda Portela and Cathy Wolfheim) to develop an Orientation Workshop for the IFC framework and implementation, which served as the basis for what is now Module 2.

The workshop was based on training guides developed for the introduction of the IFC framework and implementation process used in regional workshops in Africa, Europe, Eastern Mediterranean, the Americas and Southeast Asia (workshops organized by the WHO Regional Offices of Africa, America, Europe, Eastern Mediterranean, South East Asia and Western Pacific). Module 2 was subsequently finalized by Janet Perkins, consultant to WHO, Anayda Portela, and Ramin Kaweh. A version was tested by the Enfants du Monde team with the local IFC committee in Petit-Goâve, Haiti.

Module 5 was begun by the health team at Enfants du Monde including Cecilia Capello, Janet Perkins and Charlotte Fyon, working with Anayda Portela of WHO. Carlo Santarelli and Alfredo Fort, Area Manager for the Americas Region, WHO Department of Reproductive Health and Research at the time, provided inputs. Different sections of the module were subsequently reviewed by the regional coordinators of Enfants du Monde, the national MIFC committee in El Salvador, Ruben Grajeda of PAHO, Aigul Kuttumuratova of WHO/EURO, Raúl Mercer and Isabelle Cazottes. The module was finalized by Janet Perkins as a consultant to WHO Geneva.

Janet Perkins, as a consultant to WHO Geneva, did a final technical review and edit to harmonize all five modules. Jura Editorial copyedited Modules 1, 3 and 5. Yeon Woo Lee, an intern with WHO/MCA, updated the references to ensure compliance with the WHO style guide. Pooja Pradeep, an intern with WHO/MCA, reviewed all the modules after the editor changes were incorporated. Amélie Eggertswyler, intern with Enfants du Monde, and Hanna Bontogon, intern with WHO/MCA, reviewed the layout of Module 1. Francesca Cereghetti, also intern with Enfants du Monde, reviewed the layout of Modules 1 and 5, and Saskia van Barthold, intern with Enfants du Monde, reviewed the layout of Modules 2, 3 and 4.

The toolkit, in different stages of development and in various degrees, has been used in the following countries: Albania, Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People's Democratic Republic, Paraguay and the Republic of Moldova. We have learned from each of these experiences and have tried to incorporate the learning throughout the toolkit's development.

Such a document can only be useful if it is adapted to each context, and we have intended for it to be a living document – that improves with each use and each reflection. Thus this story will continue.

Financial support for the development of the modules over the years has been received from Enfants du Monde, WHO, PAHO, WHO/EURO, the EC/ACP/WHO Partnership and the Norwegian Agency for Development Cooperation.

INTRODUCTION TO MODULE 2

This document is the second module of a series entitled *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, designed to support the implementation of the World Health Organization (WHO) framework *"Working with individuals, families and communities (IFC) to improve maternal and newborn health"*,[2] herein referred to as the "IFC framework."

The IFC framework, originally elaborated in 2003, was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries. Grounded on the foundational principles of health promotion as outlined in the Ottawa Charter,[3] the framework and the interventions it proposes were formulated based on an examination of evidence and successful experiences in working with individuals, families and communities to improve MNH.

This evidence was updated in 2015 and we refer the reader to the publication *WHO recommendations on health promotion interventions for maternal and newborn health*, available at http://who.int/maternal_child_adolescent/documents/health-promotion-interventions/en/.

To date, the IFC framework has been implemented in a number of countries spanning the six world WHO regions, including: Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People's Democratic Republic and the Republic of Moldova. The aim of the toolkit is to support public health programmes in launching a process to work with and empower individuals, families and communities to improve MNH.

[2] See the following strategic document: Working with individuals, families and communities to improve maternal and newborn health, WHO, 2010.
[3] See WHO, 1986.

The implementation toolkit contains five modules, as described in the following table:

Module	Description
Module 1: An Overview of Implementation at National, Province and District Levels	An introduction to the process of initiating implementation of the IFC framework at national, province and district levels.
Module 2: Facilitators' Guide to the Orientation Workshop on the IFC Framework	**A resource guide for conducting a workshop to orient national, province and district actors to the key concepts, processes and interventions of the IFC framework.**
Module 3: Participatory Community Assessment in Maternal and Newborn Health (PCA)	An overview on conducting the PCA, a participatory tool designed to support district-level actors to assess the MNH situation and needs and to identify priority interventions for IFC implementation.
Module 4: Training Guide for Facilitators of the Participatory Community Assessment (PCA) in Maternal and Newborn Health	A guide to support training of facilitators to conduct the PCA.
Module 5: Finalizing, Monitoring and Evaluating the IFC Action Plan	A guide to support the finalization of the IFC action plan based on the PCA, including suggestions for monitoring and evaluation.

As outlined in the above table, this module contains a guide for conducting a workshop to orient actors to the key concepts, principles and interventions of the IFC framework. This is a critical step in IFC implementation as it contributes to gaining the support of key actors, institutionalization of the Framework and building in-country capacity to manage implementation processes.

Participants

This workshop is designed for MNH programme managers and actors who may be involved in implementation of the IFC component of the MNH strategy at the national and province level and by district actors whose district(s) have been selected for initial implementation of the component. These actors may be from Ministry of Health (MoH), Ministry of Education, representatives from international organizations (WHO, UNFPA, UNICEF, etc.) representatives from non-governmental organizations (NGOs) and others working in MNH. Ideally it will include decision makers to assure that the plans developed during the workshop can move forward.

When to hold the workshop?

This workshop is designed to be held as one of the first steps of IFC implementation when the Framework is first introduced in a country or province. During the workshop the participants will make preparations for the PCA and for coordination and moving the IFC component forward in the country. As such, it is ideally conducted early on in the process so as to facilitate implementation.

Facilitators

An expert facilitator will be responsible for conducting the workshop. The expert facilitator should be very familiar with the IFC framework and will ideally have experience in its implementation in different countries. The expert facilitator may be supported by international experts.

In addition, there will ideally be 2-3 other facilitators working under the direction of the expert facilitator. These facilitators will assist in organizing the workshop, present sessions and support groups during the group work.

Tips for facilitators

It is important to encourage all participants to actively participate in the workshop, in particular members attending from the district who may feel less comfortable in this environment. Try to remain within the agenda timing and be sure to prioritize health and lunch breaks and ending on time.

As the facilitator it is important to pay attention to the energy level of the group. We suggest that you conduct energizers throughout the workshop to keep the group motivated and build relationships between participants. A couple of ideas for energizers can be found in Annex 1 and 2.

Adapting the workshop

Prior to conducting the workshop, carefully review the contents of this resource manual and tailor it to the country context and needs. For example, review the Power Walk and try to use characters and statements to reflect local realities. Also particularly for Day 2, for the morning sessions “IFC framework: Key concepts, strategies and interventions” or “Community and intersectoral participation in maternal and newborn health programmes”, you may have relevant interventions or programmes being implemented in the country which you would like to share with the participants. You should do so, but will need to remove or adjust other content according to the allotted time.

Navigation Meeting

Participation is an important focus of the IFC framework and, as such, it is important to maintain principles of participation and allow participants to have a voice in the workshop. To ensure that there are mechanisms for participants' feedback and shared decision-making, we suggest organizing "Navigation Groups". At the end of each day, divide the plenary into 4-5 groups. Ask them to discuss the following questions:

1. What went well today during the workshop?

2. What could be improved?

3. Do you have suggestions for other issues (e.g., logistics, breaks, etc.)?

Each Navigation Group selects one Navigator to represent them during a Navigation Meeting.

The Navigation Meeting is conducted immediately after the close of the day. The Navigators meet with the facilitators for approximately 30 minutes to provide feedback. This meeting provides workshop facilitators a chance to understand the opinions of participants and respond to their needs in order to improve the workshop.

The following morning, the Navigators who attended the Navigation Meeting give a brief summary of the discussion and the changes proposed. Ideally, Navigators should change on a daily basis, i.e., a participant should serve as a Navigator only one time, allowing multiple participants to act as Navigators.

This feedback mechanism gives participants a voice by adjusting the workshop programme and ensuring that the participants' learning needs are met.

Personal Diary

We suggest providing each participant with a notebook to serve as a personal diary. They can use the diary to take notes during the sessions. In addition, you can leave some time at the end of each day for them to write down their reflections. A special session is reserved for the final day for participants to write down commitments to changes to themselves (their own way of working) and in their workplace (changes they can promote or facilitate within their working environment or within the team with whom they work).

WORKSHOP AGENDA

DAY 0		
Time	**Activity**	**Materials**
15.00-19.00	Arrival of participants • Welcome • Registration • Distribution of materials	
19.00-20.00	Facilitators' meeting • Final review of the agenda (order, material, logistics, flow, introduction, etc.) • Prepare room	• Table/chairs • Material on table • Beamer/projector, computer, laser pointer • Flipchart/markers • Other props

DAY 1			
Time	**Sessions**	**Materials**	**Presenter**
8.00-8.30	Welcome Tea & Coffee	Tea and coffee	
8.30-9.30	Workshop opening • Opening ceremony • Opening speeches • Workshop welcome		Chairperson Ministry of Health WHO representative Representatives from other partner organizations Facilitator
9.30-10.30	1. Overview of maternal and newborn health • The national and district maternal and newborn health strategies (25 minutes) • Key indicators and data at the national and district level (20 minutes) • Plenary discussion (15 minutes)	Beamer/projector PowerPoint 1: The national and district maternal and newborn health strategies PowerPoint 2: Maternal and newborn health data and key indicators at national and district level National and district MNH strategy documents	Facilitator National or district Ministry of Health
10.30-11.00	Health Break	Tea and coffee	
11.00-12.30	2. Analysis of challenges and solutions for maternal and newborn health • Why did Mrs X die? (30 minutes) • Group Work 1 (60 minutes)	Beamer/projector Flipchart/markers "Why did Mrs X die?" video or story translated in local language with illustrations to be projected as overheads Worksheets for group work	Facilitator

DAY 1			
Time	**Sessions**	**Materials**	**Presenter**
12.30-14.00	Lunch		
14.00-14.30	2. Analysis of challenges and solutions for maternal and newborn health • Presentations in plenary (30 minutes)		Groups
14.30-15.30	3. Power Walk • Power Walk exercise (30 minutes) • Power Walk discussion (30 minutes)	Large space Power Walk roles for participants on cards Flipchart/markers	Facilitator
15.30-16.00	Health Break	Tea and coffee	
16.00-16.30	Day 1 Recap and Navigation Meeting • Review of Day 1 • Diary reflections • Group work in Navigation Groups	Personal diaries Sheets of paper on every desk	Facilitator
16.30	End of Day 1		
16.30-17.00	Navigation meeting • Roundtable discussion among facilitators and Navigators	Facilitator takes notes	Facilitator and 4-5 Navigators

DAY 2			
Time	**Sessions**	**Materials**	**Presenter**
8.00-8.30	Welcome Tea & Coffee	Tea and Coffee	
8.30-9.00	Welcome and Day 1 review • Recap of Day 1 • Navigation meeting debrief		Facilitator Rapporteur
9.00-10.30	4. IFC framework: Key concepts, strategies and interventions • Present PowerPoint 3: IFC framework key concepts and principles (20 minutes) • Plenary exercise: Empowerment case studies (25 minutes) • Present PowerPoint 4: Key interventions of the IFC framework (20 minutes) • Plenary exercise: IFC intervention case studies (25 minutes)	PowerPoint 3: IFC framework key concepts and principles PowerPoint 4: Key interventions of the IFC framework Case studies Flipchart/markers	Invited specialist
10.30-11.00	Health Break	Tea and coffee	

DAY 2			
Time	**Sessions**	**Materials**	**Presenter**
11.00-12.00	5. Community and intersectoral participation in maternal and newborn health programmes • Present PowerPoint 5: Community and intersectoral participation (30 minutes) • Group work 2: Review of current and potential community and intersectoral collaboration (15 minutes) • Presentations in plenary (15 minutes)	Beamer/projector PowerPoint 5: Community and intersectoral participation Flipchart/markers	Invited specialist
12.00-12.30	6. Introduction to the Participatory Community Assessment (PCA) • Present PowerPoint 6: Introduction to the PCA (30 minutes)	PowerPoint 6: Introduction to the PCA	Facilitator
12.30-13.30	Lunch		
13.30-14.00	Energizer (Optional)	See Annex 1 or 2	Facilitator
14.00-15.30	6. Introduction to the Participatory Community Assessment (PCA)(cont.) • Discussion in plenary (30 minutes) • Group work 3: Review of PCA guides (30 minutes) • Presentations in plenary (30 minutes)	Flipchart/markers PCA guides for each participant	Facilitator/groups
15.30-16.00	Health Break	Tea and coffee	
16.00-16.30	6. Introduction to the Participatory Community Assessment (PCA)(cont.) • Presentations in plenary, cont. (30 minutes)	Flipchart/markers	Groups
16.30-17.00	Recap and Navigation Meeting • Brief review of topics from the day • Diary reflections • Group work in Navigation Groups	Personal diaries Sheets of paper on every desk	Facilitator
17.00	End of Day 2		
17.00-17.30	Navigation Meeting • Roundtable discussion among facilitators and Navigators	Facilitator takes notes	Facilitator and 4-5 Navigators

DAY 3			
Time	**Sessions**	**Materials**	**Presenter**
8.00-8.30	Welcome Tea & Coffee	Tea and coffee	
8.30-9.00	Welcome and Day 2 review • Recap of Day 2 • Navigation meeting debrief		Facilitator Rapporteur
9.00-9.30	7. Monitoring and evaluation: Brief overview • Present PowerPoint 7: Monitoring and Evaluating the IFC component (20 minutes) • Discussion in plenary (10 minutes)	PowerPoint 7: Monitoring and Evaluating the IFC component	Invited specialist
9.30-10.30	8. Planning for IFC implementation • Presentation of activities before, during and after the PCA (10 minutes) • Group work 4 (50 minutes)	Table: "Summary of activities before, during and after the PCA" for each participants Terms of Reference for National IFC Committee Terms of Reference for the District IFC Committee	
10.30-11.00	Health Break	Tea and coffee	
11.00 -12.30	8. Planning for IFC implementation (cont.) • Presentations in plenary (60 minutes) • Define the next steps in IFC implementation (30 minutes)	Flipchart/markers	
12.30-14.00	Lunch		
14.00-14.30	9. Commitment: Personal Next Steps	Personal Diaries	
14.30-15.30	Closing • Recap of workshop • Evaluation sheets • Final bang • Closing remarks and speeches	Evaluation sheets for each participant	
15.30	End of Workshop		
15.30-16.00	Facilitators' meeting/debrief		

DAY 1

WORKSHOP OPENING

Time: 1 hour

Objectives

- To welcome participants to the workshop;
- To familiarize participants with the objectives of the workshop.

Instructions to facilitator

The facilitators will be responsible for organizing the workshop opening according to local norms; however, it will typically include the following:

- **Opening ceremony (20 minutes)**

- **Opening speeches (20 minutes):** These may be delivered by Ministry of Health; a representative of WHO; representatives from other partner organizations; etc.

- **Workshop welcome (20 minutes):** This is delivered by the facilitator. You may want to provide an overview of the content and the purpose of the workshop and briefly go through the agenda. It is important that the participants know what to expect from the workshop. You may also wish to discuss organizational issues.

SESSION 1:
OVERVIEW OF MATERNAL AND NEWBORN HEALTH (MNH)

Time: 1 hour

Objectives

Participants will:
- Become familiar with the national and district MNH strategies;
- Understand key indicators and data on MNH at the national and district level.

Instructions to facilitators

- **Present PowerPoint 1: The national and district MNH strategies (25 minutes).** This PowerPoint will need to be prepared ahead of time and will typically include the MNH polic, characteristics of the MNH system, and a summary of key activities underway in the country to address MNH. Ideally it will highlight any community components of the strategy. Provide participants with the related strategic documents if possible.

- **Present PowerPoint 2: MNH data and key indicators at national and district level (20 minutes).** This presentation is to be prepared by the national team and will ideally include the following: An overview of MNH data including morbidity and mortality, causes, data related to use of care (routine and emergency), to care in the household – if there is specific data from the district this should also be presented.

- **Questions and group discussion (15 minutes):** Ask the group whether they have any questions for the presenters or any insights they would like to contribute.

SESSION 2:
ANALYSIS OF CHALLENGES AND SOLUTIONS FOR MNH

Time: 2 hours

Objectives

Participants will:
- Understand the general MNH context;
- Understand the factors contributing to poor MNH;
- Brainstorm, discuss and identify key MNH challenges and potential solutions;
- Produce a table outlining challenges and solutions.

Instructions to facilitators

- **Briefly introduce the session:** Many factors influence health. This is particularly true in MNH. This session will help us to better understand the different factors which influence MNH and to understand why it is important to work with individuals, families and communities to improve MNH.

- **Tell the story (see Annex 1) or watch the video[4] of "Why did Mrs. X die?" (30 minutes):** The video is available in English and may be accessible in other languages as well. If the video is not available in the required language, have the story translated prior to the workshop. Project the illustrations as the story is read.

- **Ask the participants if they have any questions.** Explain that you will not go into a plenary discussion on the story, but they will be able to use it as a reference during the upcoming group work. They will be able to discuss the story in greater detail during the Group Work presentations.

- **Introduce Group Work 1 (60 minutes for group work):** Mention that often there are many problems encountered at each of the different moments in Mrs X's story, and you would like them to discuss in small groups some of the different problems that are faced in assuring the appropriate care at each moment and then discuss some of the solutions.

  Explain that the participants will be divided into six small discussion groups ("buzz groups") as follows:

  1. Care of the woman in the household

  2. Care of the newborn in the household

  3. Support in the community for the woman's health

  4. Support in the community for newborn health

  5. Care received from the health services for the woman

  6. Care received from the health services for the newborn

[4] "Why did Mrs. X Die, Retold" video can be accessed at: https://vimeo.com/52622204

Each group will fill out the worksheet on the next page in their buzz group. They should consider the data reviewed earlier this morning in their discussions:

1. Ask each group to list two possible reasons for insufficient/inappropriate care or support of the woman and the newborn and the possible reasons for this in their country context.

2. For each reason identified, ask the groups to propose two possible ways to address each reason at the household level, at the community level, at the service level and at the policy level.

3. The buzz groups should now sit together to review the different suggestions and reach consensus on two main reasons and possible actions for each problem, as follows:

   a. GROUP 1 – Buzz groups 1 and 2

   b. GROUP 2 – Buzz groups 3 and 4

   c. GROUP 3 – Buzz groups 5 and 6

	Two main reasons	Possible solutions			
		At the household level	At the community level	At the service level	At the policy level
1. Self-care/ household care of women	1. 2.				
2. Care of the newborn at home	1. 2.				
3. Support in the community for the woman	1. 2.				
4. Support in the community for the newborn	1. 2.				
5. Care received from the health services for the woman	1. 2.				
6. Care received from the health services for the newborn	1. 2.				

- **Presentation of Group Work 1 in plenary (30 minutes):** Allow each group 10 minutes to present their work. Allow for discussion. Discuss with the participants whether this analysis helped them to realize the importance of working with individuals, families and communities, with other sectors beyond the health sector and think about some other key actors that they need to work with.

  [Note to facilitators: The analysis should bring out that health strategies need to go beyond just improving services and that health education is important, but limited in addressing the determinants of poor MNH. The strategy should bring together what can be done at the level of policy, health services, and individuals, families and communities and linkages between the different levels.]

- **Wrap up:** Explain that throughout the course of the workshop, you will discuss more about interventions and processes to address the different problems and needs related to MNH and how to work with the different partners in the solutions. A main point throughout will be that women, husbands/fathers, families and communities are key partners, and that it is therefore important to learn how to work with them.

SESSION 3: POWER WALK[5]

Time: 1 hour

Objectives

Participants will:
- Identify and understand different roles and power structures within society;
- Understand the interactions of gender with other determinants of health;
- Identify key health stakeholders and patterns of health inequalities.

Instructions to facilitators

- **Prior to the Power Walk:** Review the list of "characters" and "statements" of the Power Walk and adapt to local contexts and realities to ensure maximum impact for participants. We have included suggestions here which are not to be considered exhaustive. Your goal is to reveal interactions between gender and other determinants of health and highlight local, vulnerable populations. Select the best characters and statements to achieve this.

- **Introduce the Power Walk (30 minutes for exercise):** Ask all participants to stand up and move to a large open area (be sure to arrange a room/garden/terrace beforehand).

- Ask for 12 volunteers and randomly give them each a small piece of paper with one character listed, such as those suggested in the following table. Ask them to act as the character they selected. Instruct participants not to divulge their "identity" to others in the group.

Doctor in a rural health facility, male, aged 36	Midwife in a rural health facility, aged 28
Nurse working in an urban health facility	Health facility manager, male, in a urban health facility
Pregnant woman, age 22, with secondary education	Mother of five children, age 29, with no secondary education
Health committee chairman	Grandmother taking care of 4 orphans in rural area, no income, no assets
Primary school teacher, female, aged 45	Female sex worker aged 19, living in city, no secondary education
Young unmarried mother of 2, aged 21, living in the capital	Country Representative of NGO, Christian female, 42, living in the capital, university-educated
Village leader, male aged 39, no secondary education	Army general, Muslim male, aged 52
Country representative of NGO, Christian female, 42, living in the capital, university-educated	Ethnically-discriminated male, aged 40, lost a leg in an ambush, 3 wives, 10 children, no income

[5] Adapted from: Gender mainstreaming for health managers: a practical approach. Geneva: World Health Organization; 2011.

- Ask all the participants acting in character to stand horizontally behind the line of the ground, as if starting a race. Explain that you will read a number of statements out loud and ask them to do the following based on their character:

  "If you think this statement is true for you, take one step forward".

  "If you think this statement is not true for you, keep standing where you are."

  "If you think that this statement is partially true for you, take a small step forward."

  Agree on the size of the step beforehand.

- The rest of the group observes and will comment on their reactions following the exercise.

- Read the following statements (or others based on the context):

  1. I feel comfortable to visit the clinic if I have a problem.
  2. I can influence the organization of the clinic so that services for maternal health care and newborn health care are improved.
  3. I can influence whether or not a baby is exclusively breastfed up to the age of six months.
  4. I feel confident that true dialogue and understanding takes place between the health care providers and myself.
  5. I am convinced that if I pay, I will get better service.
  6. I have access to family/household resources if I need to pay for health care.
  7. I feel that health workers treat me with respect.
  8. I know my rights.
  9. My opinion is considered important by municipal or district health officials where I live.
  10. I have completed secondary school.
  11. I am allowed to be treated by a health care provider of the opposite sex.
  12. I have a say in health decisions in my community.

- After the last statement, ask participants to reveal their identity to the group. Instruct them to stay in formation while you discuss the exercise.

- **Power Walk discussion in plenary (30 minutes):** Select a couple of characters from the front cluster to describe their experience and what it felt like to be in those positions. After the group

on the "front cluster" has spoken, tell them that these characters often have the most decision making (and other) power. Note these characters on a flipchart and discuss how women and men are represented in this group.

- Follow a similar process of discussion with characters from the middle cluster. Usually these are community organizations and workers (health and otherwise) – sometimes even including nurses and other health professionals. Note these characters on a flipchart and discuss how women and men are represented in this group.

- Remind participants that these are also important partners to engage with when we want to reach the people at the back. We also want them to be able to say yes more often to the Power Walk statements. Ask participants what strategies could help to accomplish this.

- Use the same process for characters from the back cluster. Note these characters on a flipchart and discuss how women and men are represented in this group. Ask how they felt as they watched others moving forward. If no one else points it out, say that the people at the back are usually those that we are trying to directly benefit with the programmes and policies we develop and usually the most difficult to reach. These are the women and men whose health we are supposed to promote and protect. Why are they at the back?

- Ask participants to now look at how women and men are distributed throughout the Power Walk outcome. Are all the women at the back? All the men at the front? What does this mean in terms of gender? After allowing some discussion, point out that the Power Walk confirms that gender norms, roles and relations can affect men and women in different ways. It also shows that gender interacts with other determinants of health. Use examples within the Power Walk to demonstrate how education, profession, income, age, sex and gender can influence the ability of Power Walk characters to move forward or not.

- Briefly introduce the concept of empowerment: Ask why some characters at the back may not have been able to take a step forward. Introduce the definition of empowerment: **Empowerment is the capacity of individuals or groups to make choices and to transform these choices into desired actions or outcomes.**

- Emphasize the following:

  - The characters in the back cluster often have lower levels of empowerment, which sometimes explains why they have difficulty moving forward.

  - Make the links between empowerment, reducing unequal power relations, and addressing gender inequalities.

  - Ask participants whether they felt empowerment was an obstacle to moving forward.

- **Wrap up:** Tell participants that you will be discussing empowerment in more depth tomorrow and that you will be asking them to refer back to the Power Walk.

DAY 1: RECAP AND NAVIGATION MEETING

Time: 30 minutes

Briefly review the topics addressed during the day (5 minutes)

Diary reflections (10 minutes): Ask participants to take their diaries out. They will have 10 minutes to reflect and record some of their thoughts from Day 1 of the workshop. They may want to write about the most important thing they learnt during the day or how they plan to apply what they have learnt to their work.

Navigation Group Work (15 minutes): Ask the plenary to divide into 4-5 "Navigation Groups". Ask them to discuss the following questions:

1. What went well today during the workshop?

2. What could be improved?

3. Do you have suggestions for other issues (e.g., logistics, breaks, etc.)?

Each Navigation Group will need to select one Navigator to represent them during a Navigation Meeting. This meeting will be held immediately after the close of the workshop and will last approximately 30 minutes. The Navigators will then brief the group on the meeting the next morning. Ideally each Navigator will serve no more than one time in order to allow the maximum number of participants to serve in this function.

DAY 2

WELCOME AND DAY 1 REVIEW

Time: 30 minutes

- Recap of Day 1.
- Navigation meeting debrief.

SESSION 4: IFC FRAMEWORK KEY CONCEPTS, PRINCIPLES AND INTERVENTIONS

Time: 1 hour 30 minutes

Objectives

Participants will:
- Become familiar with health promotion key concepts;
- Review empowerment and the importance of empowerment at the individual and community level;
- Become familiar with the key concepts, strategies and interventions of the IFC framework.

Instructions to facilitators

- **Present PowerPoint 3: IFC framework key concepts and principles (20 minutes)**

- Explain that health promotion and the Ottawa Charter provide the conceptual basis of the IFC framework. Explain that health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. You may want to refer to the story of "Why did Mrs X die?" from the previous day to briefly discuss socioeconomic determinants of health.

- Explain that "empowerment" is a key component of health promotion. As they may recall from the Power Walk yesterday, empowerment can be understood as the process of increasing capacity of individuals or groups to make choices and to transform these choices into desired actions or outcomes. Empowerment occurs at two levels which interact:

  1. The individual level: this involves increasing personal resources, capacities, knowledge, competencies.

  2. The collective level: This involves improving collective actions for access and use of social, economic and political resources.

- Discuss powerlessness and power: Refer back to the Power Walk from the previous afternoon.

- Highlight that participation is essential to empowerment. Participation is the process whereby community members are involved as partners in assessing needs and problems, selecting priorities, developing strategies, planning, implementing, monitoring and evaluating solutions in close cooperation with the formal health sector and other actors.

- **Exercise in plenary (25 minutes):** Explain to the group that you will now review several case studies in plenary. For each study, you would like the group to answer the following questions:

  1. What are the health implications of this situation?

  2. Who has the power and who needs to be empowered?

  3. What actions or interventions can be undertaken to address individual empowerment?

  4. What actions or interventions can be undertaken to address group or community empowerment?

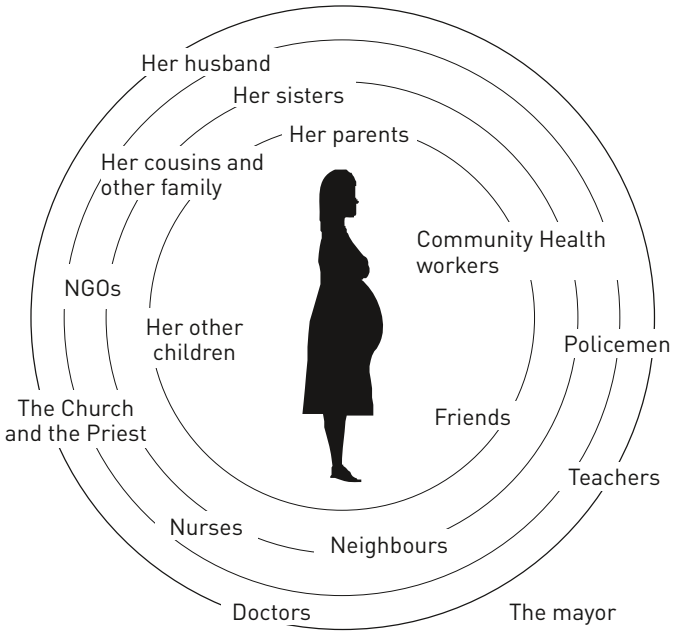
  5. What actions or interventions can be undertaken to address any related policy issues?

- Present **Exercise 1**: Power and household decision making (Read Case study of 'Maria').

Case study of Maria in a small rural community

Women do not make decisions in isolation from the context of their lives and this often involves asking or receiving advice from other family members in their household. Maria, a young mother, has been advised by the health provider to exclusively breastfeed her child until six months. The health provider has explained the nutritional and protective benefits of breastfeeding and showed her how to hold the baby, ensure the baby latches onto the nipple correctly, etc. However, Maria's mother is encouraging her to give the baby honey and telling her that by one month the baby will need to eat a cereal gruel. This is Maria's first child and she is very anxious about giving her baby the best start in life but feels under considerable family pressure to give the baby the cereal gruel.

- In plenary discuss the five questions in relation to this case study.
- You may want to use the following diagram to discuss the different influences on a pregnant woman.



- Present **Exercise 2**: Power and community participation

Case study in Country X

Small rural traditional communities in the northern part of Country X are very poor and have limited access to sexual and reproductive health services and poor access to clean water. The government recognizes the need to increase use of family planning methods and to increase demand for maternity care services. Educational materials will be printed and health providers will be trained.

- Ask the plenary to answer the five questions in relation to this case study.

- Present **Exercise 3**: Power and quality of care

Case study of Pavel in a family health centre

Health providers often work in situations with limited resources, including small number of staff, which affects their ability to perform. Pavel is a family health doctor, responsible for the health centre in an urban neighbourhood. His supervisor at the central level just came back from an important meeting and feels there are some things they need to improve and he knows how. A new health education campaign will be launched and Pavel and the midwife are to hold participatory discussions in the community as part of the campaign efforts. Thus they will need to work two additional nights a week. The midwife said that her family would not agree to this. Pavel felt frustrated and raised his voice and told her there was nothing to discuss.

- Ask the plenary group to answer the five questions in relation to this case study.

- **Present PowerPoint 4: Key interventions of the IFC framework (20 minutes)**

- Explain that the IFC framework was developed based on a review of experiences in different countries and regions and in consultation with international experts. The framework was designed to complement other efforts in the broader MNH strategy which address the service and policy level.

- Present the two primary objectives of the IFC framework:

  1. To contribute to the empowerment of women, families and communities to improve MNH;

  2. To increase access to and utilization of quality health services.

- Introduce the priority areas of intervention:

  1. Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies;

  2. Increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health;

  3. Strengthening **LINKAGES** for social support between women, men, families and communities and with the health care delivery system;

  4. Improving **QUALITY** of care and health services and of their interactions with women, men, families, and communities.

  Emphasize that ideally interventions from each priority area will be implemented simultaneously in order to achieve maximum benefit.

- Introduce the IFC priority areas of health systems strengthening:

  1. Contributing to **PUBLIC POLICIES** favourable to MNH;

  2. Contributing to the **COORDINATION** of actions within the health sector as well as between the health sector and other sectors;

  3. Promoting **COMMUNITY PARTICIPATION** in the management of MNH problems;

  4. Contributing to **CAPACITY BUILDING** of the health workforce in the IFC framework;

  5. Implementing an interinstitutional system of **MONITORING AND EVALUATION** for the IFC component.

  Explain that experience has shown that strengthening the health system within these areas optimizes implementation of interventions by assuring that a foundation for implementation is in place and also contributes to the primary aims of the IFC framework directly. Moreover, action in these areas serves to reinforce the broader health system, paves the way for scaling-up and

fosters sustainability of the IFC framework. Whereas interventions are typically planned for each of the priority areas of intervention, this may not be the case for the areas of health systems strengthening. IFC partners are advised to use the areas for self-assessment on an ongoing basis and plan actions within them when necessary.

- **Exercise in plenary (25 minutes)** (this could also be conducted as group work if time permits): Hand each participant a worksheet with the table below. Explain that you will now use case studies to discuss how the IFC interventions could contribute to improving MNH. Ask the participants to think of one intervention from each of the priority areas of intervention which could contribute to improving MNH as you read each case study and write each intervention under the appropriate area of intervention.

Priority Area of Intervention	Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	Increasing **AWARENESS** of the rights, needs and potential problems related to maternal, newborn health	Strengthening **LINKAGES** for social support between women, families and communities, and with the health care delivery system	Improving **QUALITY** of care, health services and interactions with women, families and communities

- Read Case Study 1: **Eclampsia**

Case Study 1: Eclampsia

During her pregnancy, Sujatmi experienced bad headaches, swelling and blurred vision. Things got worse when she started having seizures, so her mother called a traditional birth attendant (TBA) and a Kyai (Muslim Priest). Evil spirits were blamed for the symptoms, and herbs, water and prayers were prescribed to prevent the early birth of the baby. Only when Sujatmi failed to respond to this treatment, her family decided to take her to a hospital. Her relatives had to borrow a car to take her to the facility located two hours away. Overall it took the family four hours to reach the hospital. Upon arrival, Sujatmi received prompt treatment but the health staff could not prevent the death of her baby inside the womb. Afterwards, Sujatmi started convulsing, her condition worsened and she died on the following day.

Medical cause of death: COMPLICATIONS OF ECLAMPSIA (POISONOUS DEATH)

Source: A case in East Java adapted from "Riwayat Ibu Meninggal Akibat Kehami-Ian", Booklet Depkes RI, WHO, 1997.

- Explain to the participants that while the medical cause of Sujatmi's death was eclampsia; there were many factors that contributed to her death. State that interventions in the IFC framework aim to address these underlying causes.

- Refer participants to the table with the four priority areas and the interventions. Ask the group to brainstorm interventions from each of the four priority areas which could help women to avoid the fate of Sujatmi. Ask them to also think of any interventions not listed in the framework which are being implemented locally and to note these. List these interventions on a flipchart.

- Read Case Study 2: **Ignoring danger signs**

Case Study 2: Ignoring danger signs

Kade was 39 years old and pregnant with her third baby. She had primary school education and worked as a farmer. The birth of her first born daughter, now 14, was assisted by a TBA; during the birth of her second born son she was assisted by a midwife and had a prolonged labour of more than two days. Kade received antenatal care on a regular basis and had no problems until her fifth visit when she felt tightening in her belly. She called the midwife and a TBA who told her the waters had broken but the baby's head was not yet in the right position for birth. The midwife suggested taking Kade to the hospital but the TBA said Kade would give birth the next day, so her husband refused to move her. The TBA felt the progress would be the same as it had been with the birth of Kade's second baby. Time was passing - by now 16 hours of vital time had gone by. The midwife monitored Kade who was stable. And then suddenly she became very pale and sweaty and started shivering and vomiting. She was started on an intravenous drip of glucose (sugar) but after 30 hours of labour her heart rate and blood pressure weakened and she became unconscious. Sadly she died half an hour later.

Medical cause of death: PROLONGED LABOUR

Source: a case study in East Java adapted from "Bunga Rampai Audit Maternal Perinatal di Prop Jawa Timur". Dinas Kesehatan Daerah Propinsi Jawa Timur, 1999

- Explain to the participants that just as in the case of Sujatmi's, the causes of Kade's death go beyond prolonged labour. State that interventions in the IFC framework aim to address these underlying causes.

- Refer participants once again to the table with the four priority areas and the interventions.

- Ask the group to brainstorm interventions from each of the four priority areas which could help women to avoid the fate of Kade. Ask them to also think of any interventions not listed in the framework which are being implemented locally and to note these. List these interventions on a flip chart.

- Read Case Study 3: **Programme Summary**

Case Study 3: Programme Summary

The area of Triángulo Ixil is located in the remote highlands of Guatemala, a zone bound by mountains to the south and the west and from the north surrounded by hills over the tropical forest of Petén. Different barriers were identified that restricted the use of health services, including the women's and the community's lack of confidence in the health services, fear and language barriers. Also, the health personnel were not sensitive to the difficulties in transport, to the time families can take in deciding to seek care, and to the important role that the TBAs can play. The baseline study showed that many women did not have good knowledge of danger signs in newborns in the first hours and days of life. Women also did not know when to seek care for their own health, and decisions makers, such as the husbands, often delayed taking action in the case of obstetric emergencies. Coverage of antenatal care with a skilled provider is low; most births are not delivered by a skilled attendant. Also, Mayan women practice a rite at birth during in which the child is bathed on the floor in extremely cold water.

Source: Adapted from Project Maya Salud Neonatal, part of the Saving Newborn Lives Initiative of Save the Children Guatemala. http://www.comminit.com/en/node/42455

- Referring participants to the table with the four priority areas and the interventions, ask the group to brainstorm interventions from each of the four priority areas which could help improve MNH in Triángulo Ixil. Ask them to also think of any interventions not listed in the framework which are being implemented locally and to note these. List these interventions on a flipchart.

- **Wrap up:** Verify that participants are comfortable with the information from this session. Explain that now that they have an understanding of the IFC framework, its aims and the priority areas of intervention you will now be moving into discussion on how to concretely move the IFC framework forward in the country.

SESSION 5:
COMMUNITY AND INTERSECTORAL PARTICIPATION AND CURRENT PLANNING

Time: 30 minutes

Objectives

Participants will:
- Become familiar with community participation;
- Understand principles of participation in planning processes;
- Discuss current planning processes in the country.

Instructions to facilitators

- **Present PowerPoint 5: Community and intersectoral participation (30 minutes)**

- What is community participation for MNH? The process whereby community members are involved in assessing needs and problems, selecting priorities, developing strategies, planning, implementing, monitoring and evaluating programmes in close cooperation with the formal health sector and other concerned sectors and actors.

- Degrees of participation:

  - *Outreach:* Some community involvement; communication flows from one to the other, to inform; provides community with information; entities coexist. Outcomes: Optimally, establishes communication channels and channels for outreach.

  - *Consult:* More community involvement; communication flows to the community and then back, answer seeking; gets information or feedback from the community; entities share information. Outcomes: Develops connections.

  - *Involve:* Better community involvement; communication flows both ways, participatory form of communication; involves more participation with community on issues; entities cooperate with each other. Outcomes: Visibility of partnership established with increased cooperation.

  - *Collaboration:* Community involvement; communication flow is bidirectional; forms partnerships with community on each aspect of project from development to solution; entities form bidirectional communication channels. Outcomes: Partnership building, trust building.

  - *Shared leadership:* Strong bidirectional relationship; final decision making is at community level; entities have formed strong partnership structures. Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.

Point out that the IFC framework aims for the Involve/Collaborate levels of community participation. Consider the following statement: Community participation in health is a process. It is the process of initiation and sustaining dialogue with various members of a particular community in a structured

manner with the view to genuinely consulting them as equals in a programme of activities. The aim is to build a team between programme managers and community members to jointly understand health problems in the community, to find common solutions to such problems and to act together to solve these problems.

- How to promote community participation:
  - IFC Coordinating Committees;
  - Participatory planning processes and involving communities in the whole action planning cycle and in decision making;
  - Identify community leaders (political, religious or informal), community groups, community health volunteers, village committees, religious leaders and discuss MNH needs and how they can collaborate;
  - Link with other partners who have experience in participatory and interactive processes and in working with the community;
  - Develop the capacity of health workers to lead participatory and interactive processes, promote partnership and community involvement;
  - Establish mechanisms for ensuring community perceptions of quality of care are gathered and used in quality improvement processes;
  - Gain political support within the health sector and the district level.
- Not only is it important to collaborate with the community, it is also important to collaborate with different sectors and actors. Go back and look again at the different problems and solutions identified in our analysis on Day 1, when we thought about why MNH required an integrated approach. One of our key reflections in that session and throughout has been that MNH requires the active role of other partners in addition to health services.
- Discuss that there are a number of advantages of community and intersectoral participation, including:
  - Collective review of existing information, knowledge and experience leading to a deeper understanding of the situation and clear course of action.
  - It allows for increased understanding of what different groups can contribute.
  - It helps to clarify roles and avoid duplication of efforts.
  - It leads to a more effective use of resources.
  - People find the most appropriate solutions, make their own decisions and have the ownership of these decisions because they are directly related to their lives.

- Participation can develop self-esteem and self-confidence which are prerequisite to decision-making and follow-through.
- Sustained changes at community level cannot be achieved without real commitment from and involvement of the community.
- Interactive involvement of many people lead to cumulative learning.
- Collective learning contributes to a normative shift and eventually a change in behaviour that is sustainable because it is socially accepted or endorsed.
- Communities gain awareness through analysing the MNH situation.
- Communities participate in determining their priorities for health and finding solutions.
- Implies partnership between health services and community, and a proactive role of the community.
- Supports social networks and builds a sense of community.

- While there are many advantages to participation, it can also be very challenging. It will help them to anticipate challenges that have already been identified in the past. These include the following:
  - Collaboration and forming partnerships is a challenge and it takes time to learn to work together.
  - Participatory processes require time to implement. Accommodating timing between various organizations working collectively with common objectives while respecting each agency's independence demands more time than anticipated to achieve project sustainability, establish measurable impact and utilize participatory processes. A short term project time frame is not realistic.
  - We discussed earlier the degrees of participation – this highlights not only that the level of participation can change over time but also that the dynamic of the participation will change over time. Initially perhaps the health services will have a major role and impetus for moving forward with the participatory processes. This role may later change to a more facilitative role as the dynamics change, as other groups gain more experience, as partners change, etc.
  - Although you have community representatives who participate, this may not mean you are able to hear everyone's voices. As a programme you have to be aware of marginalized populations, power relations, and those who may be excluded, and think how to make sure their voice and interests are included.
  - Communities lose interest if long periods of time pass without follow-up by the health committee, particularly during the initial phases. The programme can risk losing the participation and interest of the leaders and women organized into groups in the process and momentum is lost.

- **Introduce Group Work 2 (15 minutes for group work):** Now you will be asking participants to work together in groups to discuss current and potential community and intersectoral participation in MNH. Divide the plenary into three groups. Ask the groups to discuss the following questions:

  Group 1:
  Do current planning processes in MNH allow for the participation of communities?
  If yes: How so? Does it work? How could their participation be strengthened?
  If no: How do you envision including community participation in MNH planning?

  Group 2:
  Who are some of the key actors and organizations that are currently involved in MNH at the national level? What other actors and organizations should/could be included?

  Group 3:
  Consider the importance of intersectoral participation. What are some key institutions that should be involved at the district level and how could they contribute?

- **Presentations in plenary (15 minutes):** Ask each group to present their outcomes to the plenary group (five minutes each). Allow the plenary group to discuss and add other ideas.

- **Wrap up:** Explain that the outcomes of the group work will be useful for the district team to determine how to promote community participation. (Note to facilitators: the same type of analysis can be done specifically in each district when planning the IFC component.)

SESSION 6:
INTRODUCTION TO THE PARTICIPATORY COMMUNITY ASSESSMENT (PCA)

Time: 2 hours 30 minutes

Objectives

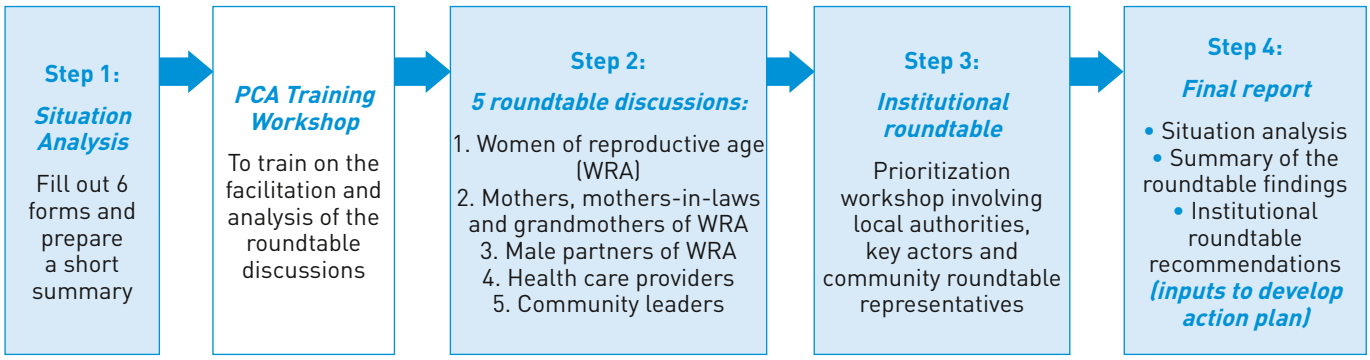
Participants will:
- Have an understanding of the planning process at district level;
- Understand the purpose and rationale of the PCA;
- Become familiar with the process of conducting the PCA;
- Conduct an initial adaptation of the PCA tools to the country context.

Instructions to facilitators

- **Present PowerPoint 6: Overview of the PCA (30 minutes)**

- The PCA is a tool that the district health services can use to assess the MNH situation and needs in a participatory manner through collaboration within the health sector and with other sectors, such as education and transport, district authorities, NGOs, religious organizations, and other community groups. Using the results of the PCA, partners can then plan actions together to help create an enabling environment for care of the mother and newborn in the home and in the community and to increase access to quality MNH services.

PCA process



- The PCA helps to initiate a process of empowerment among women, their partners, families and communities as they participate actively in assessing their problems and needs in MNH, as well as in identifying potential actions and district resources that can be leveraged to address these problems and needs. This meaningful participation in developing the interventions designed for their benefit is a right of women, men, families and communities. The PCA can also be instrumental in reorienting health services in their relations and interactions with non-health actors including the community thus contributing to the realization of rights through the institutionalization of participatory processes. The PCA is not intended to be a research tool, but rather a participatory process in which different actors become sensitized to the importance of collaborating with each other, of listening to each other, and of jointly planning interventions and solving problems

together. By helping people and groups better understand their situation and participate in finding solutions the PCA becomes an important first step in a health promotion process that empowers them to make choices and transform those choices in to action to improve their health and quality of life. Introduce the figure which lists the steps involved in conducting the PCA.

- As can be seen in the image of the PCA process, the final report from the assessment process includes data collected in the situation analysis, the findings from the roundtable discussions, and a draft intervention plan developed during the institutional forum.

- The PCA ideally will be integrated into ongoing processes. The health services network, together with the community social network, can conduct regular assessments to provide information and feedback to health programme managers on changing MNH needs, and to conduct informed health planning processes.

- The output of the PCA will be a final report (to be completed by the district committee) which will form the principle input into the joint planning process.

- **Discussion in plenary (30 minutes):** in plenary, ask the following questions:

  - How applicable is the proposed planning process in the country context?

  - How would you modify this process?

  - How applicable or feasible is the PCA? If it is not applicable in its entirety, what options could be suggested for the district level in your country? If there is a different planning process, how will you ensure the participation of community members?

  - What skills would be needed at district level to involve communities and community groups in planning, and how would you go about identifying these?

- Allow participants to discuss for 30 minutes and write down their main points on a flip chart.

- **Introduce Group Work 3 (30 minutes):** Explain that you are now going to take some time to review the question guide for the PCA. You would like the group to read through the questions and consider the following:

  - What modifications would you make to the guide to make it more appropriate for the context?

  - Are there any questions which should be removed?

  - Are there any questions which should be added?

- Divide the plenary into three groups. Each group will review one section of the PCA guide as follows:

Level of care	Questions to guide discussion
GROUP 1: **Care of the pregnant woman, mother and newborn at home** **(DEVELOPING CAPACITIES)**	**1.** How does a woman care for herself during her pregnancy? *(think about diet/nutrition, alcohol and other drugs, workload/activities, hygiene, going to antenatal care visits, etc.)* **2.** Are there any special beliefs or traditions in the community about care during pregnancy? **3.** How is the newborn cared for in the home? *(think about breastfeeding practices, keeping the baby warm, hygiene, etc.)* **4.** How does a woman look after herself after birth? *(think about diet/nutrition, workload/activities, hygiene family planning and birth spacing, attending postpartum visits for the mother and postnatal visits and vaccinations for the newborn, etc.)* **5.** What happens when there are complications or problems with the woman or newborn? How is the decision made to seek care? **6.** Are there any special beliefs or traditions in the community about care after birth? **7.** Are women and their families prepared for birth and/or complications related to pregnancy and birth? *(think about saving money for expenses, care of children, identifying a health care facility, identifying transport, a skilled attendant, a companion during birth, having adequate supplies, etc.)* **8.** Do women and their families know the danger signs during pregnancy, childbirth, after birth, and for the newborn? Which ones? **9.** Do women in this community often give birth at home? If so, who is with her and helps her during the birth? *(think about who attends her, where she gives birth, etc.)* **10.** What influences the decision to seek skilled care? *(think about costs of services, quality of services, transport availability and cost, cultural factors that affect care-seeking, gender relations between men and women, etc.)* **11.** Who in the family helps to care for the mother and her newborn? What do they do? **12.** Are husbands/male partners supportive in caring for the woman and newborn? Do men and women discuss these types of things? **13.** Is violence in the home common during pregnancy?

Level of care	Questions to guide discussion
GROUP 2: **Support in the community for the pregnant woman, mother and newborn** **(INCREASING AWARENESS and STRENGTHENING LINKAGES)**	**Awareness in the community of MNH rights, needs and problems** 1. *Explain that many governments have signed an international agreement on human rights which means that pregnant women, mothers and children have the RIGHT to special care and assistance*:* Is anything done here to ensure this right is respected? If yes, what is done to help to fulfil this right? If not, what happens? Are people in the community aware of this right? Do you think men are supportive of this right? 2. Are women in this community free to decide when to marry, to decide when to start a family, or to decide how many children they would like? If not, why do you think these rights are not being respected? 3. Do people think that MNH is a priority? 4. Do people know when and why a mother or baby dies in the community? 5. Are there community meetings about health or MNH specifically? **Links between services and the community:** 1. Do women have problems reaching care? What are some of the problems they have? What is done to help resolve these problems? *(think about distance to care, transport costs, state of the roads, availability of public transport, ambulances, partner permission to seek care, etc.)* 2. Who in the community supports the health of pregnant women, mothers and newborn? What do they do? *(think about community health workers, TBAs, support groups, any other people or groups, etc.)* 3. Are there any individuals or groups in the community who work with the health services? What do they do? *(think about collaboration with education, transport, local authorities, churches or other religious groups, etc.)* 4. Are there any people or groups in the community who are particularly vulnerable or who are not reached by the health services? If so, what sources of support could be used to help them? *(think about social support from the state, community funds, etc.)*

* The Universal Declaration of Human Rights states that "motherhood and childhood are entitled to special care and assistance."

Level of care	Questions to guide discussion
GROUP 3: **The care received from the health services** **(IMPROVING QUALITY)**	1. How do people in the community feel about the quality of care pregnant women, mothers and newborns receive from the health services? *(think about costs, waiting times, how providers treat women and families, availability of medicines and supplies, numbers of midwives, doctors and nurses, cultural differences between the community and the services, etc.)* 2. Do people have to pay for maternal and newborn health services? How do people feel about these costs? Do these costs stop people from using the services? 3. What information do the health services give to women and their families about pregnancy, childbirth and the newborn? Is this information useful? Does it reach everybody? If not, why not? 4. Do doctors, nurses, health promoters or community health workers visit pregnant women, new mothers and babies in their homes? How often? What do they do? Are there any groups who don't receive care or who need additional support? 5. If women give birth in the health centre or hospital, how are they treated? *(think about allowing a companion of choice at birth, choosing the birthing position, etc.)* 6. How are people referred from one health service to another? 7. Is the community involved in evaluating the quality of services or in suggesting how to improve the quality of services?

- **Presentations in plenary (1 hour):** Ask each group to present their section of the guide and the modifications which they suggest. If others in the plenary group have further suggestions during the presentation, note these. Allow each group approximately 20 minutes for their presentation and the ensuing discussion.

- **Wrap up:** Emphasize the importance of the PCA within the IFC framework. Highlight that the assessment is intended not only to guide the development of IFC interventions but also to initiate a process of dialogue between the health services and communities which will ideally become ongoing.

DAY 2
RECAP AND NAVIGATION MEETING

Time: 30 minutes

Briefly review the topics addressed during the day (5 minutes)

Assign homework (optional): If you have not had the time to lead the group in the Forest Chat energizer (see Annex 2), you may want to ask them to do this on their own in the evening. If you do this, allow some time for discussion during the Workshop Welcome on Day 3.

Diary reflections (10 minutes): Ask participants to take their diaries out. They will have 10 minutes to reflect and record some of their thoughts from Day 2 of the workshop. They may want to write about the most important thing they learnt during the day or how they will able to apply what they have learnt to their work.

Navigation Group Work (15 minutes): Ask the plenary to divide into 4-5 "Navigation Groups". Remind them that for the next 15 minutes you would like them to discuss the following questions:

1. What went well today during the workshop?

2. What could be improved?

3. Do you have suggestions for other issues (e.g., logistics, breaks, etc.)?

Remind them that each Navigation Group will need to select one Navigator to represent them during a Navigation Meeting. This meeting will be held immediately after the close of the workshop and will last approximately 30 minutes. The Navigators will then brief the group on the meeting the next morning. Groups should select Navigators who did not serve in this role yesterday.

DAY 3

WELCOME AND DAY 2 REVIEW

Time: 30 minutes

- Recap of Day 2.
- Navigation meeting debrief.

SESSION 7: MONITORING AND EVALUATION

Time: 30 minutes

Objectives

Participants will:
- Understand the reasons why monitoring and evaluation the IFC component is important;
- Be familiar with the basic elements of a monitoring and evaluation system specific to the IFC component;
- Discuss how monitoring and evaluation of IFC can fit into monitoring and evaluation of the broader MNH programme.

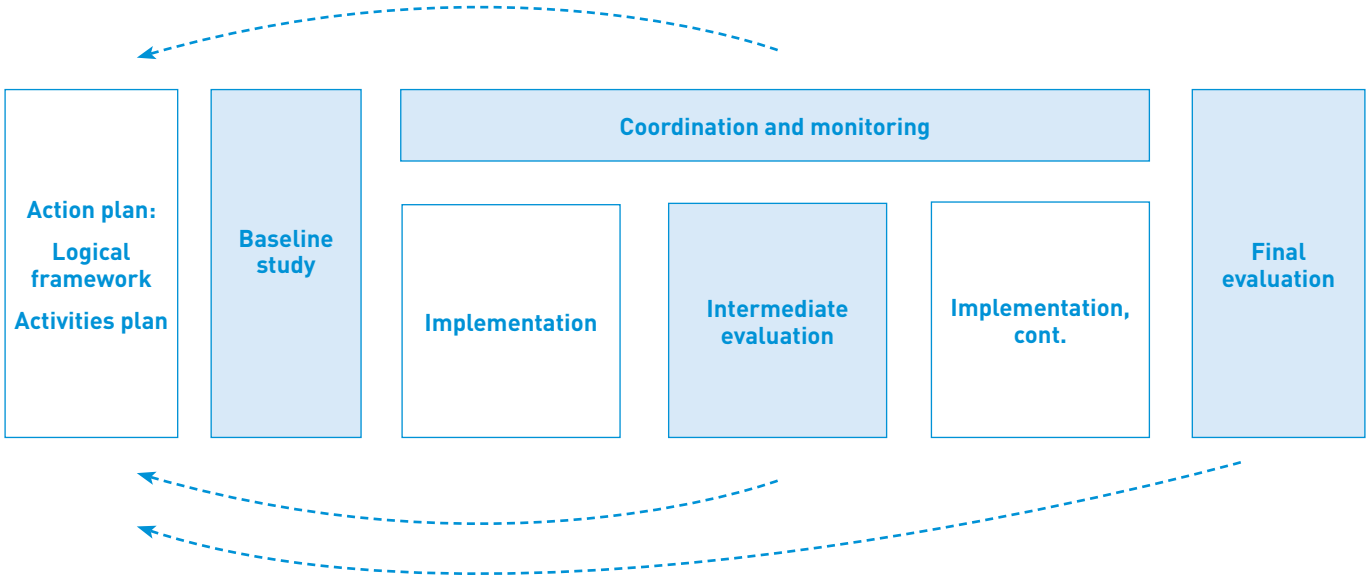
Instructions to facilitators

- **Present PowerPoint 8: Monitoring and evaluating the IFC component of the MNH strategy**
- Definition of terms: What are planning, monitoring and evaluation?
  - *Planning* can be defined as the process of setting goals and objectives, developing strategies to reach these goals and objectives, outlining the arrangements for implementation of interventions, and identifying and allocating resources. Stress that during this session we are referring to developing a plan for implementation of IFC interventions following the PCA. This plan, however, is based on the preliminary plan developed during the institutional forum.
  - *Monitoring* is the ongoing process by which stakeholders gather information to determine whether actions are being implemented as planned and the progress made toward reaching the stated objectives.
  - *Evaluation* is the rigorous assessment which serves to measure the impact that the interventions have had toward reaching the goals and objectives of the IFC component.

- Planning, monitoring and evaluation are distinct yet closely interrelated processes. Together they play a major role in enhancing the effectiveness of the IFC component and its interventions. Optimal planning helps actors focus on achieving the identified objectives both within the four priority areas of interventions and the strategic areas. A clear plan facilitates monitoring and evaluation, while monitoring and evaluation provide evidence to inform decision making throughout the intervention timeframe and for scaling of the IFC component to other districts and provinces.

- Use the following diagram to discuss key moments in IFC planning, monitoring and evaluation:

Planning, monitoring and evaluating the IFC component



- Participatory monitoring and evaluation: Explain that, as in all phases of IFC implementation, it is important to prioritize participation in monitoring and evaluation.

- Note some of the characteristics of participatory monitoring and evaluation which are different from other approaches. In contrast to traditional methods of monitoring and evaluation, participatory monitoring and evaluation is:

  - Focused on processes and measurement, rather than exclusively on measurement;

  - Oriented towards the needs of intervention participants and community members, rather than exclusively on donors and policy makers;

  - Promotes a relationship between evaluators and participants, rather than objectivity and distance; and

  - Conducted for the purpose of empowering participants, implementers and those that the actions aim to benefit alike, rather than simply judging shortcomings.

- Briefly discuss the following principles of participatory monitoring and evaluation:
  - *Participation:* Monitoring and evaluation of the IFC component emphasizes the participation of various stakeholders within the process. This principle is facilitated by IFC committees, in which different sectors and actors are represented. A particular emphasis is put on ensuring the participation of community members. All stakeholders, including community representatives, can participate in developing and providing input on tools for monitoring and evaluation, organizing and supporting the process, and analysing and using results. Moreover, monitoring and evaluation of IFC interventions is ideally conducted in collaboration with both internal (i.e., IFC committee members, community members, etc.) and external (i.e., research institutions, external consultants, etc.) actors. This ensures that the interventions are assessed from the viewpoints of both those directly involved in the component and those with a more independent position.
  - *Learning:* Participatory monitoring and evaluation stresses practical and action-oriented learning throughout the process. Monitoring and evaluation of the IFC component is optimized when it is approached as an 'educational experience' for all stakeholders. Participating actors, including community members, become aware of what is working and where weaknesses lie, contributing to empowering them to create conditions conducive to change and action.
  - *Negotiation:* Participatory monitoring and evaluation is a social process in which participating actors negotiate between varying needs, expectations and worldviews. This approach recognizes the complex interrelationships between stakeholders. It is intended to contribute to the empowerment of those stakeholders who are traditionally less likely to have their needs and expectations included in decision-making processes, with an emphasis on community members, particularly marginalized groups (minorities, indigenous people, poor people, people with disabilities, elderly people, among others).
  - *Flexibility:* In order for monitoring and evaluation to be participatory, it needs to be approached with flexibility. Monitoring and evaluation of the IFC component will need to be adjusted to the specific context of the implementation district, province and country, assuring that the process itself responds to stakeholder needs and expectations.
- Introduce a sample logical framework. If possible, display a logical framework that is already used in the country. If this is not possible you may use the following logical framework as provided in Module 5 of this toolkit. Keep in mind that your purpose is to briefly introduce a logical framework without going into too much depth on its preparation as the allotted time does not allow for this.

	Narrative summary	Indicators	Means of Verification	Assumptions/Risks
Goal	Contribute to the improvement of maternal and newborn health	[Outcome]		
Purpose	Empower women, families and communities to improve MNH and increase utilization of MNH services	[Output/Outcome]		
Outcome 1	Capacities developed	[Outcome]		
Planned Output 1.1...		[Input/Process/Output]		
Outcome 2	Awareness increased	[Outcome]		
Planned Output 2.1...		[Input/Process/Output]		
Outcome 3	Linkages strengthened	[Outcome]		
Planned Output 3.1...		[Input/Process/Output]		
Outcome 4	Quality of care improved	[Outcome]		
Planned Output 4.1...		[Input/Process/Output]		

- Selection of indicators: Indicators are empirically measurable conditions used to assess how well activities have been carried out and whether outcomes/outputs have or are being been achieved. They are critical not only to measuring progress, but also to assuring accountability among stakeholders. There are different types of indicators:

Type of indicator	Purpose
Outcome	Measures changes at the population level which may be attributable in part to IFC interventions. For example, as one of the primary aims is to increase the use of skilled care at birth, a common outcome indicator may be, "Percentage of births attended by a skilled birth attendant."
Output	Measures the results of activities at the intervention level that directly result from the inputs and processes. For example, if one intervention is to educate women on danger signs, an appropriate indicator may be, "Percentage of women who are aware of three danger signs during pregnancy."
Process	Measures the multiple activities carried out to achieve the objectives. Again using the example of educating women on danger signs, an appropriate indicator may be, "Number of women educated on danger signs during pregnancy."
Input	Measures the means required to implement the interventions. These may include human and financial resources, physical facilities, operational guidelines, training workshops, educational materials distributed, etc.

- If time permits, it may be useful to briefly look at the list of illustrative IFC indicators in Annex 3 of Module 5.

- Mention that it is ideal to conduct an impact evaluation when introducing the IFC framework into a country for the first time. Such an evaluation will provide evidence linking interventions with results and equip policy makers and managers with information to improve operation and guide scale-up. We suggest using a quasi-experimental design and a mixed methods approach (employing both quantitative and qualitative methods of data collection) comparing the intervention district to a matched control district where IFC activities are not being implemented.

- **Discussion in plenary (10 minutes):** Open the plenary to questions and discussions.

- **Wrap up:** Emphasize the importance of monitoring and evaluating the IFC component. Highlight that these are actually very complicated processes and that you have only been able to deal with them superficially during this workshop. Advise them that depending on the experience and expertise of the IFC team, it may be beneficial for them to seek the assistance of external consultants and experts when finalizing a plan and during key moments of monitoring and evaluation.

SESSION 8:
PLANNING FOR IFC IMPLEMENTATION

Time: 2 hours and 30 minutes

Objectives

Participants will:
- Develop a plan for moving forward on the implementation of the IFC component at the national and district levels.

Instructions to facilitators

- Present the table below to participants. Explain that the table contains a summary of the different activities that should be undertaken before, during and after the PCA, by the different levels involved (district and national/province).

Summary of activities before, during and after the PCA

	National and Province Levels	District level
Before the PCA	• Define the Terms of Reference of the coordination committees (see Module 1; Annex 1). • Identify the "strategic partners" and "stakeholders" for the IFC component at national level. • Develop a plan for implementation of the IFC framework at national and province levels, and identify the required resources (human and financial). • Identify one or two expert facilitators at national or province level. • Conduct a national inventory of experiences in IFC-related work. • Identify the initial IFC intervention district, in coordination with province and district level actors, according to the specified criteria (see Module 1). • Identify the key moments of interaction between the district, province and national levels. At province level, identify a representative to participate in the district and national committees. • At national level, review the PCA instruments for a first adaptation to the national context.	• Review and revise the Terms of Reference of the district committee (see Module 1; Annex 1). • With the support of the province and national committees, develop an initial plan for the implementation of the IFC framework at the district level, and identify resources (human and financial) which are required. • Present the IFC framework to local actors in the community and identify the "strategic partners" and the "stakeholders" for the district committee (or broaden the existing district MNH committee). • Select the IFC committee chair(s). • Identify a local IFC coordinator. • Identify local facilitators for the PCA.

	National and Province Levels	District level
During the PCA	• Support the district level in the different stages of the PCA. • Find pertinent information for the situation analysis (national statistics, research in the area, programme/project reports in the area). • With the district level, organize a training workshop for the PCA, and participate in the training. Organize follow-up, according to needs. • Participate in pertinent meetings during the PCA (situation analysis, roundtable discussions, analysis meetings, institutional roundtable). • Review and comment on the PCA reports.	• Conduct the situation analysis: ◦ Collect data and pertinent reports; ◦ Organize meetings for filling in and/or reviewing data collection forms; ◦ Write up the draft report. • Organize with the national/province level a training workshop for the PCA and participate in the training. • Review the roundtable discussion guide, taking into account the results of the situation analysis (with support from the national and province committees). • Organize the roundtable discussions, including identification of participants, logistics and facilitation. • Carry out the five individual roundtable discussions, including meetings for analysis, and writing up reports. • Write up the summary report of the five roundtables. • Organize and conduct the institutional forum, including compiling the report with information collected. • Write up the final report.
After the PCA	• Present results of the PCA, including the draft action plan, to national and province MNH committees and other strategic partners. • Organize a workshop for documentation of lessons learnt from the PCA, jointly with the district level, including the revision of PCA instruments. • Support the district level in the joint planning process to develop a detailed action plan. • Review and adapt tools for monitoring and evaluating the IFC component. • Support the district level in evaluating the results of IFC interventions and coordinate and disseminate these results. • Organize a workshop for documentation of lessons learnt from IFC implementation, jointly with the district level. • At national level, develop a process for scaling-up IFC implementation to other districts and provinces.	• Present the results of the PCA to the district MNH/IFC committee(s) and other strategic partners and community actors. • Organize a workshop for documentation of lessons learnt from the PCA, jointly with the national level, including the revision of PCA instruments. • Organize, jointly with the province level, a process to develop a detailed action plan based on the draft plan. • Manage the implementation and regular monitoring of IFC activities. • Evaluate the initial implementation of the IFC component. • Disseminate results from monitoring and evaluation. • Organize a workshop for documentation of lessons learnt from IFC implementation, jointly with the national level. • Support the scaling-up of the IFC framework to other districts within the province.

- **Introduce Group Work (1 hour for group work):** Divide the plenary group into three groups. If possible, divide two of the groups by those actors working at national level and those at district level. The third group can be a mix of the two.

  GROUP 1 has three tasks:

  - Review the national level activities before and after the PCA and modify according to national realities.
  - Propose a draft timeline for the different activities.
  - Review the Terms of Reference (see below) for the National IFC Committee and suggest modifications. Reflect on who could be part of the National IFC Committee.

Terms of Reference for IFC National Coordination Committees

Note: Generally the IFC National Coordination Committees will be integrated into a pre-existing national MNH committee, or may be a subcommittee of it. If separate IFC committees are formed, one of the representatives may be selected to represent the IFC component in the MNH committees.

Objective of the National Coordination Committee:

Supervise, provide technical support to and coordinate the development and implementation of the "National Plan" for the IFC component within the national MNH strategy.

Scope of Work:

1. Identify partners for implementation of the IFC component (including other sectors and relevant programmes within MoH itself, NGOs, universities and other relevant groups).
2. Represent the IFC component at national level, within other national, regional and international initiatives.
3. Advocate on the importance of this health promotion component for MNH strategies within MoH and with other sectors and groups and assure its integration into and coordination with broader strategies.
4. Coordinate the development of the national IFC plan, including planning of interventions; management and administration of financial, technical and human resources of the interventions; and assuring adequate financing for each phase of its operationalization.
5. Develop a system for monitoring and evaluating the IFC component at the national level.
6. Identify the necessary experts and support at various administrative and technical levels (national, province and district) for implementation of the national IFC plan.

7. Provide technical assistance throughout the implementation of the national IFC plan at all levels of the health system (province, district authority, community).

8. Develop coordination mechanisms and maintain communication with all strategic partners (at district, province and national levels) and with district committees during the different phases of development and implementation of the national plan.

9. Review and analyse existing strategies, programmes, and activities which work with women, their families and the community to improve MNH at national level.

10. Document and organize the experiences and lessons learnt in the area of IFC, for scale-up at national level.

Members of the National Coordination Committee:

The National IFC Coordination Committee involves the participation of representatives of organizations that work on MNH issues at the community level, including representatives of:

- MoH (one or two decision-makers in the MNH or health promotion programmes);
- WHO (national offices);
- other governmental agencies (education, water/sanitation, youth, etc.);
- NGOs (national or international);
- women's groups;
- universities;
- national champions in MNH or health promotion;
- representatives of the province and district IFC committees.

Skills and knowledge required within the Committee:

- knowledge of current MNH activities, social sciences and health education;
- familiarity with quantitative and qualitative research methods;
- experience in educational processes at community level;
- experience in community health (links between communities and services; community participation in health care improvement);
- knowledge of participatory mechanisms at the community level;
- must include or have relationships with political decision-makers, or include representatives who have the ability to influence key decision-makers.

Coordination:

The committee will select a coordinator and a secretary for a specified period of time. The committee should be limited to 10-12 members to allow the group to work effectively. It may be useful to consider forming subcommittees to carry out specific actions. The large group could meet two to three times a year to provide suggestions and oversight.

GROUP 2 has three tasks:

- Review the district level activities before and after the PCA and modify according to national realities.
- Propose a draft timeline for the different activities.
- Review the Terms of Reference for the District IFC Committee (see below) and suggest modifications. Reflect on who could be part of the District IFC Committee.

Terms of Reference for District IFC Committee

Note: It is recommended to form a subcommittee of the existing district MNH committee (where one is present) of five to ten persons for the coordination of IFC activities.

Objective of the District IFC committee:
Coordinate the implementation of the IFC component at district level.

Scope of Work:

1. Identify partners for the local implementation of the IFC component (including other relevant sectors and programmes within MoH, NGOs, and other pertinent groups at the district level).
2. Coordinate the different phases of the implementation of the IFC component, including the PCA, development of the district plan, identification of interventions, implementation of activities, monitoring and evaluation and documentation of lessons learnt.
3. Identify participants for the roundtable discussions.
4. Maintain communication and develop mechanism for effective coordination with all strategic partners during the implementation of interventions, including district, province and national stakeholders.
5. Assist in the identification of experts and support required at various administrative and technical levels in the local area, for the implementation of the IFC framework.
6. Participate in the joint planning process, specifically the planning of activities for implementation, and the identification of indicators for monitoring and evaluation of the IFC component.

7. Review and comment on proposals developed for funding IFC activities before submission.

8. Assure the integration of participatory mechanisms within routine health service planning processes.

9. Review and analyse existing strategies, programmes and activities at the district level that work with women, their families and the community for the improvement of MNH.

Members of the District IFC Committee:

The Committee should comprise a maximum of ten people, and may include:

- MoH (including representatives from the district health centre);
- health service providers with experience in MNH at district level (for example, doctors, nurses, health promoters or midwives);
- NGOs working in MNH in the area;
- representatives of community groups, local health committees and women's groups;
- local political representatives;
- the education sector;
- other selected relevant professionals in the local area;
- religious leaders.

Skills and knowledge required within the committee:

- knowledge of current activities in MNH and in health education;
- experience in educational processes at community level;
- experience in community health (links between the communities and services; community participation in the improvement of quality of health care);
- knowledge of participatory mechanisms at community level;
- skills in negotiation and facilitation;
- ability to represent the voice of women, families and communities;
- must include or have relationships with local political decision-makers, or with people who have the ability to influence key decision-makers.

Duration of service:

Each committee member will ideally be able to commit to at least two years of service on the IFC committee, after which time they may choose to rotate off and new members may be elected.

Committee chair(s):

The district committee may be chaired by the district health services director or the head of MNH services. It may also be appropriate for the committee to elect a "community co-chair", a representative of a community group who is not part of the health sector. The committee will also need to appoint or elect a local IFC coordinator, responsible for work related to the IFC component (see next page).

This committee will also elect a secretary for a specified period of time. One or two people from this District Committee may be identified to represent it on the national and/or province committees (usually the chair or co-chairs).

GROUP 3 will develop a draft plan for conducting the PCA:

- Ask them to review the PCA main steps:

1. Situation analysis
2. Training workshop
3. Five roundtable discussions
4. Institutional forum
5. Final report

- Ask them to develop a plan for the following components of the PCA:

1. Situation analysis
- Who will be responsible for conducting the situation analysis? Who will coordinate and who will participate?
- When will it be done? Define a target for completion.

2. Training on PCA
- List of PCA facilitators to be trained.
- When will it be done?

3. PCA roundtable discussions
- What groups will be targeted for the roundtable discussions? (Women of reproductive age, mothers or mother-in-laws of women of reproductive age, male partners of women of reproductive age, adolescents, healthcare providers, community leaders?) How will they select participants?
- Where will they conduct the roundtable discussions (rural or urban areas)?
- When will they conduct the roundtable discussions?
- Who will write the report? When will they do it?

4. Institutional forum
- How will it be prepared?
- When to conduct?
- Support needed?

5. Final report writing
- Who will write it?
- When will they write it?

Be sure to note their responses and decisions on a flipchart.

- **Presentations in plenary (60 minutes):** Invite each group to present the results of their group work. Allow each group 20 minutes.

- **Define the next steps in IFC implementation (30 minutes):** In plenary discuss the next steps for implementation. During this discussion also address the following questions:

1. What support do the districts need for implementing the IFC component from the national level? What type of support mechanisms can be set up?

2. It is considered important to establish a system for sharing experiences between districts. What kind of mechanisms can be set up? What support is needed from the national level to facilitate the exchange between the districts?

- **Wrap up:** Thank them for their efforts during the group work and explain that the results of their work will be used for moving forward implementation of the IFC framework in the country.

SESSION 9:
PERSONAL NEXT STEPS

Time: 30 minutes

Objectives

Participants will:
- Reflect on how they will apply what they have learned in the workshop to their work.

Instructions to facilitators

- Tell the participants that before closing the workshop they will now have a few moments to reflect on what they have learnt during the workshop and how they will apply it to their work.

- **Personal next steps (20 minutes):** Ask participants to take a few minutes to think about the following questions and write their answers in their diary:

  1. What were the most useful things that you learnt during the workshop?

  2. How will apply what you learnt to your work?

  3. How will you try to increase the participation of different actors (including communities) in your work following the workshop?

- Allow 20 minutes for participants to reflect and write.

- **Discussion in plenary (10 minutes):** Ask if there is anyone that would like to share some of their thoughts from this exercise.

WORKSHOP CLOSING

Time: 1 hour

Objective

- To close the workshop

Instructions to facilitators

- **Recap of workshop (10 minutes):** Briefly discuss the major takeaways from the workshop (i.e., the contribution of the IFC framework to the MNH strategy; the importance of participation; etc.).

- **Final evaluation (10 minutes):** Distribute the final evaluation forms (see Annex 3) and ask participants to complete them. Tell them to please answer honestly as it will help you to improve future workshops. Let participants know that they will have 10 minutes to complete the form.

- **Final bang (5 minutes):** Think of something that could be done that would leave the participants on a positive not at the end of the workshop. This could be singing a local song together; distributing a sweet or a small token; etc.

- **Closing remarks and speeches (25 minutes):** Arrange with the appropriate individuals and authorities beforehand to deliver closing remarks and speeches.

ANNEXES

Annex 1: Why did Mrs X die?

Annex 2: ENERGIZER-Bingo

Annex 3: ENERGIZER-Forest chat

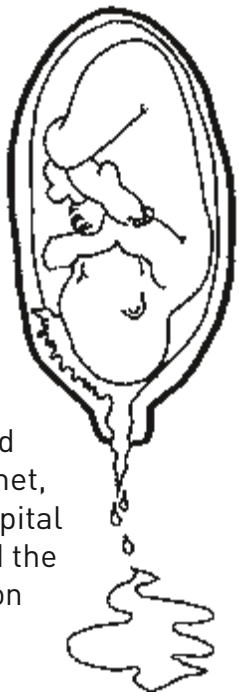
Annex 4: Final evaluation form

ANNEX 1:
WHY DID MRS X DIE?[1]

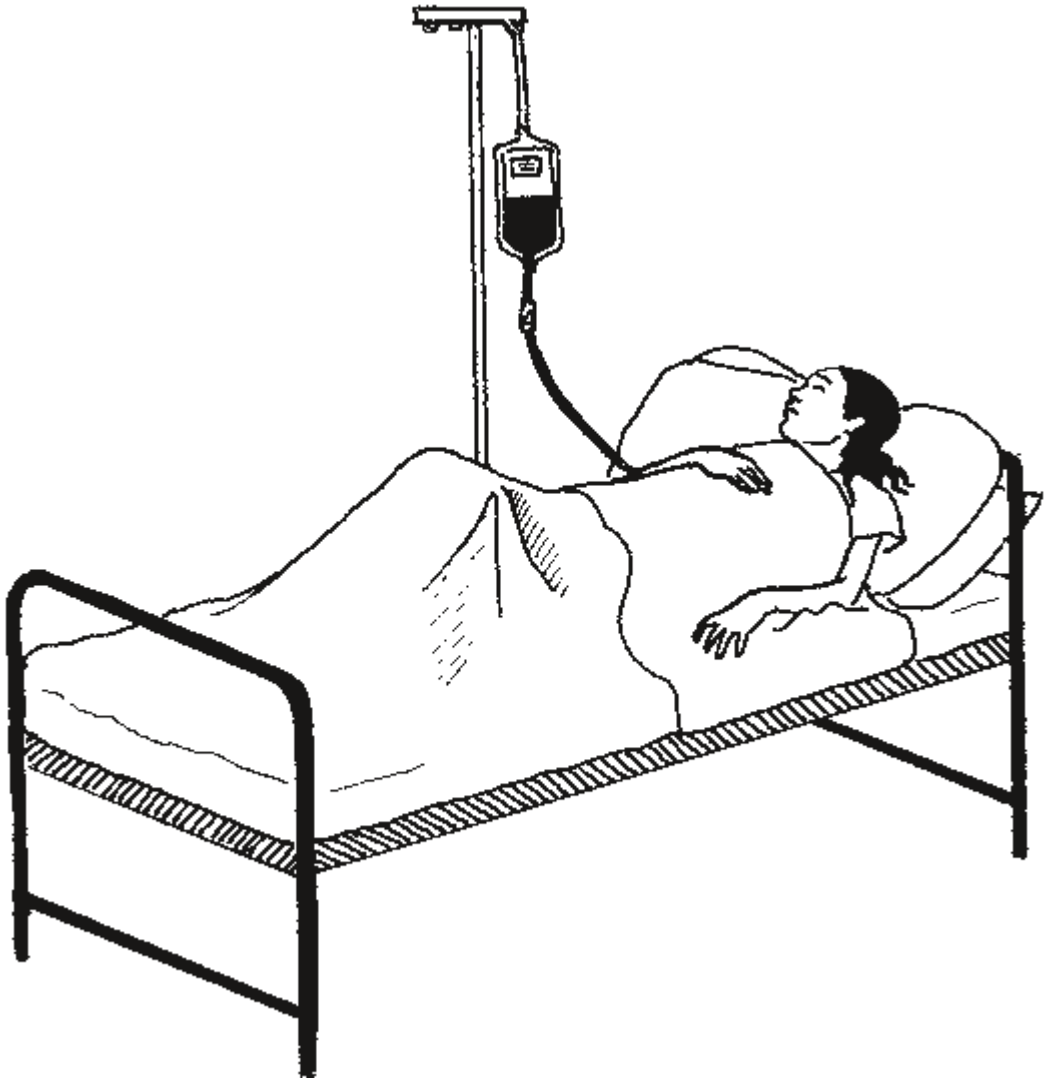
This is the story of one case of maternal death. For the sake of anonymity, let us call our unfortunate woman, Mrs X.

Mrs X died during labour in a small district hospital. The physician in charge had no doubt why Mrs X died. It was a straight forward clinical diagnosis - a case of antepartum haemorrhage due to placenta praevia, which means that the placenta, or what we call the "afterbirth", was situated too low down in the uterus. A woman with this condition will inevitably develop bleeding in the latter part of pregnancy or before delivery. The physician was satisfied with the diagnosis, looked up the book of International Classification of Diseases, entered the right code number for the condition and closed the file on Mrs X.

But the question is not completely answered, and there are others who are still looking for other answers. The obstetric profession has a small committee which is making confidential inquiries into the causes of maternal deaths according to standards that have been developed by the International Federation of Gynaecology and Obstetrics. The committee met, asked for the complete hospital record of Mrs X and examined the record in more detail. The file on Mrs X was re-opened.



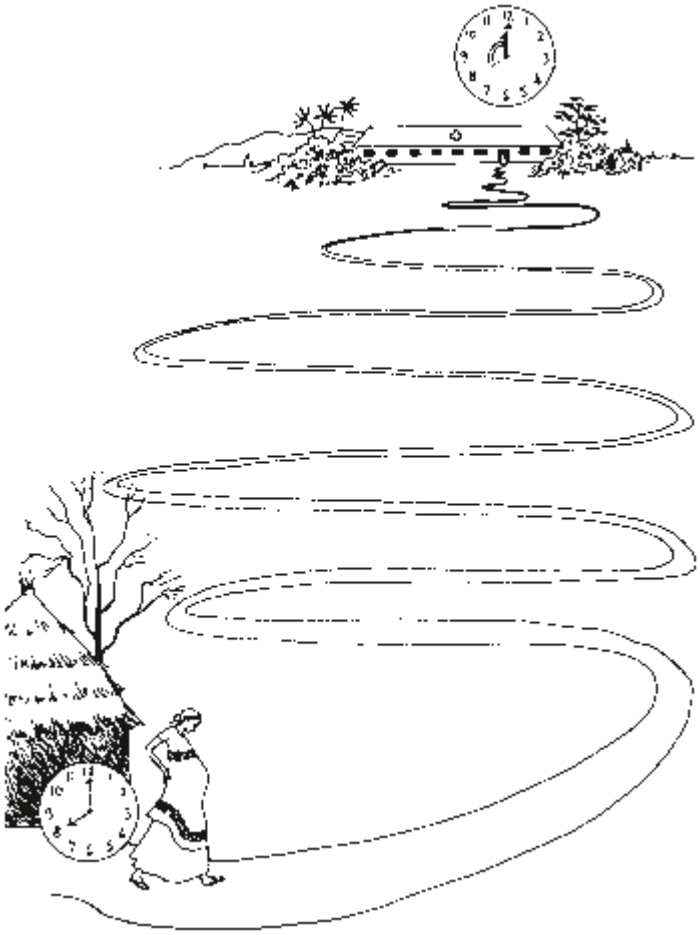
[1] From: The midwife in the community: midwifery education module 1 (Foundation module). Geneva: World health Organization, 2008.



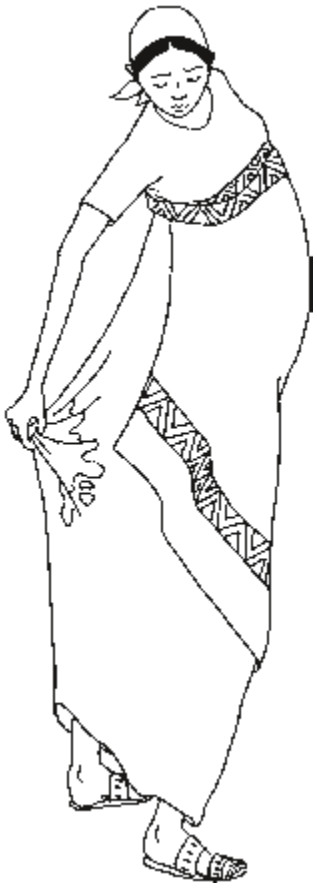
On reading the file of Mrs X, the committee found out that there were two striking points in her hospital record. The first point was that although she was admitted to hospital as a case of severe bleeding and in a condition of shock, she received only 500 cc, or ½ litre of blood by transfusion. That was all the blood the hospital had available to give her and that amount was barely sufficient to compensate for her severe blood loss. The second point was that Mrs X had to undergo caesarean section in the hospital to stop the bleeding. That operation was carried out three hours after her admission. Mrs X died during the operation.

The committee looked into the case which said that the death of Mrs X was avoidable. The committee argued in its report that, if blood transfusion had been more readily available, and if the service had been better prepared to deal with emergencies, a life would have been saved.

It took Mrs X four hours to reach hospital from the time she started bleeding severely, because transport was not readily available to take her to the hospital.

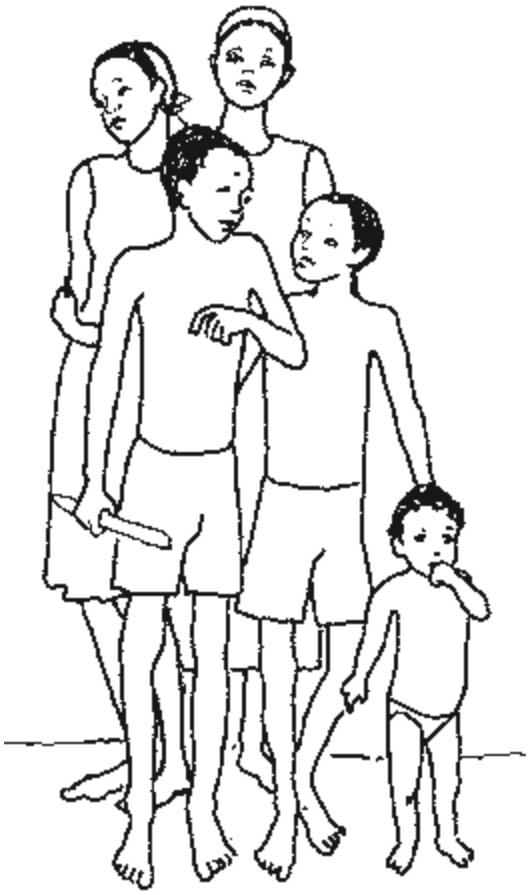


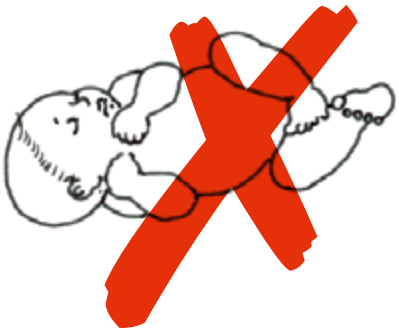
It was also revealed that this was not the first time she suffered bleeding. In fact she had two minor episodes of bleeding during the same month and on both occasions the bleeding stopped spontaneously. This is a very dangerous signal in late pregnancy.
It always indicates that a severe attack of bleeding is imminent, yet Mrs X was never warned about this and no action was taken.



Mrs X was not a very healthy woman. Even before pregnancy, she suffered from chronic iron deficiency anaemia caused by malnutrition and parasitic infestations. That severe anaemia must have contributed to the fact that she could not endure the additional severe blood loss. Her reserves of blood were already at a very low level.

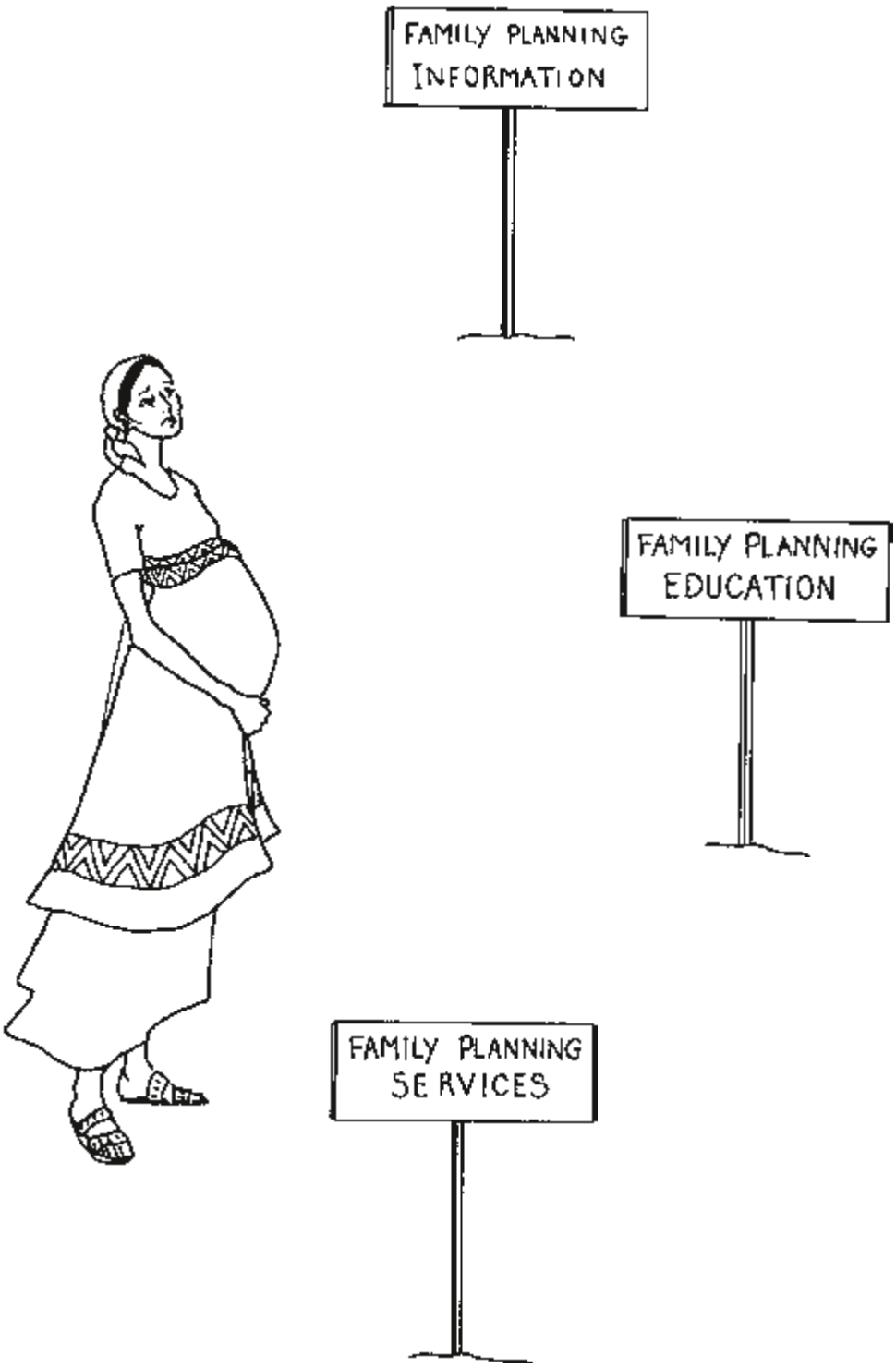
Mrs X is 39 years old, five of her children are still living, three of them are males, and Mrs X did not want another child.



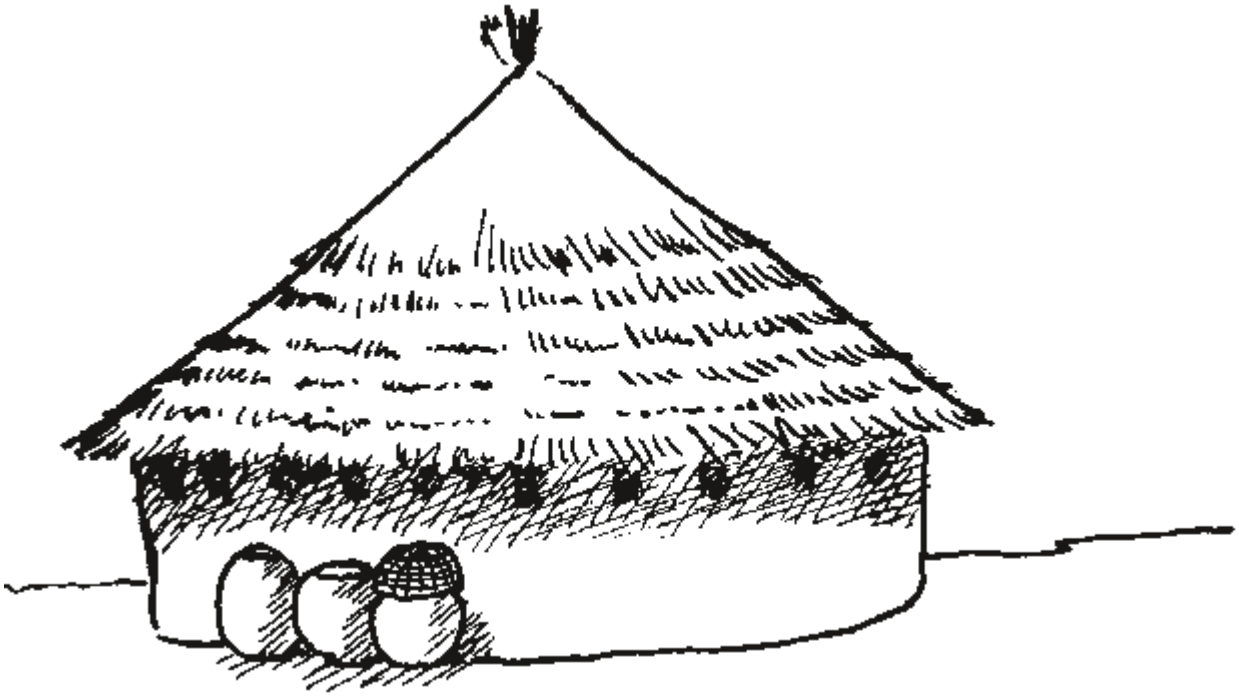


In addition, because of her age and because of her parity, her pregnancy carried a much higher risk than her previous pregnancies.

Mrs X never had access to any family planning information, education or services, and therefore never had the opportunity to use any method of family planning in her life.

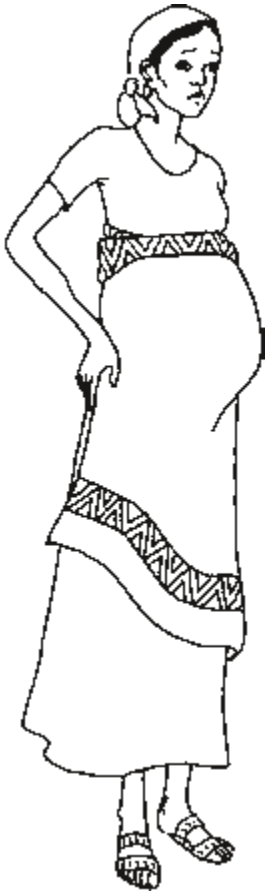


If this unwanted pregnancy of Mrs X had not taken place, she would not have died from the cause she died from.



Mrs X was also a housewife, and her husband a poor agricultural labourer.

She was an illiterate woman and she lived with her husband in a remote village.



A woman of Mrs X's socioeconomic position has a relative risk of maternal mortality:

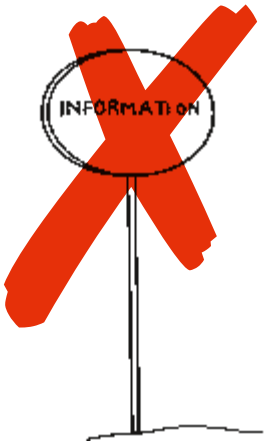
5 times
more than the average in the whole country.

10 times
more than a woman in a higher socioeconomic position in the country in which she is living.

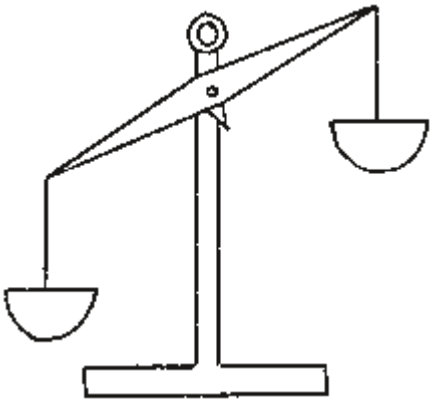
100 times
more than a woman living in a developed country.

The real reason why Mrs X died was because of her socioeconomic position:

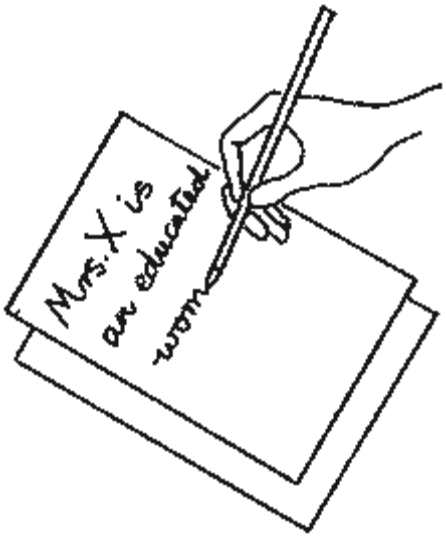
Mrs X died because of poverty.



Mrs X died because of lack of knowledge and information.



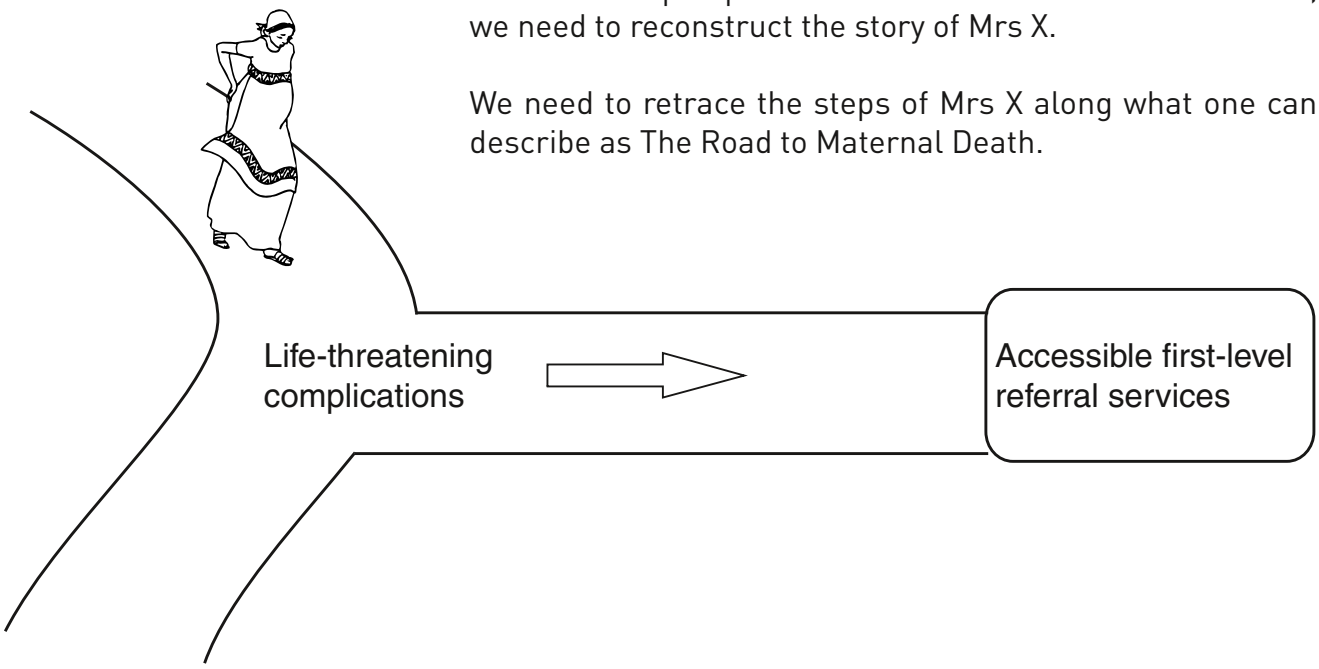
Mrs X died of social injustice.



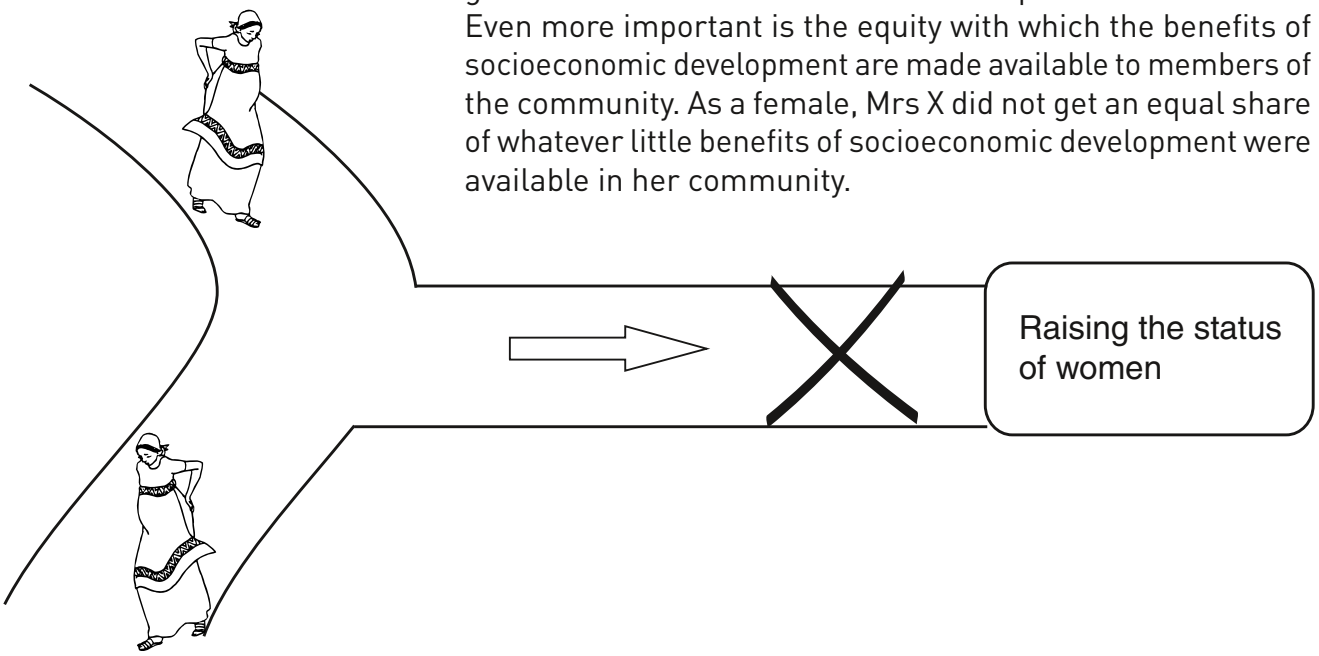
If Mrs X had been an educated woman, if she had been gainfully employed, and if she had had her fair share of nutrition within society, her risk of dying would have been much less.

It is clear that there are different perspectives in the way one looks at the causes of maternal mortality. In order to answer the question "Why did Mrs X or other Mrs Xs die?" we need to take all these perspectives into consideration. In other words, we need to reconstruct the story of Mrs X.

We need to retrace the steps of Mrs X along what one can describe as The Road to Maternal Death.



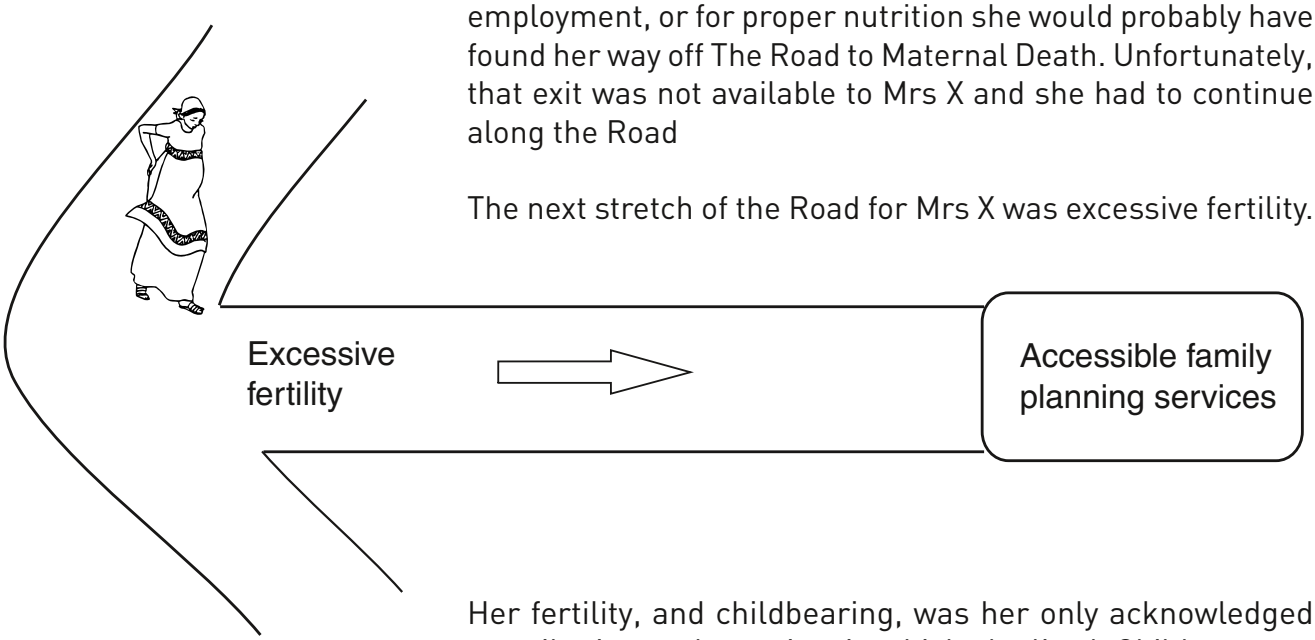
Mrs X did not voluntarily go on that Road to Maternal Death. She was led to the start of the Road by the poor socioeconomic development of the community in which she was born, and in which she lived. But it is not just the general level of socioeconomic development that matters. Even more important is the equity with which the benefits of socioeconomic development are made available to members of the community. As a female, Mrs X did not get an equal share of whatever little benefits of socioeconomic development were available in her community.



At that stage on The Road to Maternal Death there was a way out for Mrs X.

If Mrs X had had the opportunity for some education, for gainful employment, or for proper nutrition she would probably have found her way off The Road to Maternal Death. Unfortunately, that exit was not available to Mrs X and she had to continue along the Road

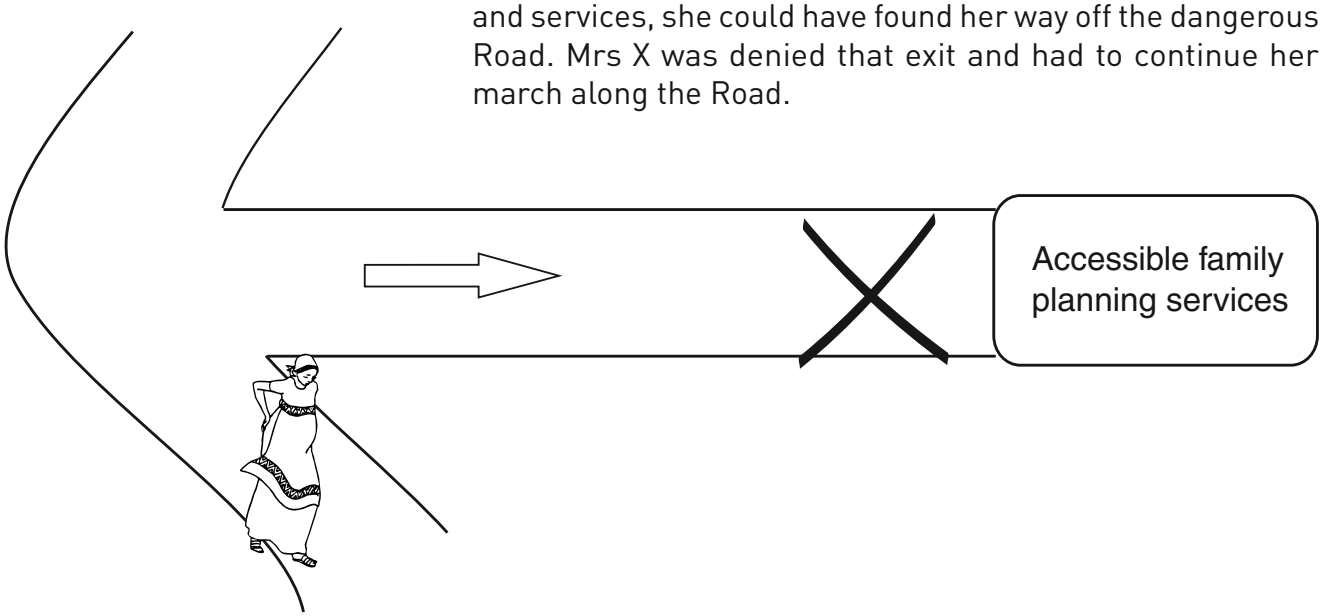
The next stretch of the Road for Mrs X was excessive fertility.



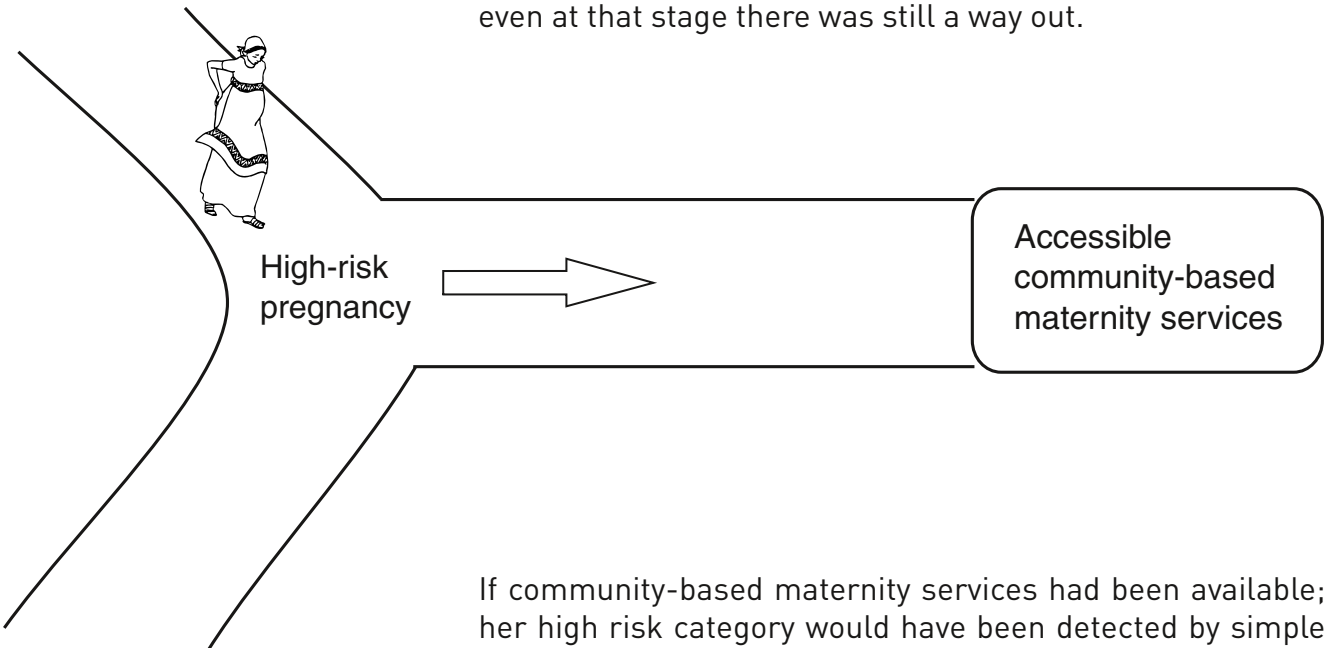
Her fertility, and childbearing, was her only acknowledged contribution to the society in which she lived. Children were the only goods she could produce and the only goods she could deliver. Her status as a woman in her community depended completely on her role as a mother. Excessive fertility not only increased her chances of travelling further along The Road to Maternal Death, but because of advancing age and parity she was at increasingly higher risk during pregnancy and childbirth.

Still at this stage on The Road to Maternal Death there was a way out.

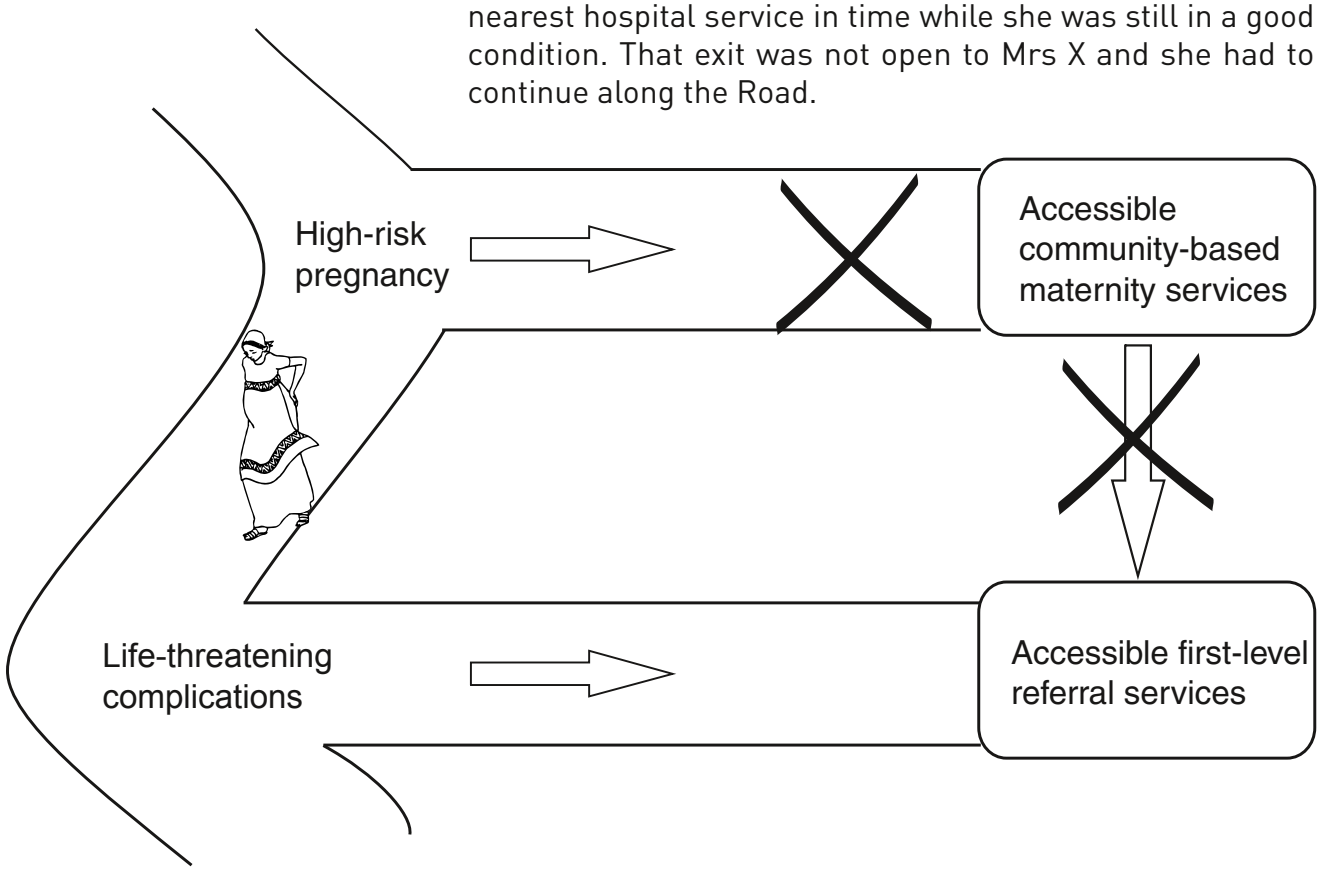
If Mrs X had access to family planning information, education and services, she could have found her way off the dangerous Road. Mrs X was denied that exit and had to continue her march along the Road.



Now, because of her advanced age, because of her advanced parity, because of her poor nutrition, because of her severe anaemia, she came under what we call an obstetric category – the category of high risk pregnancy. By high risk pregnancy we mean that small group of women who have most of the complications. That was the stage Mrs X found herself at, yet even at that stage there was still a way out.



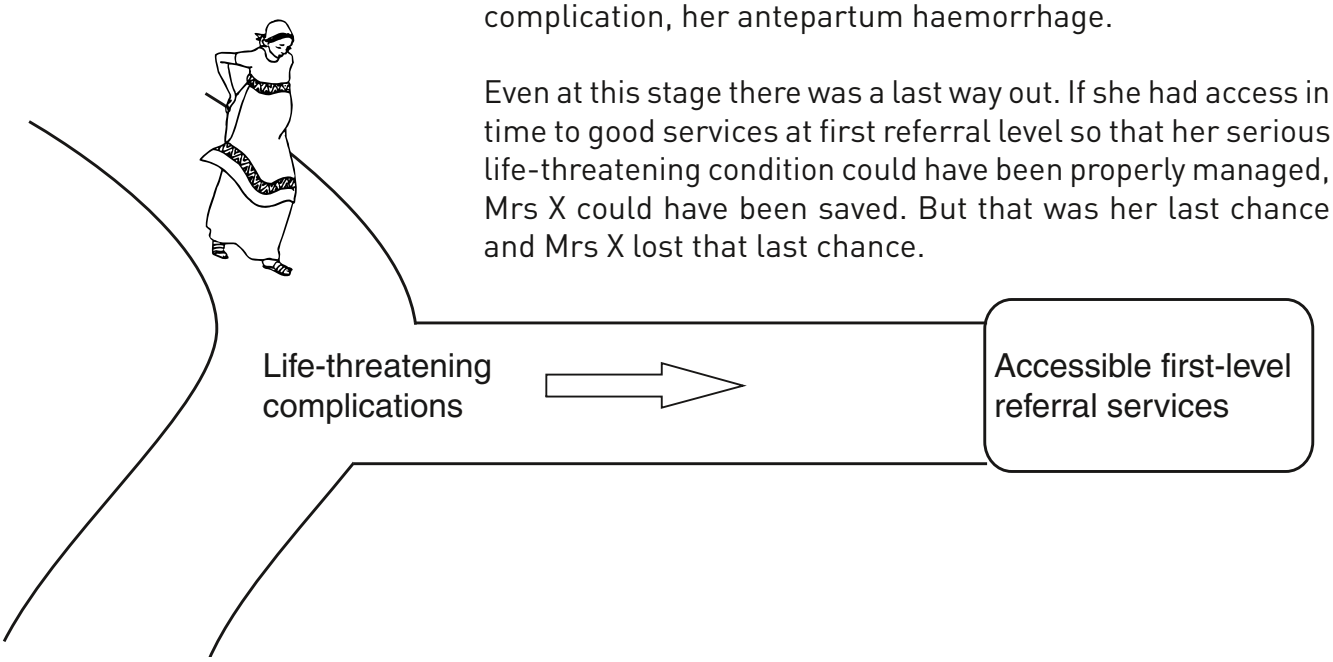
If community-based maternity services had been available; her high risk category would have been detected by simple screening; her anaemia would have been corrected; warning signals such as her episodes of bleeding would have been carefully noted; and she would have been referred to the nearest hospital service in time while she was still in a good condition. That exit was not open to Mrs X and she had to continue along the Road.



And that was the critical part of the Road, that was the stage of what we call life-threatening complications. These include conditions such as haemorrhage, eclampsia, sepsis, obstructed labour, complicated abortion and other less common but serious conditions.

The inevitable happened. Mrs X developed her life-threatening complication, her antepartum haemorrhage.

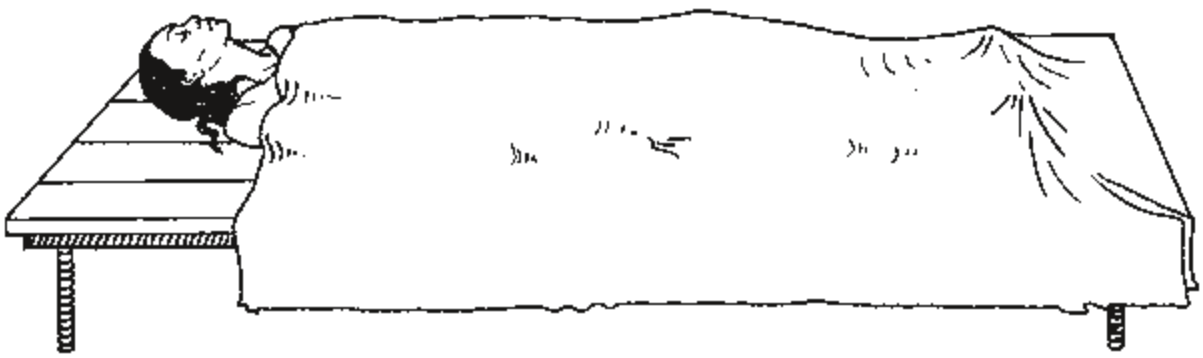
Even at this stage there was a last way out. If she had access in time to good services at first referral level so that her serious life-threatening condition could have been properly managed, Mrs X could have been saved. But that was her last chance and Mrs X lost that last chance.



That was the unfortunate journey of Mrs X along the slippery, dangerous Road to Maternal Death. The journey has left us with a vision of how women die and how women can be rescued. Women risk death when they step onto The Road to Maternal Death at any stage. Women can be rescued if they can be helped to follow one of the ways off the Road. It may not be possible to restrict completely the access to The Road to Maternal Death. It is certainly possible to let women off the Road through its various exits, but any successful strategy for mothers' survival will have to effectively utilize every exit along The Road to Maternal Death.

If we try to emphasize only the earlier exits then we are going to miss the women who join the Road later on or who continue along it. If we emphasize only the later exits, the medical exits, and we do not give equal emphasis to the earlier social exits, the load on those medical exits will be too much for the medical services to cope with.

Mrs X is dead.



ANNEX 2:
ENERGIZER-BINGO

Time: 30 minutes

Objective:

- Have fun playing a game;
- Move around and be active;
- Get to know one another other.

Instructions to facilitators:

- Prior to the workshop, prepare a Bingo sheet (see sample sheet below). You will need to adapt the Bingo sheet to the local/national context being sensitive to the group's background and culture.

  Below are a few examples of what one could include on a Bingo sheet. The number of boxes on the Bingo sheet will depend on the group size. For a group of 30-35 participants, a Bingo sheet with 25 statements, in a sheet of 5x5 boxes would be appropriate. If the group is significantly smaller, you may choose to prepare 16 statements on a sheet of 4x4 boxes.

  Below are some possible statements for the Bingo sheet:

  Family/Children: Has five children; has five grandchildren; has three girls; has three boys; knows or has met their great-grandmother/father; etc.

  Travels: Has lived in the capital; has travelled outside of the country; has seen the ocean/mountain/desert/local natural monument, etc.; has been on a mountain top; has visited a national or regional monument, etc.

  Skills/movement: Has ridden a bicycle; has ridden in a truck; has ridden a horse; has flown on an airplane; etc.

  Hobbies-arts: Has written a poem; has written a song; likes to dance; likes to paint; enjoys arts/crafts; etc.

  Hobby-music: Plays the guitar; plays [local instrument]; likes to sing; etc.

  Hobby-sports: Plays football; plays basketball; plays cricket; loves to watch the Football World Cup; etc.

  Personal: Has been in love; has married their love; loves to eat chocolate; has a tattoo; is afraid of snakes; is afraid of rats; loves to eat hamburgers; loves to eat pizza; hates to cook; loves to cook; etc.

- Ask all participants to stand up and come to the centre of the U-shape tables. Alternatively, you can go outside on a terrace, a garden, etc., where there is a large enough space for the group to move around freely.

- Give instructions for the Energizer: *"We will be playing "BINGO" now. Who has played Bingo before? As a child or with your children now? It is a game, and we will have a winner at the end. Your task is to go around and find the person who can sign one of the boxes on the sheet. The winner will be the one who has checked out all the boxes of the sheet first. Once you are done, scream BINGO, so we know you are finished. Are there any questions?"*

- Hand out the sheets for each participant (see Annex 1)

- Give participants time to check the boxes (20-25 minutes).

- Once there is a winner, stop the game and have all participants stand in the inside circle of the U-shape table.

- Debriefing:
  - Congratulate the winner or winners. Give them a little gift (e.g., chocolate bar etc.)
  - Ask them who they found, how the game was for them.
  - Ask a few questions from the sheet (For example: *So who has seven children? Bravo.*)

Sample Bingo Sheet

Often stays up past midnight during the week	Once worked at a restaurant	Knows the French national anthem	Knows how to Salsa dance	Has jumped out of an airplane
Is a vegetarian	Is an only child	Has been to India	Never planned to study in Paris	Enjoys sleeping
Reads the "Economist" magazine	Loves the World Cup football championship	Loves Chinese food	Has four siblings or more	Loves to buy new clothes
Hates the theatre and opera	Paris Hilton fan	Watches the news every night	Plays the piano	Has a tattoo
Born outside the country of their parents	Afraid of snakes	Owns a motorcycle	Has been to the Taj Mahal	Rides a bike to university

ANNEX 3:
ENERGIZER–FOREST CHAT

Time: 30 minutes

Objective:

- To reflect on their lives and motivations;
- To get to know one another better;
- To share their dreams and reconnect with their ideals.

Instructions to facilitators:

- Explain to the group that they will now go on a "Forest Chat".

- Ask participants to please pair up with one other person who they do not know very well and/or worked little with either in the past or the during the day.

- Ask them do discuss the following questions:

  1. Why did you get involved in improving the well-being of your population, your community? What were your original ideals?

  2. What did you get involved to do, and what are you doing now?

  Ask them to think back and reflect.

- Invite them to go on their Forest Chat to discuss these questions. (Be clear about where they should walk.) Each participant should be allowed 10 minutes to respond to these questions.

- Ask participants to return in 20 minutes.

- After 10 minutes have passed, give a signal (i.e., ring a bell) to remind them to switch to the other person.

- Let them know when 3 minutes and then 1 minute remain.

- When all are back in plenary, ask:

  1. What did you learn about your Forest Chat partner?

  2. What did you learn about yourself?

- Invite 3-4 people to debrief and discuss their experience.

ANNEX 4:
WORKSHOP FINAL EVALUATION FORM

1. Please circle the answer you feel is most appropriate for each of the following aspects of the training course, using the following ratings:

1 – Insufficient 2 – Poor 3 – Satisfactory 4 – Good 5 – Excellent

Statements	Rating scale				
1. Achievement of course objectives	1	2	3	4	5
2. Achievement of personal expectations	1	2	3	4	5
3. Relevance of workshop to your work	1	2	3	4	5
4. Usefulness of workshop materials	1	2	3	4	5
5. Workshop methodologies	1	2	3	4	5
6. Organization of the course	1	2	3	4	5
7. Workshop facilities	1	2	3	4	5
8. Administrative support	1	2	3	4	5
9. Facilitators	1	2	3	4	5

2. Course length: _____ Too long _____ Too short _____ Just right

3. What topics covered in this training do you think will be most useful to you?

.....

.....

.....

.....

4. On which topics would you have liked more information or preferred to spend more time?

.....

.....

.....

.....

5. On which topics would you have liked less information or preferred to spend less time?

.....

.....

.....

.....

Other comments or suggestions:

.....

.....

.....

.....

THANK YOU!

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