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

A Toolkit for Implementation

Module 3:
Partcipatory Community Assessment in Maternal and Newborn Health

World Health Organization

Enfants du Monde

Pan American Health Organization
World Health Organization
Americas

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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.

ISBN 978-92-4-150852-0

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Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Graphic design and Print: Imprimerie Villière - 74160 Beaumont - France
Cover photo credits: Enfants du Monde.

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ACRONYMS

CHW	Community health worker
EmOC	Emergency obstetric care
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
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)
IMCI	Integrated Management of Childhood Illness
MNH	Maternal and newborn health
NGO	Non-governmental organization
PCA	Participatory community assessment
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
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, 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 3

This document is the third 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.

This third module provides guidance on conducting a PCA. Based on the results of this assessment, collaborating partners can use the IFC framework as a health promotion tool to strengthen the broader MNH strategy. They do so through planning actions together to contribute to creating an enabling environment for care of the woman and newborn in the home, for support from the community and for quality care in the health facility during pregnancy, childbirth and after birth.

Those reading this guide who are planning to undertake a PCA in MNH will benefit from having already studied Module 1 of this toolkit, as well as having participated in an orientation workshop on the IFC framework (see Module 2). These initial steps will provide actors participating in the PCA with a foundation of the principles and processes of the IFC framework and will contribute to ensuring that a useful, effective and participatory assessment is carried out.

The assessment process outlined in this guide is designed to be used the first time that the IFC framework and the PCA are implemented in a country or province. Certain aspects may be adapted once districts in a province have experience in participatory processes and in integrating the IFC component into the broader MNH strategy. Suggestions for scaling up the IFC framework to other districts are discussed in Module 1 (see Module 1, section 2.16).

Who should use this module?

The IFC implementation process at the district level, including the PCA, is typically led by a district IFC coordination committee. The district process will ideally be supported and sustained by the national and province levels, and we therefore also recommend that representatives from these levels be familiar with the steps required to conduct the PCA. Since the PCA aims to obtain information that may influence national or province policies, the PCA final report will be of use to decision-makers at all levels.

This module is intended to be used by national, province and district teams and assumes that these actors have little or no experience in participatory health planning processes. Those involved in the PCA should be prepared to learn *from* and *with* community members.

It will be beneficial for all involved in conducting the PCA to have their own copy of this guide for study.

Adapting the process and instruments

The participatory process outlined in this guide is a generic one. Therefore IFC coordinators, committee members and others involved in conducting the PCA are advised to review and adapt this guide and its instruments to suit their national and local situations, needs, and objectives according to their context.

Structure of the module

Section 1 provides an overview of the PCA, including a summary of the topics to be assessed, as well as the coordination mechanisms for conducting a PCA. It also presents an overview of the methodology and the training required to conduct the PCA.

Section 2 describes the process of conducting the situation analysis, the first step of the PCA.

Section 3 provides guidance on the roundtable discussions, including the various preparatory activities needed, the roundtable methodology, and report writing.

Section 4 provides guidance on conducting the institutional forum, the final step in the PCA.

Section 5 outlines the components of the final report and suggestions for disseminating results.

The **annexes** at the end of the document are the assessment instruments that may be adapted to be used during the PCA.

1. OVERVIEW OF THE PARTICIPATORY COMMUNITY ASSESSMENT (PCA)

1.1 WHAT IS THE PCA?

The PCA is a mechanism for initiating collaboration between the health system and the community. It supports local actors, including women, family and other community members, in assessing problems and needs in MNH, as well as identifying potential actions and local resources that can be leveraged to address these problems and needs.

The PCA is not intended to be a research tool, but is a participatory process in which different actors can learn to work together, listen to each other, and jointly plan to address their needs. The PCA is a systematic process that helps people and groups better understand their situation and participate in finding solutions. Thus it becomes an important first step in a health promotion process that empowers people to improve their health and quality of life.

The PCA can also serve as an important tool in the promotion of the rights of women and community members. As participation is a right that community members are entitled to, the PCA provides a concrete tool to encourage their participation in the identification of their needs and in the design of interventions aiming to benefit them. As such, the PCA will ideally be conducted with the broader vision of contributing to a realization of these rights.

Although the PCA has been designed as one step in the IFC implementation methodology, it should be underlined that participatory assessments and processes will ideally be integrated into the routine health planning cycle, if not already present. 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 in order to inform health planning processes (see Module 1, section 3.8). The institutionalization of these processes can greatly contribute to the realization of rights of community members and ultimately to their empowerment.

1.2 CHARACTERISTICS OF THE PCA

Some of the basic characteristics of the PCA are as follows:

1. It utilizes a participatory approach that includes members of the community and different stakeholders in the collection and analysis of information on the local MNH situation (see Box 1.1) and is intended to be the first step in the empowerment of individuals, families and communities.

2. It contributes to the promotion of rights of women and men by allowing them to meaningfully participate in voicing their needs and designing interventions meant to benefit them.

3. It combines different methods for compiling a wide range of information and experiences, such as a situation analysis and roundtable discussions with different actors who are influential in MNH matters.

4. It encourages a detailed analysis of the MNH situation, supporting the identification of feasible interventions from the IFC framework that can strengthen the local MNH strategy.

5. It supports programme managers and other actors to take the next steps in implementation of the IFC component, playing a central role in the design and implementation of interventions.

Some of the potential benefits of the PCA are summarized in Box 1.1.

Box 1.1: The benefits of a community-based participatory assessment in MNH

- Community members are enabled to participate in a health assessment process and thereby develop capacities in working together for their own benefit.
- Communities identify their priority health concerns and needs (which may differ from those identified by a national health authority or external researchers), and plan interventions consistent with these needs.
- Linkages are built or strengthened between local health services and their users, thereby promoting use of services and improving quality.
- Understanding and trust between different stakeholders, such as women, men, health service providers, community leaders, and religious leaders is increased.
- Interest among community members in MNH and awareness of the issues affecting it is increased.
- Programme activities and results are more likely to be sustained after project funding or other outside support comes to an end.

Source: Adapted from Howard-Grabman and Snetro (2003) and Palmer (2006).

1.3 SUMMARY OF TOPICS TO BE ASSESSED

In accordance with the IFC framework, Table 1.1 suggests topics to be addressed during the PCA, based on the four priority areas of intervention: developing capacities, increasing awareness, strengthening linkages and improving quality of care. Note that while the IFC priority areas of health systems strengthening (see Module 1, section 1) are also central to the IFC framework, they are considered primarily by IFC coordinators and partners and therefore not discussed during the course of the PCA.

Inspired by the priority areas of intervention, the themes to be discussed during the PCA will ideally be tailored and adapted to suit the local MNH context. For example, some programmes have preferred to begin by focusing on only one thematic area of the framework such as quality of care. Those actors who are participating in the PCA process (either as facilitators, note-takers or observers, or providing input) will be best able to select and adapt themes when they are well-acquainted with the IFC framework and its interventions.

Table 1.1: Themes to be reviewed during the PCA

Thematic areas of the IFC framework	Themes to review during the PCA
1. Developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	• Care in the home during pregnancy, childbirth and after birth • Utilization of health services during pregnancy, childbirth and after birth • Recognition of the danger signs indicating obstetric and neonatal complications • Decision-making processes to seek care in the case of obstetric and neonatal complications • Preparation for childbirth and potential obstetric or neonatal complications (birth preparedness and complication readiness)
2. Increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health	• Awareness of the rights associated with sexual and reproductive health and maternal health • The role of men (i.e. husbands, partners, fathers) and other influential family members (i.e. mothers, mothers-in-law, grandmothers) related to the health during pregnancy, childbirth and after birth • Participation of community members in reviewing health information and in maternal and perinatal death reviews
3. Strengthening **LINKAGES** for social support between women, families and communities and with the health delivery system	• Financial barriers in preventing access to MNH services and community responses to this barrier • Geographic and transportation barriers preventing access to MNH services and community responses to these barriers • Role of traditional birth attendants (TBAs) in linking women and families to the formal health delivery system
4. Improving **QUALITY** of care, health services and interactions with women, families and communities	• The perspective of women, families and communities of the quality of MNH services • Mechanisms for community participation in the definition, monitoring and evaluation of quality of MNH services • Support during birth by a companion of the woman's choice • The interpersonal and counselling skills of health care providers

1.4 LOCAL COORDINATION OF THE PCA

The district IFC committee (see Module 1, section 3.4) has the overall responsibility for the PCA. As mentioned, if a local health committee already exists, this IFC committee can be a sub-group of the larger committee. When overseeing the PCA it will ideally include at least the following persons:

- the district health authorities;
- a representative from a health, education, rights or women's non-governmental organization (NGO);
- a representative from the local political authority office (e.g. mayor's office); and
- a representative from a community group.

The district committee will usually identify (and possibly hire) a local IFC coordinator (see Module 1, section 3.5). A smaller **PCA team** can also be formed, under the authority of the district committee, to be responsible for the organization and implementation of the PCA.

The PCA team could include:

- **the local IFC coordinator:** to coordinate all aspects of the PCA; and
- **two local facilitators:** to support the data collection for the situation analysis and the organization and facilitation of the roundtable discussions.

This team would ideally have support from:

- **one or two expert facilitators,** usually from the national or province level with experience in qualitative and participatory processes and in documenting these experiences; and
- **a representative** from the province and/or national committees.

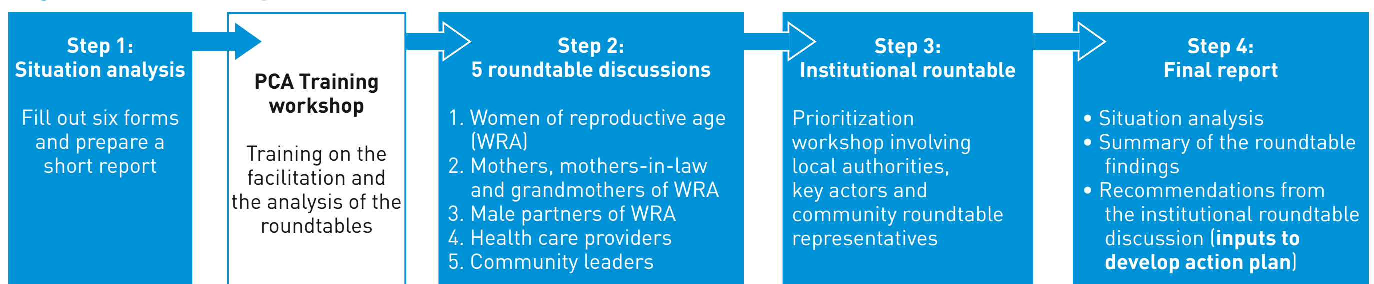
Including equal numbers of both women and men is an important goal when forming the PCAs teams. This contributes to ensuring that a gender perspective is maintained throughout the entire process of the PCA.

There is more information on the role of the facilitators in sections 3.7 and 3.8, and Annex 1 provides sample terms of reference.

1.5 OVERVIEW OF PCA METHODOLOGY

The four key steps of the PCA outlined in Fig. 1.1 are designed to be followed sequentially as the results from one stage will be used for the next. As can be seen in the figure, the workshop to train facilitators and note-takers for the roundtables will ideally take place after the situation analysis has been conducted (see section 1.8).

Fig. 1.1: The PCA process



Each of these four steps will be discussed in more detail in the following sections of this guide. Table 1.3 contains a summary of the different activities to be undertaken before, during and after the PCA by the different levels involved (district, province and national).

The amount of time required to conduct the PCA will depend on how much time and how many resources are available, and the team's experience in participatory processes. In most cases the process of a complete PCA in a district, from the planning stage to dissemination of results, will take between three and four months. A suggested timeframe is provided in Table 1.2, but note that different activities may run concurrently.

When expanding the IFC framework to new districts in a province that has already conducted a PCA, actors may agree on an alternative methodology for planning IFC interventions after reviewing the PCA results. However, it is important to maintain the core principles of the IFC framework in the adaptation process, including participation and collaboration (see Module 1, section 2.16 and Module 5, section 2.1). Planning interventions based on results of a PCA requires less time and effort (usually a maximum of two to three months).

Table 1.2: PCA timeframe

Activity	Timeframe
Situation analysis and report	2-3 weeks
Training workshop (preparation and workshop)	2 weeks
Preparation for the roundtables, including identification of participants	2 weeks
Five roundtable discussions	3 weeks (1-2 per week)
Summary report and preparation of institutional forum	2 weeks
Institutional forum (preparation and implementation)	1 week
Final report	2 weeks

1.6 PRESENTATION OF THE IFC FRAMEWORK TO THE COMMUNITY

Module 1 describes the need for advocacy and partnership-building activities to engage local actors in MNH generally and the IFC framework specifically. Once the district IFC committee and PCA team have been formed, an important preparatory step before starting the assessment is to **engage local community members** in the process. The district committee can organize community meetings with different groups and individuals to explain that there is interest in improving MNH in the community, to briefly present the IFC framework and the need for action in this area, and to raise interest and obtain support for the process.

Community leaders need to be convinced that their involvement will not only create a successful MNH programme, but will also be worthwhile for them and their mission to serve their communities. Interested and relevant groups and individuals may also be integrated into the district committee. Mechanisms to keep the community informed of progress and to receive their ideas and feedback should be discussed – emphasizing that communities have a right to this information and to participate in the actions implemented in their community. Experience has shown that this first important step of sensitizing others to the work that is to be done is often overlooked, and affects collaboration in later steps.

1.7 PRINCIPLES OF THE PCA

Partnership and collaboration

The PCA and the IFC component are optimized when based on collaborative partnerships and intersectoral action at all levels (district, province and national). In order to achieve this, partnerships are built or strengthened both within the health system and with other sectors including:

- local development committees, local health committees;
- social networks and civil society organizations (e.g. women's groups, NGOs, cooperatives, indigenous groups);
- other public sector institutions (e.g. education, transport and local authorities);
- religious groups and institutions;
- different types of health services (e.g. hospitals, health centres, health posts, public and private, traditional healers);
- other health programmes (e.g. Integrated Management of Childhood Illness (IMCI), sexually transmitted infections (STIs), HIV/ AIDS, immunizations, malaria, family planning, tuberculosis);
- the private sector.

Listening and learning

It is important that both facilitators and participants of the PCA be open to learning from each other, overcoming biases, allowing the learning process to happen in its own time, and to listening rather than lecturing.

Capacity building

The facilitation of the participatory process aims to develop the skills and knowledge of community members through a process of learning, sharing and analysing. The different actors involved in the PCA share their knowledge as well as their perspectives on problems, needs and local assets. The process allows the community to develop their capacities, as well as helping the health services develop an understanding of their communities. The PCA is therefore not simply a process of obtaining information from the community, but rather a first step in a process of dialogue, sensitization and empowerment.

Non-judgmental

The PCA involves open discussion about the situation at the community level, and will at times explore sensitive topics. It is important to encourage people to talk and demonstrate that their views and knowledge are valued. The facilitators must avoid being critical or judgemental about people's beliefs, values or behaviours. It is not intended to be an evaluation, but a forum for dialogue to identify needs and solutions.

Realistic expectations

It is important to provide community members with clear information about the assessment and the objectives and likely results need to be explained clearly. Some situations are likely to raise expectations. Expectations should be addressed openly and honestly, and promises that may not be kept should be avoided. High and unrealistic expectations will lead to disappointment and loss of interest in participatory processes.

Voluntary participation

Participation in the roundtables must be voluntary, (i.e. there must not be any coercion or pressure to participate). Participants can only make a decision to participate after having been fully informed of the PCA process. Participants need to know that they can withdraw their participation at any time without any consequences.

Confidentiality

A PCA may involve discussion of sensitive subjects. Facilitators must respect the confidentiality of community participants at all times during the process. It is the responsibility of the PCA team to agree beforehand how information will be shared in reports (e.g. names should not be used). They are also advised to develop a procedure for storing documents (such as the registration forms or the notes of the discussions) with potentially sensitive information and when these documents will be destroyed. It is essential that community members do not suffer any consequences as a result of disclosing personal information during the discussions. This can be avoided by focusing discussions on "typical people" rather than on the individual participants. For example, rather than asking participants to discuss their own problems, the facilitator can ask participants to discuss problems considering their own reality as well as others in the local area. It is important that all participants in the PCA are aware that the information discussed is confidential and not to be shared outside the roundtable. Nevertheless, it is also important that participants understand this confidentiality cannot be guaranteed; for instance, the IFC committee and PCA team do not have control should a participant break this confidentiality rule.

Gender equity

Gender considerations are integral to the PCA, and the process tries to promote gender equity by assessing the views and opinions of both male and female participants. Particularly in those roundtable discussions where both men and women participate (such as providers or community leaders), facilitators should be aware of any gender inequities during discussions – for instance, if women are not participating and men are dominating the discussion. Any difference between the opinions of men and women should also be noted and taken into account when analysing results. Moreover, gender considerations will ideally remain prominent throughout the process of conducting the PCA and analysing results. This may include reflecting on how gender roles, identity and stereotypes for both men and women influence MNH (e.g. men's involvement in MNH or women's involvement in household decision-making processes).

Cultural considerations

The PCA team will ideally be living in the local area. However, the team members will benefit from an awareness of differences between themselves and other members of the local communities they are working with, including gender, socio-economic status, religious orientation, ethnic group and language. Understanding these differences will help not only in discussing MNH issues with the different community groups, but also in analysing the information and determining appropriate action plans. An intercultural assessment process must be sensitive to the history, needs, strengths and resources of different community groups, and consider how to address the situation and needs of these groups.

1.8 THE PCA TRAINING WORKSHOP

An essential aim of the IFC framework is to build the technical capacity of all those working in MNH to work within the IFC framework and with participatory processes. In many settings, those working in MNH have no experience in processes such as the PCA, and therefore it will be important to conduct a training workshop. The training guide is presented in Module 4 of the IFC Implementation Toolkit, and includes detailed session guides for trainers and handouts for participants. The training workshop is designed to span 4.5 days and includes a practice roundtable discussion with analysis and feedback.

Timing of the training: *Ideally, the situation analysis will be conducted prior to the training workshop,* so that the PCA team can share preliminary results during the workshop. If possible, those attending the training will have previously attended the IFC orientation workshop.

Participants: The PCA team (including coordinators and facilitators) from the district level, as well as those working on the IFC implementation at the province and national levels that will be supporting the district level are invited to attend the workshop.

Trainers: The expert facilitator will generally be responsible for training the local group, with support from national and province partners. In order to optimally perform this role, the expert facilitator should be familiar with the IFC framework and have previously conducted a PCA training.

Training objective: To train the district PCA team and other provincial and national representatives on the PCA methodology and instruments to be used.

Key themes/sessions:

- A review of the IFC framework and the key concepts;
- Review of the situation analysis results;
- Review and adaptation of roundtable discussion guide(s);
- Training on facilitation, group management, and note-taking skills for the roundtable discussions, including communication skills and synthesis skills for facilitators;
- Analysis and report-writing from the roundtable discussions;
- Preparation for the roundtable discussions (including logistics and participant identification);
- Practice roundtable discussion with a community group, including analysis and report-writing;
- Preparation for the institutional forum;
- Preparation of the final report.

The practice roundtable discussion provides an opportunity for the facilitators and note-takers to run through an entire roundtable discussion, as well as for the PCA team to ensure the organizational and logistical requirements have been met. If the practice discussion goes well, the results can be used in the final report and it will not be necessary to repeat that roundtable.

Note: *It is important that the PCA team ensures that participants are invited to this practice roundtable ahead of time, and will therefore need to organize it before the training workshop begins. The national and province coordinators can help the PCA team to organize this, if needed.*

Table 1.3: 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) that 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.

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 forum).
	• 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.
		• With the national/province level, organize 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.

2. SITUATION ANALYSIS

2.1 AIMS OF THE SITUATION ANALYSIS

The situation analysis provides an overview of the situation of MNH and community structures at the district level. The data collected during the situation analysis is used for the following purposes:

- to orient the district, province and national IFC committees to the situation in the district related to MNH, including some of the key challenges and opportunities for improving the situation;
- to identify the local actors (organizations and individuals) that can be invited to participate in some of the roundtable discussions;
- to provide information that will help the PCA team determine which themes to explore in more depth during the roundtable discussions;
- to provide information on MNH and the IFC component in the district that will be presented during the roundtable discussions and during the institutional forum (see Annex 3 and Annex 5);
- to provide important information that can then be studied during the institutional forum and the joint planning process (after the PCA).

2.2 WHEN TO DO THE SITUATION ANALYSIS?

The situation analysis is ideally conducted after a district IFC committee has been formed, after the members of this committee have attended an orientation workshop on the IFC framework, and after the members of the PCA team have been identified (see section 1.5). Preferably it is conducted before the training on the PCA so that the results from the situation analysis can be presented and reviewed at the PCA training workshop (see Module 4).

Information compiled and analysed in this phase will be used in the roundtable discussions, and therefore the situation analysis is not designed to be conducted at the same time as the roundtables.

2.3 CONTENT OF THE SITUATION ANALYSIS

Annex 2 contains the forms used to conduct the situation analysis. These forms are designed to facilitate the analysis of the local situation by organizing the information available:

Form 1: Description of the local area

Form 2: Statistics on maternal and newborn health in the local area

Form 3: Health services in the district

Form 4: Inventory of institutions and organizations present in the local area

Form 5: Inventory of experiences in community health and participation

Form 6: Inventory of research in the local area

Map of the district:

During the collection of data for the situation analysis, it is advisable to create a map of the implementation site to locate various different elements. This is described on the first page of Annex 2.

2.4 SOURCES OF INFORMATION

It is important to note that many countries have previously carried out studies or evaluations of the MNH situation or of social and economic development indicators. Form 6 will help the local group identify the studies and evaluations that might contribute to the situation analysis. The following sources of information can also be considered:

- demographic and health surveys;
- vital statistics;
- epidemiological surveillance systems;
- government censuses;
- service statistics (health centres, hospitals, health posts);
- household surveys;
- quantitative and/or qualitative research or published studies of the area carried out by the Ministry of Health, NGOs, universities or others (identified using Form 6);
- reports on human or social development (e.g. from United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), the World Bank);
- published studies of the area (identified using Form 3);
- reports of community dialogues or focus groups; and
- municipal/district authority reports or surveys.

2.5 WHO SHOULD COMPLETE THE SITUATION ANALYSIS?

Generally the local coordinator is responsible for collecting the information, with support from the local facilitators. In some settings, the PCA team may need support in conducting the situation analysis. The national and/or province committees can organize support for this process as required.

Representatives of the province and national committees may support the local team by helping to identify sources of data, to understand the meaning of the data collected, or identify any problems with the data. Once the data has been collected, the forms can be filled in by one or two people. The coordinator can then organize a meeting to allow other committee members to review what has been compiled and make suggested changes.

2.6 REPORT OF THE SITUATION ANALYSIS

The suggested format for the situation analysis report comprises five key components:

1. Methodology (brief description of the process of data collection and sources used)
2. The six data collection forms (and map, if available)
3. Summary paragraph on the MNH situation
4. A written summary of "Challenges and opportunities for MNH"
5. A PowerPoint presentation summarizing the key data

After the forms have been completed, we suggest that the PCA team synthesize the data collected. First, they may write up a one-paragraph summary of the current situation of MNH in the local area, using the key MNH statistics collected in Form 1. They can note here if there are any differences between the local situation and the national situation.

Then they can summarize the data in a section on "Challenges and opportunities for MNH". By reviewing the forms, they can make an assessment of the challenges to MNH in the local area, as well as the positive factors that have been identified. Then they can determine whether the data can tell them anything about the challenges and opportunities in each of the four priority areas of intervention of the IFC framework.

Finally, in addition to this written synthesis, the team is also advised to prepare a PowerPoint presentation of the results of the analysis. This presentation can be reviewed during the PCA training workshop and modified according to the input received by participants. This presentation will then be used during the roundtable discussion and may also be used as an advocacy tool, such as when introducing the IFC framework to other stakeholders. It is preferable to prepare a presentation that is concise, generally not exceeding 15 slides (see Box 2.1 for suggested format).

Box 2.1: Suggested format for situation analysis PowerPoint presentation

1. *Description of the local area (3 slides):* Characteristics of the location and population; economic activity; education levels; transport services; other basic services; communications and media (Form 1).

2. *Description of the national, province and district situation in MNH (3 slides):* Recent trends in MNH; current situation in MNH; any differences in MNH between the district area and the national situation (if applicable); any differences in MNH between urban and rural areas; other important health trends in the local area (e.g. breastfeeding, use of family planning, HIV/AIDS, abortion, female genital mutilation, violence); utilization of maternal and child health services (Form 2).

3. *Health services in the area (3 slides):* Service network; health personnel; communication and referral systems between the different levels of the health system; availability of health education materials; monitoring, evaluation and epidemiological surveillance (Form 3).

4. *Institutions and organizations in the area (1 slide):* Description of present institutions, organizations, stakeholders, and level of coordination between the different groups (Form 4).

5. *Activities in MNH and IFC (1 slide):* Summarize what is being done to improve MNH in the local area (Form 5).

6. *Summary of key research findings in the local area (1 slide):* Discuss any important or relevant research findings (if any were identified) (Form 6).

7. *Summary of challenges and opportunities for MNH in the district (2 slides):* Use the synthesis described above to summarize key challenges and opportunities found in the data.

When preparing the presentation it is important to adapt it to the audience being addressed, assuring that the information presented is accessible and easily understood. For example, if used during the roundtable discussions, it may need to be substantially simplified, such as in making complex statistics or terminology understandable to the lay person.

3. THE ROUNDTABLE DISCUSSIONS

3.1 WHY CONDUCT ROUNDTABLE DISCUSSIONS?

A roundtable discusión in Sonsonate, El Salvador

The second stage of the PCA is a series of roundtable discussions with different community groups. Before presenting the methodology for these roundtable discussions, it is important to identify the rationale for using this approach.

Roundtable discussions provide a platform to listen to what various stakeholders within the health system (women, families, representatives of community groups, decision-makers, NGOs, etc.) wish to communicate with respect to the MNH situation and possible solutions. It is a forum to initiate the process of empowerment of different stakeholder groups by supporting their active participation in the IFC implementation. It is also an important part of a right-based approach as it allows community members to not only have a voice but also to participate in designing the interventions that are meant to benefit them. This PCA contributes to allowing them to become "actors" rather than "beneficiaries".

Roundtable discussions allow the opportunity for:

- understanding the cultural and social context of the community from the perspective of different stakeholders;
- identifying socioeconomic determinants of MNH in the area that do not easily surface during non-participatory analyses;
- listening directly to women and their families on their MNH needs and the changes and improvements expected by the community;
- exploring possible solutions to respond to these needs;
- promoting dialogue between women, their families and community representatives and health service providers, and giving participants the opportunity to relate to different people, exchange ideas, and reflect on what has been said and heard; and
- identifying other stakeholders who can collaborate in the process of improving MNH.

3.2 OVERVIEW OF THE ROUNDTABLE DISCUSSION GROUPS

Each discussion group ideally includes 15-20 participants. We suggest holding five roundtable discussions, one for each of the following groups:

1. Women of reproductive age
2. Male partners of women of reproductive age
3. Other influential family members/household decision-makers (i.e. mothers, mothers-in-law and grandmothers) of women of reproductive age[4]
4. Community leaders
5. Health care providers

See Table 3.1 and section 4.3 for more information on the profiles for each roundtable and the identification of the participants. In roundtable discussions where the group includes women and men (e.g. community leaders, health-care providers), the PCA team is advised to aim for achieving gender parity to attain a balance in gender perspectives.

The district, province and national committees may consider adding roundtables with other groups or eliminating some of the roundtables, to adapt to the local context and characteristics of the area. For example, if the situation analysis indicates that adolescent pregnancy is a significant problem and cause of maternal mortality and morbidity, discussion groups could be organized with adolescents and parents of adolescents. Or the situation analysis may show that certain groups such as TBAs play a very important role in maternal and newborn care, and so a separate discussion could be held with them.

We suggest organizing the roundtables to take place in locations within the community itself. This contributes to providing a neutral and natural environment where power relationships are minimized and also reduces the burden of travel for participants. Each roundtable is designed to run like a workshop with a mix of plenary sessions and group work and to last a maximum duration of four and a half hours.

[6] These influential family members will generally be women; however, if the IFC committee determines that it would be worthwhile to invite male household decision-makers who are not partners, it is advisable to hold a separate roundtable discussion for this group.

3.3 REVIEW OF THE ROUNDTABLE FACILITATION GUIDE

Before beginning to organize roundtables, we strongly suggest that the PCA team review the roundtable facilitation guide (provided in Annex 3) in order to adequately prepare for the discussions. A first review and adaptation of the guide will generally have already been carried out by national representatives. Based on this adaptation, the PCA team and district committee can make further adaptations using their knowledge of the local situation and the findings from the situation analysis. It is also important to adjust the guide so that the session does not last more than **four and a half hours**. Time is set aside during the PCA training workshop for review the guide, but it may be helpful for the team to conduct an initial review and suggest changes. Box 3.1 provides some considerations for adapting the PCA guide.

Box 3.1: Considerations for adapting PCA guides

Terminology: Replace generic terms with more appropriate local terms. If local groups speak their own dialect or language, the roundtable discussion guide will also need to be translated.

Health problems/needs: After conducting the situation analysis, the group will have a clearer idea of some of the key health problems affecting local communities. The guiding questions can be adapted to ensure that important local problems are discussed and addressed. For example, the situation analysis may show that violence during pregnancy is a major concern. If this is the case, then specific questions could be added.

Cultural practices: Questions can be added to the roundtable facilitation guide to ensure discussion of cultural practices and beliefs that exist in certain areas, for example, adding questions on female genital mutilation.

3.4 VOLUNTARY PARTICIPATION

Informed consent is a term used in research to ensure that researchers follow principles of ethics, in particular that they recognize a participant's right to make an informed choice to participate in the research. Although the PCA process is not research, it is important to make sure that roundtable participants know the purpose of the PCA, are participating of their own free will and understand that they can decide to withdraw at any point without consequences.

There are several moments that voluntary participation can be addressed: when recruiting participants, when registering the participants, and when opening the roundtable. Some points to cover when explaining the voluntary nature of their participation include:

- describing the objectives of the PCA;
- describing the process of the PCA;
- explaining what the results of the roundtables will be used for;
- explaining what will be done with the infor-

mation collected following the roundtables (i.e. registration forms how will they be stored, when will they be destroyed);

- explaining that their participation is voluntary and they can withdraw their participation in the roundtable at any time without any consequences;
- explaining that participants will be reimbursed for their travel expenses;
- providing participants with contact information for a person who can be contacted if they have questions (i.e. a local PCA coordinator).

3.5 IDENTIFICATION OF PARTICIPANTS AND ROUNDTABLE LOCATIONS

With the support of the local coordinator, the PCA team identifies who will represent each category of community stakeholder in the individual roundtable groups. Table 3.1 below indicates the different profiles suggested for each roundtable discussion (including the institutional forum). The district coordinator generally is responsible for managing the process of identifying and inviting participants.

Since the roundtables aim to assess the situation of a large and diverse population within a district, the local coordinator and PCA team are advised to take measures to ensure that the roundtables are representative of the different geographic, ethnic and socio-economic “communities” living in the district.
For the roundtables involving **health care providers and community leaders, as well as the institutional forum**, it will usually be easiest to organize the meeting in a central location in the district, and to invite participants from a range of locations (urban and rural) within the district. Forms 3 and 5 from the situation analysis (Annex 2) can be used to help identify providers and community leaders who could be invited to the meetings.

For the roundtables involving **women, husbands/ partners and influential family members**, it is particularly important to ensure the representation of poor and marginalized groups, and specifically of communities that have a high burden of maternal and neonatal morbidity and mortality. This is critical to a rights-based approach and can contribute to reducing health inequities. Usually, participants from these groups live in rural villages and may find it hard to travel to a central location. Therefore, it is important to try to organize these roundtables in villages or small towns that are more accessible to participants. To ensure a diverse group that can touch upon different situations, it is advisable to invite participants from at least two or three different villages nearby. Where relevant, transport costs for participants may be provided and the agenda organized so that participants can have adequate time for travel.

Box 3.2: Tips for organizing roundtables

- Determine the date, hour and location for the roundtables before inviting participants. Choose convenient dates and times for the community, and an accessible location.
- Invite 20-25 persons for each roundtable, aiming for a minimum of 15 persons per roundtable.
- Aim to have at least one person per specified characteristic for the roundtable (see Table 3.1).
- Explain the importance of participation, however emphasize that their participation is voluntary. They have a right to stop or withdraw their participation at any time.
- Assure participants that the discussions will be confidential.
- Guarantee the participants payment of transport and refreshments, as well as childcare for the children of female participants.
- Confirm that the roundtable will last approximately four and a half hours.
- For the roundtables with health care providers and/or community leaders, it may be necessary to prepare invitation letters or conduct personal visits to explain the discussions and the importance of their participation.
- Give a reminder leaflet to each participant, with the place, time and date of the roundtable.
- Fill out a registration form for the identification of the participants (name and address, assigned roundtable and profile (Table 3.1), number and ages of accompanying children).

In areas where there are many poor people in central urban areas, the team is strongly encouraged to ensure that participants from these neighbourhoods are represented. In this case, there are two options: either organize the roundtables in a central location, and invite both rural and urban participants (with transport arranged for rural participants), or alternatively, organize an extra set of roundtables to consider an urban setting and a rural setting. The PCA team and district IFC committee can weigh the costs and benefits of organizing the roundtables in different ways.

When deciding whom to invite, the group can enlist the assistance of local community members who know the area well and can help the team identify participants who represent the criteria in Table 3.1. The local health services may also have records of families who have had an obstetric or neonatal emergency. Community health workers (CHWs) are also a good source of knowledge to identify participants.

When inviting participants, explain the objectives of the roundtable and how results will be used. Also explain that participation is voluntary and confidential (see section 3.4). Ask if they have any questions and provide them with contact information of a person connected to the roundtables.

3.6 ORGANIZATION OF THE ROUNDTABLE DISCUSSIONS

A checklist for organization of the roundtables is included in Annex 6. The steps to be followed for organizing the roundtable discussions are as follows:

1. Develop a specific timeline of activities for the organization of each of the individual roundtable discussions and the institutional forum.

2. Identify the venue for the roundtables – a comfortable, private, and well-ventilated room with a **roundtable** or rectangular tables that can be placed in a u-shape, with comfortable chairs or benches. If the room does not have a table, place the chairs in **a circle** in such a way that all the participants can see each other. Make sure that there are areas for small group work, either in the same room or in separate rooms. Section 3.5 above provides some guidance on where in the district roundtables may be held.

3. The meeting place should have an additional room where the child minders can care for the children of the women who are participating.

4. Organize for child minders to be present during the roundtables that require this service, normally the roundtables with women and maybe those with other influential family members (grandmothers, mothers-in-law). Organize materials that they will need including diapers/nappies, paper and colouring crayons, etc. so the children can draw and play.

5. Make arrangements for refreshments for the participants, their children, child minders, facilitators, note-takers, and observers. It is important to remember that community members arriving at the roundtables may be hungry because of travel time, poverty or food shortages, so you may want to have a snack ready before starting the roundtable work.

6. Organize transport or payment of transport for the participants, where relevant.

7. Purchase and prepare the required materials (see Annex 6).

8. Ensure that facilitators and note-takers have a copy of the revised roundtable facilitation guide.

9. Prepare a short presentation on the situation analysis, the MNH strategy and the roundtable objectives (see Annex 3).

10. Have educational materials on MNH available to distribute to the participants after the roundtables.

11. Prepare the flipchart sheets to be used in the discussions (see Annex 3).

12. Prepare blank name cards that participants can use to write their names on.

Table 3.1: Proposed participant profiles, with their characteristics, for the roundtable discussions
The PCA team is advised to ensure that the roundtables include people with the specified characteristics listed below. Some people may represent several characteristics (for example, a woman may be selected who has a newborn, and who had an obstetric emergency)

1. Women of reproductive age *	2. Husbands and partners of women of reproductive age	3. Other influential family members (i.e. mothers, mothers-in-law, grandmothers) of women of reproductive age
• Pregnant women with at least one child younger than four years old • Women who have newborn babies • Women who gave birth at home assisted by a TBA • Women who gave birth at home with a skilled attendant • Women who gave birth in a health facility • Women who had an obstetric emergency • Women whose newborn had some type of emergency * Excluding: women awaiting their first birth; well-known leaders in women's organizations, community, religious and/or political groups; TBAs	**Husbands or partners of:** • Pregnant women with at least one child younger than four years old • Women who have newborn babies • Women who gave birth at home assisted by a TBA • Women who gave birth at home with a skilled attendant • Women who gave birth in a health facility • Women who had an obstetric emergency • Women whose newborns had some type of emergency	**Influential family members of:** • Pregnant women with at least one child younger than four years old • Women who have newborn babies • Women who gave birth at home assisted by a TBA • Women who gave birth at home with a skilled attendant • Women who gave birth in a health facility • Women who had an obstetric emergency • Women whose newborns had some type of emergency
4. Community leaders	**5. Health care providers**	**6. Institutional forum**
• Representative of TBAs • Representative of health volunteers • Representative of traditional healers or doctors • Representative of community/ neighbourhood leaders • Representative of women's groups • Representative of neighbourhood councils or rural syndicates • Representative of civic or communal committees • Representative of religious groups • Representative of political groups • Representatives of indigenous groups	• Midwives • Obstetricians/gynaecologists • Paediatricians • Doctors (generalists) • Nurses • Health promoters • CHWs • Nurse and midwife auxiliaries • Administrative personnel • Pharmacists • Health educators • Psychologists or social workers	• Representative of district political authorities (mayor, governor, etc.) • Representative of district health authority • Representative of district education authority • Representative of district transport authority • Representative of religious institutions • Representatives of NGOs that work in health and especially in MNH • Representatives of the private/ business sector • Representatives of indigenous leaders • Community representatives (two participants elected from each individual roundtable) • Representative of mass media

3.7 STRUCTURE OF THE ROUNDTABLE DISCUSSIONS

The facilitation guide for the individual roundtables can be found in Annex 3. Those organizing and facilitating the roundtable are advised to study this annex in detail. It is estimated that each roundtable will last four and a half hours (half a day's work).

The aim of the roundtables is to discuss the situation and problems in the community related to MNH. Participants will work in three small groups to discuss issues related to the four priority areas of intervention of the IFC framework:

1. Care of the pregnant woman, mother and newborn at home (i.e. developing CAPACITIES)
2. Support in the community for the pregnant woman, mother and newborn (i.e. AWARENESS of MNH rights, needs and problems **AND** LINKAGES for social support).
3. Care received from the health services for pregnant women, mothers and newborns (i.e. improving QUALITY).

Participants first discuss the current situation in their community in these areas, and then identify a list of problems in each area. They also identify and note any positive factors (opportunities) in their community. Afterwards in plenary they select three priority problems in each priority area together. They also brainstorm about possible actions to help solve these problems. The institutional forum, discussed in section 4, will focus more on actions than these discussions.

At the conclusion of the discussion, the group will need to select two representatives who will present the outcomes of their discussion and represent their group during the institutional forum.

Since the time for the roundtable is limited (half a day), the agenda contains only group work and plenary discussion. It is possible, however, to adapt the guide to make it more interactive. Some suggested participatory activities are contained in Annex 7.

3.8 FACILITATION AND NOTE-TAKING DURING THE ROUNDTABLE DISCUSSIONS

The local coordinator is typically responsible for organizing the facilitation teams for each roundtable discussion, according to availability and needs. For each roundtable **a team of six** is recommended, which would generally include:

- Three facilitators: One facilitator for each small group. During the plenary sessions, one can facilitate while the others help take notes on the flipcharts and help to organize participants. See Box 3.3 on guidance for the selection of facilitators.
- Three note-takers: One note-taker per small group. During the plenary two can take notes and the other can help organize the room and participants. Note-takers must have the capacity to synthesize and summarize the ideas with precision.

The facilitators and note-takers can also assist with the registration of participants, the organization of the refreshments, the child minders and payment of transport costs, among other tasks. The note-takers and facilitators can switch roles, so long as each group has a skilled facilitator.

Box 3.3: Selection of facilitators

✓ Have experience in managing groups (group dynamics, active listening, managing situations of conflict or that involve the imposition of opinion or power of participants)

✓ Are dynamic

✓ Are familiar with the facilitation guide

✓ Are of the same sex as the group (female facilitators for women's groups, and male for men's groups), if feasible or if required

✓ Have a thorough knowledge of MNH and the IFC framework and its interventions

✓ Are neutral (they should not display political or religious affiliations or ideologies during the discussion)

✓ Are not well-known in the local area, such as well-known health facility staff or a well-known local leader (if well-known health services staff or public figures facilitate, participants may fear to criticize or speak their opinions about health and other public services)

✓ Are non-judgmental, unprejudiced, open-minded and willing to learn from the community

✓ Have good communication skills, including use of appropriate, simple and clear language and good listening skills

✓ Are able to speak local language(s) (if applicable)

✓ Are patient and able to work in a team

✓ Are culturally sensitive, and aware and respectful of local customs, norms and beliefs

Observers may also be present, although it is recommended not to have too many observers during the roundtables. If interested, selected representatives of the province or national committees could attend some of the roundtables. We suggest no more than two observers. Carefully consider whether they will have any effect on the dynamic of the group or the participants' ability to speak freely (for example, a well-known health authority representative). They can assist by taking notes and with analysis of the discussions. At no time should they participate directly in the discussion.

Some points to remember during the facilitation of the roundtable discussions are:

- The task of the facilitators is to promote the exchange of ideas, accepting that there are no correct or incorrect answers or comments. The task is to promote a dialogue among the participants that will identify MNH needs, problems and possible solutions.
- If during the session the participants have questions regarding MNH or if someone provides incorrect information, the team should make note of the point and clarify any doubts and points discussed at the close of the meeting. The facilitators can also provide leaflets on MNH, where possible.
- The facilitators should be prepared to adjust the agenda in response to sudden changes, such as late arrival of participants, lack of a meeting space, shortage of materials, the unexpected absence of a team member. Keeping the objectives in mind will help the assessment team decide how to respond to changes and challenges.
- The facilitators should remember to inform each group what the next steps are in the process after the roundtable discussions.

3.9 ANALYSIS AND REPORT OF THE ROUNDTABLE

Soon after each roundtable discussion, preferably the same afternoon or next day, the PCA team meets to discuss the roundtable and analyse the discussion and the information that was collected. Observers from the province and national committees who participated in the discussion can also help in the analysis of information. Annex 4 contains the analysis form that can be filled in after each individual roundtable. Each analysis form, once filled in, will serve as a report of the discussion.

3.10 SUMMARY REPORT FROM THE ROUNDTABLES

After the roundtables have been completed, a summary report of all five discussion groups needs to be written. We suggest keeping the report concise, limiting it to ten pages. A suggested format for the report is provided in Box 3.4.

To summarize the problems, opportunities and actions from the five different groups, the team can use Table 3.2. They can write up four tables, one for each priority area of intervention of the IFC framework. They should eliminate repetition of problems, opportunities and actions among the different groups and ensure that they are placed in the relevant area of the IFC framework.

After the summary report has been written, it is useful to have the entire PCA team who participated in the roundtable discussion review it.

Box 3.4: Suggested format for roundtable summary report

1. Short summary of participation in each roundtable (including characteristics of participants and the dynamic of the discussion)

2. Summary of the table of priority PROBLEMS, OPPORTUNITIES and ACTIONS for MNH in the community:
   - Care in the home of the pregnant woman, mother and newborn;
   - Awareness of the rights, needs and potential problems related to MNH;
   - Linkages for social support between women, families, communities and between; communities and the health delivery system;
   - Quality of care received from the health services.

Annex:
- Analysis forms from each individual roundtable.

Table 3.2: Compilation of priority problems, opportunities and solutions from the roundtables (with example included from Topic 2)

Fill out one table for each priority area of intervention of the IFC framework (developing CAPACITIES, increasing AWARENESS, strengthening LINKAGES and improving QUALITY). The classification scheme below may be used to identify the roundtables. These will later be used for the analysis of the roundtable (see Annex 4). Below is an example of "Strengthening Linkages".

Priority area of intervention 3: Strengthening LINKAGES for social support between women, families, communities and between communities and the health services			
Priority problems identified (and by which group?)	**Pertinent quotes on this problem (said by which group?)**	**Opportunities to help solve this problem**	**Actions identified to help solve this problem (and by which group?)**
For example: • Difficulties in travelling to the health facilities (W, G, M, P)	*For example:* • *"There is no point even trying to get to the hospital...it takes at least four hours to get there and by that time it will be too late" (M)*	*For example:* • New mayor committed to improving the state of the roads	*For example:* • Adapt public transport schedule to the needs of the population (W,P) • Free of charge transport for children and pregnant women (M, P, G) • Repair the roads (L,G)

W = woman's group, G = grandmothers and mothers-in laws, M = men's group, L = community leaders, and P = health care providers

4. THE INSTITUTIONAL FORUM

4.1 AIMS AND OBJECTIVES OF THE INSTITUTIONAL FORUM

The institutional forum is very similar to the other roundtable discussions in structure, but it has a slightly different aim. The aim of the institutional forum is to bring together local community members, community decision-makers and representatives of relevant institutions to present the IFC framework within the local MNH strategy, review the findings of the individual roundtables, and reach a consensus on the actions needed to help address the problems identified.

4.2 TIMING OF THE FORUM

The institutional forum is longer than the other roundtable discussions as it is designed to last 1.5 days. It is ideal to organize it at least two weeks after the final individual roundtable in order to allow enough time to finalize the summary report, invite participants and prepare for the meeting.

4.3 INSTITUTIONAL FORUM PARTICIPANTS

The institutional forum will include more participants than the roundtable discussions; however, it is advisable to not exceed 30 participants. As noted in Table 3.1, the institutional forum may include the following institutional stakeholders from the community:

- representative of district political authorities (mayor, governor, etc.);
- representative of district health authority;
- representative of district education authority;
- representative of district transport authority;
- representative of religious institutions;
- representatives of NGOs that work in health and especially in MNH;
- representatives of the private/business sector;
- representatives of indigenous leaders; and
- representative of mass media.

In addition to these different local stakeholders, this roundtable will normally also include:

- two representatives from each individual roundtable (ten in total);
- members of the district IFC committee who are not already participating as facilitators or note-takers; and
- one or two representatives of the province and national IFC committees.

4.4 PREPARING FOR THE INSTITUTIONAL FORUM

The following steps are important for preparing for this forum:

1. The PCA team delivers the invitations to the selected representatives and asks them to confirm their participation, both in verbal and written form. Inform them of the location, date and time of the session. It is important to inform them that the workshop will last 1.5 days. Participants representing the individual roundtables should be reminded of the date of the institutional forum.

2. The PCA team meets with the participants representing the individual roundtables to brief them on what will happen at the institutional forum. They explain that the purpose of the institutional forum is to provide an opportunity for policy-makers to meet and discuss the findings from the different community roundtables. The role of the representatives is to help explain the findings of the community roundtables and to make sure these are considered during the institutional forum. Remind them that the same rules will apply, including maintaining anonymity and confidentiality (i.e. do not mention specific names) of the other participants from the community roundtable which they are representing.

3. The PCA team prepares presentations in advance. They may also need to revise the presentations prepared for the individual roundtables, taking into consideration that the educational level of this group may be higher. Since this workshop lasts 1.5 days, there is also more time available. They are advised to prepare:

   a. presentations of the MNH strategy at national and/or province level and district level (including the IFC component);

   b. a presentation of an overview of the IFC framework, the PCA and their objectives; and

   c. a presentation of the situation analysis findings (see section 2.6).

The team should select in advance who will prepare these presentations, and practice them beforehand if needed, remembering to use simple language and terminology (see Annex 5 for more information).

4. They will also need to prepare other workshop materials, including:

   a. flipchart sheets summarizing the problems identified in the individual roundtable discussions (see Table 1 in Annex 5);

   b. handouts (photocopied) summarizing the priority problems and actions identified in the individual roundtable discussions (see Table 2 in Annex 5);

   c. a scoring chart for actions, either as photocopies or as a large flipchart (see Table 3 in Annex 5);

   d. activities charts, either as photocopies or as a large flipchart (see Table 4 in Annex 5); and

   e. copies of the IFC framework strategic document for group work.

It may be helpful to practice a run-through of the forum, to ensure all the preparations have been made.

4.5 FACILITATION OF THE INSTITUTIONAL FORUM

The workshop agenda and facilitation guide for the meeting is contained in Annex 5. The local coordinator needs to decide who is going to facilitate this forum. Since four small groups will be involved in this workshop, eight facilitators/note-takers will be required. The province or national committee members may be able to help facilitate the group work.

The institutional forum involves the following steps:

1. Introduction of the IFC framework, its objectives and priority areas of intervention;
2. Review of the results of the situational analysis and the five individual roundtable discussions (including priority MNH problems and actions);
3. Reaching a consensus on the priority problems and needs facing the communities of the district;
4. Review of the solutions proposed in the individual roundtable discussions and reaching an agreement on the recommended priority actions to contribute to improving MNH; and
5. For each priority action selected, identification of specific activities, actors to be involved and their roles, and the necessary resources, including the existing resources that can be leveraged in the development of subsequent plans.

4.6 REPORT OF THE INSTITUTIONAL FORUM

It is advisable for the facilitation team to meet soon after the workshop to write up a brief summary of the meeting. They may want to include the following information:

1. The meeting participants:
   - verify that the participant registration form is complete and annex it to the report; and
   - write a summary of participants including number of participants, where they come from, age ranges, and characteristics/profile. Also note the number of facilitators, note-takers and observers.
2. Reflection on the dynamic of the discussion:
   - Did some people participate more than others? Who participated more? Who participated less? What were the reasons?
   - Were there any interruptions?
   - Were there any problems in the discussion? (points of disagreement, problems reaching consensus, issues that need to be resolved in later discussions)
3. Type up the results of the meeting into clean tables:
   - the list of prioritized problems;
   - the actions identified and the actions prioritized;
   - Table 3: The scoring chart, including the prioritized problems and prioritized actions; and
   - Table 4: The activities chart.

5. FINAL REPORT AND RESULTS DISSEMINATION

5.1 WRITE-UP OF THE FINAL REPORT

The final PCA report contains the compiled information from the three key PCA activities:

- the situation analysis;
- the roundtable discussions and summary report; and
- the prioritized problems and actions from the institutional forum.

The report will usually be written by the local coordinator, with support from the PCA team and expert facilitator(s), as well as from the national and province committees. As with the previous reports prepared, it is important that it be concise, normally not exceeding 30 pages. Box 5.1 provides a suggested reporting format.

Box 5.1: Suggested format for PCA Final Report

1. Executive summary (one page)
2. Background information on the PCA (including objectives)
3. Situational analysis
   a. Methodology of the situation analysis, including sources used
   b. Situation analysis report
4. Roundtable discussions
   a. Methodology for the individual roundtable discussions
   b. Summary report of the five roundtable discussions
5. Institutional forum
   a. Methodology for the institutional forum discussion
   b. Summary report
6. Conclusions and recommendations of the PCA
7. Annexes
   a. Completed forms from the situation analysis
   b. Summary description of the participants from the roundtable discussions
   c. Analysis forms of the five roundtable discussions
   d. Tables from institutional forum

The local coordinator can draft the report, including the concluding paragraphs, and then meet with other team members to allow for review and comments. The expert facilitators and representatives from the province and national level can also help review the document.

5.2 FINALIZATION OF THE PROGRAMME OF WORK

Once the final report has been developed, the district IFC committee will move into the phase of finalizing an action plan in order to commence implementation of IFC activities and set up a system for monitoring and evaluating interventions. This process is introduced in section 3.7 of Module 1 and described in detail in Module 5 of the toolkit.

5.3 RESULTS DISSEMINATION

Ideally it is best to disseminate the results of the PCA once the district committee has developed its final action plan (see Module 5). This will help the community feel that the committee is acting rapidly on the findings. If results are disseminated earlier, the committee is strongly advised to move swiftly into the joint planning process.

At the district level, the results of the PCA and finalized action plan may be presented to the district and MNH committees. It may also be necessary to arrange face-to-face meetings with decision-makers who were not able to attend the institutional forum to present the PCA results to them. It may be helpful to reproduce copies of the report, or it could also be helpful to prepare a brief one-page summary of the PCA and its results.

It is also important to disseminate the results to the community. This contributes to accountability and transparency within the IFC component and also serves to maintain participation throughout implementation. The district IFC committee determines a strategy for dissemination to the community. For example, the results may be discussed with community groups, including those who participated in the PCA itself.

At the province and national levels, the results of the PCA and finalized plan should also be presented and discussed with the respective IFC and MNH committees. This meeting can also provide an opportunity to address the scale-up strategy of the IFC framework to other provinces or communities (see Module 1, section 2.16).

REFERENCES

Anderson T (1991). The reflecting team: dialogues and dialogues about the dialogues. New York: Norton.

Bateson G (1979). Mind and nature: a necessary unity. New York: Bantman.

Becker L, Pickett J, Levine R (2006). Measuring commitment to health: global health indicators working group report. Washington (DC): Center for Global Development.

Bhattacharyya K, Murray J (1999). Participatory community planning for child health: implementation guidelines. Arlington (VA): Basics Project.

Cecchin G (1987). Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. Fam Process. 26:405–413.

Cernea M (1992). Re-tooling in applied social investigation for development planning: some methodological issues. In Scrimshaw NS, Cleason GR, editors. Rapid assessment procedures: qualitative methodologies for planning and evaluation of health related programmes. Boston: International Nutrition Foundation for Developing Countries.

Comité Promotor por una Maternidad sin Riesgos en México (2006). Hacia la prevención de la mortalidad materna: guía para una estrategia comunitaria [Towards the prevention of maternal mortality: a guide for a community strategy]. Mexico City: Comité Promotor por una Maternidad sin Riesgos en México (in Spanish).

Commonwealth of Australia (2006). Cultural competency in health: a guide for policy, partnerships and participation. Canberra: Commonwealth of Australia.

Cornwall A, Pratt G, Scott-Villiers P (2004). Participatory learning groups in an aid bureaucracy. Brighton: Institute for Development Studies (Lessons for Change Series, No. 11).

De Negri B, Thomas E (2003). Making sense of focus group findings: a systematic participatory analysis approach. Washington (DC): Academy for Educational Development.

EngenderHealth (2001). COPE® for maternal health services: a process and tools for improving the quality of maternal health services. New York: EngenderHealth.

Family Health International (2010). Research ethics training curriculum, 2nd edition. Durham (NC, USA): Family Health International (http://www.fhi360.org/training/en/RETC2/index.html, accessed 17 January 2013).

Gonzales F, Arteaga E, Howard-Grabman L (1998). Scaling up the WARMI project: lessons learned mobilizing Bolivian communities around reproductive health. Washington (DC): Basics Project.

Hafeel A, Tagadur S, Payyappapallimana U, Shankar D (2001). Evaluación participativa rápida sobre las tradiciones locales de salud [Rapid participatory evaluation on local health traditions.] Revista Compas. No.4 Por el Desarrollo Endógeno (in Spanish).

Hanley B (2005). Research as empowerment? Report of a series of seminars organised by the Toronto Group. York: Toronto Group,Joseph Rowntree Foundation.

Howard-Grabman L, Snetro G (2005). How to mobilize communities for health and social change, a health communication partnership field guide. Baltimore: Health Communication Partnership.

International HIV/AIDS Alliance, FRONTIERS Prevention Project (2006). Tools together now: 100 participatory tools to mobilise communities for HIV/AIDS. Brighton (United Kingdom): International HIV/AIDS Alliance, FRONTIERS Prevention Project.

Laverack G (2005). Health promotion practice: power and empowerment. London: SAGE Publications.

Marsten C, Renedo A, McGowen CR, Portela A (2013). Effects of community participation on improving uptake of skilled care for maternal and newborn health: a systematic review. PLoS ONE. 8(2):e55012.

Maturana HR (1978). The biology of language: the epistemology of reality. In Miller G, Lennenberg EH, editors. Psychology and biology of language and thought. New York: Academic Press.

Maturana HR, Varela FJ (1987). The tree of knowledge. Boston: New Science Library.

Mielke E, Bradley J, Becker J (2001). Improving maternal and child health services through COPE. QA Brief. 9:(2).

MSPAS, CEES, OPS. Diagnóstico comunitario participativo en los municipios de Izalco y Nahuizalco, Departamento de Sonsonate, El Salvador [Participatory community assessment in the municipalities of Izalco and Nahuizalco, Department of Sonsonate, El Salvador.] San Salvador: Ministerio de Salud Pública, Concertación Educativa de El Salvador, Organización Pan Americana de la Salud (in Spanish).

Oltheten T (1995). Participatory approaches to planning for community forestry: results and lessons from case studies conducted in Asia, Africa and Latin America. Rome: Food and Agricultural Organization of the United Nations (Community Forestry Working Papers, No. 2).

Ottolenghi E, Riveros P, Blanding S (2008). Assessment of the Bolivia postabortion care community mobilization program. Washington (DC): United States Agency for International Development, Acquire Project.

PAHO (2002). Regional strategy for maternal mortality and morbidity reduction, Washington (DC): Pan American Health Organization.

PAHO (2005). Guía para el diagnóstico local participativo: componente comunitario de la estrategia AIEPI. [Guide for the participatory local assessment community component of the IMCI strategy]. Washington, (DC): Pan American Health Organization (in Spanish).

Palmer L (2006). Addressing the social dynamics of sexual and reproductive health: CARE's exploration with social analysis and community action. Atlanta: CARE.

Portela A, Santarelli C (2003). Empowerment of women, men, families and communities: true partners for improving maternal and newborn health. Brit Med Bull. 67:59–72.

SAFE International Research Partnership (2003). SAFE strategy development tool: a guide for developing strategies to improve attendance at delivery. Aberdeen: University of Aberdeen, The Dugald Baird Centre for Research on Women's Health.

Scrimshaw NS, Cleason GR, editors (1992). Rapid assessment procedures: qualitative methodologies for planning and evaluation of health related programmes. Boston: International Nutrition Foundation for Developing Countries.

Segal L (1986). The dream of reality: Heinz von Foerster's constructivism. New York: Norton.

UNHCR (2009). Resolution 11/8. Preventable maternal mortality and morbidity and human rights. In: United Nations Human Rights Council, eleventh session, New York, 17 June 2009. New York: United Nations Human Rights Council.

UNICEF, WHO, UNFPA (1997). Guidelines for monitoring the availability and use of obstetric services. New York: United Nations Children's Fund.

WHO (1986). Ottawa Charter for Health Promotion. Geneva: World Health Organization (WHO/HRP/HEP/95.1).

WHO (1994). Information support for new public health action at district level. Report of a WHO expert committee. Geneva: World Health Organization (WHO Technical Report Series, No. 845).

WHO (1996). Safe motherhood needs assessment. Geneva: World Health Organization.

WHO (2002). Making decisions about contraceptive introduction: a guide for conducting assessments to broaden contraceptive choice and improve quality of care. Geneva: World Health Organization (WHO/RHR/02.11).

WHO (2004). Child health in the community "Community IMCI", briefing package for facilitators. Geneva: World Health Organization.

WHO (2005a). Making pregnancy safer through district/municipality team approach: a problem solving process. Geneva: World Health Organization.

WHO (2005b). The world health report 2005: make every mother and child count. Geneva: World Health Organization.

WHO (2006a). Quality information in field research: training manual on practical communication skills for field researchers and project personnel. Geneva: World Health Organization.

WHO (2006b). Reproductive health indicators: guidelines for their generation, interpretation and analysis for global monitoring. Geneva: World Health Organization.

WHO (2010a). Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization (WHO/MPS/09.04).

WHO (2010b). Indicators for assessing infant and young child feeding practices, part 1, definitions. Geneva: World Health Organization.

WHO (2011). Research policy: developing proposals that meet ERC requirements. Geneva: World Health Organization (http://www.who.int/rpc/research_ethics/guidelines/en/index.html, accessed 17 January 2013).

WHO, UNFPA, UNICEF, Averting Maternal Death and Disability programme of Columbia University (2009). Monitoring emergency obstetric care: a handbook. Geneva: World Health Organization.

ANNEXES

Annex 1: Terms of reference for PCA facilitators

Annex 2: Forms for the situation analysis

Annex 3: Facilitation guide for the roundtable discussions

Annex 4: Analysis form for the individual roundtable discussions

Annex 5: The institutional forum

Annex 6: Checklist for organization of the roundtables/institutional forum

Annex 7: Additional participatory exercises for roundtable discussions

ANNEX 1: TERMS OF REFERENCE FOR PCA FACILITATORS

To carry out the PCA, it is important to identify facilitators for the roundtable discussions. It is useful to identify one or two **expert facilitators** who can support two **local facilitators**. Profiles for these persons are found in the table below.
Each country will pay or compensate facilitators in accordance with their specifications.

Expert facilitators (one or two persons)	Local facilitators (two persons)
Profiles	
• Knowledge of MNH issues • Significant experience in the execution and analysis of focus groups, systematic observation, community dialogue, roundtable discussions, life histories, among others • Experience in preparation of reports with conclusions, recommendations and findings • Significant experience in participatory and community processes • Experience in management of groups with diverse characteristics; skills in negotiation and facilitation • Experience in training on participatory methodologies	• Minimum education: Bachelor's degree or equivalent • Located in the intervention district or know it well • Demonstrate interest in MNH and/or are familiar with current activities in the district • Experience in participatory and community processes • Skills in interpersonal communication • Experience in management of groups • Analytical skills to participate in the analysis of information collected • Ability to review and comment on reports • Computer skills • Minimum experience: 2-5 years
Scope of work	

1. Attend meetings of the national committee and if appropriate, present progress on support provided
2. Support the local coordinator in carrying out all phases of development and implementation of the PCA, in particular the roundtable discussions, their analysis and preparation of reports
3. Train local facilitators and the PCA team on the different stages of the PCA
4. If required by the national, province or district committees could be a part of the team for design of intervention strategies at the local level
	1. Be trained in the different aspects of the PCA
	2. Participate in the activities for each phase of the PCA
	3. Identify participants for the roundtable discussions
	4. Assist the local coordinator in the organization of the individual roundtable discussions and the institutional forum
	5. In working groups with the expert facilitators and the local coordinator:
	  • Collect information for the situation analysis
	  • Analyse information collected in the different phases of the PCA
	  • Review and comment on the reports

ANNEX 2: FORMS FOR THE SITUATION ANALYSIS

Form 1: Description of the local area

Use this form to describe various different aspects of the intervention zone, including characteristics of the district area and population, economic activities, education, transport services, other basic services and media.

Form 2: Statistics on maternal and neonatal health in the local area

Use this form to record important statistics on maternal, perinatal and neonatal mortality and morbidity; other health indicators; and the coverage and use of services. If possible, provide data from national, province and district levels for the key statistics. Also, try to include data for both urban and rural populations or any information available disaggregated by wealth or socio-economic levels, where possible (usually available through Demographic and Health Surveys (DHS), for example).

Form 3: Health services in the local area

Use this form to record information about the health services network operating in the intervention area, especially with information on MNH provision. Specific information required includes the network of services, the health personnel working in the district area, communication and referral systems between different levels, availability of educational materials, and the monitoring, evaluation and epidemiological surveillance in the area.

Form 4: Inventory of institutions and organizations present in the local area

Use this form to identify the different social actors and stakeholders working in the intervention area. This information will also be very important when planning interventions after the PCA.

Form 5: Inventory of experiences in community health: a listing of programmes and projects

Use this form to document different programmes and projects in community health that have recently been or are currently being implemented in the intervention area. Try to document programmes that have had similar objectives to the IFC framework (for example maternal health education, community transport schemes, community involvement in quality of care). Also document the lessons learnt from these programmes so that successful initiatives can be built upon or unsuccessful approaches avoided. A summary sheet is available at the end to summarize the various different programmes and projects.

Form 6: Inventory of research in the local area

It is helpful to undertake a short review of studies that have been conducted in the intervention zone. This form can help summarize the results. The team should ask all the various partner institutions at national, province and district levels for any research reports related to MNH they might have.

Map of the district

Throughout data collection for the situation analysis, it will be useful to prepare a map of the district which locates:

- The health service network
- Distances to the referral hospital in case of neonatal and obstetric emergencies
- Principal towns or villages with population estimates
- Geographical obstacles to accessing services (mountains, rivers, etc.)
- Populations with special needs such as indigenous groups, extreme poverty areas, excluded groups, ethnic groups, marginalized populations, linguistic groups, etc.

Title page

Name of the local area: ....

Persons completing the forms:

....

....

....

Date: ....

FORM 1: Description of the local area

Sources used: ______________________________

A. CHARACTERISTICS OF DISTRICT AND ITS POPULATION:		
Type and size of population (urban, peri-urban, rural)		
Total population		
Number of women of reproductive age		
Population growth rate and/or total fertility rate		
Estimated number of pregnant women		
Number of newborns (←30 days)		
Names of areas with high poverty indices		
Identify and locate populations with special needs, such as indigenous groups, high poverty levels, excluded, ethnic, marginalized, linguistic groups		
Migratory trends (male and female)		
B. ECONOMIC ACTIVITY		
Average household income (indicate range, if possible)		
Employment: • % employed • % unemployed • % working in the informal sector		
Principal sources of income (e.g. agricultural, private enterprise, informal)		
% households headed by women		
C. EDUCATION		
Illiteracy		Overall rate: Male rate: Female rate:
School enrolment rates	Primary Secondary	Overall: Boys: Girls: Overall: Boys: Girls:
Average years of school attendance		Male: Female:
Number of primary schools in the local area (locate them on the map)		
Total number of secondary schools in the local area		
Total number of private schools in the local area		

D. TRANSPORT SYSTEMS	
Are there areas without a public transport system? Which?	
Type(s) of transport used by inhabitants to travel to nearest health service	
Average cost to travel to nearest health facility	
Time required via public transport to reach nearest health facility (indicate range for different localities in the district and indicate if this differs by season)	
Time required on foot to reach nearest health facility (indicate range for different localities in the district and indicate if this differs by season)	
E. OTHER BASIC SERVICES	
% of population with sustainable access to improved water sources	
% of households with electricity	
% of households without waste disposal	
Status of dwellings: % households with dirt floors % households with cement floors	
% households with telephone	
F. MEANS OF COMMUNICATION	
% households with radio	
% households with TV	
Number of local newspapers and magazines	
Number of local radio stations	
Local televisions channels	
Other means of communication, such as telephone, megaphones, word of mouth, cell phones, amateur radio	

FORM 2: Statistics on maternal and neonatal health in the local area

Sources used: ______________________________

Note: If you have data disaggregated by rural/urban population or by wealth index/quintile, then include it in these forms.

A. MATERNAL mortality and morbidity

- **National target for maternal mortality:** ______________

INDICATOR	National level		Province level		District level	
	Current	5 years ago	Current	5 years ago	Current	5 years ago
Total and absolute number of maternal deaths						
Maternal mortality ratio*						

***Maternal mortality ratio:** Number of maternal deaths per 100,000 live births. Estimate may not be available at province and district level.

INDICATOR	National level		Province level		District level	
	Causes	%	Causes	%	Causes	%
Principal causes of maternal mortality	**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**	

What are the most frequent causes of maternal morbidity in the local area?

____

____

____

B. PERINATAL, NEONATAL and INFANT mortality and morbidity

- **National target for perinatal mortality:** ________________
- **National target for neonatal mortality:** ________________

INDICATOR	National level		Province level		District level (if available)	
	Current	5 years ago	Current	5 years ago	Current	5 years ago
Perinatal mortality rate (week 22 of gestation through 7 days postpartum)						
Stillbirth rate						
Neonatal death rate (through 28 days postpartum)						
Infant mortality rate (during first year of life)						
% of neonatal deaths occurring in the first 7 days postpartum		X		X		X

Perinatal death rate: Number of perinatal deaths per 1,000 total births (live and still births)
Stillbirth rate: Number of stillbirths per 1,000 total births (live and stillbirths)
Neonatal mortality rate: Number of neonatal deaths per 1,000 live births
Infant mortality rate: Number of infant deaths per 1,000 live births during the reporting year

INDICATOR	National level		Province level		District level	
	Causes	%	Causes	%	Causes	%
Principal causes of perinatal mortality	**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**	
Principal causes of perinatal mortality	**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**		**1.** **2.** **3.** **4.** **5.**	

What are the most frequent causes of neonatal morbidity at district level?

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C. Other indicators in maternal and newborn health

INDICATOR	National level	Province level	District level
Life expectancy at birth			
Total fertility rate			
Median spacing interval between births (in months)			
% live births with low birth weight (less than 2.5 kg)			
Breastfeeding: Median duration of breastfeeding (in months): • All breastfeeding • Exclusive breastfeeding • Predominant breastfeeding			
Among those children who were breastfed, the % who: • Began breastfeeding within an hour of birth • Began during the first day following birth • Received solid foods before 4 to 6 months			
Median age of women at first birth			
% of all pregnancies to women under 18 years of age			
Abortion ratio (no. of abortions per 1,000 live births)			
% of women (15 to 44) using a MODERN method of contraception			
Condom use (%): • Men • Women			
HIV prevalence: • In the general population • Among pregnant women			
% of women reporting violence in the home during the previous year per type: • Verbal/psychological • Property and belongings • Physical • Sexual			
Other indicators relevant to the local area:			

D. Coverage and use of health services

COVERAGE	National level	Province level	District level
Antenatal care • % of pregnant women having at least one visit • % of pregnant women having at least four visits • Average week of pregnancy at first visit			
Average # of antenatal visits received by pregnant women			
% of pregnant women who have a plan for birth and complications			
% of births assisted by a skilled attendant			
% of institutional births (hospital/ health centre)			
% of births at home and assisted by: • Skilled attendant • Unskilled attendant			
% of deliveries by caesarean section			
% of women attending postpartum care: • Within the first 24 hours following birth • On day 3 (48–72 hours) following birth • Between 7–14 days following birth • At 6 weeks following birth			
% of newborns attending postnatal care: • Within the first 24 hours following birth • On day 3 (48-72 hours) following birth • Between 7-14 days following birth • At 6 weeks following birth			
Other indicators relevant to the local area:			

FORM 3: Health services in the local area

Sources used: ____

A. Service network

	Total number	Name/ location	Provide antenatal care with a skilled attendant?	Provide childbirth care with a skilled attendant?	Provide post-partum care for women with a skilled attendant?	Provide post-natal care for newborns with a skilled attendant?	Emergency obstetric care*	
							Basic	Comprehensive
Health posts								
Health centres								
Hospital								
Maternity waiting homes								
Private care facilities								

*** A basic emergency obstetric care (EmOC) facility is one that is performing these seven signal functions:** 1. Administer parenteral antibiotics; 2. Administer uterotonic (i.e. parenteral oxytocin) drugs; 3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia, (i.e. magnesium sulphate); 4. Manually remove the placenta; 5. Remove retained products (e.g. manual vacuum aspiration, dilatation and curettage); 6. Perform assisted vaginal birth (e.g. vacuum extraction, forceps delivery); 7. Perform basic neonatal resuscitation (e.g. with bag and mask). Source: WHO, UNFPA, UNICEF, and AMDD, 2009.

****Comprehensive EmOC has nine signal functions:** In addition to all of those included in basic EmOC, a comprehensive EmOC facility is one that also performs surgery (e.g. caesarean section) and blood transfusion. Source: WHO, UNFPA, UNICEF, and AMDD, 2009.

B. Health personnel in the local area

	Total number	Area and location of work	Public or private?	Trained during the previous 3 years in: • Community health • Health education • Health counselling • Other topics Specify which topics were covered.
Traditional birth attendants				
Other traditional providers (e.g. shaman or medicine men)				
Promoters/ health educators				
Auxiliary nurses/ auxiliary midwives				
Nurses				
Midwives				
General medical practitioners				
OB/GYNs				
Neonatologists/				
Paediatricians				
Anaesthesiologists				
Others:				

Are there sufficient health personnel to meet the maternal and newborn health needs of the district? Is sufficient staff available at all times? Are there any population segments excluded?

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C. Communication and referrals

TOPICS	Description
Communications mechanisms between health services and the community CHWs, health talks, radio, etc.)	
Communication and referral mechanisms between traditional birth attendants/CHWs and health services	
Communication and referral mechanisms between health centres and the referral hospital	
Health services in the district that have a functioning ambulance and a budget for fuel to operate it, for the transportation of obstetric/neonatal emergencies to the next level of referral	

D. Educational materials

If possible, collect copies of the educational materials that are used in the health services at the different levels of care.

Complete the table

Materials on:	Do they exist? (Yes/No)	Are they available and in use by health services? Indicate name of the materials and service which is using.	Are they used in the communities. Indicate name of the material and agency which is using.
Care during pregnancy			
Birth and complications plan			
Post-partum care			
Care of the newborn			
Breastfeeding			
Family planning			
HIV/AIDS			
Malaria in pregnancy			
Violence in the home			
Other topics: *Specify*			

Make a list and briefly describe any educational activities carried out in the local area during the last 12 months:

E. Monitoring, evaluation and surveillance

Describe the surveillance system for maternal and neonatal health, and the information and data transmission systems between the different levels (including the community):

FORM 4: Institutions and organizations present in the local area

Sources used: ____

A. Inventory of institutions and organizations

Note: Review Form 2 to help in identifying the organizations working in the district.

Institutions and organizations (names)	Location	Director	Main activities
1. NGOs that work on health issues			
2. NGOs that work on education issues			
3. NGOs that work on other related issues (including rights, social support, etc.) (specify)			
4. Community groups (for example, health committees, women's groups (mother clubs, work groups, etc.), school parent groups, groupings of neighbourhood councils, associations, or farmer associations)			
5. Public institutions and local authorities (for example mayor's offices, police, social security, education)			
6. Religious institutions (for example churches, mosques)			
7. Private sector (large and small businesses who employ persons from the community, institutions, etc.)			
8. National and international organizations (including universities, international NGOs, donors)			

B. Institutional and organizational communication:

1. What means of coordination exist between the identified institutions/organizations and the community?

____

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2. What activities are carried out in the community that promote health care? What person/institution is in charge of these activities?

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3. What health promotion activities are being carried out by local NGOs? Do they coordinate their activities with health services and the community?

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FORM 5: Inventory of experiences in community health

Sources used: ______________________________

(a) Inventory of experiences: Summary table

Name of programme or project	Objectives	Period of implementation	Geographic area	Organizations institutions involved

(b) Individual programme/project listings (photocopy form as required)

Name of programme, project or initiative:

Implementing organization: Partners:

Implementation period:

Contact (name, email or physical address, telephone):

1. Geographic areas

Province(s)	District	Villages or communities	Health service(s) (names)	Urban/rural

2. Financing and other assistance:

Financed by	Amount	Other technical assistance

3. Target population characteristics:

Number of communities	
Ethnic group(s)	
Poverty index	
Target populations, groups or segments (pregnant women, adolescents, adults, etc.)	
Size of populations	

4. Intervention

Programme/project objectives	
Summary of specific interventions	
Expected or achieved results	
Lessons learnt	
Partnerships or collaboration with: • Community organizations • Other organizations (specify) • The health sector • The education sector (specify) • Other actors (specify)	

Other comments:

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FORM 6: Inventory of research in the local area

Prepare a list of research, including maternal or perinatal death reviews or "near-miss" analysis, studies about local MNH-related practices and beliefs and on other themes of health, education and social development that have been carried out in the past 5-10 years in the district.

Title of research activity	Main issues under study	Specific year(s) of study	Population being studied/ geographical area	Type of study (epidemiological, sociological, ethnographic, qualitative, etc.)	Name of research organization with contact information

ANNEX 3:
FACILITATION GUIDE FOR THE ROUNDTABLE DISCUSSIONS

Roundtable discussion overview with materials needed[5]

Total time required: 4 hours 30 minutes

Time	Activity	Materials required
15 minutes	Participant registration with refreshments	• Registration form • Snack
40 minutes	**Introduction:** • Presentation of MNH strategy and objectives of the roundtable discussion • Verification of voluntary participation • Overview of the agenda • Presentation of participants • Presentation of the discussion rules • Presentation of the situation analysis results	• Flipchart with objectives • Prepared presentation • Flipchart with discussion rules • "Care of the pregnant woman, mother and newborn" diagram • Name cards for participants (with marker pens)
1 hour and 30 minutes	**Group work: Problems and opportunities (three working groups)** • Introduction to the group work • Group discussion on situation, problems and needs: 1. Care in the home for the pregnant woman, mother and newborn 2. Support in the community for the pregnant woman, mother and newborn: (a) Awareness of MNH rights, needs and problems (b) Linkages for social support 3. Care received from the health services for the pregnant woman, mother and newborn	• Flipcharts and markers • Speaker timer symbol
30 minutes	**Refreshments**	**Food and drinks**
1 hour and 15 minutes	**Plenary: Situation, problems and needs, and possible actions** • Reports from groups with comments, questions, clarifications after each group report • Discussion and consensus on the three main problems for each area • Brainstorm on solutions	• Flipchart and markers • Coloured dots/stickers • Speaker timer symbol
20 minutes	**Closing:** • Short summary of the discussion • Selection of two group representatives for the institutional forum • Evaluation of the discussion • Thank-you • Payment of transport costs • Contact information	• Money and receipts for transport costs

[5] Note: If more time is available for the roundtables, the agenda can also be adapted. Annex 7 contains participatory tools that can be used in addition to the sessions listed above or that can be used to facilitate these sessions.

Sessions in detail

1) Introduction (40 minutes)

Note: The presentations listed below will need to be prepared in advance.

- **Presentation of MNH strategy and the roundtable objectives (10 minutes):** First, briefly introduce the broader MNH strategy that the Ministry of Health and its partners are undertaking in the district area or nationally to address MNH needs. Explain that as part of this strategy consultations are being organized with different community members to get their perspective on the problems and needs, as well as possible solutions. Explain to the participants which group they are representing (mothers, grandmothers, men, etc.), and what the objectives are. Write the objectives on a flipchart beforehand.

> ***Objectives***
>
> 1. To discuss the health of pregnant women, mothers and newborns in our community.
> 2. To identify the key problems that prevent pregnant women, mothers and newborns from receiving the care and attention they need.
> 3. To identify some possible actions to help solve these problems.

Explain that their opinions are very important in planning actions to improve MNH in their community. In addition, it is their right to participate in determining the needs that they think are most important to address and plan the activities meant to benefit them and the community. This discussion today can be part of fulfilling this right.

- **Describe the process (3 minutes):** Explain that today they will work in small groups to identify problems that prevent pregnant women, mothers and newborns from receiving the care and attention they need. A facilitator will ask questions and a note-taker will record what they discuss. They will then work with the larger group and share the different problems and solutions identified. Emphasize that NOT all the problems are going to be discussed today, but that this discussion is a starting point. Explain that a report will be written of all the different roundtables held and will be presented at the institutional forum. During the forum, different representatives from local authorities and local organizations will develop a plan to improve MNH based on the different inputs received. Explain what will be done with the information collected following the roundtables (i.e. how the registration forms will be stored, and when they will be destroyed).

- **Verification of voluntary participation (2 minutes):** Explain to the participants, as was already mentioned to them when they were recruited and registered, that their participation is voluntary. They can decide to withdraw at any time without any consequences. Before explaining the schedule, confirm that all participants feel comfortable and agree to participate. If they have any questions or concerns, they may bring them up at any time.

- **Overview of the agenda (5 minutes):** Review the agenda with the group and ask if they feel comfortable with it. Confirm that the entire meeting should take about four and a half hours. Explain that there will be a session where they will work in smaller groups and then come back to the larger group for plenary discussion.

- **Presentation of the participants (5 minutes)**: Ask each participant to present themselves (name, where they are from, what they do, etc.). You can use a group dynamic (keeping in mind time constraints) or ask participants to say something original about themselves. Ask all the facilitators, note-takers and observers to present themselves as well.

- **Presentation of the discussion rules (5 minutes):** Explain that their participation is appreciated and valuable to the process. Explain that it is important to hear from everyone and to make sure that everyone feels comfortable presenting their views. In order to assure an open discussion and a comfortable environment, go over the discussion rules with the group (see box), and ask them if they agree or would like to remove or add other rules. Show the participants the "speaker timer symbol" (for example a smiley face) that means they have talked for more than 3 minutes, and should allow others to talk instead.

Discussion rules for the roundtables

- All ideas, opinions and suggestions, whether positive or negative, are welcome.
- Everybody has the right to express their opinions and participate.
- Tell the facilitators if something is unclear.
- It is important not to dominate the conversation, and to give others the opportunity to express their ideas.
- Let each person finish his/her idea.
- Everything discussed is confidential and should not be talked about with others outside of the meeting. Do not mention the names, surnames, or situations that were discussed.
- It is important to listen and to be listened to.
- Language used must be respectful and not threatening.
- Participants should only talk about the topic under discussion.
- Participants should not talk for more than three minutes at one time.
- Participation is voluntary, therefore you may withdraw your participation at any time.

- **Presentation of the situation analysis results (10 minutes):** The facilitators provide a brief and simple presentation of some of the key findings from the situation analysis. We recommend that the key data on MNH from Form 2 (Annex 2) be presented. Since participants may not understand percentages, rates or other complex statistics, the team should try and keep the data simple and/or use pictures or drawings to help demonstrate key points. A flipchart or PowerPoint can be used. If PowerPoint is used, it is advised to not exceed five slides.

2) Small group work: MNH problems and opportunities (1 hour and 30 minutes)

Introduction to the group work: Show the image "Care of the pregnant woman, mother and newborn" on a flipchart or poster (see below). The image shows four levels of care or support that affect the health of pregnant women, mothers and newborns. Explain the four areas to the group.

1. **Care in the home for the pregnant woman, mother and newborn:** The first level is the care the pregnant women, mother and baby should receive in the home. This includes care during pregnancy, childbirth, after childbirth and for the newborn, for example:
    - eating enough healthy foods;
    - washing regularly;
    - avoiding heavy work;
    - knowing the danger signs during pregnancy, after birth and for the baby;
    - seeking care from health services;
    - discussing in the home what to do in an emergency;
    - using family planning to space births;
    - exclusive breastfeeding; and
    - receiving support from husbands/male partners and other family members, etc.
2. **Awareness in the community of the rights, needs and problems of the pregnant woman, mother and newborn:** The second level of care includes:
    - awareness in the community of the rights of the pregnant woman, mother and baby to appropriate care;
    - awareness in the community about the problems that the pregnant woman, mother and baby face; and
    - awareness among men of their role in MNH.
3. **Links between services and the community:** The third level is also at the community level, and focuses on the social support linkages between the community and individual families and women, as well as social support linkages between the community and the health services. It includes:
    - care and support for women and newborns from community groups, local authorities and institutions;
    - the ability to reach health services in the community, for example, being able to reach health workers or the clinic/hospital, or having support to get to care;
    - making sure that costs for care do not impede women and babies from using care; and
    - relations and communication between the community and health services to ensure that services respond to community needs.
4. **Care received from the health services:** Finally, the last level of care is received from the health services themselves, for example:
    - costs of services;
    - the hours that services are open;
    - the way the providers interact with women and their families;
    - the number of doctors, nurses and midwives;
    - the availability of medicines; and
    - the way health services take women's and community perceptions into consideration.

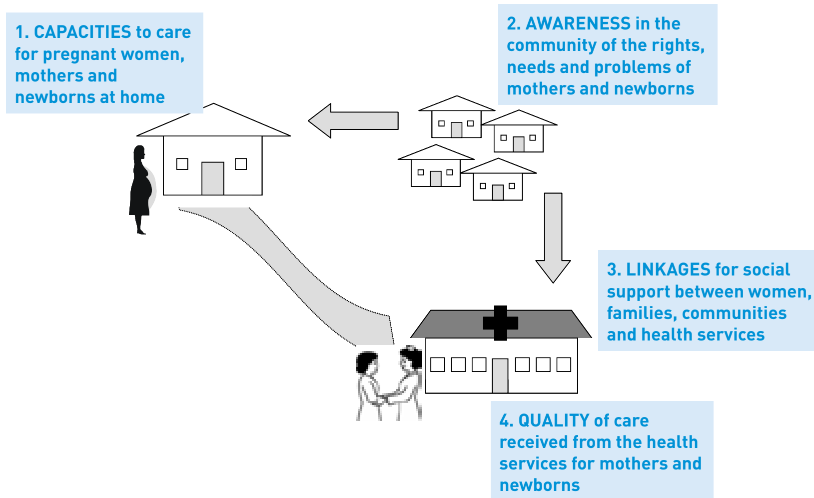

Diagram: Care and support of the pregnant woman, mother and newborn

Mention that often there are many problems at each of the levels and we would like to discuss them in small groups. Explain that Group 1 will work on level 1 (care in the home), Group 2 will work on levels 2 and 3 (awareness and linkages) and that Group 3 will work on the fourth level (quality of health services).

Divide the participants into 3 groups. Each group will ideally have one facilitator and one note-taker.

The group work process:

1. Before starting, ask each group to select a representative who will report the group's work to the plenary group. If the group does not feel comfortable presenting in plenary, then tell them that you (the facilitator) can present on their behalf.

2. Prepare a large flipchart and put the group name at the top. On one sheet write "problems" and on another sheet write "opportunities".

3. Help the group to discuss what the current situation is in their community related to this topic, and what some of the key problems are. It is important to take into account the different needs of:

   - pregnant women;
   - women and their babies during birth;
   - women after birth;
   - newborns.

   A list of questions to guide the discussion of each theme is proposed in the table below. You can complete the list or adapt it, but it is important that the main issues be addressed. As they discuss their situation, help them write this up into a list of problems on the flipchart. Keep probing to help them define the problem more clearly, for example, "Why do women not eat well?", "Why do women prefer to give birth at home instead of in the health centre?", etc. Try to write down related problems together and avoid repeating the same points.

4. If they mention any positive things about the situation, write these on the "opportunities" sheet (although they may not necessarily identify any).

5. NOTE: It is important to remember to keep the discussion focused on MNH, and help the group to write down problems and needs related to MNH.

6. Help the group prepare the presentation to the plenary, by doing a summary on a flipchart.

The discussion guide:

(To be adapted at the national and local level)

Level of care	Questions to guide discussion
GROUP1: 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 prenatal check-ups, 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 care for 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)* **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)* **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)* **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?
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 that 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)* **2.** Who in the community supports the health of pregnant women, mothers and newborn? What do they do? *(think about CHWs, TBAs, support groups, any other people or groups?)* **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)* **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)*

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, number of midwives, doctors and nurses, cultural differences between the community and the services, etc.)* **2.** Do people have to pay for MNH 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 CHWs 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?

Note-taking during the group discussion

During the group discussion, the note-takers should take careful notes of the discussion, including:

- the discussion of the current situation;
- the problems and needs identified (from the flipchart);
- pertinent quotes that support the points being made;
- positive opportunities that are present in the community.

The note-takers can use special sheets to capture these elements from the discussion (see next page for example).

Sample note-taking form

ROUNDTABLE:______________ GROUP: ____________________________DATE: ____________

Question/topic area	What is the current situation?	What problems and needs are identified?	Supporting quotes	Opportunities to improve the situation
For example, write: Care in the home of the woman during pregnancy				

------------------------------------ **REFRESHMENT BREAK** ------------------------------------

During the break, the facilitators and note-takers are advised to take some time to review the list of problems identified in the group work, and check that they are clearly defined. If opportunities were identified, they can review these as well. They should also verify that there is no repetition in the problems identified by the group or between groups.

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3) Plenary session: Problems, needs and actions (1 hour and 15 minutes)

Ask one facilitator to facilitate the session, one to take notes on the flipchart, and two can take notes of the discussion.

Prioritizing problems:

1. Ask the representative (or facilitator) from each group to present a summary of the discussion with the list of problems identified. Try to limit each presentation to five minutes.

2. After each topic is presented, tape the flipchart sheet(s) to the wall. Put up all the "problem" sheets next to each other.

3. After each presentation, ask the plenary group if they have questions or comments, whether they agree with the problems identified, and/or if they would like to add or remove any problems for this topic.

4. Explain that they now must **prioritize** this list of problems, i.e. they have to select the most important problems. To help identify the most important problems, they should think about **the problems that most affect the health of mothers and newborns, particularly for the poorest families.**

5. Hand out a strip of 12 coloured dots (stickers) to each participant. Ask everyone to come up to the flipcharts, and select three problems from each group/level that they think are the most important (stick one dot next to each priority problem). If the same problems are repeated on different sheets, they should try not to choose the same problem more than once. Help those who cannot read by identifying the problems they feel are important. If there are many people who cannot read, then work with the larger group and read each list of problems and try to come to a consensus by discussing in plenary.

6. After they have voted with the dots, add up the tally and circle the priority problems identified by the group. Let the group review and reflect on the priorities selected and see if there are any objections or points to clarify.

Identifying actions to help solve the problems

7. Next, ask the group to brainstorm about actions to help solve the priority problems they have just identified.

8. Prepare flipcharts as follows:

Table 3.2: Action grids

Level of care or support: e.g. Care received from the health services	
Priority problems identified	**Actions to help solve the problems***
Problem 1:	
Problem 2:	
Problem 3:	

9. Write the three priority problems just identified in the left-hand column.

10. Ask each group representative or note-taker to present the list of opportunities that they identified during the group discussion.

11. The group should then brainstorm actions to help solve their problems. Remind them to think about:

- the opportunities that they have discussed in their group work;
- any other ongoing activities and programmes in their community, and whether these should be continued and/or strengthened; and
- actions at various levels, including policy actions, health service actions, community actions, and household actions.

12. Write the responses on the flipcharts. They can put a star next to actions that are ongoing in the community.

13. Once they have finished discussing and brainstorming, read over the sheets again to check that they agree with their recommendations.

*Note: Mark ongoing or existing actions with a star

4) Closing (20 minutes)

- **Short summary of the discussion (5 minutes):** Briefly summarize what has been discussed, and thank participants for their contributions and participation.

- **Selection of group representatives for the institutional forum (5 minutes):** Explain that a roundtable discussion with institutional representatives and decision-makers (give examples) will be held later to review the results of all the roundtables and propose some possible actions. Explain that you would like to select two representatives from this roundtable to represent the community at that workshop. Explain that the institutional forum will last one and a half days, and that the people chosen should be able to dedicate this amount of time. If nobody can attend for the whole meeting, ask if anybody can attend for the first day only. The facilitators should help the group select two representatives (usually two of the more active participants). Once the participants have been selected determine a time to meet with them to discuss and prepare them for their participation in the institutional forum (see above section 4.4).

- **Evaluation of the discussion (5 minutes):** Explain to the group that other activities like this will be held with other groups and in other communities and you would like to ask them to help improve it. Ask the following questions to the group:

  - What is your opinion of this roundtable discussion?

  - Was there good participation? Why yes, or why not?

  - Did you feel comfortable with the themes discussed?

  - Are there other themes that we should have included?

  - What would you suggest to improve this roundtable discussion?

- **Thank you (5 minutes):** Thank the participants for attending the discussion and giving their time to contribute to a process that aims to improve the health of women and newborns in the community.

- **Payment of transport costs:** Pay transport costs to participants (only to those who require it).

- **Contact information:** Repeat the information for the person the participants should contact in case of additional questions.

ANNEX 4:
ANALYSIS FORM FOR THE INDIVIDUAL ROUNDTABLE DISCUSSIONS

Overview

1. Comment on the organization of the roundtable (including logistics, organization, facilitation and note-taking), and write up any suggestions for changes that can be taken into account for the next discussion group.

2. From the registration forms create a registration table that includes the participant profiles (such as sex, age, marital status, education level, ethnicity, profession, location (rural vs. urban, etc.). However, do not include the participant's names, but instead insert "P1" or "Mrs X". This can help ensure the anonymity of the participants. Once the registration table is complete (annex it to this form) and write a summary including the number of participants, where they come from, age ranges, and characteristics/profile. Also note the number of facilitators, note-takers and observers.

3. Write a reflection on the dynamic of the discussion:

   - Did some people participate more than others? Who participated more? Who participated less? What were the reasons?

   - Were there any interruptions?

Analysis of problems and needs

4. Take the flipchart sheets for each of the groups, and read through the notes from the note-taker. Fill in Table 1 below. Make sure that the problems are clearly defined when you write them up. If the meaning is not clear, check if the note-taker captured the meaning of the discussion. If there is still repetition of problems within one group, try to delete repeated statements. Put an asterisk (*) next to the problems identified as "priority" during the plenary.

Table 1: Overview of current situation, problems and opportunities

Summary of the current situation	List of problems identified *(asterisk the priority problems)*	Supporting quotes	Any opportunities identified?
Care of the pregnant woman, mother and newborn in the home			
Awareness in the community of MNH rights, needs and problems			
Linkages for social support			
The quality of care received from the health services			

Analysis of actions

5. Take the flipchart sheets from the actions plenary session and write up the results in Table 2 below.

Table 2: Priority problems and actions

Level of care/support	Priority problems	Actions identified
Care of the mother and newborn in the home	1.	
	2.	
	3.	
Support in the community	1.	
	2.	
	3.	
Care received in the health services	1.	
	2.	
	3.	

Conclusion

6. Were there any problems during the discussion? (points of disagreement, problems reaching consensus, issues that need to be resolved in later discussions)

7. Was there anything discussed in the group that you feel should be discussed in subsequent roundtables? If so, you may wish to adapt your question guide.

8. Is there anything that was discussed that will be important to highlight during the institutional forum?

ANNEX 5: THE INSTITUTIONAL FORUM

Overview of the materials needed

Total time required: 1.5 days

Day 1		
Time	**Activity**	**Materials required**
15 minutes	**Participant registration with refreshment**	• Registration form • Snack
45 minutes	**Introduction:** • Presentation of participants • Presentation of the objectives of the roundtable discussion • Overview of the agenda • Presentation of the discussion rules	• Flipchart with objectives • Flipchart with discussion rules • Name cards for participants (with marker pens)
30 minutes	**Presentation of the national and district MNH and IFC work plans:** • Presentation of national MNH and IFC plans • Presentation of district MNH and IFC plans	• Prepared presentations • Overhead projector
30 minutes	**Refreshments**	**Food and drinks**
30 minutes	**Presentation of the IFC framework and PCA** • Presentation of the objectives of the IFC framework the four priority areas of intervention • Presentation of the PCA objectives and methodology • Questions and discussion	• Prepared presentation • Overhead projector • "Care of the pregnant woman, mother and newborn" diagram
30 minutes	**Presentation of the situation analysis results** • Presentation by local coordinator or other district IFC committee members • Questions and discussion	• Prepared presentation • Overhead projector • Copies of slides or report for participants
1 hour and 30 minutes (total)	**Plenary: Prioritization of problems** • Overview of the problems identified in the roundtables, for the four priority areas of intervention: 1. Care in the home for the pregnant woman, mother and newborn 2. Awareness of MNH rights, needs and problems 3. Linkages for social support 4. Care received from the health services for the pregnant woman, mother and newborn • Discussion • Prioritization exercise	• Flipcharts and markers • Table 1 prepared as four flipcharts. • Coloured dots/stickers • Markers
1 hour 30 minutes	**Lunch**	**Food and drinks**
30 minutes	***Plenary continued...***	
2 hours	**Group work: Review of recommended actions** • Four groups review actions identified in the individual roundtables • Discussion • Finalization of list of actions for the two retained priority problems • Scoring exercise	• Handouts with priority problems and actions identified in the individual roundtables (Table 2) • Four copies of the IFC framework • Scoring chart (either photocopies or as a flipchart) (Table 3) • Flipchart and markers

Day 2		
Time	**Activity**	**Materials required**
1 hour 30 minutes	**Plenary: feedback from group work on actions** • Each group presents back their prioritized actions using Table 3 • Questions and discussion	• Flipcharts and markers • Speaker timer symbol
30 minutes	**Refreshments**	
1 hour	**Group work: Activities and resources** • Four groups fill out Table 4 on activities and resources	• Copies of Table 4 (activity chart) or large flipcharts
45 minutes	**Plenary: feedback from group work on activities and resources**	
30 minutes	**Closing:** • Next steps • Short summary of the discussion • Evaluation of the discussion • Thank-you • Payment of transport costs	• Money and receipts for transport costs • Evaluation forms

Sessions in detail

1) Introduction (45 minutes)

Note: The presentations listed below will need to be prepared in advance.

- **Introduction of the participants (20 minutes):** Ask the participants to introduce themselves (name, where they are from, position, what they do, etc.). Ask all the facilitators and observers to present themselves as well.

- **Presentation of the objectives of the institutional forum (5 minutes):** Explain to the participants why they have been invited to the discussion, and what the objectives are. Write the objectives on a flipchart beforehand:

Objectives

1. To understand the local maternal and newborn health strategy, including the framework *Working with individuals, families and communities to improve maternal and newborn health* (IFC).
2. To review the findings from the situation analysis and the individual roundtable discussions.
3. To use this information to identify priority problems and key actions for working with individuals, families and communities to improve maternal and newborn health.
4. To identify actions and resources to support the development of the IFC action plan.

Highlight that they are providing inputs for developing an action plan. Their inputs will be reviewed by the district committee who will then use their draft to finalize an action plan. It is important to underline that **their draft plan will be changed and is not final.**

- **Overview of the agenda (10 minutes):** Review the agenda with the group and ask if they feel comfortable with it. Confirm that the entire meeting should last about one and a half days. Explain that there will be sessions where they will work in smaller groups and then come back to the larger group for plenary discussion.

- **Presentation of the discussion rules (10 minutes):** Go over the discussion rules with the group (see box below) and ask them if they agree, or would like to remove or add other rules. Show the participants the "speaker timer symbol" (for example a smiley face) which means they have talked for 3 minutes, and should allow others to talk instead.

2) Presentation of the national and district MNH and IFC plan (30 minutes):

- **National and/or province presentation (15 minutes):** A member of the national and/or province IFC committees presents their programme of work on MNH, including the IFC framework.
- **District presentation (15 minutes):** A member of the district IFC committee (either the committee chair or coordinator) presents their work on MNH and the IFC framework.

Discussion rules for the institutional forum

- All ideas, opinions and suggestions, whether positive or negative, are welcomed.
- Everybody has the right to express opinions and participate.
- When something is unclear we will tell the facilitators.
- It is important not to dominate the conversation, giving others the opportunity to express their ideas.
- Let each person finish his/her idea.
- Everything talked about during the meeting is confidential and should not be discussed with others outside of the meeting. This includes the names, surnames, or situations that were discussed. The topics can be talked about in general, but not the people or the specific situations discussed.
- It is important to listen and to be listened to.
- Language used must be respectful and not threatening.
- Participants should only talk about the topic under discussion.
- Participants should not talk for more than three minutes at one time.

3) Presentation of the IFC framework and the PCA (30 minutes)

- Present the IFC framework including the objectives and priority areas of intervention.
- Introduce the four levels of care and support, e.g. care in the home, awareness in the community, links between the community and health services, and quality of health services. Use the image "Care and support of the pregnant woman, mother and newborn" (on a flipchart or poster).
- Present the objectives of the PCA and the methodology used.
- Ask the participants whether they have questions or comments.

4) Presentation of the situation analysis results (30 minutes)

- The local coordinator presents the key findings from the situation analysis (maximum 10 slides).
- Distribute copies of the PowerPoint presentation to all the participants.
- Questions and discussion.

5) Plenary: Review of problems identified in the five roundtables and prioritization (1 hour 30 minutes)

Before the roundtable:

Prepare four large flipcharts with the prioritized problems in the five different roundtables for each level of care and support, and the group who identified those problems as per Table 1 below.

Table 1: Summary of problems (to prepare and fill in BEFORE the meeting)

Topic : e.g. Care and support of the pregnant woman, mother and newborn at home	
Priority problems identified	**Groups that identified them**
For example:	
Women and families are not aware of danger signs during pregnancy	Women, groups that identified them and mother-in-laws, providers
Women do not eat properly during pregnancy due to lack of time and money	Grandmothers and mother-in-laws, men
etc.	

During the roundtable:

- The facilitators present the problems prioritized by the different groups on four large flipchart sheets prepared before the meeting (one for each level of care and support, e.g. household, awareness, links and health services) as shown in Table 1. They may also choose to present these findings in a PowerPoint presentation. The presenter can elaborate the reported problems using some of the quotes written up from the meetings (see Table 3.2, section 3). S/he also asks the group participant representatives to confirm if the findings are correct, and if they have anything to add about their roundtable discussion.
- Ask the participants to review the problems identified during the roundtables for each level of care, one at a time. Highlight problems that were identified by many groups and ones that were not. Also highlight problems that are common to more than one theme and appear in more than one flipchart (for example, poor quality health services may affect the decision to seek care, as well as the care received in the health facility). Elaborate or reformulate the problems if necessary.
- Ask the plenary group whether they feel there are any other priority problems that may not

have been considered by the previous groups that they feel should be added. See if others agree, and if so, add them to the list.

- Next, ask the plenary group to prioritize these problems. To help identify the most important problems, **they should think about the problems that most affect the health of mothers and newborns, particularly for the poorest families.**
- Hand out a strip of eight coloured dots/stickers to each participant. Ask them to come up to the flipcharts and use the dots **to prioritize two problems for each level of care**.
- When they have finished placing their dots, count up the dots and circle the two priority items for each level of care. Check whether the group is happy with its decision.

6) Group work: Review of recommended actions (2 hours)

Before the roundtable:

- Prepare handouts with the problems prioritized from the five different roundtables and actions identified for each level of care and support, as per Table 2 below. Remember to include the group who identified those problems and actions.
- Prepare copies of the IFC framework strategic document[6], one per group.

Table 2: Compilation of priority actions from the roundtables, with examples included (to prepare and fill in BEFORE the meeting)

Topic : e.g. Links between the community and health services	
Priority problems identified (and by which group)	**Actions identified (and by which group)**
For example: Difficulties in travelling to the health facilities (W, G, M, P)	*For example:* • Adapt public transport schedule to the needs of the population (W,P) • Free of charge transport for children and pregnant women (M, P, G) • Repair the roads (L,G)

W = Women, G = Grandmothers and mothers-in-law, M = Men,
L = Community leaders, and P = Health care providers.

[6] Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2010. http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/index.html

During the roundtable:

- Briefly explain that five community roundtable discussions were held, the different profiles of each (e.g. women of reproductive age, etc.), and provide a summary description of the participants as noted in number 2 in Annex 4 above.

Group discussion:

- Divide the participants into four groups:

  1. Care and support of the pregnant woman, mother and newborn in the home (developing **CAPACITIES**)

  2. Awareness in the community of MNH rights, needs and potential problems (increasing **AWARENESS**)

  3. Links between the community and health services (strengthening **LINKAGES**)

  4. The care received from the health services (improving **QUALITY**)

- Ask each group to nominate a representative to present their work in plenary.

- Distribute one copy of the IFC framework strategic document to each group and ask them to look at the page with the priority areas of intervention (page 12). Explain that the IFC interventions are recommended at a global level because they have proven to have an impact on MNH. The group facilitator should review each IFC intervention in detail with all the participants. Emphasize that actions are needed in the four priority areas of intervention for improving the capacity of households for care in the home and to increase the use of skilled care.

- Distribute the handouts with the actions for all the prioritized problems from the five roundtables (Table 2) and ask the participants to review them.

- Each group should work on the two problems that were prioritized in the previous plenary session. Write each problem at the top of a flipchart. Ask the group to review the actions that were identified in the individual roundtables for these priority problems and ask them whether they would like to add to the list or to reformulate some of the actions listed. They may also wish to consider some of the actions listed under problems that were not prioritized.

- Ask the group to think about whether any of the IFC interventions that have not yet been mentioned are relevant, and whether they want to add them in order to address the priority problems. The group should produce a revised list of actions for each prioritized problem. Check with the group to see if there is anything else to add as a possible action that wasn't already considered.

Scoring exercise:

- Once they have a final list of problems and actions, they should score each action in order to reach a consensus on two interventions for each problem.

- Using Table 3 below, ask the group to discuss each action for each problem according to the following criteria:

  - Feasibility of implementing the intervention according to available human, financial and other resources and based upon existing experiences in the area or in the country.

  - Avoiding negative impact: some interventions may have negative impacts as well as positive ones, or may impact some groups negatively.

  - Benefiting the poorest: it is important that the interventions chosen benefit the poorest members of society, as well as wealthier individuals.

- Replicability (potential for scaling up), i.e. elaboration of a project that is not too complicated or expensive and that can be replicable on a larger scale in other areas by NGOs or by the government.

• Ask each participant in the group to score the interventions on a scale of 1 to 3 for each criterion according to their definition above:

- Feasibility: 3 – highly feasible, 2 – some feasibility, 1 – little feasibility

- Avoiding negative impact: 3 – should have no negative impacts, 2 – may have one or two negative impacts, 1 – may have several negative impacts

- Benefiting the poorest: 3 – should benefit the poorest, 2 – may have some positive benefit for the poorest, 1 – unlikely to benefit the poorest

- Replicability: 3 – highly replicable, 2 – some replicability, 1 – little replicability

• The group should add up the points for each action and identify the two actions for each priority problem that have the highest score.

Table 3: Prioritization of actions

Group: e.g. Developing capacities					
Interventions	**Criteria (1 to 3 points for each criterion)**				
	Feasibility	Avoiding negative impact	Benefiting the poorest	Replicability	Total Score
e.g. Problem A					
e.g. Action A1					
e.g. Action A2					
e.g. Action A3					
e.g. Action A4					
e.g. Problem B					
e.g. Action B1					
e.g. Action B2					
e.g. Action B3					

7) Plenary: Presentation of group work on actions (1 hour 30 minutes)

• Ask the representative of each group to present the results of their group work (Table 3) in plenary. Allow time for discussion after each presentation.

• Ask the other participants whether they have questions, clarifications or comments and whether they agree with the prioritization done by the other group. Give the participants time to reflect on the actions in the different areas, and to see if they make sense together. Thinking about synergy between the actions may generate some additional suggestions or modifications.

• Ask one facilitator to facilitate the session, one to take notes on the flipchart, and the other two to take notes of the discussion.

8) Group work: Identifying activities for the implementation plan (1 hour)

- Divide the participants into four groups again. Ask each group to nominate a representative to present their work in plenary. Explain they should get as far as they can in the time allocated.
- In each group, use Table 4 to discuss the activities required to implement the priority actions selected. Ask the participants to identify the following:
  - Activities required to implement each action;
  - Actors to be involved with each activity and their role;
  - Resources necessary to implement the activities (list available resources and from where these resources come);
  - If the resources are not available, how to mobilize them.

Table 4: Activity Chart

Group: e.g. Increasing awareness							
Selected key	Activities required	Actors and roles		Resources			
		Actor	Role	Necessary resources	Available resources	Where are resources from?	How to mobilize additional resources
e.g. Problem A							
	• • • •						

9) Plenary: Group presentations and next steps (45 minutes)

- Ask the representative of each group to present the group report on activities in plenary.
- Ask the other participants whether they have questions, clarifications or comments.
- Lead a discussion on how the district IFC committee can mobilize support for this work, and what recommendations they have for moving forward.
- Explain to the participants that their inputs and their recommendations have contributed a first draft of the IFC implementation plan and that the next step will be for the district IFC committee to continue working to refine this plan.
- Ask the participants if any of them would be interested in still being involved and in providing their support to the district IFC committee in the process.

10) Closing (20 minutes)

- Short summary of the discussion.
- Evaluation of the discussion: hand out the evaluation form to all the participants to complete.
- Thank-you: thank participants for their participation.
- Payment of transport costs.

ANNEX 6: CHECKLIST FOR ORGANIZATION OF THE ROUNDTABLES/INSTITUTIONAL FORUM

No.	Task	Status (check if completed)	Person responsible	By when?
1.	Identify venue for roundtables (ensure it has a separate area for children, an area for roundtable, and an area for refreshments)			
2.	Ensure venue has good sized table(s), chairs			
3.	Invite participants			
4.	Organize transport for participants			
5.	Organize child-minders for women's groups			
6.	Organize food and drinks for every roundtable			
7.	Ensure there are flipchart stands (at least 3)			
8.	Organize materials for roundtables: - flipchart paper - notepads - pens/pencils - coloured dots/stickers - masking tape and sellotape - scissors - coloured marker pens (lots!) - name badges for facilitators and note-takers - card/paper for name cards			
9.	Create or photocopy leaflets on maternal, newborn and child health (if these are wanted)			
10.	Create/photocopy the registration forms for the roundtables			
11.	Photocopy sufficient copies of the finalized facilitation guides (Annex 3) (with the final list of questions)			
12.	Organize a laptop and projector for doing the analysis after the roundtable (if possible, otherwise, organize multiple copies of the analysis forms (Annex 4))			
13.	Identify and confirm facilitators and note-takers for each roundtable (with roles assigned for group work as well)			
14.	Prepare a short presentation of the situation analysis and MNH programme for the roundtables			
15.	Prepare flipcharts for the group work and plenary in the roundtables			
16.	Prepare the presentations for the institutional forum			
17.	Prepare the flipcharts for the institutional forum			
18.	Meet with representatives from the community roundtable to prepare them for the institutional forum			

ANNEX 7: ADDITIONAL PARTICIPATORY EXERCISES FOR ROUNDTABLE DISCUSSIONS

The roundtable methodology included in Annex 3 is designed according to a half-day discussion. The methods used are group and plenary discussions. If the PCA team has additional resources to organize longer roundtables with community groups, the sessions can be made more participatory and interactive. The following exercises are suggested for those who are able to time-table longer sessions[7].

Group 1: CAPACITIES

Picture work "Story with a gap"

Provide the participants with the following three pictures:

1. A pregnant woman

2. a) A woman with a healthy newborn baby

   b) A grave or funeral procession (or similar)

Explain that pictures 2. a and 2. b represent two alternative outcomes from a pregnancy. Ask them to draw six pictures: three for outcome 2. a and three for outcome 2. b to illustrate what might have happened in between these events. You could divide them into two groups to draw each scenario. Ask them to think about the themes they have just discussed, and what might happen when women die during pregnancy or childbirth.

Afterwards, ask the group to explain their drawings in plenary. Lead a discussion on what happens in these tragic circumstances when women or babies die.

Story telling

This exercise is similar to the pictures exercise above. Facilitators invent the beginning and ends of a story, for example:

- Beginning: "Mary was tired after a long day working. Now in her eighth month of pregnancy, she was finding it harder to carry on with her normal daily activities. Her husband was due to return later that evening. She went into her kitchen to see what food she had in the cupboard...

- Alternate endings:

  (a) ....Mary felt so happy. Her baby boy was now 6 weeks old and was fit and healthy – the doctor had given him the all clear at her check-up!

  (b)....Mary's mother wept deeply. Her own sister had died during childbirth, and now she was grieving at the funeral of her own daughter.

Ask the group to invent two different stories to describe what might have happened in these two situations. The facilitator can help write the story down if nobody in the group can write. Again, they could be divided into two groups to write the alternative stories. They should present their stories in plenary with the facilitators leading the discussion.

Group 2: AWARENESS and LINKAGES

Identifying "rights"

During the plenary, give a brief explanation of the meaning of human rights.

Human rights are basic rights and freedoms to which all human beings are entitled. It is the duty of governments to protect the rights of their citizens, and many international legal documents have been signed to defend human rights. Among human rights is the right to health. The right to health is an inclusive right that does not only include access to health care but also a wide range of factors that can help

us lead a healthy life, such as education. The right to health contains freedoms such as the right to choose health providers. It also contains entitlements from the state, for example equal opportunity for all to enjoy high quality services. There are also specific rights for maternal, newborn and child health: the Universal Declaration of Human Rights establishes that "motherhood and childhood are entitled to special care and assistance". In addition, the United Nations Office of the High Commissioner for Human Rights has declared that maternal mortality and morbidity is not solely an issue of development, but a matter of human rights (United Nations Human Rights Council; 2009). It is important to understand that neither maternal health or newborn health are personal benefits, they are human rights that concern each and every person.

Then explain that the national Ministry of Health believes that human rights are important and that many of these rights apply to MNH. Next, read out the following scenarios and ask participants to discuss if this is a violation of rights and why. To support the facilitator, the relevant rights for each scenario are indicated between brackets. Encourage discussion and help participants make sure that a variety of rights are considered throughout the session.

1. A woman is denied emergency obstetric care because she cannot afford the services

- **right to life and right to health:** a woman should not be deprived of her right to life on the basis of her earnings.

2. A woman would like to continue breastfeeding her newborn but has to go back to work

- **right to earn an income and support a family:** a woman has a right to support a family without this activity jeopardizing her livelihood;

- **right to health [of newborn]:** a mother has a right to take time to give her newborn a healthy life.

3. An adolescent has to leave school because she is pregnant

- **right to education and information:** an adolescent has a right to receive an education whether or not she is pregnant;

- **right to be treated equally [age and sex discrimination]:** an adolescent should be treated with the same respect as an older woman even if she is pregnant and have the same opportunity to be in school as a boy;

- **right to choice:** an adolescent has the right to decide whether she wants a child.

4. A woman has to ask permission from her husband and/or mother-in-law to access health services

- **right to health and security:** health services can improve the woman's health and prevent disease;

- **right to choice:** a woman has a right to seek help and counsel where and from whom she wishes;

- **right to information:** a woman has a right to access information without restraint;

- **right to be treated equally [sex and gender non-discrimination]:** a woman has the same right as a man to seek access to health services without needing permission.

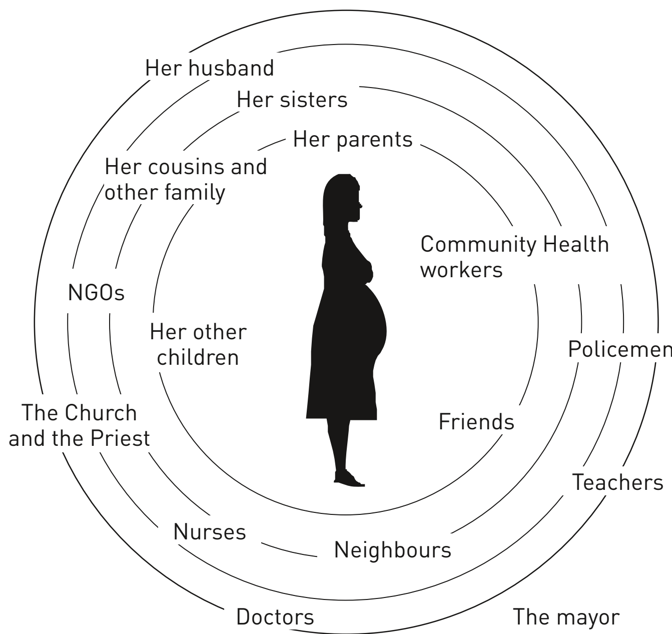
You can then encourage the group to identify situations they have heard about or lived related to MNH in which some human rights were not respected.

Map of social support

In advance, prepare a large flipchart sheet with a picture of a pregnant woman in the centre, with a series of concentric rings around it.

Ask the participants to think about all the different types of people or organizations that could provide support to the pregnant woman or the woman after birth to care for herself and her newborn. Explain that those who provide the most support should be placed within the circle closest to the woman, while those who provide little or no support should be placed at the last ring. Use the results of the situation analysis to prompt the group to think of the different organizations or institutions in the community, if they do not think of them themselves.

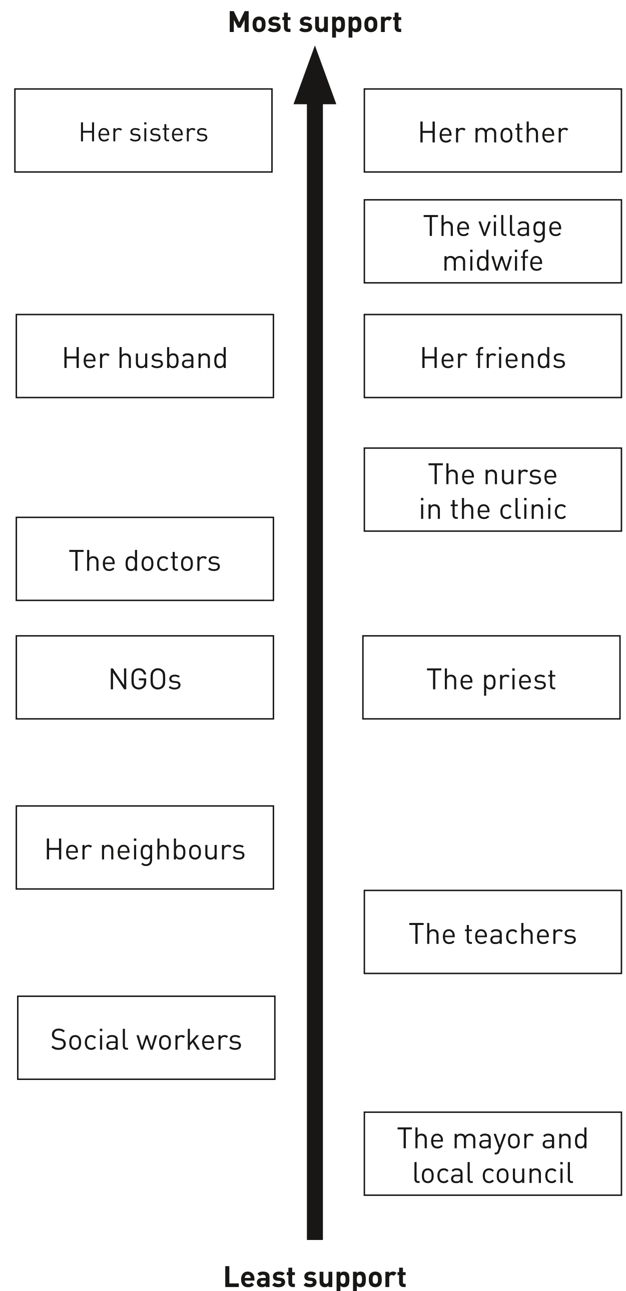
They may end up with a drawing like this one:



Ranking line of social support

Similar to the map, ask the participants to rank (i.e. put in order) the different people or institutions who help pregnant women and new mothers and newborns.

Social support
for the pregnant woman and newborn



Group 3: QUALITY OF CARE

Role-plays

Divide the participants into two groups and ask them to create a short 5-minute role-play demonstrating what is (a) good quality care; or (b) poor quality care for pregnant women and newborns within the health services. You can give them paper, cardboard, old newspaper and marker pens to help create props for the role-play.

Afterwards, they can present their role-play in plenary. Ask the participants to reflect on the meaning of high quality care within the health services.

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ISBN 978 92 4 150852 0