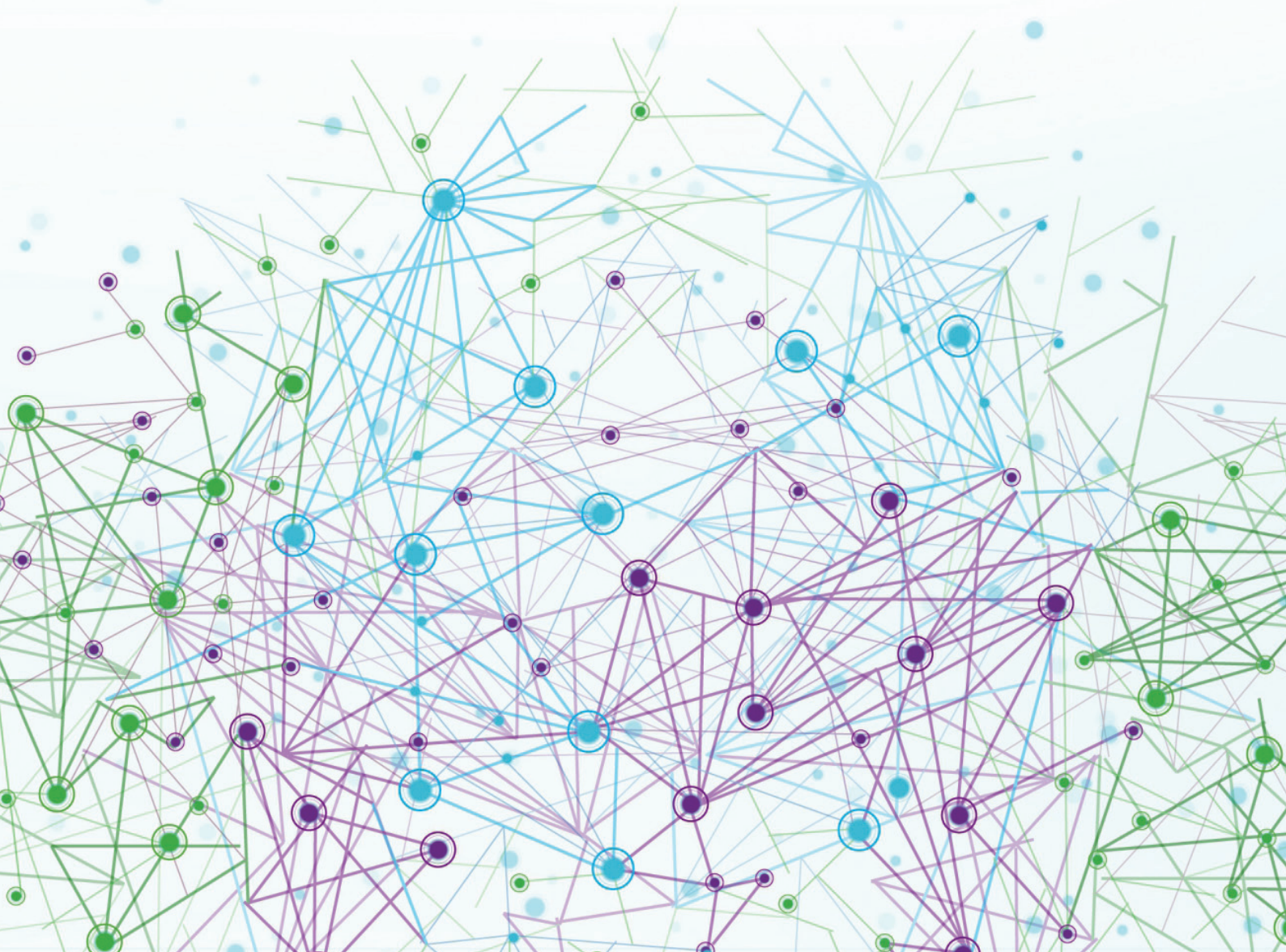


COVERAGE MONITORING NETWORK

HOW TO CONDUCT **COMMUNITY** **ASSESSMENT**





What is a community assessment?

A community assessment is the first step in the development of community engagement activities. It is a research and learning process which leads to an understanding of the community dynamics, which may influence and/or have an impact on CMAM program access and uptake. A community assessment involves the collection and analysis of data, including but not limited to the demographic and socio-cultural profile, social organization and communication channels, key community actors, local understanding of malnutrition, local perceptions of a CMAM program and any existing community engagement strategies. Once completed, the community assessment should drive the elaboration of community engagement activities, instantly applying research and learning into programmatic planning.

What are the objectives of a community assessment?

There are five main reasons why a community assessment should be conducted:

- 1 To explore community systems, structures and actors, including existing networks of community volunteers, which could potentially be used for community engagement**
- 2 To understand community knowledge, perceptions and behaviours regarding childhood acute malnutrition and other illnesses, as well as CMAM services**
- 3 To assess factors, which influence community decisions to access to and use CMAM services**
- 4 To assess the strengths and weaknesses of the current community engagement strategies, as well as opportunities and threats for future CMAM collaboration**
- 5 To develop an action plan and a comprehensive community engagement strategy to improve access and uptake of the CMAM services.**



Contents

◆ What is a community assessment?	02
◆ What are the objectives of a community assessment?	02
◆ Who carries out a community assessment?	04
◆ How is a community assessment carried out?	04
◆ Preparation for a community assessment	06
◆ Preparing qualitative sampling frame	07
a. How to sample information sources?	07
b. Which data collection methods & tools to use?	07
c. How to develop an interview guide?	09
◆ Data collection & compilation (Day 5-9)	10
a. How to document collected data?	10
b. How to synthesise data?	10
◆ Data analysis (Days 13 & 14)	13
Annex I	22
Annex II	30
Annex III	33
Annex IV	65
Annex V	99
Annex VI	92
Annex VII	93
Annex VIII	94
Annex IX	97
Annex X	98



Who carries out a community assessment?.....

The community assessment is spearheaded by a CMAM program manager leading a carefully selected team with varied professional experience.

How is a community assessment carried out?

The community assessment within a CMAM program framework has not yet been set in stone and thus offers abundant opportunities for customization, depending on program’s needs in specific areas of intervention. However, it does rely on principles of formative research and/or socio-cultural studies, which need to be strictly observed to assure the validity of findings.

The model of a community assessment described below is designed to fit within and broaden the focus range of a Semi-Quantitative Evaluation of Access and Coverage (SQUEAC). However, it can be carried out independently of a coverage assessment following seven interrelated steps shown in **Figure 1**.

FIGURE 1

SEVEN STEPS OF A COMMUNITY ASSESSMENT PROCESS USING SQUEAC METHODOLOGY

Stage One

- STEP 1** Training of enumerators & identification of stakeholders
- STEP 2** Qualitative data collection
- STEP 3** Data interpretation & analysis

Stage Two

- STEP 4** Semi-structured interviews with caretakers of SAM/MAM children during Small Area Survey
- STEP 5** Data analysis, triangulation & weighting

Stage Three

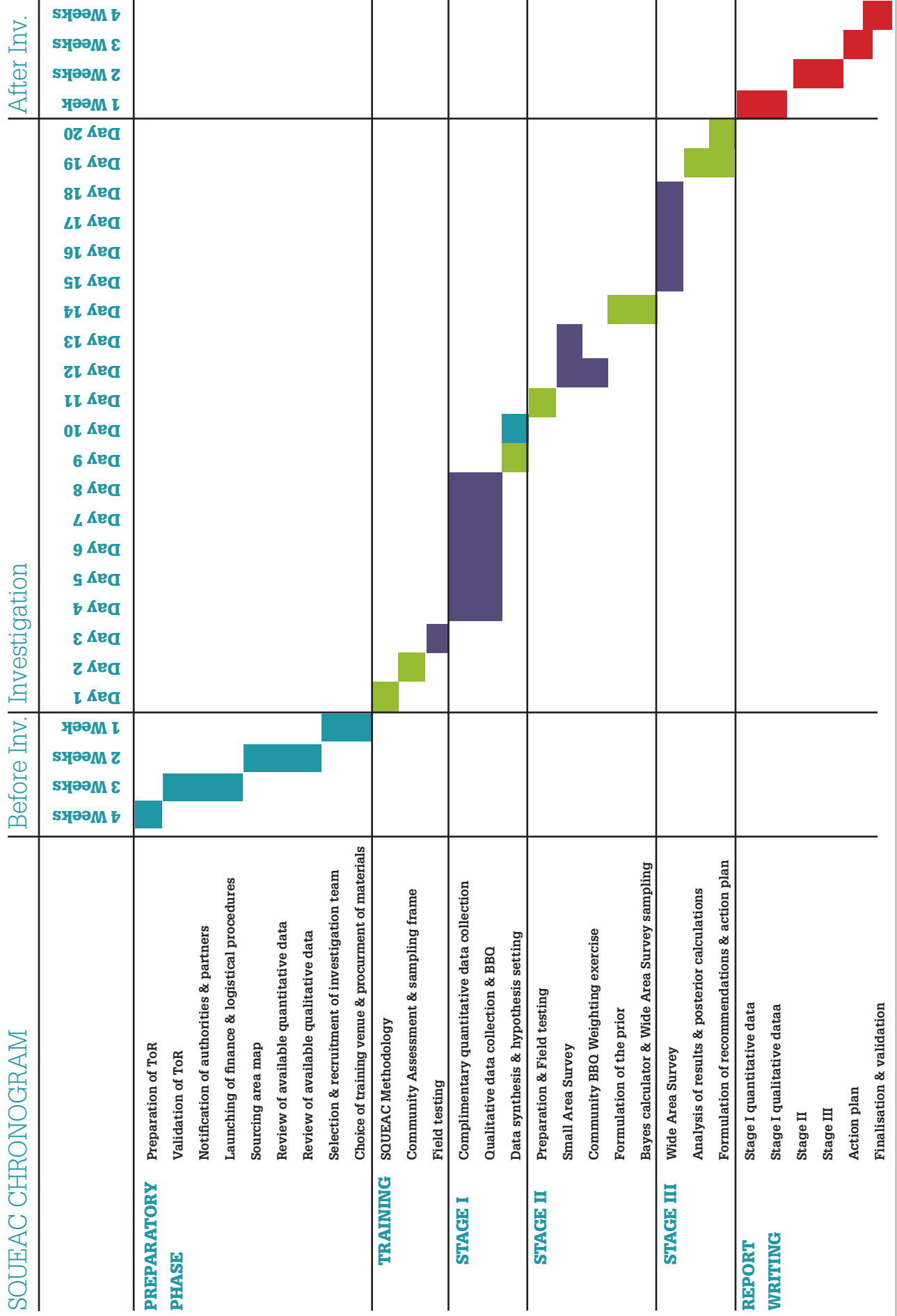
- STEP 6** Semi-structured interviews with caretakers of SAM/MAM children during Wide Area Survey
- STEP 7** Data analysis, validation & action plan

The success of a community assessment is directly proportional to the depth and quality of the training of participants, as described in the following section. It also depends on the richness of information sought through custom-designed interview guides and the range of sampled information sources. Unlike in other areas, more does not necessarily mean better.

A community assessment within SQUEAC framework should follow the chronogram below:



SQUEAC CHRONOGRAM





Preparation for a community assessment?

◆ **SELECTING A DATA COLLECTION TEAM**

It is recommended that individual team members have a good understanding of the geographical, socio-cultural and linguistic context of the area in which the study will be carried out. An experience with the implementation of surveys, such as SMART, KAP-B, RSCA or VCA, is an additional bonus. Special attention should be paid to the gender balance within the team, assuring a representation of women of at least 30%, aiming for 50%, if circumstances allow. The participation of community members and/or health district representatives will not only enrich the collection of data and the interpretation of results but it will also allow for a live transfer of competencies and spur follow-up actions within each party's limits.

◆ **TRAINING ON QUALITATIVE RESEARCH**

Before a community assessment is launched, a CMAM program manager needs to organize a comprehensive training on the qualitative data collection, which will permit all data collectors to familiarize themselves with the objectives, methods and tools of the study. An example of such training module with detailed instructions and recommendations, including innovative teambuilding activities, is attached in Annex 1. Previous trials of this training highlight the importance of simulations of interview guides' elaboration and/or their adaptation to context as well as their use within semi-structured interviews and group discussions. These sections of the training module should never be discarded or reduced as they offer a floor for discussion and correction of potential errors which could distort the collected data (especially in the first few days), and consequently lower the exactitude of the whole study.

◆ **GAIN UNDERSTANDING OF THE CONTEXT**

As a next or parallel step, it is very important to gain an understanding of the programme's context. The following points should feed into this process:

- ◆ **Gather comprehensive information about the CMAM program** (Is it a short-term intervention to address a nutrition emergency or will it be a permanent part of PHC services? What is health system capacity to deliver the CMAM service? What support is needed?)
- ◆ **Map out existing community volunteer networks, the frequency, variety and quality of their activities.** Investigate their structure, work terms and conditions as well as their commitment to unpaid labour.
- ◆ **Map out existing community actors, i.e. community (opinion) leaders, health committees, CBOs, etc.** List their initiatives and/or activities, target populations and coverage. Pay special attention to activities with a health focus. Identify potential strengths and weaknesses of these actors, if involved in CMAM community outreach. Gather suggestions on the most appropriate groups and networks to carry out CMAM community outreach activities.



Preparing a qualitative sampling frame

a | **HOW TO SAMPLE INFORMATION SOURCES?**

Qualitative data collection depends on multiple sources for the purpose of triangulation. It is therefore important to gather information from the largest possible variety of sources to achieve the highest representativeness. As the community assessment aims to shed light on the complexity of contexts, within which CMAM programs are operating, the sampling should not only strive to gather viewpoints of community actors directly linked to the program but also those whose perceptions may be influential for the mind-set and decision-making of the concerned populations. These may include, but are not limited to:

- ◆ **Community members (M/F)**
- ◆ **Carers of malnourished children (M/F)**
- ◆ **Teachers**
- ◆ **Traditional birth attendants**
- ◆ **Traditional healers**
- ◆ **Religious authorities**
- ◆ **Local leaders**
- ◆ **Community-based organisations (CBOs), associations or cooperatives**
- ◆ **Community health workers (CHWs) or volunteers**
- ◆ **Health centre personnel**
- ◆ **Health district representatives.**

In order to ensure the representativeness of all health zones as well as the equitable participation of identified key informants, a unique and simple tool has been developed for the purpose. The qualitative data collection sampling matrix will enable you to consider all important factors, visualize them and transcribe them into daily planning. Please refer to Annex 2 for the sampling matrix.

The straightforward table layout with a list of health zones, their classification (urban vs. rural) and a distance from the district office in the left column and an array of chosen key informants in the first row, allows to pick and choose in an ad hoc manner the information sources for the study, making sure that an equal number is selected per each category and per health zone. Any personal preferences of actual community figures by a team member are not recommended due to a certain risk of partiality which may distort overall results. In this respect, and in terms of quality and scope assurance, it is important to note that the initial sampling might change, if necessary. Depending on the circumstances, the assessment leader might increase the sampling size, add new key informants and/or replace them, if the incoming data provides evidence about tendencies of interest which may require more investigation.

b | **WHICH DATA COLLECTION METHODS & TOOLS TO USE?**

The qualitative study has at its disposition a number of commonly-known methods and tools, used and applied in endless combinations. The community assessment, developed within the SQUEAC framework, puts into use primarily key informant interviews (semi-structured/informal interviews or (focus) group discussions), which represent invaluable sources of first-hand information. Case studies, analyses and observation are equally used and strongly encouraged as they tend to complement key informants' testimonies. Mapping, ranking and study of secondary sources are commonly used in preparatory stages and/or during the interpretation/contextualization of gathered data. Overleaf is a list of data collection methods to choose from:



SEMI-STRUCTURED INTERVIEWS A semi-structured interview is a tool for the qualitative data collection, during which a facilitator engages in a conversation with one person, making use of an interview guide prepared in advance. The facilitator is free to add or skip questions, depending on the circumstances. A semi-structured interview can be used to identify individual thoughts, perceptions or feelings about subjects in question. It can also evoke sensitive matters, such as gender relations or family planning, which individuals might be hesitant to answer in a collective setting.

INFORMAL INTERVIEWS An informal interview is a tool for the qualitative data collection, during which a facilitator engages in a causal conversation with one person during a random or arranged meeting. The choice of questions is at facilitator's discretion but need to pertain and contribute to the study. An informal interview may be used to identify individual thoughts, perceptions or feelings about a particular question/dilemma.

GROUP DISCUSSIONS A group discussion is a tool for the qualitative data collection, during which a facilitator engages in a conversation with more than one person, making use of an interview guide prepared in advance. The facilitator is free to add or skip questions, depending on the circumstances. A group discussion can be used to identify a collective mind-set and reflections about subjects in question. If the group is at ease and consents to answering, a group discussion may also evoke sensitive matters. However, these should be dropped if a group is suddenly uncomfortable and slides into silence.

FOCUS GROUP DISCUSSIONS A focus group discussion is a tool for the qualitative data collection, during which a facilitator guides a group through a series of questions on a specific topic. The facilitator must be able to stimulate the discussion, maintain the focus on the topic, and mediate any discussions or conflicts which may arise.

CASE STUDIES A case study is a tool for the qualitative data collection, during which a subject of study, "the case", is examined up-close, in-depth and in detail. During the community assessment (within the SQUEAC framework), "the case" is most often a malnourished child, whose story of illness and/or recovery is captured through testimonies of his family, health personnel and/or any other community members who observed his health evolution.

OBSERVATION An observation is a process of systematically observing objects, events, people and/or relationships. It is an essential qualitative data collection tool on the community behaviour, which cannot be collected otherwise. It allows for a more complete understanding of the community and its context. In CMAM, the observation may be directed towards children and caretakers for signs of traditional practice or feeding/breastfeeding practices. The observation at health facilities may focus on the quality of service, the availability of RUTF, client interactions, etc.

MAPPING Mapping is an effective tool to visualize the community's resources. These may include community infrastructure (health clinics, schools, churches) or available human resources. Mapping encourages common understanding of palpable issues and stimulates the discussion on their resolution. In CMAM, mapping may include but is not limited to, community health worker networks, community-based organizations and their agendas, community-led initiatives, etc.



RANKING Ranking means placing something in order of significance. It helps to quickly identify people's beliefs, judgments, attitudes and preferences regarding events or tendencies marking their community. During the community assessment it is a useful tool for the prioritization of barriers and boosters, as captured and documented in exchanges with key informants.

Other tools include a seasonal calendar, a social mapping & relationship identification tool, a communication channel matrix and a review of secondary sources, such as program reports or existing qualitative surveys, which may provide guidance for the primary data collection or its analysis.

C | **HOW TO DEVELOP AN INTERVIEW GUIDE?**

The qualitative data collection via key informant interviews relies on custom-designed interview guides, developed and/or adapted prior to the community assessment for each key informant category. Although interview guides aim to gather data on similar- if not the same - matters, the scope and manner of certain questions differ depending on the role of specific key informants within the community. The complete interview guide package strives to assure the complementarity of collected data – which would also allow its triangulation by source and method.

The development of any interview guide should start with a brainstorming session of a program team about the type and scope of information they would like to get from the study. All ideas should be organized in thematic groups and explored in more detail, if necessary. Consequently, the team should prioritize key informants per each question (as not all informants could be in a position to answer and/or it is not possible to ask all questions to all informants) and reflect upon the best formulations/wording, using a local terminology and/or jargon, which could enable all participants to reply honestly and without hesitation or shame.

An interview guide may be a simple, one-page document with up to 10-15 well-defined, open questions, inviting a key informant to provide replies without the limitation of length and/or content. An interview guide may also be a more complex document with up to 100 questions, exploring great details of key informant's beliefs and perceptions. It is recommended to use this kind of document if enumerators do not have sufficient experience with qualitative research and would not be able to collect detailed data without precise and meticulous instructions. On the other side, the use of interview guides could be minimized if the assessment team has a long and documented history of qualitative research expertise.

In no circumstances should an interview guide include questions with Yes/No answers and/or multiple choice questions, which would automatically limit key informants' inputs.

Please see **Annex 3** for examples of detailed and target-specific interview guides.



Data collection & compilation

DAY 5 - 9

One of the key responsibilities of an assessment team leader during the roll-out of a community assessment is the continuous mentoring and guiding of the team through its stages. The team needs to be heavily involved in the collection and analysis of data, adhering to its objective and evidence-based interpretation rather than personally-biased views. In this respect, it is strongly recommended to **organize daily team meetings to synthesize daily findings, clarify doubts and adapt tools, methods and/or sampling to the particularities of the studied zone.** Such intensive collaboration will eventually lead to collective understanding of the situation and a consensual identification of appropriate strategies to remedy defined shortfalls.

a | **HOW TO DOCUMENT COLLECTED DATA?**

Any collected data is of no value if not properly documented and stored. Previous experience has shown that well-developed interview guides do not guarantee the influx of high quality data if assessment team members fail in note-taking and/or transcriptions of recorded interviews. While certain teams may provide concise but generalized answers, cutting out the juicy core, the others may jot down key terms, forgetting to expand them at later stages. In consequence of both, the assessment team leader is left with uninformative sheets of paper which are difficult to process, to say the least.

In order to avoid similar situations, it is highly recommended to brief the assessment team on the principles of effective note-taking, including but not limited to, following lessons learnt:

- 1 The assessment team must familiarize themselves with the content of interview guides prior to conducting key informant interviews.** It is advised to establish a set of abbreviations, noted on the back side of an interview guide, to facilitate the note-taking and/or its interpretation.
- 2 The assessment team should clearly define roles (facilitators, note-takers) and responsibilities prior to conducting key informant interviews.** Generally speaking, facilitators focus on moderating discussions, observing participants and taking discreet notes about their behaviour and body language and/or the overall atmosphere of the exchange. On the other hand, note-takers try to capture all information, using key words and quotes, which would help them to expand those notes off the field.
- 3 The effective note-taking does not equal rewriting whole sentences word-for-word.** Note-takers should avoid this practice by all means as it could distract them from capturing other incoming contributions, leading to losses of important links in informants' reasoning. However, essential verbal contributions, including representative quotes, should be captured literally.
- 4 Neither note-takers nor facilitators should take the liberty to leave out certain informants' declarations as not interesting or not important.** Notes should reflect veritably the entire content of the exchange without any judgment or interpretation by the assessment team. In case the team wishes to record their observations, they need to mark them clearly and justify their conclusions.



- 5** Upon return from the field and/or in between two interviews the assessment team should consolidate and expand their notes in order to produce a meaningful documentation of the encounter. It is strongly recommended to do it as soon as possible, but no later than the same evening, as essential details may be forgotten or the level of certainty may drastically decrease. During this exercise the assessment team should ascertain that all answers have been thoroughly rewritten and unanswered questions are justified. As a next step, the assessment team should highlight or circle key terms which stood out during the interview. Any observations which support these choices should be duly documented.

In case the assessment team has a possibility to use voice recorders or mobile telephones with such function, it is recommended to record interviews/groups discussions in their entirety and then transcribe them word-by-word in a word processing application. Consequently, the text will need to be translated into a working language with utmost accuracy.

b | **HOW TO SYNTHESISE DATA?**

A synthesis and a detailed analysis of collected data is an intricate process, which requires as much (if not more) attention as its collection. Its success rests upon a focused and unbiased contribution of all team members, who bring forward their opinions and confront them with resurfacing complementary or contradictory factors. Under no circumstances should the analysis of collected data be done by the assessment leader or any other leading personality only.

In order to facilitate the study of incoming data, the assessment team may use a number of tools which have been developed for the purpose.

BBQ OR BARRIERS, BOOSTERS AND QUESTIONS

The BBQ is a simple tool, which allows the assessment team to organize key elements, representing factors with a positive or negative effect on access and coverage, in a table format and triangulate each by source and method. It helps the team to visualize the problematic and its recurrence in key informants' answers. In consequent stages, the factors with the highest periodicity are weighted higher than elements mentioned occasionally.

The use of the BBQ tool should be initiated on the first day of the community assessment, revised and modified each following day. Previous experience has shown that "skipping" a day or two in this exercise leads to drastic decrease in its quality as a varied content of interviews becomes blurry under the influence of new encounters. Thus, the assessment leader should plan team's daily trips in such way that they have enough time and energy to meet and consolidate daily findings. It is also advised that the team leader reviews all notes and ascertains that all barriers and boosters were traced onto the BBQ tool.



FIGURE 2

COMPONENTS OF THE BBQ TOOL

Boosters

- ◆ List boosters to coverage here at the end of each day of data-collection.
- ◆ Mark each booster with symbols that indicate the sources & methods that were used to collect the data. This allows you to check that findings have been validated using triangulation by source and method. Any findings not confirmed by triangulation should prompt an entry in the central Questions section.
- ◆ This list will grow over time.
- ◆ Periodically check whether findings may be combined & redraft as required

Questions

- ◆ Use this section to list questions and issues that need to be resolved by additional data collection. These should include findings that have NOT been confirmed by triangulation.
- ◆ Record issue, data source and method to be used to collect data.
- ◆ This section will require frequent redrafting

Key/Legend

- ◆ Use this section to list the symbols used in the Boosters & Barriers sections to indicate sources & methods

Barriers

- ◆ List barriers here at the end of each day of data-collection.
- ◆ Mark each barrier with symbols that indicate the sources & methods that were used to collect the data. This allows you to check that findings have been validated using triangulation by source and method. Any findings not confirmed by triangulation should prompt an entry in the central Questions section.
- ◆ This list will grow over time.
- ◆ Periodically check whether findings may be combined & redraft as required

It is recommended that each team reviews their notes and lists main barriers and boosters cited during the interview immediately after the exchange or before the daily feedback session at the latest. Most common barriers and boosters in CMAM programmes¹ are listed in the table below. The barriers and boosters should be similar to these although they should be adapted to the context. Each barrier and booster should be accompanied by a symbol indicating the source and method that were used to collect the data.

TABLE 1

MOST COMMON BARRIERS & BOOSTERS IN CMAM PROGRAMMES

Category	Barrier	Booster
GEOGRAPHIC	<ul style="list-style-type: none"> ◆ Distance ◆ Population movement ◆ Seasonal barriers 	<ul style="list-style-type: none"> ◆ Community access to nutrition services is facilitated through numerous OTP centres or mobile units.
TEMPORAL	<ul style="list-style-type: none"> ◆ Carer busy ◆ Carer sick ◆ Long waiting time 	<ul style="list-style-type: none"> ◆ Supply of RUTF ◆ Short waiting times/efficient patient flow ◆ Regular active case finding activities with appropriate & timely referral
SOCIO-CULTURAL	<ul style="list-style-type: none"> ◆ Alternative health practitioners preferred ◆ Lack of awareness about malnutrition ◆ Lack of awareness about the program ◆ Husband refusal ◆ Stigma ◆ Insecurity 	<ul style="list-style-type: none"> ◆ Awareness of the signs and symptoms of SAM ◆ Awareness that the child was SAM ◆ Awareness that SAM can be treated effectively ◆ Awareness that the service to treat SAM is available at the local clinic ◆ Key community figures actively support the program by referring children and support CHW activities ◆ RUTF well accepted
FINANCIAL	<ul style="list-style-type: none"> ◆ High opportunity cost ◆ Lack of money ◆ Cost of treatment ◆ Transport cost 	<ul style="list-style-type: none"> ◆ Awareness that the treatment is free of charge
QUALITY OF CARE	<ul style="list-style-type: none"> ◆ Relapse ◆ Poor delivery of service ◆ Unsuitable treatment interface ◆ Wrong admission and discharge criteria ◆ Non respondent ◆ Previous rejection (of a known child) ◆ Poor outreach activities ◆ Poor program monitoring ◆ RUTF stock breaks 	

¹ Becart E, 2014, Meta-analysis of Barriers and Boosters from 78 coverage assessments supported by the CMN.



Upon arrival of all teams from the field, all identified barriers and boosters should be presented and discussed during a feedback session facilitated by the team leader. Simultaneously, the team leader should copy each barrier and booster onto a flipchart paper (visible to all team members), adding sources and methods every time they are mentioned by the teams. Owing to the fact that certain barriers and boosters are likely to be cited numerous times, the use of abbreviations is extremely helpful. They can be summarised in a legend on another flipchart. It is also recommended to keep a tally of the number of times the same source cited a particular barrier or booster.

If, at the end of the day, certain barriers and boosters were mentioned only once, they should be shifted to another flipchart entitled Questions. These points deserve further investigation and should be kept in mind for the next day's data collection.

The BBO is a very organic tool, demanding constant redrafting as teams add new data, combine it or discard invalidated findings. Once the final list of barriers and boosters is established and all sources, methods and demographic information are noted, the team can proceed with the weighting of individual elements in order to prioritise which are the most important barriers and boosters impacting on coverage, which comes at the end of Stage 2.

Data analysis

DAY 13 & 14

BBQ WEIGHTING

The BBQ Weighting exercise consists in a prioritisation of barriers and boosters identified during the assessment by giving a “weight” or a “score” to each item according to the impact which it represents for the program's coverage.

In order to avoid an abusive subjectivity or the influence of a sole point of view (for example from the programme staff minimizing the barriers linked with the quality of the service or certain sociocultural aspects), it is recommended that a team leader lists barriers and boosters in the order of importance according to various sources: bibliographical review², programme staff, SQUEAC investigation team and the community.

Then, barriers and boosters must be weighted one at the time BUT considering their links to other elements as well as their overall impact on access and coverage. It is recommended to weight each barrier and booster in two waves. Firstly, the assessment team weights on a full scale (e.g. 1 through 5) while only two values (the most voted for) are retained for the second round. Before proceeding further, it is beneficial to have an open discussion about the weighted element and reasons justifying one value or another. The second round of voting is secret (eyes closed) and all assessment team members must participate (e.g. by raising a hand). The results are carefully noted and communicated to the team. The value receiving the majority of votes is marked onto the BBQ tool. The process is repeated for all barriers and boosters in a BBQ tool.

As a next step, a team leader should organise a half-day workshop with health district representatives, health professionals and community members (approximately 5-6 people representing community leaders, traditional healers, women, etc.) with the main objective to identify and prioritise barriers and boosters with the biggest impact on the program coverage.

² SMART, NCA, KAP, RSCA, etc.



During this workshop, a team leader will need to present the finalised BBO tool and explain the findings. Then, he will need to engage the participants in a weighting exercise, which will also take place in two waves. Firstly, he can divide the participants into smaller working groups while each chooses five barriers and boosters, which (according to them) have the biggest impact on program's coverage. They weight them accordingly and present their arguments in a plenary followed by an open discussion on final results. Secondly, the team leader presents BBO scores from the bibliographical review and SQUEAC investigation team. The workshop participants will need to validate overall scores for each element and formalize operational recommendations for barriers, which received the highest score.

TABLE 2

**EXCERPT FROM BBO WEIGHTING EXERCISE SHOWING
DIFFERENT SCORES AND THEIR FINAL APPRAISAL**

Barriers	Boosters	Bibliographical review	SQUEAC team	Workshop	Overall score
Weak decision-making power of mothers concerning a therapeutic choice for the child.		3	3	3	9
	Grandmothers have a capacity to influence husbands.	1	2	2	5
Traditional medicine is still the first therapeutic choice for malnourished children		2	5	5	12

SOME PRACTICAL ADVICE:

- ◆ Don't reveal the scores of the bibliographical review and SQUEAC investigation team before the workshop participants finish their own weighting;
- ◆ Invite active community representatives who do not fear to express themselves in public;
- ◆ Keep in mind an equal representation of women;
- ◆ Reserve the time for discussion and seek a final consensus. If it is not possible, proceed to voting.

NB: The prioritisation of elements having an impact on the program has to lead towards the elaboration of operational recommendations. A detailed and profound examination should allow to specify the contents of each item and to produce specific recommendations:





In other words, the community health design, which encompasses the community mobilisation element, engages the community in all key stages of the project cycle, including the diagnosis and formulation of action plans. The implication of community representatives at this stage increases the chances of adhesion to the project and eventually the program's success and the increase in coverage.

COMMUNITY BBQ WEIGHTING

The Community BBQ Weighting exercise aspires to validate preliminary findings of the qualitative data collection, organized and analysed with the help of the BBQ tool. Its prime objective is to give a voice to the community and collect their feedback and precision on identified elements. Previous experience has shown that the assessment team's perceptions of the importance of individual factors slightly differ from the community's outlook. Their input is thus pivotal for the correct assessment of determining barriers and boosters and their translation into meaningful recommendations.

The choice of a community for the organization of this exercise rests with an assessment leader. Preferably, it should be an "exemplary" locality, which could veritably represent or experience challenges of the whole area of investigation. For example, a village should be neither too close nor too far away from the centre of the health district. Once the community is chosen, the assessment team should inform the community immediately to allow its mobilization for the exercise. A representative group should not be smaller than 5 men and 5 women. It is important that the gender balance is absolutely respected.

In preparation for the exercise, a team of two or three assessment team members should prepare flashcards in A4 format depicting each barrier and booster. They can be drawn by hand or put together electronically with the help of images available online. The team should also prepare multiple sets of voting cards displaying points 1 - 6.

Upon arrival in the community, the team should introduce the activity and then present each barrier and booster individually. Images displayed on each flashcard may help community members remember addressed points. Afterwards, it is recommended to give the community time to reflect upon preliminary findings. This can be done through an open discussion and/or the ranking exercise, the goal of which is to get the first overview of the community's initial vision of the importance of individual elements. In this respect, it should be noted that the group consensus may not reflect personal opinions of each participant – which will be disclosed at a later stage during secret voting.

In order not to lose any important piece of information, the assessment team should designate a note-taker who would record all exchanges and views.

Once all barriers and boosters are ranked, the assessment team should distribute a series of voting cards to each participant and invite them to vote on barriers and boosters one by one. The team should in no way attempt to influence or control individual votes. All should be noted and averaged to get a resulting value per category. Then, these should be compared with the "informed" weighting of the assessment team and used for the formulation of the prior.

Please see **Annex 4** for a Community BBQ Weighting Toolbox.



COMMUNITY PROFILE

Following or in parallel with the BBQ tool, which represents the first level of the data analysis, the assessment team should initiate a thorough review of the documentation from key informants' interviews. Disregarding the format of chosen interview guides, the study should be organized by themes, which will allow regrouping interviewees' opinions and detecting consistencies or deviances in their perceptions. While doing this, it is recommended to always note sources (e.g. "Community health worker, HZ Bishange"), the periodicity of essential contributions and all representative quotes. These details will undoubtedly refine subsequent analyses and add frankness to the final report.

A good community profile should aim to factor in the following thematic areas; however the scope of each depends on key objectives of the assessment, capacities of the assessment team and to a certain extent on the availability of secondary sources, which could enrich the study.

- 1 **Demographic profile**
ethnicity, religious affiliation, economic status, etc.
- 2 **Sociocultural profile**
cultural and social norms, traditions, beliefs, attitudes, perceptions and taboos related directly or indirectly to the malnutrition
- 3 **Social organization and key community actors**
structure, institutions, leadership, gender organization and childcare
- 4 **Formal and informal communication channels**
- 5 **Local understanding of the malnutrition**
symptoms, causes, effects, health seeking patterns, stigmatisation
- 6 **Perceptions of CMAM program**
access and perception of health centres (distance, cost, quality and variety of care, admissions, interface, sensitization, etc.
- 7 **Community Engagement Strategies**
volunteer networks (coverage, capacity, aptitude, activity frequency, planning & follow-up), community sensitization and screening activities (actors, themes, tools, frequency, variety)

As the qualitative study composes of a varied, often hardly predictable data, spreadsheets or databases have not been found as useful tools for the data organisation. A simple blank document (or a series of documents) with thematic headings seems more suitable. However, each assessment leader should determine an adequate strategy for this task and instruct his team accordingly. A mere copying of text onto a document may not only be time-consuming but also confusing if new additions are not matched with previous notes. In other words, the qualitative data should not only be organised by themes but also by different categories within those themes, depending on the spectrum of collected material.



Once the transfer of data into an electronic form is complete, the assessment team should proceed to a consolidation of findings and a detailed analysis of individual sections. If the assessment schedule allows, it is recommended to dedicate one whole day to a group analysis. If not, the assessment leader should designate few experienced team members to carry out this analysis independently and present their conclusions to the whole team for validation. The analysis of data by the assessment leader or any other leading personality only is highly discouraged. A comprehensive understanding of community profile components by all team members is crucial for consecutive assessment stages and the development of valuable recommendations for the programme.

Please see **Annex 5** for a Community profile template.

SOCIAL MAPPING AND RELATIONSHIP IDENTIFICATION

Social mapping and relationship identification tool serves as a genuine visualization of diverse customary, religious and administrative authorities operating in the area of intervention, their interactions and positioning on a power ladder. Reflections fuelling its layout may provide a valuable insight into the distribution of key community actors and the complementarity of their roles. This may eventually lead to an identification of “stakeholder gaps”, juxtaposing current CMAM programme actors with potential players, whose capacities have not been explored extensively. It may also disclose less apparent power relations which may be affecting, in a positive or negative fashion, the actual implementation of the programme.

Before the onset of the qualitative data collection it is recommended to sensitize the assessment team to observe (and inquire on) the social organization of targeted communities. This preparatory work may facilitate the completion of the exercise which should be integrated into team’s restitution days - preferably immediately after Stage I. Its simple and unique objective is to draw a diagram, which would represent a network of community actors and their relationships of interdependence, as disclosed during the primary data collection. The consultation of secondary sources may help to amend and/or validate the resulting figure – but a consensus of all assessment team members about its final representation must be sought.

Please see **Annex 6** for a Social mapping and relationship identification tool and further instructions.

COMMUNICATION CHANNEL MATRIX

A communication channel matrix represents a straightforward five-row/five-column grid designed to map out an array of communication channels used by CMAM programmes for exchanges with the target population. Frequently, CMAM programmes outsource the communication to community-health workers, who become community’s exclusive persons of reference for the malnutrition and/or other matters. Less frequently, they may include mass media in the diffusion of key messages. Other communication channels are often undervalued or completely absent. In this respect, the communication channel matrix moves beyond being a mere assessment tool, transforming into a learning platform, the added value of which lies in demonstrating a full range of options and in tracing future opportunities.

The left-hand column of the communication channel matrix represents classic communication settings while the top row represents actions or communication objectives. Successively, each empty square is marked with ✓ or ✗ depending on the use of a respective communication channel within CMAM programming.



The concentration of ✓ signs in the “Diffusion of messages” column implies the so-called “top-down approach” where organisations simply “drop” their messages onto the beneficiary population who is consulted neither prior nor after the intervention. As this approach has been under the constant criticism in many contexts, the aim is to move from mere diffusing to “engaging” and “empowering” communities to take ownership of problems which target their milieu. In this respect, an optimal communication channel matrix for future programming should include at least a couple of communication settings for each objective – moving from a bottom left towards an upper right corner.

In early stages of “new and improved” community mobilisation strategies the “Community engagement” column may be difficult to implement as it requires a high level of community initiative to deal with local challenges outside of formal structures or partnerships of CMAM programmes. For this reason, CMAM programs may initially choose to leave it blank, making it the absolute goal of their community engagement efforts to fill those empty slots within few years’ time.

FIGURE 5

EXAMPLE OF A COMMUNICATION CHANNEL MATRIX

red squares represent communication channels used within CMAM framework, blue ones represent recommended complementary activities aiming to reinforce the community sensitisation and behaviour change

Communication channels	Diffusion of messages	«Opinion leader» encourages the action	«Role model» demonstrates the struggle & success	Community engagement	Dialogue about barriers & solutions
« PEER 2 PEER »	✓		✗	✗	✗
« DOOR 2 DOOR »	✓			✗	✗
COMMUNITY DISCUSSIONS	✓	✗	✗	✗	✗
COMMUNITY THEATRE / SPECIAL EVENTS	✓	✗	✗	✗	✗

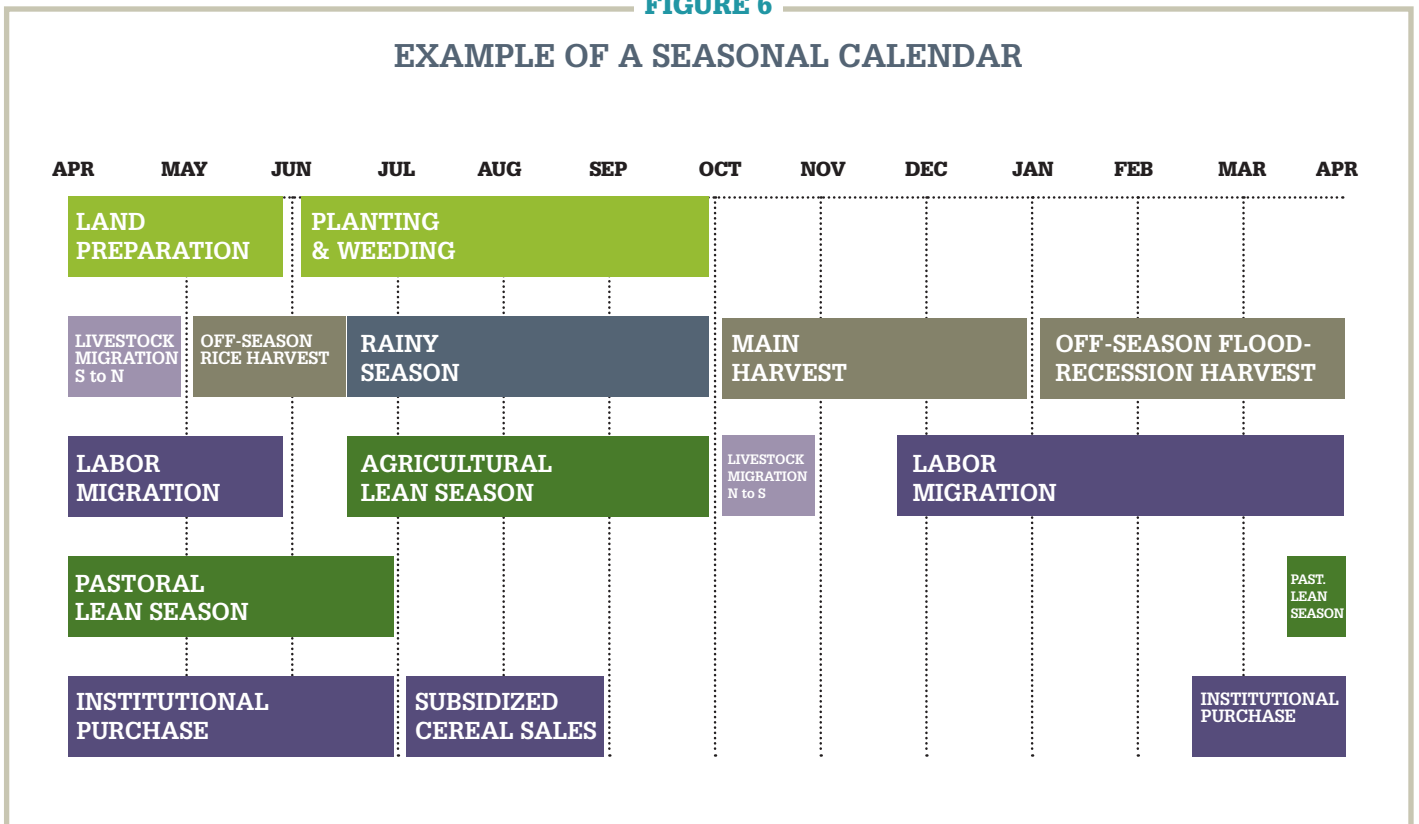
Please see **Annex 7** for a Communication channel matrix template and further instructions.



SEASONAL CALENDAR

Seasonal calendar is a tool, which helps to explore changes taking place in the community over a period of one year, e.g. rains/droughts, social and economic conditions as well as prevalence of diseases, cultural events and holidays. It can be used to identify periods of vulnerability and people's coping strategies at the time. In the framework of CMAM programming, a seasonal calendar may explain, among others, tendencies in admissions and defaulting over the course of the year.

FIGURE 6



Please see **Annex 8** for a Seasonal calendar template.



SWOT TOOL

A SWOT tool is a simple planning and evaluation method used to identify positive (**S**trengths and **O**pportunities) and negative (**W**eaknesses and **T**hreats) factors within projects, organisations, communities, etc. that promote or hinder successful implementation of services and social change efforts.³



The tool groups key pieces of information into two main categories:

- ◆ **Internal factors** – the strengths and weaknesses internal to the project/organisation, and
- ◆ **External factors** – the opportunities and threats presented by the environment external to the project/organisation.

It is best used in collaboration with programme staff and/or community members to identify problematic areas and to explore new possibilities. Similarly to BBQ tool, it can identify a series of recommendations to consider before developing an action plan.

Depending on a team's leader assessment strategy, the SWOT tool can be used as early as the initial training and test the team's awareness about the programme and its context or as late as the assessment's final stages and summarise all findings and observations collected throughout the SQUEAC investigation.

Please see **Annex 9** for a SWOT tool template.

³ <http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/swot-analysis/main>



CONCEPT MAP

A concept map is a graphical tool for organising and representing knowledge. It is a diagram representing findings (i.e. barriers and boosters) and various relationships among them. Findings are normally represented as boxes or circles connected to each other using labelled arrows. Relationships between findings may be expressed using such phrases as 'gives rise to', 'contributes to', 'results in', and 'is required by', 'encourages', 'allows', etc.

Concept maps are a great addition to the calculation of the prior mode and are strongly recommended. For that purpose, a team leader needs to organise a short working session with the entire assessment team at the end of Stage 2. The objective of the exercise is to list all barriers identified during Stage 1 on individual post-it notes and organise them on a sheet of flipchart paper. Then, the team needs to trace, label and all relationships among them. The same procedure is repeated for boosters and added to prior mode estimation template.

Please see **Annex 10** for an example of Concept Map tool.

Concept maps can also be useful for note-taking during interviews, when working out and communicating how different findings (e.g., barriers) are related and interact with each other each other in complex or cyclical processes (e.g., vicious or virtuous circles), or in forming hypotheses for further investigation.

Annex I	COMMUNITY ASSESSMENT TRAINING & SIMULATION GUIDELINES	22
Annex II	QUALITATIVE SAMPLING FRAMEWORK	30
Annex III	INTERVIEW GUIDES	33
Annex IV	COMMUNITY BBQ WEIGHTING TOOLBOX	65
Annex V	COMMUNITY PROFILE	89
Annex VI	SOCIAL MAPPING AND RELATIONSHIP IDENTIFICATION TOOL	92
Annex VII	COMMUNICATION CHANNEL MATRIX	93
Annex VIII	SEASONAL CALENDAR	94
Annex IX	SWOT TOOL	97
Annex X	CONCEPT MAP TOOL	98



Annex I

COMMUNITY ASSESSMENT TRAINING & SIMULATION **GUIDELINES**

The main objective of this document is to briefly outline the methodology for community assessment training and simulation, which shall complement training in SQUEAC (Day 1) while leaving an adequate space for adaptation by each facilitator.

The training module is designed in a very logical manner, allowing participants to digest information as they move through different sections and apply them immediately in practical exercises and simulations. The aim is to activate their analytical skills, which they will need during the investigation, and to position them as active contributors rather than passive doers.

ACTIVITY 1: HUMAN KNOT

Human Knot is an excellent teambuilding activity aiming to teach new people to work together. The activity will allow the facilitator to observe how different team members react to obstacles, how they communicate and contribute to the solution. It will also disclose natural leaders and team's reactions to their leadership. All this may be very useful during the initial team composition and the first day challenges. Debrief at the end of the activity will offer an opportunity to exchange ideas on a variety of topics and their link to the SQUEAC investigation.

Instructions:

- 1 | *This activity is suitable for any group size but a group of 10-16 people is ideal. In case of a bigger number of participants, split the group in two.*
- 2 | *Ask the group to form a circle (shoulder to shoulder).*
- 3 | *Ask everyone to lift their right arm and reach across to take the hand of a person standing in front of them.*
- 4 | *Ask everyone to lift their right arm and reach across to take the hand of another person standing in front of them.*
- 5 | *Make sure that no one is holding both hands of the same person or hands of the person standing next to them.*
- 6 | *Perform the test of feasibility: ask one person to squeeze the hand of another person and let the signal travel around. If, at the end of the test, all people felt the squeeze on both of their hands, the circle is complete and the task is feasible.*
- 7 | **The aim is to untangle the knot without letting go hands of persons one is holding.** *In other words, the group needs to find a way to form an alternative circle where a person to their right will be the person holding their right hand and the person to their left is the person holding their left hand.*
- 8 | *The activity normally lasts 15-30 min. If you work with more than one group, add an aspect of competition to the activity to motivate groups to move faster.*
- 9 | *The group should communicate among themselves and perform necessary moves but never let go hands of their partners. If you see them doing it, you can impose punishments (e.g. adding blindfolds).*
- 10 | *At the end of the activity, debrief with all participants. How did it go? How did you feel? How did your feelings change with time? What was your strategy? Who came up with the solution? Who was leading the group? How may this activity represent what we'll be doing in the field? What messages may we want to teach you?*

**The selection of debrief questions depends on your observations. Be perceptive and creative with key messages you want to communicate. This activity may become one of the highlights of the training, which the participants will most likely not forget.*



ACTIVITY 2: COMMUNITY ASSESSMENT

This is the first learning section of Day 2 where you should try to squeeze all the theory of qualitative data collection for SQUEAC. Make your presentation as informative and as entertaining as you possibly can. This is a 90 min session which will most probably exhaust your audience. Adult learners are known to pay attention 8-12 minutes at the time so try to use different facilitator tools to captivate their interest and help them remember. Change the rhythm of your presentation every 8 minutes, change the activity every 20-30 minutes and give them a well-deserved break after 90 minutes.

Your presentation should primarily cover the following topics:

1 | Brief explanation of the “community assessment” Ask your audience to define the “community”. How do they understand the term? What does it encompass? Why do we need to study it?

It is possible that you'll be working with experienced surveyors who will not hesitate with the definition. However, they may struggle with the description of the community which they are part of. The reason behind this natural phenomenon is our (human) tendency to “discard the obvious” (because everyone knows it/everybody does it so it's ok) which means that certain cultural/social/religious norms and behaviours are never talked about or questioned. Show your participants the importance to evaluate all aspects and make them think what defines the community where you'll be working. You don't need to collect the answers; this is only the beginning of an important brainstorming process, fruits of which you will collect at a later stage.

2 | Overview of “areas of interest” Following your definition of the community, ask the participants to name areas which the community assessment should attempt to explore. This is an important consciousness raiser which will contribute to the quality of data collection process throughout the investigation. Not only will it help the participants to gather information you're looking for but they will also be more creative and natural during interviews (not sticking solely to questions on your interviews guides). Actively contributing to the content of this section will help them remember what to ask for while they are in the field.

3 | Explanation of “stages” of the community assessment Your participants now understand the purpose and content of the community assessment but they are most likely wondering how you'd like to make it happen. Quench their thirst by explaining how the community assessment will be organised and how it will complement the SQUEAC.

4 | Overview of “tools and methods” available for the community assessment Quench another “how” by presenting a list of available tools and methods for the community assessment. Ask them to define each in their own words and point out important differences. Use this opportunity to map out which of your participants have already led (focus) group discussions and/or semi-structured interviews and ask them to share their experience. How was it organised? What were the challenges? How did they go about them? What would they do differently? What should they never forget? Listen attentively and validate their contributions. This exchange may be one of the most beneficial learning sessions not only for your participants but also for you. Look for context-specific nuances which may have influence your organisation and planning.

5 | List of key informants Following the training on SQUEAC (Day 1) and the extent of the qualitative data collection, ask your participants to draw a list of key informants which should be interviewed. You may choose to break them into groups (to change the rhythm) but only if you have enough time before the break. Allow not more than five minutes for reflection. Ask one group to present while others comment. There will surely be overlapping answers!!

6 | Hints of practical advice This is a wrap-up section of your presentation and a chance to set a tone for the community assessment. There is no time to lose so make sure your participants are clear on how to approach communities respectfully. Make a list of key messages and instruct participants to respect them at all times. The investigation should not disturb the targeted community or its relation with the host organisation/health facilities. Make sure that the participants know how to react in tricky situations.



ACTIVITY 3: INTERVIEW GUIDES

This is a tipping point of your training day and the last bit of the “theoretical” part. Your participants should have a good understanding of the work to be done by this point so start testing them!

- 1 | *Explain the structure of the interview guide (themes, probes and differentiation by key informants).*
- 2 | *Pick any three overarching themes and ask the participants to brainstorm on probes. What questions would they ask the interviewees to learn more about their understanding of the subject? This is a crucial step in your participants' understanding of interview guides' composition, of the depth of the information sought as well as of the need to use their imagination and creativity to collect high quality data.*
- 3 | *Make a link between this activity and the composition of interview guides. Comment on the necessity to complete each guide to the extent possible, but not necessarily in the same order. Reiterate the importance of adding ad hoc questions, whenever circumstances allow for it.*
- 4 | *Explain how the collected data will be analysed on a daily basis and used at a later stage.*

ACTIVITY 4: DEAR COMMUNITY I

Dear community is a series of simulation exercises with a double purpose and a double objective. Firstly, they will boost your participants' understanding of the actual content of interview guides and the most efficient manner of working with them, increasing their self-esteem, motivation to contribute and excel. Secondly, they will give you an opportunity to observe your participants and correct eventual mistakes (whenever necessary), decreasing a possibility of setbacks or data inconsistencies.

Dear community I is a simulation exercise of a semi-structured group discussion.

- 1 | *Assign two participants as surveyors, three groups of two as observers while the rest will play a role of community members.*
- 2 | *Change location (e.g. use outside premises, if available) to reflect a potential community scenery. If not possible, re-arrange the seating so that community members are seated in the middle, surveyors in front of them, and observers on the sides. Make sure that there are no obstructions of view for any of the participants.*
- 3 | *Ask the surveyors to commence the group discussion as they would do normally (with all necessary presentations, complimentary questions, etc.) and to start making their way through the interview guide.*
- 4 | *Ask the community members to respond to questions, adding a little spice to the exercise as they see fit. Invite your “community members” to assume different community roles or personas, asking funny or difficult questions, which would test the work ethic of the two surveyors.*
- 5 | *Ask the observers to call for a time-out whenever they spot inconsistencies (content, behaviour, etc.). Call for a time-out yourself if inconsistencies are not observed.*
- 6 | *After cca. 15-20 minutes, start switching roles. Inactive observers will switch roles with active community members, inactive community members with surveyors. Make sure that all participants are equally involved and enjoy themselves!! More they enjoy more they will play, more they'll get out of it.*
- 7 | *End the simulation exercise after cca. 60 minutes (or as soon as the interview guide is completed).*
- 8 | *DEBRIEF EXTENSIVELY! How did you enjoy the exercise? Did you like your roles? Why? Why not? What did you learn? etc.*

**ACTIVITY 5: DEAR COMMUNITY II**

Dear community II is a simulation of a semi-structured interview. Its aim is to further enhance participants' learning while collecting usable qualitative data. Participants should work in pairs or groups of four (whatever is more feasible) interviewing key programme staff (supervisors, community mobilisers, etc.) and/or community volunteers (if available).

- 1 | *Ask participants to form pairs or groups of four and assign an interviewee for each.*
- 2 | *Distribute respective interview guides and invite them to start the interview.*
- 3 | *Oscillate among groups, observing them individually and providing an extra support.*
- 4 | *End the simulation exercise after cca. 30 minutes (or as soon as the interview guide is completed).*
- 5 | *DEBRIEF EXTENSIVELY! What were the main challenges of this exercise? How was it different from the preceding simulation? What did you learn? What is still unclear? etc.*

ACTIVITY 6: LET THE BEAT BUILD

Let the beat build is an innovative teambuilding activity aiming to teach new teams to work together and coordinate their actions. It may be an important skill in the days to come, lowering a possibility of occurrence of certain logistical (or other) frustrations. In this training, it may serve as well serve as an energiser or a good introduction of the last informative session.

Instructions:

- 1 | *This activity is suitable for any group size. Ask the participants to rearrange their seats in a circle, forming smaller groups of three or four within.*
- 2 | *Ask each group to create their own beat (with hands, feet, mouth, pens or pencils, etc.). The beat should be catchy and easy to reproduce.*
- 3 | *Ask each group to present their beat, asking other participants to join in.*
- 4 | *After all groups have presented their beat, ask all groups to reproduce their beat on your signal. The result will most likely be horrible (everyone making the noise at the same time).*
- 5 | *Ask the participants whether they liked it. Why? Why not?*
- 6 | *Ask the group to work together and create a nice piece of music with each group's beat represented. Give them few minutes to figure it out. If you're lucky, they'll come back with a marvellous orchestra of sounds, adding tones and rhythms you never dreamed of.*
- 7 | *Debrief! How did it go? How did you feel? Who was leading the group? What was the difference between the first and second part of the exercise? How may this activity represent what we'll be doing in the field? What messages may we want to teach you?*

ACTIVITY 7: SQUEAC LOGISTICS

This is the last activity of the day and your participants may be as eager to go home as you are but you need to prepare them for the "real thing".

- 1 | *Review team's roles and responsibilities vis-à-vis different stages of SQUEAC and Community Assessment.*
- 2 | *Explain daily team rotations and the necessity to expose them to different tasks.*
- 3 | *Distribute SQUEAC calendars and contact lists.*
- 4 | *Review daily routine (morning meetings @ xx, daily restitution @ yy) and make sure they do not limit themselves to the field work only.*
- 5 | *Open the floor for additional questions, as necessary.*



Annex I a

COMMUNITY ASSESSMENT TRAINING & SIMULATION **AGENDA**

08.00	WELCOME	Presentation of the agenda Politeness rules' reminder
08.30	HUMAN KNOT	Communication Problem-solving Leadership Personal space & proximity
09.15	COMMUNITY ASSESSMENT	Purpose Areas of interest Stages Tools & Methods Sources Practical advice
10.45	BREAK	
11.00	INTERVIEW GUIDES	Structure (Themes & probes) Approach Analysis
11.30	DEAR COMMUNITY I	Semi-structured group discussion simulation
13.00	LUNCH	
14.00	DEAR COMMUNITY II	Semi-structured interview simulation (work in pairs)
15.00	LET THE BEAT BUILD⁴	Team cohesion Coordination Contribution to common goals
15.30	SQUEAC LOGISTICS	Team's roles and responsibilities Organigram + contact list Daily routine
16.00	REVIEW OF THE WORKSHOP & CLOSING	

⁴ In case of time constraints, skip the activity.



Annex I b

COMMUNITY ASSESSMENT TRAINING & SIMULATION **MODULE**

 COVERAGE MONITORING NETWORK <h1>SQUEAC</h1> COMMUNITY ASSESSMENT [Health District, Region, Country] [Month Year] [Name SURNAME]		<h3>COMMUNITY DEFINITION</h3>  COVERAGE MONITORING NETWORK	 A group or network of persons who share COMMON VALUES. <ul style="list-style-type: none"> ▪ geographical location ▪ cultural and linguistic origins ▪ religious affiliation ▪ political and social heritage ▪ interests and aspirations ▪ any beliefs, preferences, resources, needs, etc.
<h3>COMMUNITY MOBILISATION DEFINITION</h3>  COVERAGE MONITORING NETWORK	<ul style="list-style-type: none"> ▪ Process of activating and engaging local populations in the planning, implementation, evaluation and long-term integration of programmes. ▪ Dialogue with various segments of the population to develop context-specific programmes. ▪ Understanding of main sociocultural characteristics of beneficiary communities. 	<h3>COMMUNITY MOBILISATION OBJECTIVES</h3>  COVERAGE MONITORING NETWORK	<ul style="list-style-type: none"> ▪ Develop a CMAM programme adapted to the sociocultural context in which it is/will be operating ▪ Increase the coverage of CMAM programme ▪ Increase the appropriation and support of the programme by beneficiary communities ▪ Strengthen case finding and referral, follow-up and supervision of community outreach activities
<h3>COMMUNITY ASSESSMENT PURPOSE & AREAS OF INTEREST</h3>  COVERAGE MONITORING NETWORK	<p>Purpose: to understand the community dynamics which may influence and/or have impact on access to or acceptance of a CMAM programme.</p> <ul style="list-style-type: none"> ▪ demographic profile <ol style="list-style-type: none"> ethnicity/religious affiliation/ economic status, etc. cultural and social norms, traditions, beliefs, attitudes, perceptions, taboos, etc. ▪ social organisation (structure, institutions, leadership, etc.) ▪ gender organisation and childcare ▪ key community figures ▪ communication channels 	<h3>COMMUNITY ASSESSMENT PURPOSE & AREAS OF INTEREST</h3>  COVERAGE MONITORING NETWORK	<ul style="list-style-type: none"> ▪ local understanding of malnutrition (symptoms, causes, effects, solutions, stigmatisation) ▪ health seeking patterns ▪ access and perceptions of health centre (distance, cost, quality and variety of care, admissions, interface, perceptions & use of treatment, etc.) ▪ volunteer networks (coverage, capacity, aptitude, activity frequency, planning & follow-up, etc.) ▪ community sensitisation & screening (actors, themes, tools, frequency, variety, etc.) <p style="text-align: center;">↓</p> <p style="text-align: center;">BARRIERS and BOOSTERS to access and uptake</p> <p style="text-align: center;">+</p> <p style="text-align: center;">identification of gaps in community mobilisation</p>



COMMUNITY ASSESSMENT STAGE II

Weighting

AWARENESS ABOUT CMAM SERVICE - Screening by community volunteers - Self referral - Peer referrals	3	M, W, T, TH, LL	AB, BH, BO, AR, DJ, KB, ZK	GD, S
	5	TBA, LL, RA	AB, AL, BO, DJ, HM, MO, KB, KU	GD, S
AWARENESS ABOUT MALNUTRITION - Lack of food, hunger - Breastfeeding during pregnancy, abrupt weaning				



COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT



COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT PRACTICAL ADVICE



COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT PRACTICAL ADVICE

- **Contact community leaders** upon your arrival and present survey's objectives in transparent manner. Seek their permission, necessary.
- **Choose a place** for your activity carefully. Make sure your interlocutors feel comfortable and safe and not easily disturbed.
- **Face your interlocutors.** Make sure they can see hear you easily.
- **Introduce yourself, your team and the activity.** Let your interlocutors present themselves, if they wish to do so. Seek their clear consent to participate in activity and acknowledge their availability. Guarantee confidentiality and anonymity of their contributions.
- **Observe your audience.** Sense how they might feel what might keep them at distance and what might establish good relations.



COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT PRACTICAL ADVICE

- **Pay attention to individuals who keep silent.** Try to include them in the conversation.
- **Show respect** for your interlocutors, especially important community figures. **Avoid interrupting them** while they talk and **listen attentively**. Do not influence your interlocutors. Avoid making pedagogical speeches.
- **Recognize and document all contributions.** Avoid displaying your opinion and/or disagreement. Note contributions truthfully (as stated by interlocutors); avoid excessive interpretation.
- **Thank** your interlocutors for their time, assistance and hospitality.



COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT QUESTIONS



COVERAGE MONITORING NETWORK

QUALITATIVE SAMPLING FRAMEWORK



HZ	M	W	C-SAM ^M	T	TBA	TH	RA	CL	CBO	CHW	HCP	HD	NGO
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
XXX (U/R, ?km) OTP Day													
TOTAL													

* The principal objective of a qualitative sampling framework is to assure the representativity of all health zones (HZ) as well as the unbiased participation of all key informants in the qualitative data collection. The number of interviews per health zone can be calculated according to the following formula:

$$n = \frac{\text{no. of days, which can be dedicated to the activity} \times \text{no. of teams} \times 2}{\text{no. of health zones in the health district/area of intervention}}$$

(representing two semi-structured interviews/group discussions per team per day)

The minimum number of interviews/group discussions per health zone should not be less than 2. If a resulting figure is < 2, the number of days per activity and/or the number of teams should be increased. Alternatively, a representative zone can be chosen for a maximum of three zones.

KEY FOR LOCATION

XXX: insert name of health zone
(add more rows, if necessary. The left-hand column should include all health zones in your area of intervention)
U/R: urban/rural setting
? km: insert distance from the centre of health district
OTP day: insert day of the week during which OTP services are available

KEY FOR DATA COLLECTION METHODS

GD: Group discussion
SSI: Semi-structured interview
O: Observation

KEY FOR KEY INFORMANTS

M: Men
W: Women
C-SAM: Carer of malnourished child
T: Teacher
TBA: Traditional Birth Attendant
TH: Traditional healer
RA: Religious authority
CL: Community leader
CBO: Community-based organisation
CHW: Community Health Worker
HCP: Health Centre Personnel
HD: Health District Representative
NGO: NGO/Programme staff

Annex Ila
PLANNING CALENDAR



	Team 1	Team 2	Team 3	Team 4	Team 5	Team 6	Team 7	Team 8
DAY 1								
DAY 2								
DAY 3								
DAY 4								

* out of which XX men and XX women

Annex IIb

SUMMARY OF KEY INFORMANTS



Key informant	No. interviews	No. interviewees	Ethnic group
Women			
Men			
Carers of malnourished children (W)			
Carers of malnourished children (M)			
Teachers			
Traditional Birth Attendants			
Traditional healers			
Community health workers			
Religious authorities			
Community leaders			
Community-based organisations			
Health centre personnel			
Health district			
NGO			
TOTAL			



Annex III

INTERVIEW GUIDES

- ◆ Annex 3a: **Men**
- ◆ Annex 3b: **Women**
- ◆ Annex 3c: **Carers of malnourished children** (beneficiaries of cmam programme)
- ◆ Annex 3d: **Community leaders** (religious authorities, village chiefs or others)
- ◆ Annex 3e: **Community-based organisations & school establishments**
- ◆ Annex 3f: **Traditional healers & traditional birth attendants**
- ◆ Annex 3g: **Community health workers**
- ◆ Annex 3h: **Health center personnel**
- ◆ Annex 3i: **Health district & NGO representatives**
- ◆ Annex 3j: **Marasmus & Kwashiorkor images**

INTERVIEW GUIDE: COMMUNITY MEMBERS (Men)

No. people interviewed Out of which women and men Ethnic group: Date:

District: Health zone: Village: Team:

Personal & Community Profile

RESPONSIBILITIES

- ◆ What are your usual daily activities?
- ◆ Do you have any other, less regular responsibilities (week/month)?
If yes, explain.
- ◆ Does someone help you?
- ◆ **If yes, who? How?**
- ◆ What do other family members do?

FEEDING PRACTICES

- ◆ What staples are available/eaten in your household? Why?
- ◆ Is there any food, which you or other family members cannot eat?
If yes, what? Why?
- ◆ Is there any food, which women cannot eat when they are pregnant / breastfeeding?
If yes, what? Why?
- ◆ Is there any food, which children cannot eat?
If yes, what? Why? At what age?
- ◆ How many meals do you eat per day in your household? Why?
- ◆ How are meals shared among all members in your household? Why?

BREASTFEEDING / WEANING

- ◆ Do women breastfeed children?
- ◆ **If yes, until what age? How often?**
- ◆ Do they give babies the first milk (« colostrum »)? Why? Why not?
- ◆ Do they give babies other types of food/drink?
If yes, what? At what age? Why?
- ◆ Do they experience any problems when breastfeeding?
If yes, which? Why?
- ◆ Do they breastfeed children when pregnant? Why? Why not?
- ◆ Who advises them on breastfeeding practices?





PREGNANCY / CHILDBIRTH

- ◆ What care do women receive when they are pregnant?
- ◆ Who advises them during the pregnancy? Why? How?
- ◆ Do they experience any difficulties during the pregnancy?
- If yes, which? Why? What do they do to remedy them?**
- ◆ What role do you play during the pregnancy?
- ◆ Do you think your role is sufficient? Why? Why not?
- ◆ Where do women give birth? Why?
- ◆ Who accompanies them? Why?
- ◆ Would they like to give birth elsewhere/differently? Where? How?
- ◆ Which care do they receive after giving birth? Why?

FAMILY PLANNING

- ◆ Do you have sexual contact with your wife when she's pregnant? Why? Why not?
- ◆ Do you have sexual contact with your wife after giving birth?
- If yes, after what time?**
- ◆ Do you wish your wife to get pregnant after giving birth? Why? Why not?
- ◆ Does your wife wish to get pregnant after giving birth? Why? Why not?
- ◆ Do you know means of contraception?
- If yes, which?**
- ◆ Do you use them? Why? Why not?

CHILDHOOD DISEASES

- ◆ Which childhood diseases are the most frequent in your community? Why?
- ◆ What are causes of these diseases?
- ◆ Which therapeutic itineraries do you use? Why?

MALNUTRITION (show images of marasmus / kwashiorkor)

- ◆ Are there children in your community who look like this?
- If yes, which type is more frequent?**
- ◆ Is it a disease like others? Why? Why not?
- ◆ Which local terms are used to describe it?
- ◆ How is it perceived in the community? Why?
- ◆ Is it a « new » disease?



If yes, since when? Why do you think this disease appeared in your community?

- ◆ Do you think that this condition is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour and/or community relationships?
- ◆ How are its causes and symptoms described?
- ◆ Which therapeutic itineraries are used to treat this disease? Why?

Awareness Of CMAM Programme

- ◆ Have you heard about CMAM programme?

If yes, from whom? What did you hear?

- ◆ Do you hear about CMAM programme often? How often?
- ◆ Do you know which children are targeted by the programme?
- ◆ Do you know which treatment they receive?
- ◆ What do you think about this treatment?
- ◆ How is it perceived in the community? Why?
- ◆ What do you think about CMAM programme?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers to the use of this programme?

If yes, explain.

Coverage / Rejection / Defaulting

- ◆ Are there many children in your community who benefit from CMAM programme?
- ◆ Do you know other children in your community who need this service?

If yes, why aren't they in the programme?

- ◆ Do you know any children who were rejected? Why?
- ◆ Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?



Sensitisation & Screening

- ◆ Who sensitises the community? How often? On what subjects?
- ◆ Do you assist in sensitisation sessions? Why? Why not?
- ◆ What do you think of those sessions? Are they interesting? Boring? Why?
- ◆ What do you think of the information shared? Is it useful? Not useful? Why?
- ◆ Do you think the sensitisation is sufficient? Why? Why not?
- ◆ How should it be reinforced?
- ◆ Are there people in your community who measure children?
- ◆ If yes, who? How often? How?

INTERVIEW GUIDE: COMMUNITY MEMBERS (Women)

No. people interviewed Out of which women and men Ethnic group: Date:

District: Health zone: Village: Team:

Personal & Community Profile

RESPONSIBILITIES

- ◆ What are your usual daily activities?
 - ◆ Do you have any other, less regular responsibilities (week/month)?
 - ◆ Does someone help you?
- If yes, who? How?**
- ◆ What do other family members do?

FEEDING PRACTICES

- ◆ What staples are available/eaten in your household? Why?
 - ◆ Is there any food, which you or other family members cannot eat?
- If yes, what? Why?**
- ◆ Is there any food, which women cannot eat when they are pregnant / breastfeeding?
- If yes, what? Why?**
- ◆ Is there any food, which children cannot eat?
- If yes, what? Why? At what age?**
- ◆ How many meals do you eat per day in your household? Why?
 - ◆ How are meals shared among all members in your household? Why?

BREASTFEEDING / WEANING

- ◆ Do you breastfeed your children?
- If yes, until what age? How often?**
- ◆ Do you give your babies the first milk (« colostrum »)? Why? Why not?
 - ◆ Do you give your babies other types of food/drink?
- If yes, what? At what age? Why?**
- ◆ Do they experience any problems when breastfeeding?





If yes, which? Why?

- ◆ Do you breastfeed children when pregnant? Why? Why not?
- ◆ Who advises you on breastfeeding practices?
- ◆ Do you share your experience with other mothers in the community? When? Where? Why?

PREGNANCY / CHILDBIRTH

- ◆ What care do you receive when you are pregnant?
- ◆ Who advises you during the pregnancy? Why? How?
- ◆ Do you experience any difficulties during the pregnancy?
- ◆ **If yes, which? Why? What do you do to remedy them?**
- ◆ What role do fathers play during the pregnancy?
- ◆ Do you think their role is sufficient? Why? Why not?
- ◆ What change would you like to see in this respect? Why?
- ◆ Where do you give birth? Why?
- ◆ Who accompanies you? Why?
- ◆ Would you like to give birth elsewhere/differently? Where? How?
- ◆ What care do you receive after giving birth? Why?

FAMILY PLANNING

- ◆ Do you have sexual contact with your husband when pregnant? Why? Why not?
- ◆ Do you have sexual contact with your husband after giving birth?
- ◆ **If yes, after what time?**
- ◆ Do you wish to get pregnant after giving birth? Why? Why not?
- ◆ Does your husband wish that you get pregnant after giving birth? Why? Why not?
- ◆ Do you know means of contraception?
- ◆ **If yes, which?**
- ◆ Do you use them? Why? Why not?

CHILDHOOD DISEASES

- ◆ Which childhood diseases are the most frequent in your community? Why?
- ◆ What are causes of these diseases?
- ◆ Which therapeutic itineraries do you use? Why?



MALNUTRITION (show images of Marasmus / Kwashiorkor)

- ◆ Are there children in your community who look like this?
- If yes, which type is more frequent?**
- ◆ Is it a disease like others? Why? Why not?
- ◆ Which local terms are used to describe it?
- ◆ How is it perceived in the community? Why?
- ◆ Is it a « new » disease?
- If yes, since when? Why do you think this disease appeared in your community?**
- ◆ Do you think that this condition is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour and/or community relationships?
- ◆ How are its causes and symptoms described?
- ◆ Which therapeutic itineraries are used to treat this disease? Why?

Awareness Of CMAM Programme

- ◆ Have you heard about CMAM programme?
- If yes, from whom? What did you hear?**
- ◆ Do you hear about CMAM programme often? How often?
- ◆ Do you know which children are targeted by the programme?
- ◆ Do you know which treatment they receive?
- ◆ What do you think about this treatment?
- ◆ How is it perceived in the community? Why?
- ◆ What do you think about CMAM programme?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers to the use of this programme?
- If yes, explain.**

Coverage / Rejection / Defaulting

- ◆ Are there many children in your community who benefit from CMAM programme?
- ◆ Do you know other children in your community who need this service?
- If yes, why aren't they in the programme?**
- ◆ Do you know any children who were rejected? Why?
- ◆ Do you know any children who abandoned the treatment? Why?
- If yes, how could we motivate them to return?**



Sensitisation & Screening

- ◆ Who sensitises the community? How often? On what subjects?
- ◆ Do you assist in sensitisation sessions? Why? Why not?
- ◆ What do you think of those sessions? Are they interesting? Boring? Why?
- ◆ What do you think of the information shared? Is it useful? Not useful? Why?
- ◆ Do you think the sensitisation is sufficient? Why? Why not?
- ◆ How should it be reinforced?
- ◆ Are there people in your community who measure children?
- ◆ If yes, who? How often? How?

INTERVIEW GUIDE: CARERS OF MALNOURISHED CHILDREN

(Beneficiaries Of CMAM Programme)

No. people interviewed Out of which women and men Ethnic group: Date:

District: Health zone: Village: Team:

Awareness Of CMAM Programme

- ◆ How did you hear about CMAM programme?
- ◆ What did you hear?
- ◆ Do you hear about CMAM programme often? How often?
- ◆ Why did you decide to come to the health centre?
- If child's illness is mentioned:**
- ◆ When did you notice that your child is ill?
- ◆ What symptoms /problems did you notice?
- ◆ Was your child measured at home?
- If yes:**
- ◆ Who measured him? How? What was said?
- ◆ After what time did you decide to come to the health centre?

- If more than two weeks:**
- ◆ Why did you wait so long?
- ◆ Since when have you been in the programme?
- ◆ Have you noticed a difference in the condition of your child?
- ◆ What difference?

- DECISION-MAKING**
- ◆ Did someone encourage you to go to the health centre?
 - If yes:**
 - ◆ Who encouraged you?
 - ◆ Does this person encourage you to continue the treatment? Why?
 - ◆ Does this person accompany you to the health centre?
 - If not, would you like to be accompanied? Why?**





Awareness Of Malnutrition

- ◆ Do you know causes of your child's condition?
- If yes, what are they?**
- ◆ Do you know effects of this condition?
- If yes, what are they?**
- ◆ Do you think that it's a disease like any other? Why? Why not?
- ◆ How did you try to treat this condition before going to the health centre?
- ◆ Which words do people use to describe it?
- ◆ Does the health centre staff use the same words?
- If not, what words do they use?**
- ◆ Did the health centre staff explain your child's condition?
- If yes:**
- ◆ What did they tell you?

Quality Of CMAM Programme

- ◆ How long do you have to wait before being served? Why?
- ◆ What do you do while waiting? Is it comfortable?
- ◆ How much time do you spend with the nurse during the consultation?
- ◆ Is he/she kind? Why? Why not?
- ◆ What does the health centre staff give you to treat the disease?
- ◆ Did they explain the reason for this treatment?
- ◆ Have you always received a complete ration?
- If not, why not? How many times?**
- ◆ Did the health centre staff explain how to use it?
- If yes, do you observe their instructions?**
- ◆ Does your child like to eat it?
- ◆ Does/did he/she display any symptoms after eating it?
- If yes, what symptoms?**
- ◆ Do you continue the treatment?
- ◆ Have you tasted the product?
- ◆ Do you share it with other family members? Why?
- ◆ What is an approximate duration of the treatment?
- ◆ Will you continue the treatment until your child fully recovers? Why? Why not?



Appreciation Of CMAM Programme

- ◆ What do you think of CMAM programme (+/-)? Why?
- ◆ Will you refer other children in your community? Why? Why not?
- If positive answer given:**
- ◆ Have you already referred other children in your community? When? Why?
- ◆ What would you change to improve the quality of the programme?
- ◆ Is it easy to get to the health centre?
- If not, what makes it difficult?**
- ◆ What means of transport do you use?
- ◆ What is the price of the journey there and back?
- ◆ How long does it take you?
- ◆ Who takes care of your children during your absence?

Coverage / Rejection / Defaulting

- ◆ Do you know other children in your community who need the treatment?
- If yes, why aren't they in the programme?**
- ◆ Are these children or their parents stigmatised by any community members? Why?
- ◆ Do you know about any children being rejected? Why?
- ◆ Do you know about any children abandoning the treatment? Why?
- ◆ How could we motivate them to return?

INTERVIEW GUIDE: COMMUNITY LEADERS

(Religious Authorities, Village Chiefs Or Others)



No. people interviewed Out of which women and men Ethnic group: Date:
 District: Health zone: Village: Team:

Community Profile

- ◆ What is your role in the community?
- ◆ What are your main activities?
- ◆ What are main challenges in your community?
- ◆ Do they have impact on people's health?

If yes, describe.

COMMUNITY ORGANISATION

- ◆ How is your community organised?
- ◆ Do community members meet regularly?
- ◆ **If yes, for what purpose? How often? Where? At what time of the day?**
- ◆ How are decisions made in your community?
- ◆ How are decisions communicated to all community members?
- ◆ What other (formal and informal) communication channels are available in your community?
- ◆ Which communication channels are most efficient? Why?
- ◆ Do community-based organisations exist in your community?

If yes, how many? What are their roles and activities?

How are they perceived?

- ◆ Do you have a contact with other communities?

If yes, for what purpose? How often?

FAMILY ORGANISATION

- ◆ How do M/W share their family roles?
- ◆ Who makes decisions for the family? Why?
- ◆ Are there any situations, in which another person can decide? Explain.
- ◆ Has there been any change in this respect in the last years? Explain.
- ◆ How would you describe intergenerational relations?
- ◆ Does young generation reproach their parents/grand-parents? Explain.
- ◆ Where do young women learn how to take care of their babies? Why?
- ◆ Do men learn how to take care of their babies? Why? Why not?
- ◆ Do you think that men should be more involved? Why? Why not?



Awareness Of The Malnutrition

show images of Marasmus / Kwashiorkor)

◆ Are there children in your community who look like this?

◆ **If yes, which type is more frequent?**

◆ Is it a disease like others? Why? Why not?

◆ Which local terms are used to describe it?

◆ How is it perceived in the community? Why?

◆ Is it a « new » disease?

◆ **If yes, since when? Why do you think this disease appeared in your community?**

◆ Do you think that this condition is stigmatised? Why?

◆ How does this stigmatisation mark people's behaviour and/or community relationships?

◆ Do you know symptoms of this disease?

◆ **If yes, can you name few?**

◆ Do you know its causes?

◆ **If yes, can you name few?**

◆ Do you know its effects?

◆ **If yes, can you name few?**

◆ What therapeutic itineraries are available in your community to treat this disease? Which ones are the most frequent? Why?

Awareness Of CMAM Programme

◆ Have you heard about CMAM programme?

◆ **If yes, from whom? What did you hear?**

◆ Do you hear about CMAM programme often? How often?

◆ Do you know which children are targeted by the programme?

◆ Do you know which treatment they receive?

◆ What do you think about this treatment?

◆ How is it perceived in the community? Why?

◆ What do you think about CMAM programme?

◆ How is it perceived in the community? Why?

◆ Are there any obstacles/barriers to the use of this programme?

◆ **If yes, explain.**

◆ What would you change to improve its quality?



Coverage / Rejection / Defaulting

- ◆ Are there many children in your community who benefit from CMAM programme?
- ◆ Do you know other children in your community who need this service?
- ◆ **If yes, why aren't they in the programme?**
- ◆ Do you know any children who were rejected? Why?
- ◆ Do you know any children who abandoned the treatment? Why?
- ◆ **If yes, how could we motivate them to return?**

Sensitisation & Screening

- ◆ Who is responsible for the sensitisation of the community?
- ◆ Do these people sensitise the community on the malnutrition?
- ◆ **If yes, how often?**
- ◆ Do you know which subjects are addressed?
- ◆ What do you think of those sessions? Are they interesting? Boring? Why?
- ◆ What do you think of the information shared? Is it useful? Not useful? Why?
- ◆ Who is targeted by sensitisation sessions on the malnutrition?
- ◆ Who else should be targeted by these sessions? Why?
- ◆ Do you actively participate in sensitisation sessions?
- ◆ **If yes, why? How? How often?**
- ◆ **If no, why not?**
- ◆ Do you think the sensitisation is sufficient? Why? Why not?
- ◆ How should it be reinforced??
- ◆ Are there people in your community who identify malnourished children?
- ◆ **If yes, who? How? How often?**
- ◆ What do you think of their work? Why?
- ◆ Who should be included in this? Why?

INTERVIEW GUIDE: Community-Based Organisation/ Associations/Cooperatives/School Establishments or Others

No. people interviewed Out of which women and men Ethnic group: Date:
 District: Health zone: Village: Team:

Organisational & Community Profile

- ◆ What is your role in the community?
- ◆ What are your main activities? How often do you carry them out?
- ◆ How are you organised?
- ◆ How are decisions made in your organisation?
- ◆ How do you communicate with the population? Why?
- ◆ How does the population perceive you? Why?
- ◆ How would you describe your community?
- ◆ What are its main challenges? Why?
- ◆ How does the community address these challenges? Why?
- ◆ How are decisions made in your community?
- ◆ Do you participate in a decision-making? Why? Why not?
- ◆ How are decisions communicated to all community members?
- ◆ What other (formal and informal) communication channels are available in your community?
- ◆ Which are most efficient? Why?

MALNUTRITION

(show images of Marasmus / Kwashiorkor)

- ◆ Are there children in your community who look like this?
- If yes, which type is more frequent?**
- ◆ Is it a disease like others? Why? Why not?
- ◆ Which local terms are used to describe it?
- ◆ How is it perceived in the community? Why?
- ◆ Is it a « new » disease?
- If yes, since when? Why do you think this disease appeared in your community?**





- ◆ Do you think that this condition is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour and/or community relationships?
- ◆ How are its causes, symptoms and effects described?
- ◆ Do you agree? Why? Why not?
- ◆ Which therapeutic itineraries are used in your community to treat the malnutrition? Why?
- ◆ Do you agree? Why? Why not?

FAMILY ORGANISATION

- ◆ How do M/W share their family roles?
- ◆ Who makes decisions for the family? Why?
- ◆ Are there any situations, in which another person can decide? Explain.
- ◆ Has there been any change in this respect in the last years? Explain.
- ◆ Where do young women learn how to take care of their babies? Why?
- ◆ Do men learn how to take care of their babies? Why? Why not?
- ◆ Do you think that men should be more involved? Why? Why not?

Awareness Of CMAM Programme

- ◆ Have you heard about CMAM programme?
- ◆ **If yes, from whom? What did you hear?**
- ◆ Do you hear about CMAM programme often? How often?
- ◆ Do you know which children are targeted by the programme?
- ◆ Do you know which treatment they receive?
- ◆ What do you think about this treatment?
- ◆ How is it perceived in the community? Why?
- ◆ What do you think about CMAM programme?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers to the use of this programme?

If yes, explain.



Coverage / Rejection / Defaulting

- ◆ Are there many children in your community who benefit from CMAM programme?
 - ◆ Do you know other children in your community who need this service?
- If yes, why aren't they in the programme?**
- ◆ Do you know any children who were rejected? Why?
 - ◆ Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?

Sensitisation & Screening

- ◆ Who is responsible for the sensitisation of the community?
 - ◆ Do these people sensitise the community on the malnutrition?
- If yes, how often?**
- ◆ Do you know which subjects are addressed?
 - ◆ What do you think of those sessions? Are they interesting? Boring? Why?
 - ◆ What do you think of the information shared? Is it useful? Not useful? Why?
 - ◆ Who is targeted by sensitisation sessions on the malnutrition?
 - ◆ Who else should be targeted by these sessions? Why?
 - ◆ Do you actively participate in sensitisation sessions?

If yes, why? How? How often?

If no, why not?

- ◆ Do you think the sensitisation is sufficient? Why? Why not?
- ◆ How should it be reinforced??
- ◆ Are there people in your community who identify malnourished children?

If yes, who? How? How often?

- ◆ What do you think of their work? Why?
- ◆ Who should be included in this? Why?

INTERVIEW GUIDE: TRADITIONAL HEALERS, TRADITIONAL BIRTH ATTENDANTS, STREET MEDICINE SELLERS

No. people interviewed Out of which women and men Ethnic group: Date:
 District: Health zone: Village: Team:

Personal Profile

- ◆ What is your role in the community?
 - ◆ How long have you been practicing this activity?
 - ◆ How have you learnt it?
 - ◆ Do you have any apprentices?
 - ◆ How often are you consulted?
 - ◆ Do you collaborate with other THs/TBAs? Why? Why not?
 - ◆ Do you collaborate with health centres? Why? Why not?
 - ◆ Is there any difference between your treatment and others?
- If yes, what difference?**

Community Profile

FEEDING PRACTICES

- ◆ What staples are available in your community?
 - ◆ Is there any food, which community members cannot eat?
- If yes, what? Why?**
- ◆ Is there any food, which women cannot eat when they are pregnant / breastfeeding?
- If yes, what? Why?**
- ◆ Is there any food, which children cannot eat?
- If yes, what? Why? At what age?**

BREASTFEEDING / WEANING

- ◆ Do women breastfeed their children?





If yes, until what age? How often?

- ◆ Do they give babies the first milk (« colostrum »)? Why? Why not?
- ◆ Do they give babies other types of food/drink?

If yes, what? At what age? Why?

- ◆ Do they experience any problems when breastfeeding?
- If yes, which? Why?**
- ◆ Do they come to you to be treated?
- ◆ Do they breastfeed children when pregnant? Why? Why not?
- ◆ Do you advise women on breastfeeding practices?

PREGNANCY / CHILDBIRTH

- ◆ What care do women receive when they are pregnant?
- ◆ Who advises them during the pregnancy? Why? How?
- ◆ Do they experience any difficulties during the pregnancy?
- If yes, which? Why? What do they do to remedy them?**
- ◆ What role do fathers play during the pregnancy?
- ◆ Do you think their role is sufficient? Why? Why not?
- ◆ Where do women give birth? Why?
- ◆ Who accompanies them? Why?
- ◆ Would they like to give birth elsewhere/differently? Where? How?
- ◆ Which care do they receive after giving birth? Why?

Childhood Diseases & Malnutrition

CHILDHOOD DISEASES

- ◆ Which childhood diseases are most frequent in your community? ..
- ◆ In which months are they prevalent?
- ◆ How do you treat them?

MALNUTRITION

(show images of Marasmus / Kwashiorkor)

- ◆ Are there children in your community who look like this?
- If yes, which type is more frequent?**
- ◆ Is it a disease like others? Why? Why not?
- ◆ Which local terms are used to describe it?
- ◆ How is it perceived in the community? Why?



- ◆ Is it a « new » disease?
- If yes, since when? Why do you think this disease appeared in your community?**
- ◆ Do you think that this condition is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour and/or community relationships?
- ◆ What are symptoms of this disease?
- ◆ What are its causes?
- ◆ What are its effects?
- ◆ Do you treat this disease?
- If yes, how?**
- ◆ Do you know any other treatments of this disease?
- If yes, which?**
- ◆ In which time of the year do children develop this disease most frequently?

Awareness Of CMAM Programme

- ◆ Have you heard about CMAM programme?
- If yes, from whom? What did you hear?**
- ◆ Do you hear about CMAM programme often? How often?
- ◆ Do you know which children are targeted by the programme?
- ◆ Do you know which treatment they receive?
- ◆ What do you think about this treatment?
- ◆ How is it perceived in the community? Why?
- ◆ What do you think about CMAM programme?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers to the use of this programme?
- If yes, explain.**
- ◆ What would you change to improve its quality?

Coverage / Rejection / Defaulting

- ◆ Are there many children in your community who benefit from CMAM programme?
- ◆ Do you know other children in your community who need this service?



If yes, why aren't they in the programme?

- ◆ Do you know any children who were rejected? Why?
- ◆ Do you know any children who abandoned the treatment? Why?

If yes, how could we motivate them to return?

Sensitisation & Screening

- ◆ Who sensitises the community? How often? On what subjects?
- ◆ Do you assist in sensitisation sessions? Why? Why not?
- ◆ What do you think of those sessions? Are they interesting? Boring? Why?
- ◆ What do you think of the information shared? Is it useful? Not useful? Why?
- ◆ Do you think the sensitisation is sufficient? Why? Why not?
- ◆ How should it be reinforced?
- ◆ Are there people in your community who measure children?
- ◆ If yes, who? How often? How?

INTERVIEW GUIDE: COMMUNITY HEALTH WORKERS

No. people interviewed Out of which women and men Ethnic group: Date:

District: Health zone: Village: Team:

Personal Profile

- ◆ What is your role in the community?
- ◆ Since when have you been working in your role?
- ◆ How do you feel in your role? Why?
- ◆ Have you been trained?
- ◆ **If yes, when? How many times?**
- ◆ Are you satisfied with the level of training? Why? Why not?
- ◆ Are you supervised?
- ◆ **If yes, by whom? How? How often?**
- ◆ Do you collaborate with other community health workers?
- ◆ **If yes, how? Why? How often?**
- ◆ Do you collaborate with other community members and/or health centre personnel?
- ◆ **If yes, how? Why? How often?**

SENSITISATION

- ◆ Do you organise sensitisation sessions in your community?
- ◆ **If yes, how5 & how often do you organise them?**
- ◆ What tools do you have at your disposal?
- ◆ Who do you target in your sensitisation sessions? Why?
- ◆ What other people should be targeted by your sensitisation sessions? Why? Why don't you target them?
- ◆ What other people should actively participate in the sensitisation of the community? Why?
- ◆ How should be sensitisation reinforced? Why?

SCREENING

- ◆ Do you screen malnourished children?
- ◆ **If yes, how & how often do you organise this activity?**
- ◆ What tools do you have at your disposal?





- ◆ How do you refer children to the health centre?
- ◆ Do health centres accept your referrals?
- If not, why not?**
- ◆ Who follows up on referred children? How often?
- If no follow up is done, explain.**
- ◆ Are there many children in your community who benefit from CMMAM programme?
- ◆ Do you know other children in your community who need the treatment?

If yes, why aren't they in the programme?

- ◆ Do you know children who abandoned the treatment?

If yes, why? How could we motivate them to return?

- ◆ Who follows up on defaulting children? How often?

If no follow up is done, explain.

DECISION-MAKING & REFUSAL OF TREATMENT

- ◆ Which family member do you talk to if a child needs to be referred to a health centre?
- ◆ Who makes a decision following your recommendation?
- ◆ Do both parents accept?

If not, why do they refuse?

How could we avoid these situations?

- ◆ Do you sensitise parents on their child's condition?

If yes, what kind of information do you share?

Childhood Diseases & Malnutrition

- ◆ What are main challenges in your community?
- ◆ Do they have impact on the health of the community?
- If yes, explain.**
- ◆ Which childhood diseases are most frequent in your community?
- ◆ In which months are they prevalent?
- ◆ What therapeutic itineraries are available to treat them? Which are most frequent? Why?

MALNUTRITION

- ◆ Which local terms depicting the malnutrition are used in your community?



- ◆ How is it perceived? Why?
- ◆ Is it a « new » disease?
- If yes, since when? Why do you think it appeared in your community?**
- ◆ How do community members describe its symptoms?
- ◆ Do community members understand its causes?
- If yes, how do they describe them?**
- ◆ Do community members understand its effects?
- If yes, how do they describe them?**
- ◆ Which therapeutic itineraries are available in your community to treat the malnutrition? Which are most frequent? Why?
- ◆ Do you think that this condition is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour or community relationships?

Perception Of CMAM Programme

- ◆ What do you think of CMAM programme?
- ◆ What are its strengths/weaknesses?
- ◆ What would you change to improve its quality?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers for the use of this service?
- ◆ If yes, explain.

INTERVIEW GUIDE: HEALTH PERSONNEL

No. people interviewed Out of which women and men Ethnic group: Date:

District: Health zone: Village: Team:

Personal Profile

- ◆ What is your role at the health centre?
 - ◆ Since when have you been working in this role?
 - ◆ How do you feel in your role? Why?
 - ◆ Have you been given training?
- If yes, when? How many times?**
- ◆ Are you satisfied with the level of training provided? Why? Why not?
 - ◆ Are you supervised? Does anyone follow up on your activities?
- If yes, who? How? How often?**
- ◆ Do you collaborate with other people/health centres integrated in the programme?
- If yes, with whom? How? Why? When? How often?**

Community Profile

- ◆ What are main challenges of the community where you work?
 - ◆ Do they have impact on the health of the community?
- If yes, explain.**

CHILDHOOD DISEASES

- ◆ What are most frequent childhood diseases in the community where you work?
- ◆ In which months are they prevalent?
- ◆ Which therapeutic itineraries are available in the community where you work? Which are most frequent? Why?

MALNUTRITION

- ◆ Which local terms depicting the malnutrition are used in the community where you work?





- ◆ How is it perceived? Why?
 - ◆ Is it a « new » disease?
 - ◆ What are main causes of this disease in the community where you work?
 - ◆ Do community members understand its symptoms, causes and effects?
- If yes, how do they describe them?**
- ◆ Which therapeutic itineraries for the malnutrition are available in the community where you work? Which are most frequent? Why?
 - ◆ Do you think that this condition is stigmatised? Why?
 - ◆ How does this stigmatisation mark people's behaviour or community relationships?

SENSITISATION

- ◆ Who is responsible for the sensitisation of the community where you work?
 - ◆ Do these people sensitise the community on the malnutrition?
- If yes, how often?**
- ◆ Do you know which subjects are addressed?
 - ◆ Who is targeted by the sensitisation on the malnutrition?
 - ◆ What other people should be targeted by these sensitisation activities? Why?
 - ◆ Are you involved in sensitisation sessions?
- If yes, why? How? How often?**
- If no, why not?**
- ◆ Who should actively participate in the sensitisation on the malnutrition? Why?
 - ◆ Is the sensitisation sufficient? Why? Why not?
 - ◆ What would you change to improve the quality of sensitisation?

SCREENING

- ◆ Are there people in the community where you work who identify malnourished children?
- If yes, who? How? How often?**
- ◆ What do you think of their work? Why?
 - ◆ Who should be included in this activity? Why?



Quality Of CMAM Programme

- ◆ Do you perform systematic screening on all children who come for a consultation?

If not, why not?

- ◆ What kind of referral (CHW, auto-referral, peer referral, etc.) is most frequent? Why?
- ◆ How is screening & referral by CHWs organised?
- ◆ Who follows up on children referred by CHWs?

If no follow up is done, explain.

- ◆ How do you refer children to ITC?
- ◆ Who follows up on children referred to ITC?

If no follow up is done, explain.

- ◆ Who makes a decision to admit a child into the programme? According to what criteria?
- ◆ Do you experience any difficulties related to admissions?

If yes, what kind of difficulties?

- ◆ Do you reject children referred by CHWs or other community actors?

If yes, why? How many %?

- ◆ Who fills in the registers and/or monitoring forms?
- ◆ Do you experience any difficulties in this respect?

If yes, explain.

- ◆ How many times per month do you update the registers?
- ◆ Do children in this community abandon the treatment?

If yes, why? How many %? Which ethnic group?

- ◆ Who follows up on defaulting children? How?

If no follow up is done, explain.

- ◆ How could we motivate them to return?
- ◆ Do you experience stock breakouts?

If yes, which products are concerned? Why? What does it imply?

- ◆ Do you organise sensitisation sessions for carers of malnourished children in the programme?

If yes, how? How often? With which tools?

If no, why not?

Perception Of CMAM Programme

- ◆ What do you think about CMAM programme?
- ◆ What are its strengths/weaknesses?
- ◆ What would you change to improve its quality?
- ◆ How is it perceived in the community? Why?
- ◆ Are there any obstacles/barriers for the use of this service?

If yes, explain.

INTERVIEW GUIDE: DISTRICT & NGO REPRESENTATIVES

No. of people interviewed..... Out of which women and men Team: Date:

Personal Profile

- ◆ What is your role?
- ◆ Since when have you been working in your role?
- ◆ How many people work under your supervision?
- ◆ How would you describe your relationships with other stakeholders involved in the programme?
- ◆ Are you in regular contact with them? If yes, how often?
- ◆ How do you share your tasks and responsibilities?

Community Profile

- ◆ What is the ethnic composition of the community where you work? Does it influence your work methods? How?
- ◆ Which languages are spoken in the community where you work? Do they represent a linguistic barrier? Explain.
- ◆ Which religions are most frequent? Do they have an impact on people's behaviour? Explain.
- ◆ Are there important socioeconomic differences among people in the community where you work? Do they influence internal community relationships? If yes, how?
- ◆ What is the level of education in this community?
- ◆ What are main sources of income for people living in the community where you work?

COMMUNITY ORGANISATION

- ◆ How is the community where you work organised?
- ◆ Who makes decisions in the name of the community? How are decisions communicated?
- ◆ What (formal & informal) channels of communication are available in the community where you work? Which are most efficient? Why?
- ◆ Are there any community-based organisations in the area? If yes, how many? What are their roles and activities? How does





the community perceive them? Do you work with them? Why? Why not?

MALNUTRITION

- ◆ Which local terms depicting the malnutrition are used in the community where you work?
- ◆ How is it perceived? Why?
- ◆ Is it a « new » disease?
- ◆ Does the community understand its symptoms, causes and effects?
- ◆ **If yes, how do they describe them?**
- ◆ Which therapeutic itineraries are available in this community to treat this disease? Which are most frequent? Why?
- ◆ Do you think that the community understands the CMAM programme well? Why? Why not?
- ◆ How is it perceived? Why?
- ◆ Are there any obstacles/barriers to the use of this programme?

If yes, explain.

- ◆ Do you think that this disease is stigmatised? Why?
- ◆ How does this stigmatisation mark people's behaviour or community relationships?

SENSITISATION

- ◆ Who is responsible for the sensitisation of the community where you work?
- ◆ Do they sensitise the population on the malnutrition?
- ◆ **If yes, how often? Do you know which subjects do they address?**
- ◆ Who is targeted by the sensitisation on the malnutrition?
- ◆ What other people should be targeted? Why?
- ◆ Who should be actively involved in the sensitisation of the population? Why?
- ◆ Are sensitisation efforts sufficient? Why? Why not?

Perception Of CMAM Programme

- ◆ What are particularities of this CMAM programme?



- ◆ How do you organise and/or are involved in the following:
 - Supervision at health centres;
 - Supervision of CHW/volunteer networks;
 - Screening & referrals;
 - Follow-up of Absences, defaulting, etc.
 - Community mobilisation activities.
- ◆ **Describe in great detail.**
- ◆ What are main challenges of your programme? Why?
- ◆ What are its strengths & weaknesses? Justify.
- ◆ What factors may likely influence the access to service and/or its coverage? How could they be addressed?



1



2



3





Annex IV

COMMUNITY BBO WEIGHTING TOOLBOX*

BARRIERS

- ◆ Lack of awareness about malnutrition
- ◆ Stigmatisation
- ◆ Lack of awareness about CMAM programme
- ◆ Geographical barriers
- ◆ Transhumance
- ◆ Heavy workload of women
- ◆ Weak decision-making power of women
- ◆ Recourse to traditional healers
- ◆ Shortcomings in the quality of CMAM programme
- ◆ RUTF stockouts
- ◆ Shortcomings in CHW networks
- ◆ Insufficient sensitisation
- ◆ Difficulties to generate quality statistics

BOOSTERS

- ◆ Certain knowledge about malnutrition
- ◆ Efficacy of treatment
- ◆ Good quality of CMAM programme
- ◆ Care free of charge
- ◆ Good collaboration among partners
- ◆ Engagement of community leaders
- ◆ Efficacy of community health workers
- ◆ Referral by beneficiaries
- ◆ Use of mobile clinics

VOTING CARDS

* Please note that this is a basic set, which can be expanded and modified, as necessary.



Barrier

LACK OF AWARENESS ABOUT MALNUTRITION





Barrier

STIGMATISATION





Barrier

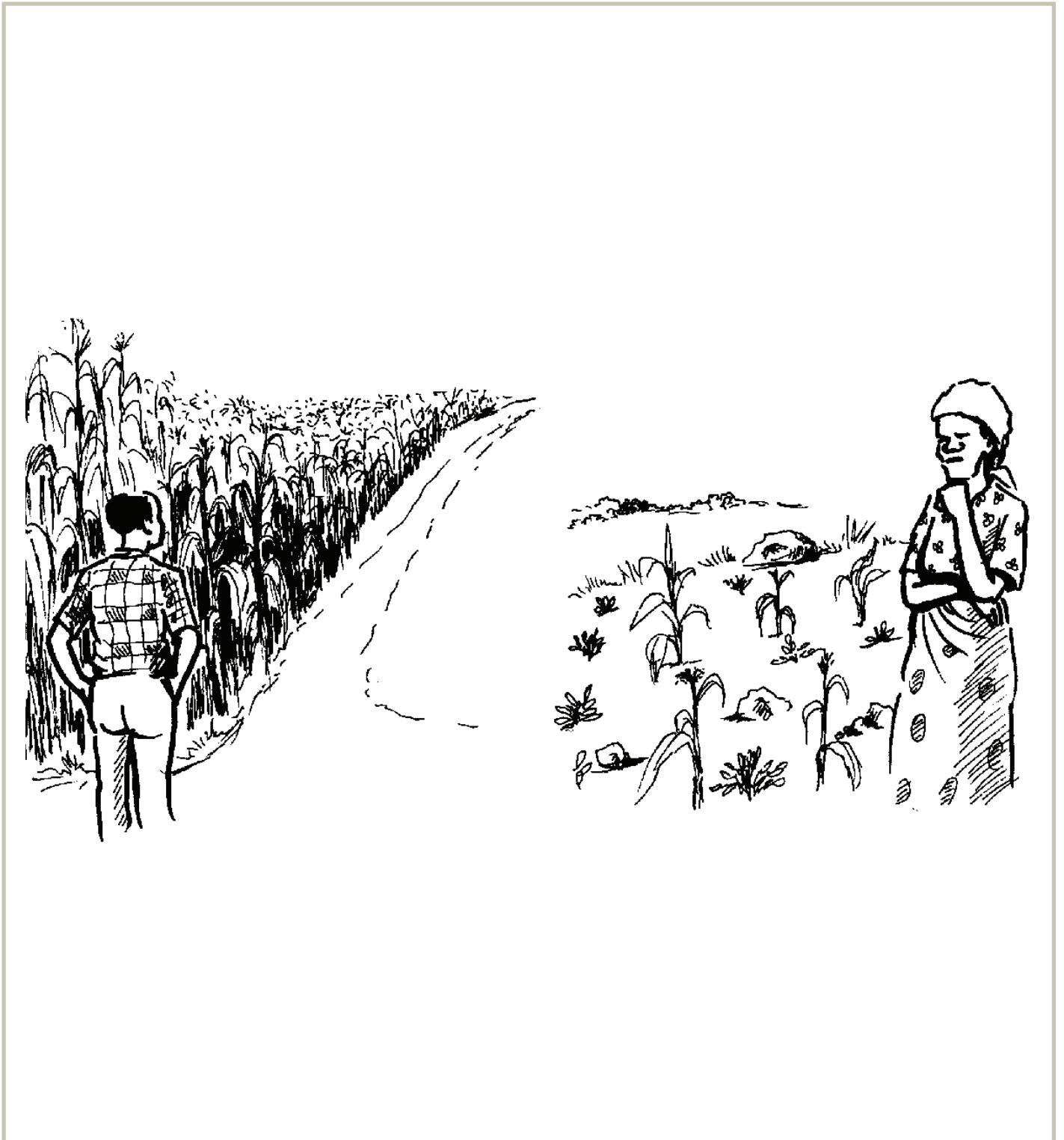
LACK OF AWARENESS ABOUT CMAM PROGRAMME





Barrier

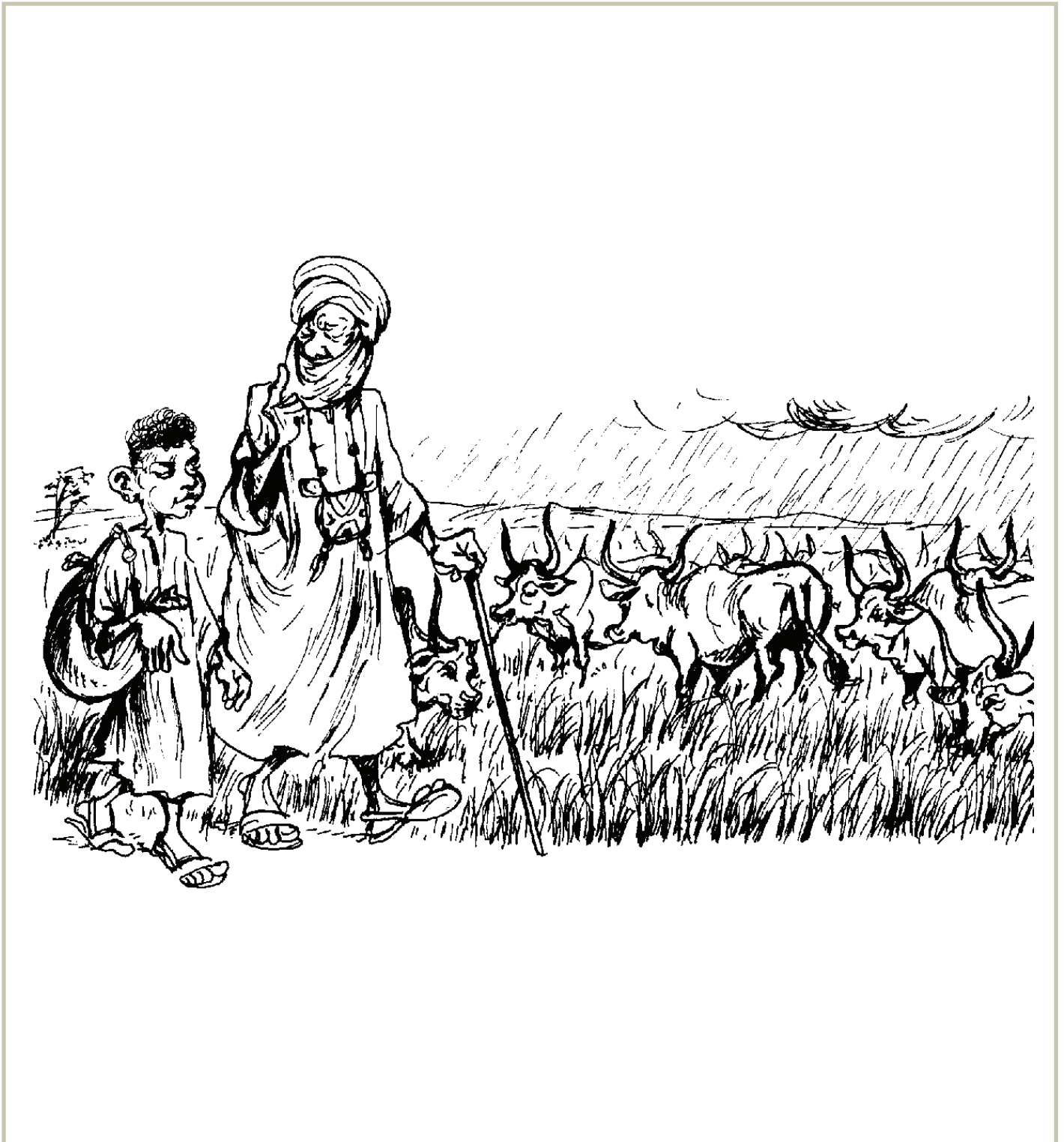
GEOGRAPHICAL BARRIERS





Barrier

TRANSHUMANCE





Barrier

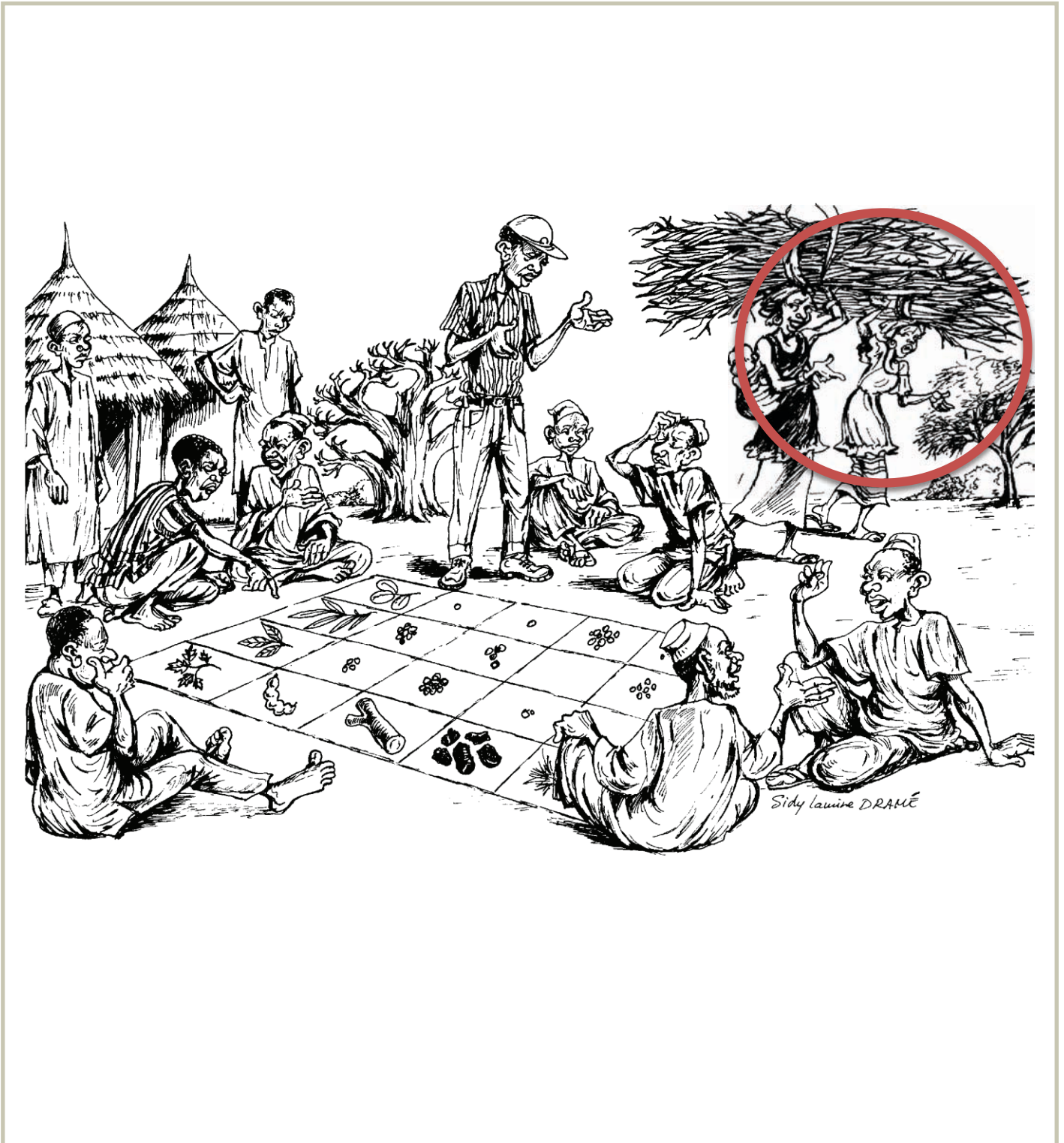
HEAVY WORKLOAD OF WOMEN





Barrier

WEAK DECISION-MAKING POWER OF WOMEN





Barrier

RECOURSE TO TRADITIONAL HEALERS





Barrier

SHORTCOMINGS IN THE QUALITY OF CMAM PROGRAMME





Barrier

RUTF STOCKOUTS





Barrier

SHORTCOMINGS IN CHW NETWORKS





Barrier

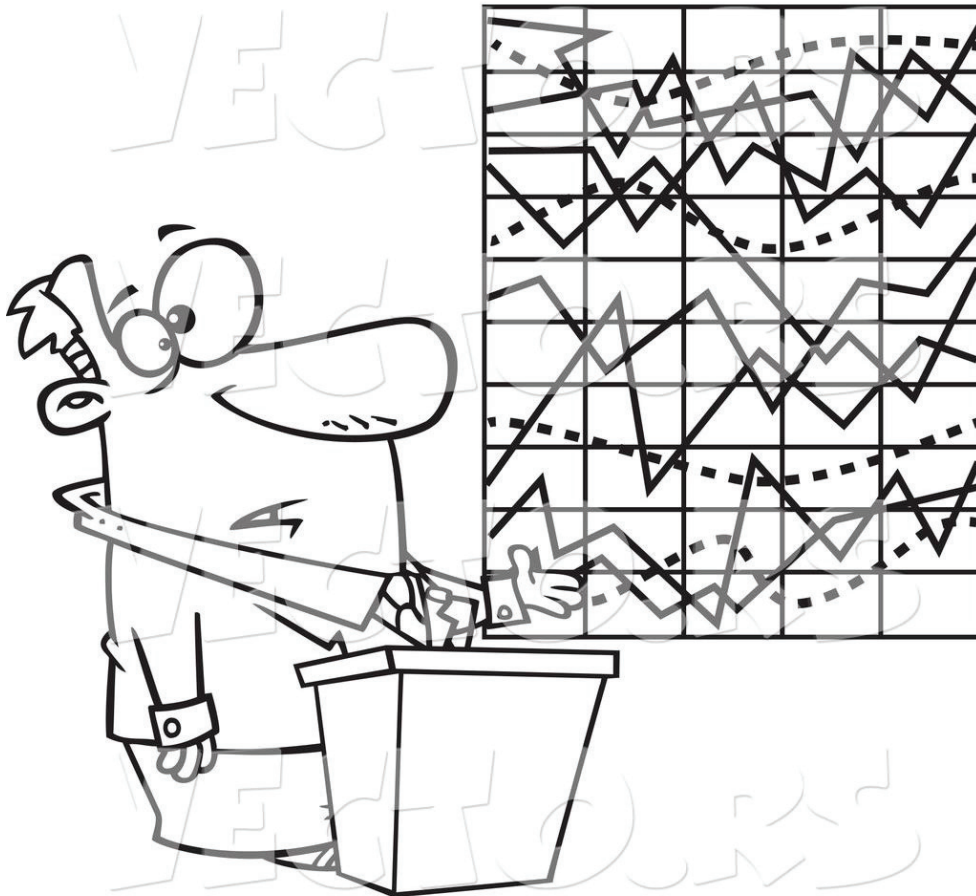
INSUFFICIENT SENSITISATION





Barrier

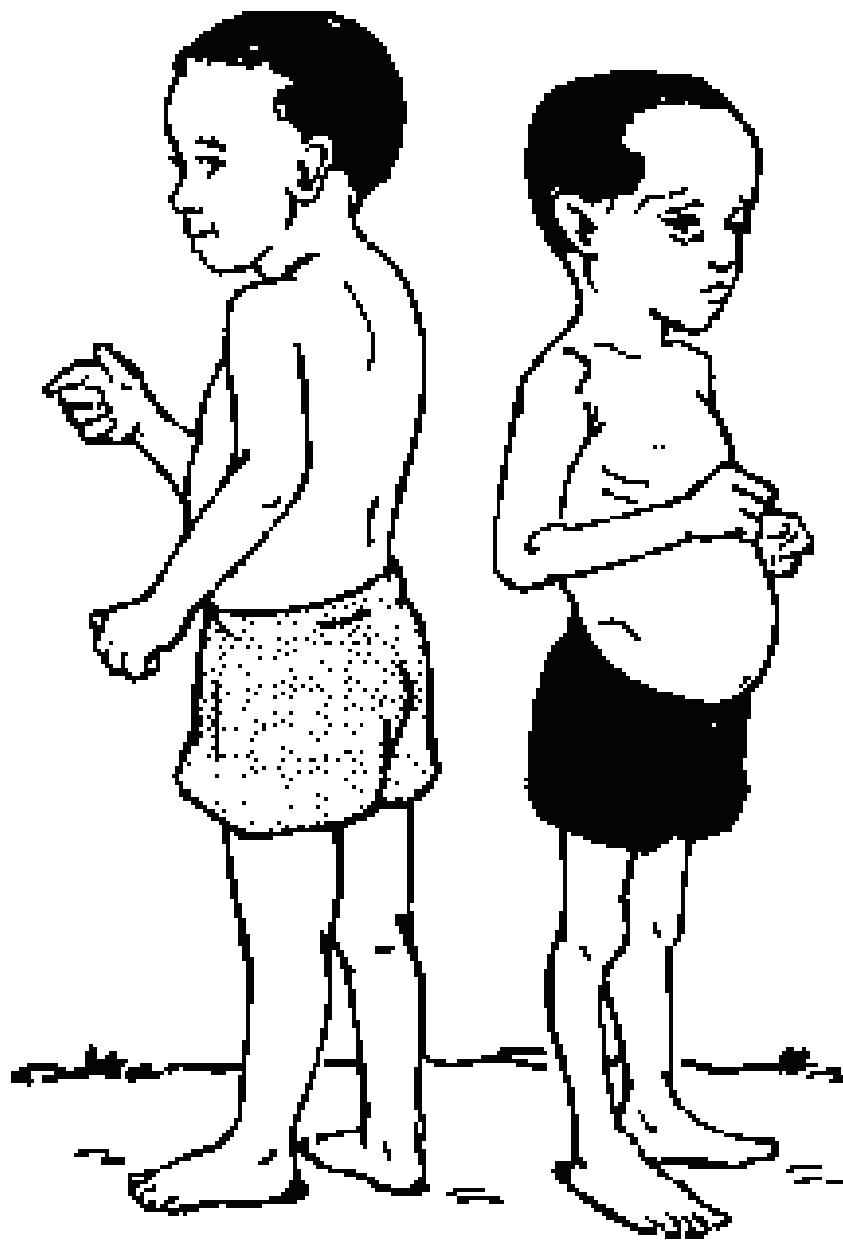
DIFFICULTIES TO GENERATE QUALITY STATISTICS





Booster

CERTAIN KNOWLEDGE ABOUT MALNUTRITION





Booster

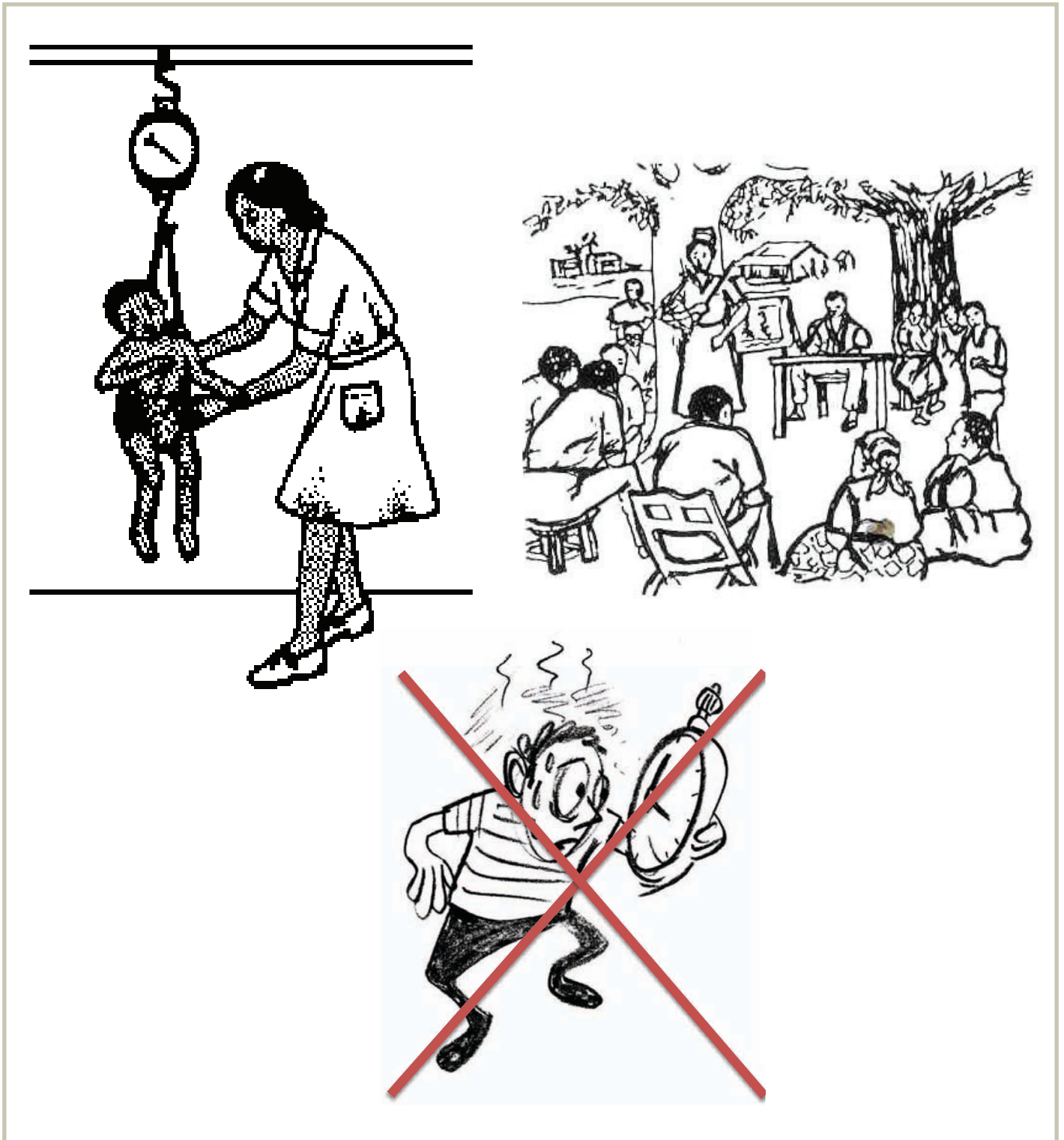
EFFICACY OF TREATMENT





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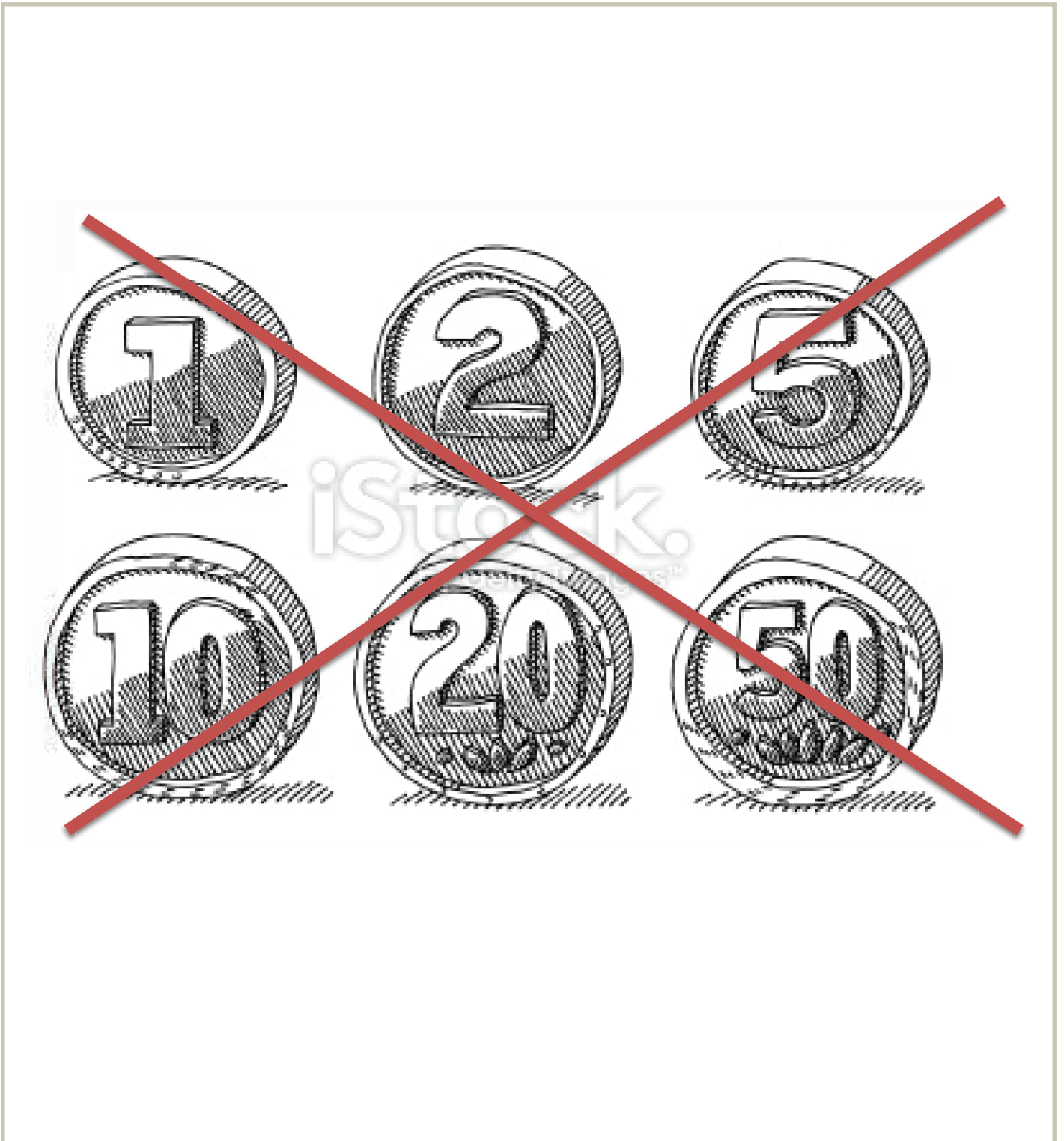
GOOD QUALITY OF CMAM PROGRAMME





Booster

CARE FREE OF CHARGE





Booster

GOOD COLLABORATION AMONG PARTNERS





Booster

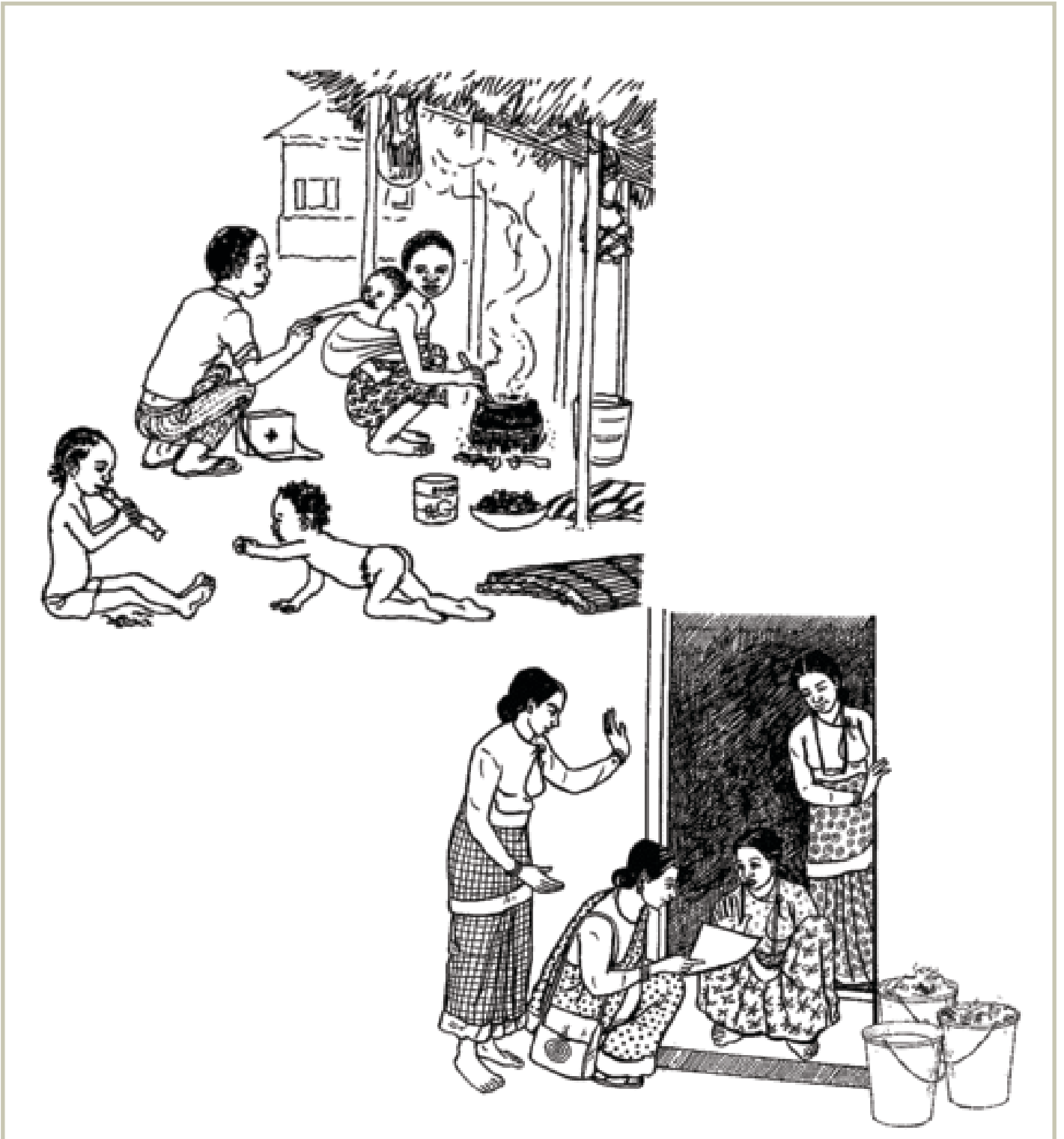
ENGAGEMENT OF COMMUNITY LEADERS





Booster

EFFICACY OF CHWS





Booster

REFERRAL BY BENEFICIAIRES











Booster

USE OF MOBILE CLINICS





Voting Cards



Annex V

COMMUNITY PROFILE

Geography

- ◆ location, topography, climate, natural & man-made hazards

Demographic profile

ETHNIC GROUPS

- ◆ representativity (%), spoken languages, stereotypes

RELIGIOUS AFFILIATION

- ◆ representativity (%), beliefs having impact on the perception of malnutrition

SOCIOECONOMIC STATUS

- ◆ education, occupation, income
- ◆ casts, roles
- ◆ migration

Sociocultural profile

SOCIOCULTURAL NORMS

- ◆ gender relations / decision-making
- ◆ marriage / family planning
- ◆ childcare
- ◆ daily activities

FEEDING BEHAVIOURS & DIETARY PATTERNS

- ◆ distribution of meals
- ◆ food taboos

BELIEFS & PRACTICES

- ◆ pregnancy & childbirth
- ◆ exclusive breastfeeding / weaning



Social organisation and key community actors⁶

- ◆ structure, institutions, leadership

Formal and informal communication channels⁷

Local understanding of malnutrition

- ◆ Local terminology
- ◆ Symptoms
- ◆ Causes
- ◆ Effects
- ◆ Health-seeking patterns
- ◆ Stigmatisation

⁶ link with social mapping & identification tool

⁷ link with communication channel matrix



Perceptions of CMAM programme

PERCEPTIONS OF HEALTH CENTERS

- ◆ distance
- ◆ cost
- ◆ quality and variety of care
- ◆ admissions
- ◆ client interface
- ◆ sensitisation

Community outreach

VOLUNTEERS NETWORKS

- ◆ role, status, coverage,
capacity, aptitude

SCREENING

- ◆ actors, tools, frequency,
planning & follow-up

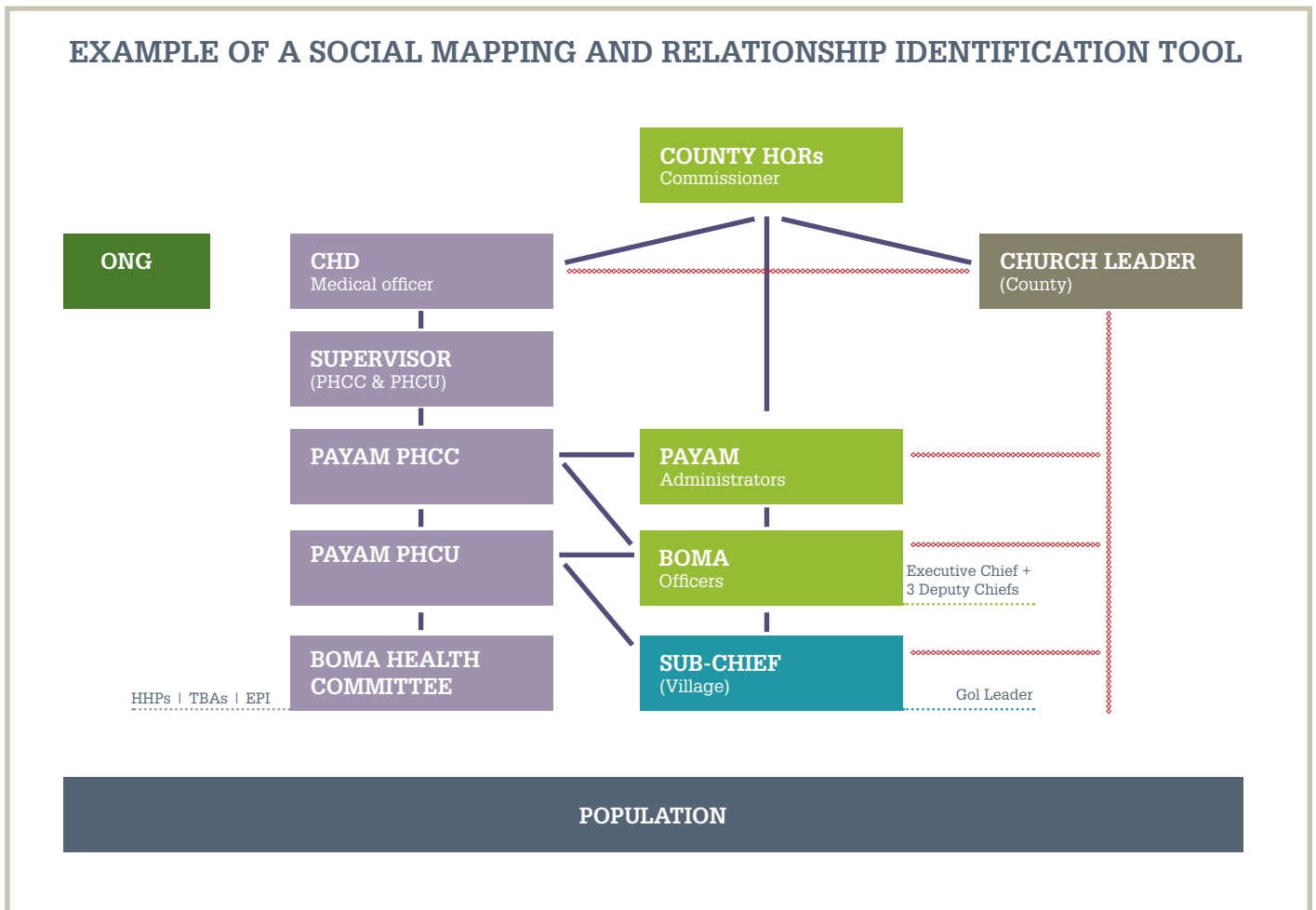
SENSITISATION

- ◆ actors, themes, tools,
frequency, variety, planning
& follow-up



Annex VI

SOCIAL MAPPING AND RELATIONSHIP IDENTIFICATION TOOL



Data courtesy of Coverage Monitoring Network

Instructions:

- 1 The assessment team will need few sheets of flip chart paper and colour markers.
- 2 Tell them to think about all administrative, ecclesiastical, customary and health authorities and their relationships. “Who is at the head of the structure? Who is subordinate to whom? Who counsels? How do different authorities co-exist in the community? How do they communicate?”
- 3 Ask the team to sketch a diagram, which would depict all actors and relationships among them.
- 4 Ask the team to add communication channels used by these instances.
- 5 The whole exercise may take 30 - 60 minutes, depending on knowledge and skills available within the team. Encourage them to discuss in detail. Observe and guide them, as necessary.
- 6 It is recommended to pair the exercise with a “Seasonal calendar” and “Communication Channel Matrix”, dividing the whole team into three groups working independently. This arrangement may save some time but a presentation of each team’s work and a successive validation by the whole group must be planned for.



Annex VII

COMMUNICATION CHANNEL MATRIX

Communication channels	Diffusion of messages	«Opinion leader» encourages the action	«Role model» demonstrates the struggle & success	Community engagement	Dialogue about barriers & solutions
« PEER 2 PEER »					
« DOOR 2 DOOR »					
COMMUNITY DISCUSSIONS					
COMMUNITY THEATRE / SPECIAL EVENTS					
MASS MEDIAS					

Diffusion of messages refers to mere diffusion of key messages with the help of community health workers or other actors. The aim is to sensitize, not discuss or engage.

Opinion leader refers to an influential person in the community who is respected and listened to. An opinion leader may be a religious leader, village chief or a teacher. As opinion leaders have great power to influence people's ideas and opinions, their involvement in community sensitization is crucial. This may include, among others, their speeches after prayers regarding malnutrition or its treatment, their presence during sensitization activities, etc.

Role model (in CMAM programming) refers to a carer of malnourished child who could share his story with other community members, particularly other parents. Living the same trauma, the role model has a great potential to make a link with other carers and transform their perceptions through his own experience. The use of role models in community mobilisation strategies is still rather rare, sometimes ad-hoc, stemming out from their own initiatives. Few examples of their interventions could include their presence during sensitisation activities and/or screening, radio discussions, etc.

Community engagement refers to community-led initiatives, independent of CMAM programming, e.g. activities of community leaders, CBOs, etc. with respect to malnutrition or its causes.

Dialogue about barriers and solutions refers to a vibrant exchange on different levels regarding evident barriers to utilisation of service and finding locally appropriate solutions.

Peer refers to a person in similar, if not identical, circumstances. We may be referring to mothers communicating with other mothers, fathers to fathers, schoolchildren to schoolchildren.

Door 2 door refers to a personalized form of sensitization where a target of sensitization is visited in its home. In this respect, people bringing messages move from house to house to reach all residents of the village.

Community discussion refers to a group sensitization session, often divided by gender.

Community theatre/Special events refers to bigger-scale community events organized sporadically, e.g. at the occasion of world days.

Mass media refers to radio, TV, newspapers, internet, SMS messaging.

Instructions:

- 1 The assessment team will need few sheets of flip chart paper and colour markers.
- 2 Present them a template of a communication channel matrix, explaining the significance of all items in the left column and top row. Show them how the two interact.
- 3 Ask the team to reflect upon the use of various communication channels within CMAM programming and ask them to mark each square with ✓ or ✗ symbols, depending on whether a particular channel is utilized.
- 4 Ask the team to justify their observations with an example of activities falling under each category. Make sure that they do not use the same example for multiple channels.
- 5 Please allow 30 - 60 minutes for the exercise. Encourage the team to discuss in detail; observe and guide them.
- 6 Towards the end of the exercise, ask the team to colour the squares with a ✓ sign and interpret the results.
- 7 Consecutively, ask them to choose a different colour and mark all squares with a ✗ sign, which could be used in future CMAM programming. Ask them to justify their choice.
- 8 It is recommended to pair the exercise with a "Seasonal calendar" and a "Social Mapping and Relationship Identification" tool, dividing the whole team into three groups working independently. This arrangement may save some time but a presentation of each team's work and a successive validation by the whole group must be planned for.



Annex IX
SWOT TOOL

STRENGTHS

WEAKNESSES

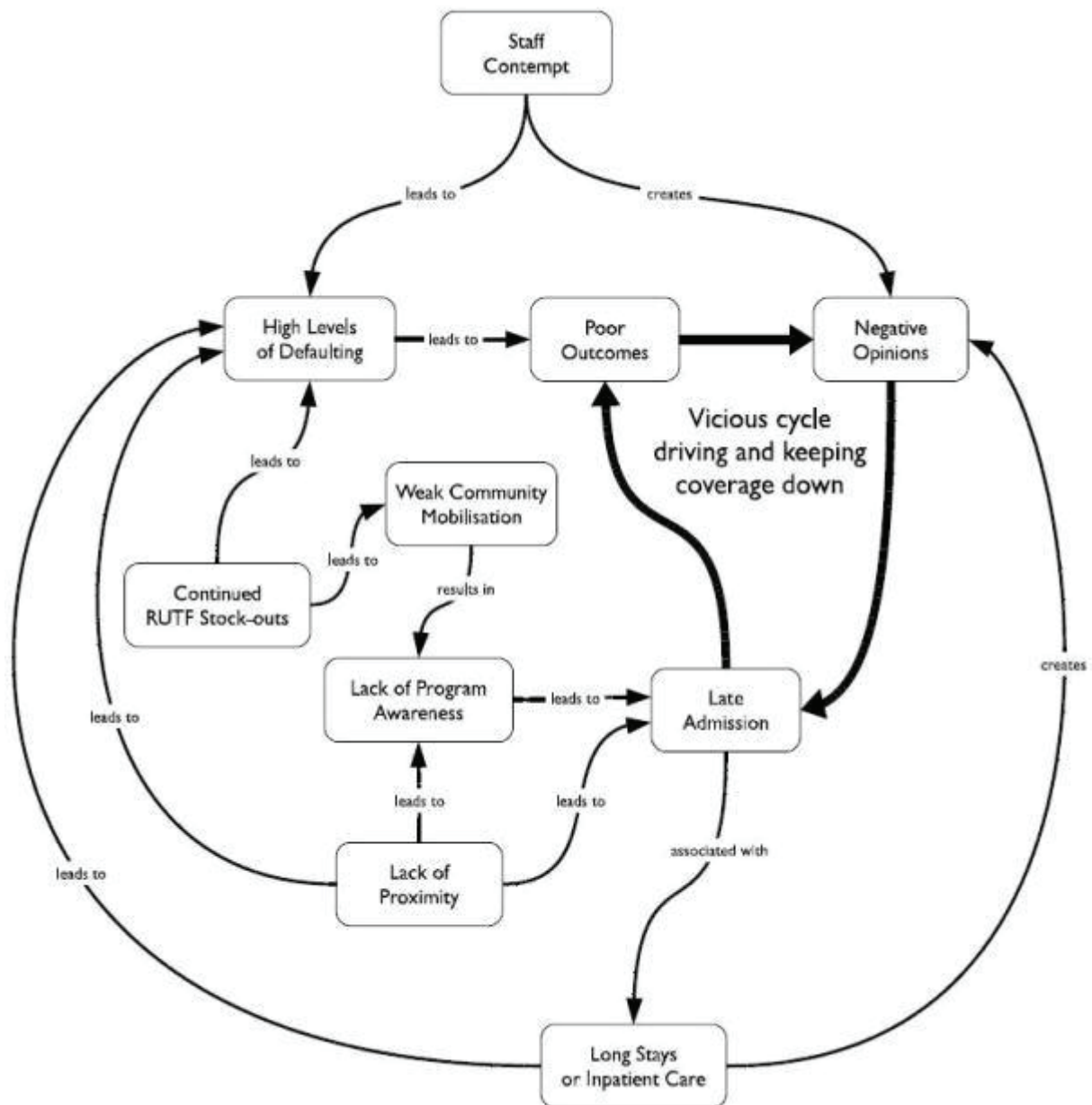
OPPORTUNITIES

THREATS



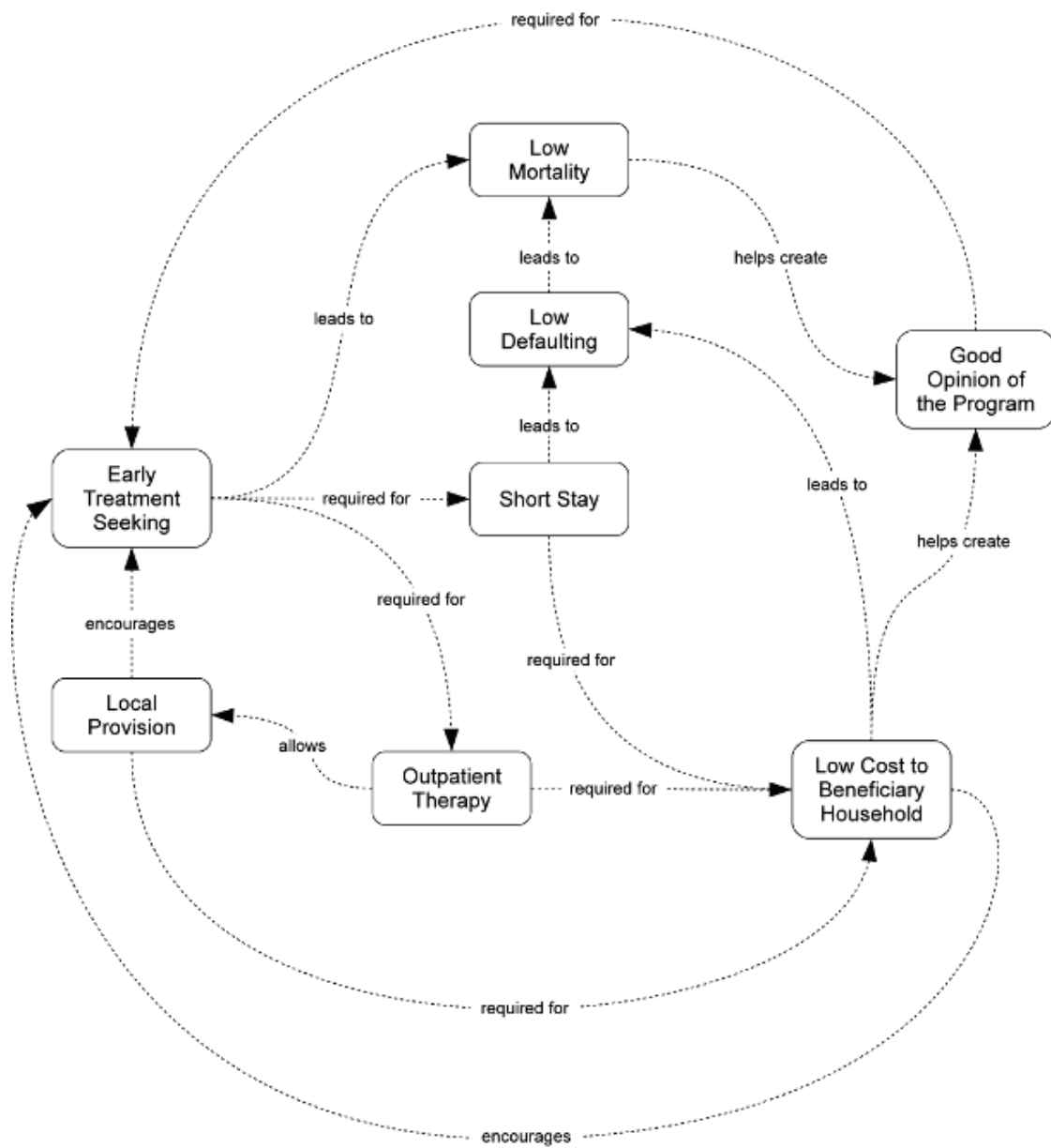
Annex X CONCEPT MAP TOOL

EXAMPLE OF A CONCEPT MAP FOR PROGRAMME BARRIERS USING EXPLICITLY DEFINED RELATIONSHIP TYPES AND AN EXPLANATORY ANNOTATION





**EXAMPLE OF A CONCEPT MAP FOR PROGRAMME BOOSTERS USING EXPLICITLY
DEFINED RELATIONSHIP TYPES**





COVERAGE HIGHLIGHTS NETWORK

HOW TO CONDUCT
COMMUNITY
ASSESSMENT

