



**ACTIVITY REPORT 127**

Participatory Community Health  
Enquiry and Planning in Selected  
Urban Slums of Indore, Madhya  
Pradesh

and

A Field Guide for Community  
Facilitators of PCHEP

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We hope that this report and field guide will be further enriched with use by and feedback from other readers and implementers, and we look forward to their comments and suggestions.



# Acronyms

|            |  |
|------------|--|
| ANC        | Antenatal Care   |
| ANM        | Auxiliary Nurse Midwife  |
| AWC        | Anganwadi Center   |
| BCC        | Behavior Change Communication                                      |
| BGMS       | Bhartiya Grameen Mahila Sangh                                      |
| CBO        | Community-based Organization                                       |
| CECOEDECON | Center for Community Economics and Development Consultants Society |
| DDK        | Disposable Delivery Kit  |
| DHFW       | Department of Health and Family Welfare                            |
| EHP        | Environmental Health Project                                       |
| FGD        | Focus Group Discussion   |
| GOI        | Government of India  |
| ICDS       | Integrated Child Development Services Scheme                       |
| IDSSS      | Indore Diocese Social Service Society                              |
| IMC        | Indore Municipal Corporation                                       |
| LBW        | Low Birth Weight   |
| MCH        | Maternal and Child Health  |
| MP         | Madhya Pradesh   |
| MY Hosp.   | Maharaja Yashwantrao Hospital                                      |
| NGO        | Non-governmental Organization                                      |
| PHC        | Primary Health Care  |

|       |  |
|-------|--|
| PRA   | Participatory Rural Appraisal                      |
| SHG   | Self-help Group                                    |
| TA    | Technical Assistance                               |
| TBA   | Traditional Birth Attendant                        |
| TT    | Tetanus Toxoid                                     |
| UP    | Uttar Pradesh                                      |
| USAID | United States Agency for International Development |

# 1. The Purpose of this Document

This document delineates the processes followed by and the principles and findings that emerged from a ten-day workshop on participatory community health enquiry held in Indore with the NGO-CBO partners implementing the USAID EHP Urban Child Health Program, March 20–30, 2003. The purpose of the workshop was to enhance the program partners' skills in: (1) conducting a participatory community enquiry with accurate triangulation and reporting of findings; (2) outlining and documenting a process through which a community takes ownership of the program objectives and processes; (3) prioritizing interventions based on community needs; and (4) planning subsequent actions. This workshop was designed specifically to guide urban health programs in the slums of Indore with limited access to and availability of health care facilities.

The processes and principles that emerged from this exercise may be replicated/adapted by program planners, managers, and implementers working in similar situations.



## 2. Overview of the USAID-EHP Urban Health Program in Indore

The USAID-EHP Urban Health Program in India aims to improve child health and nutrition among the urban poor in selected cities by providing technical assistance to improve newborn care practices, age-appropriate immunization, control of diarrheal disease, prevention of malnutrition, and sanitation and hygiene. The program also aims to increase the commitment of various stakeholders to include health elements in urban slum development efforts. Indore was selected as the first site for this technical assistance .

### 2.1. Key technical assistance activities in Indore

#### 2.1.1. Stakeholder meetings

At a series of urban health stakeholder meetings held during July–September 2003, participants agreed on the following program directions:

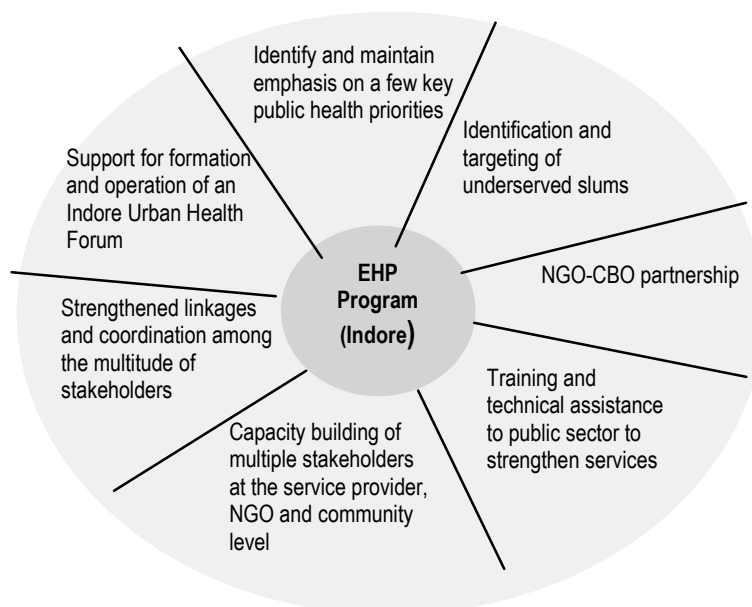


Figure 2.1: Program directions that emerged as a result of a series of stakeholder meetings.

## 2.1.2. Situation analysis

A situation analysis of the health of the urban poor in Indore was carried out to guide program development in the city. The situation analysis covered the following topics:

- an Indore city profile
- urbanization and urban poverty
- Madhya Pradesh government policies and plans for urban health
- child health conditions in Indore
- an assessment of health services in Indore
- learning from the Indore Habitat Improvement Project.

Key findings included the following:

- Urban average child health data masks the inequities that the urban poor suffer. Available urban child health data does not provide a clear picture of the magnitude of the problems of the urban poor.
- Despite the growth of urban poverty in Madhya Pradesh (MP), the allocation of health sector resources between rural and urban areas is still heavily biased in favor of rural areas.
- Even though the poor constitute almost 50% of MP's urban population, the allocation of health resources remains tilted in favor of the better-off urban sections.
- Existing public sector health services in urban areas have remained largely under-utilized, especially by the poor.
- For a large variety of illnesses, slum dwellers go to private, under-qualified medical providers.
- Cultural and traditional beliefs play a significant role in influencing the adoption of appropriate maternal and child health-related behaviors. Breastfeeding, for example, is initiated three days after delivery due to the belief that this enables the mother to recoup from the stress of parturition. During this interim period the newborn receives herbal concoctions, tea, etc.
- Key public health issues—such as the risk of home deliveries, low birth weight (LBW) babies, and malnutrition among mothers and children—are the same for the urban poor as for the rural poor.

- NGOs in Indore city have focused their efforts on promoting groups for savings and credit, with added elements of vocational training and health camps. Because of an earlier effort (i.e., Self Help Groups), NGOs' had considerable inroads into the slums, which provided an appropriate platform for building a health program.
- Indore has a rich culture of community level processes. Though most of the community-based organizations (CBOs) do not have a background in health work, their tremendous capacity to mobilize people could be used to further the objectives of urban child health programs in vulnerable slums.

### 2.1.3. Health vulnerability assessment

While efforts to fight urban poverty have focused on slums, the category of “slum” excludes some of the poorest settlements. At the present time, “slum” has several meanings: squatter settlements, private subdivisions, traditional inner city quarters, urban villages, or any settlement that does not conform to state defined norms<sup>1</sup>. This definition may vary from one state to another, however, with the result that an area categorized as a slum in one state may not be called a slum in another.

This phenomenon of variant definitions leads to a gross underestimate of urban poverty. Smaller and less established slums are often not covered; temporary settlements of construction site workers are completely missed; and pavement dwellers (among the poorest) are also omitted in the estimates. At times underestimates of urban poverty are also seen in recognized slums where “hidden” populations exist, such as rental groups or populations living on the edges of a slum; this is especially the case in cities experiencing rapid urbanization. Including all these populations would yield higher estimates of urban poverty—a picture much closer to the reality. Identifying slums as the only areas of urban poverty, therefore, is not an effective manner for reaching the vulnerable sections in a city.

A health vulnerability study was undertaken to identify and map the vulnerable population in Indore from a health perspective and also to identify the key internal and external factors that predispose certain urban populations to health vulnerability. The most vulnerable slum locations are the main focus of USAID-EHP's program of technical assistance in Indore. The process started with a list (obtained from the Municipal Corporation and Mayor's Office) of 438 slums, a number which eventually grew to 539 through this participatory mapping and validation process. Of these 539 slum locations, 156 were identified as vulnerable based on the following criteria:

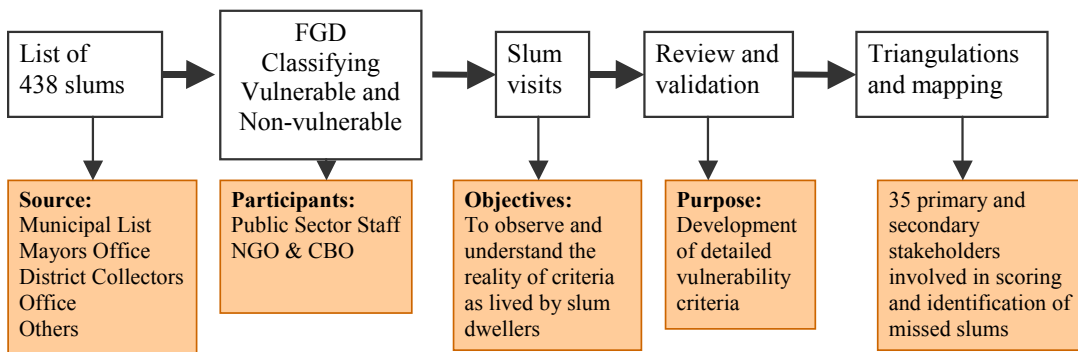
- economic conditions (e.g., occupation)

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<sup>1</sup>Planning Commission. (1997). *Estimates of Poverty*. New Delhi: Planning Information Bureau, Government of India. Available at <http://www.niua.org/niuaorg/USH/index.html>

- social conditions (e.g., gender inequity)
- living environment (e.g., water and sanitation facilities)
- access and usage of public health services (e.g., ICDS, DHFW)
- disease incidence
- collective organized community effort

These locations were then further categorized into three groups: most vulnerable, moderately vulnerable, and marginally vulnerable. This assessment provides an example of a methodology to identify and map all recognized and unrecognized slum areas and to classify these according to health vulnerability.



## 2.2. Program directions

### 2.2.1. Community-based programming: NGO-CBO partnership

The process and plan for providing technical assistance to community-based urban health efforts in Indore slums led to the formation of partnerships between NGOs and CBOs due to their complementary attributes.

Five NGOs along with partner CBOs are implementing the program in 73 slums in Indore covering approximately 26,500 households (or a population of 1.3 lakhs). Interventions are focused on improving service coverage of the urban poor, the adoption of appropriate behaviors (through BCC and promoting health coverage activities such as immunization camps), and building the capacity of lead and *basti* CBOs.

## 2.2.2. Technical assistance to the public sector in Indore

| Technical Assistance (TA)                         | Need identified  | Technical Assistance planned or completed:   |
|---|--|--|
| TA to Department of Public Health                 | Several meetings and consultations with Health Department officials led to the identification for 1) an improved Urban Health Information system and related capacity building of staff, and 2) an approach to strengthening coordination and monitoring at the ward level.          | <p>Strengthening capacity building of field staff in monitoring coverage and use of data is to be completed by the 2<sup>nd</sup> quarter of 2004.</p> <p>A ward-level core group approach to strengthen coordination mechanisms and linkages with the community was developed.</p>              |
| Technical Support to Indore Municipal Corporation | Through interactions with IMC officials and a review of conditions in the slums, the need was identified to support a hygiene sanitation pilot to improve hygiene conditions in select slums and to strengthen the capacity of IMC officials regarding GOI's public welfare schemes. | <p>A Hygiene Improvement Pilot (with community participation) in coordination with IMC in two slums is in process.</p> <p>Capacity building of IMC officials (workshops and handouts on the various schemes in simple Hindi) on public welfare schemes is planned for third quarter of 2003.</p> |

The other activities of the EHP-USAID urban health program in India include:

- advocacy for urban health issues
- developing a knowledge inventory of information on urban health
- overall program monitoring and evaluation
- providing technical assistance to other cities based on the lessons learned from Indore to support the State Governments of India in developing proposals for the National Reproductive and Child Health Program.



### 3. Community-Based Programming: The NGO-CBO Partnership in Indore

The NGO-CBO partnership model emerged as a result of the complementary attributes of these two types of organizations and the increased opportunities for sustainability that could be realized through collaboration.

#### 3.1. Objectives

The specific objectives of the NGO-CBO partnership are as follows:

- To increase the adoption of behaviors appropriate to child health priorities.
- To increase coverage by key child health services.
- To increase the capacity of slum-based CBOs to sustain improved behaviors and service coverage.
- To increase coordination between public sector providers and communities.

#### 3.2. Evolution of the partnerships and the formation of the NGO-CBO consortia

The steps that led to the partnerships and the formation of the NGO-CBO consortia are described below.

Step 1: Evolution of partnerships (November-December 2002)

Many of the NGO and lead CBOs<sup>2</sup> were introduced to each other and could identify common areas of interest during consultations and meetings. Detailed discussions also helped NGOs identify the strengths of the lead CBOs they proposed to support.

#### Step 2: Request for proposal (December 2002)

Pursuant to the agreement to work through an NGO-CBO consortia, a request for proposals was made to the NGOs and CBOs. Proposals were received from 12 NGO-CBO consortia.

#### Step 3: Screening and selection of NGO-CBO consortia (January 2003)

The process for appraising the proposals was kept neutral and consultative. A screening committee was constituted to evaluate the NGO-CBO consortia on the basis of a comprehensive checklist. At the end of the screening process, five NGOs along with partner CBOs were selected and are now implementing the program in 73 slums in Indore, covering approximately 26,500 households (or a population of 130,000).

#### Step 4: Capacity-building needs assessment and implementation (ongoing)

A needs assessment was conducted in January before the program began to identify and prioritize the areas that require strengthening through outside support. Needs are reviewed regularly, and capacity-building sessions are organized accordingly.

Each of the five NGO-CBO consortia collaborated on developing strategies to meet the program objectives. Activities and tasks were defined with respect to time and resource requirements. The activities included: (1) community mobilization and resource mapping in the target slums using participatory techniques and focus group discussion; (2) building the capacity of lead CBOs and slum-based CBOs; (3) conducting a community enquiry; (4) undertaking BCC activities; (5) undertaking health coverage activities at each slum and cluster level; (6) developing linkages with health, water and sanitation service providers; and (7) community-based monitoring.

Since the beginning of the program, the consortia have made progress in all of these activities. The mapping of resources and identifying potential resources to promote health care have been completed in most slums. The consortia have been provided behavior change communication material selected by the program partners after a review of urban-specific material collected from various organizations in and around Madhya Pradesh. Based on field testing, the most effective material was identified, and a user's guide for each set of BCC material was developed.

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<sup>2</sup> A lead CBO is a community group that has been active in one way or another at the basti or cluster level, that has more capacity, and that will train and strengthen basti level CBOs.

Immunization and health camps are being organized to increase service coverage in underserved areas, and efforts are being made to forge links with health service providers to offer these services in these areas. Mechanisms have been developed to review the progress of the consortia and to provide guidance and supervision on a regular basis.

### 3.3. Capacity-building initiatives

The NGO-CBO contract award and the implementing of the various activities presuppose a certain amount of capacity building of the consortia to improve their ability to meet program objectives and to perform better. As part of EHP's technical assistance efforts, a capacity-building needs assessment was conducted to identify and prioritize key needs, which are in four broad areas:

1. Orientation to the program.
2. Participatory approaches to mobilize and involve communities in the program activities through community enquiry.
3. Institutional capacity building and techniques for community-based monitoring for tracking behaviors and services (presumably through exposure visits and reflections).
4. Specific technical issues for the child health team in light of limited experience in providing health care.

An outcome of this needs assessment was a capacity-building plan that is summarized below:

Table 3.1: Capacity-building plan for Indore program partners

| Thematic Area  | Target Trainees  | Methodologies   |
|--|--|---|
| <p>Technical Training</p> <p><i>Information</i></p> <ul style="list-style-type: none"> <li>• Newborn care</li> <li>• Immunization</li> <li>• Diarrhea prevention</li> <li>• Prevention of malnutrition</li> <li>• Hygiene and sanitation promotion</li> </ul> <p><i>Skill enhancement</i></p> <ul style="list-style-type: none"> <li>• Community mobilization</li> <li>• Communication and BCC</li> <li>• Participatory process (PRA, Community Enquiry)</li> <li>• Identification and follow-up of target population</li> </ul> | <ul style="list-style-type: none"> <li>• - NGO representatives - Lead CBOs</li> <li>• - Basti CBOs</li> <li>• - Govt. Health functionaries (ANMs)</li> </ul> | <ul style="list-style-type: none"> <li>• Group learning</li> <li>• Handouts</li> <li>• Case study</li> <li>• Discussions</li> <li>• Demonstration exercises</li> <li>• Exposure visits</li> <li>• Field visits (slum and hospital visits)</li> <li>• Games</li> <li>• Role plays</li> <li>• Counseling</li> <li>• Mock visit</li> <li>• Social mapping</li> </ul> |
| <p>Program Management</p> <ul style="list-style-type: none"> <li>• Coordination, monitoring and supportive supervision</li> <li>• Community-based monitoring</li> <li>• Finance and accounting</li> <li>• Documentation and reporting</li> <li>• Institutional strengthening of CBOs</li> </ul>  | <ul style="list-style-type: none"> <li>• NGO workers</li> <li>• Lead CBOs</li> <li>• Basti CBOs</li> </ul>   | <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Practice using representative cases from other urban health programs</li> <li>• Field visits</li> </ul>  |
| <p>Urban Issues</p> <ul style="list-style-type: none"> <li>• Vulnerability</li> <li>• Sanitation and welfare schemes</li> </ul>  | <ul style="list-style-type: none"> <li>• NGOs</li> <li>• Lead CBOs</li> <li>• Basti CBOs</li> </ul>  | <ul style="list-style-type: none"> <li>• FGDs</li> <li>• Social mapping</li> <li>• Group lessons learned</li> <li>• Handouts</li> </ul>   |

A ten-day capacity-building workshop was organized with NGO and CBO participants on participatory approaches for community health enquiry from March 20–30, 2003.

## 4. Overview of the Workshop

To be empowering an enquiry needs to be underpinned by principles of mutual respect and equality between all participants. Focusing on what is positive and constructive in a community rather than on problems helps build an attitude of self-reliance and collective action rather than dependence. Special attention must be given to soliciting and prioritizing the voices of the poorest and most vulnerable. The enquiry also needs to directly support decision making and action in order to justify diverting resources from implementation. Finally, any investigation must be linked to an ongoing learning process and contribute to building capacity and networks.<sup>3</sup>

### 4.1. Objectives

The capacity-building workshop on participatory community health enquiry was planned with the following objectives:

- To enhance the program partners' skills in conducting a participatory community enquiry with accurate triangulation and reporting of findings.

*Process:* The participants conducted a mock visit before an actual field visit to practice the techniques for generating and enhancing group participation. The field visit, followed by a debriefing session, enabled the participants to capture all the critical lessons learned (as described in a later section).

- To outline and document a process through which a community takes ownership of the program objectives and process.

*Process:* During the field exercise the participants focused on issues that were pertinent to the program and the community rather than simply practicing specific techniques. In fact, the techniques were not predetermined, but were flexible so that they could evolve according to the community's aptitudes and interests. Every effort was made by the facilitators to involve the community in identifying areas of intervention as a result of the enquiry.

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<sup>3</sup> Mayoux L. (2003). "Empowering enquiry". Enterprise impact news, Issue 16, January/February. Published by The Enterprise Development Impact Assessment Information Service ([www.enterprise-impact.org.uk](http://www.enterprise-impact.org.uk))

- To prioritize interventions based on community needs and context.

*Process:* The issues and problems that emerged from the enquiry were analyzed with the community to identify the most pertinent problems and techniques for addressing them.

- To develop a participatory action plan with the community.

*Process:* Workshop participants developed action plans for the future course of the effort based on the outcomes of the enquiry and the community's analysis.

## 4.2. Summary of activities

The ten-day exercise involving 40 members from the NGOs, lead CBOs, basti CBOs, and EHP included the following activities:

- Program orientation for all participants to develop a common understanding of the Indore Urban Health Program (Day 1: 2 hours).
- Technical information on newborn care to guide the community enquiry process (technical area prioritized by the program partners for capacity building) and discussion on general principles of participation (Day 1: 4 hours).
- Introduction to participatory processes, including a mock exercise to practice and understand the basics of participation (Day 2).
- Field visit to apply participatory approaches to conducting a community enquiry on newborn care for NGO participants and their respective CBOs (Days 3 and 4: Group 1; Day 6 and 7: Group 2)<sup>4</sup>
- Reflections on and debriefing of the field visit and formulation of the action plans (Days 3, 4 and 5: Group 1; Days 6, 7 and 8: Group 2)

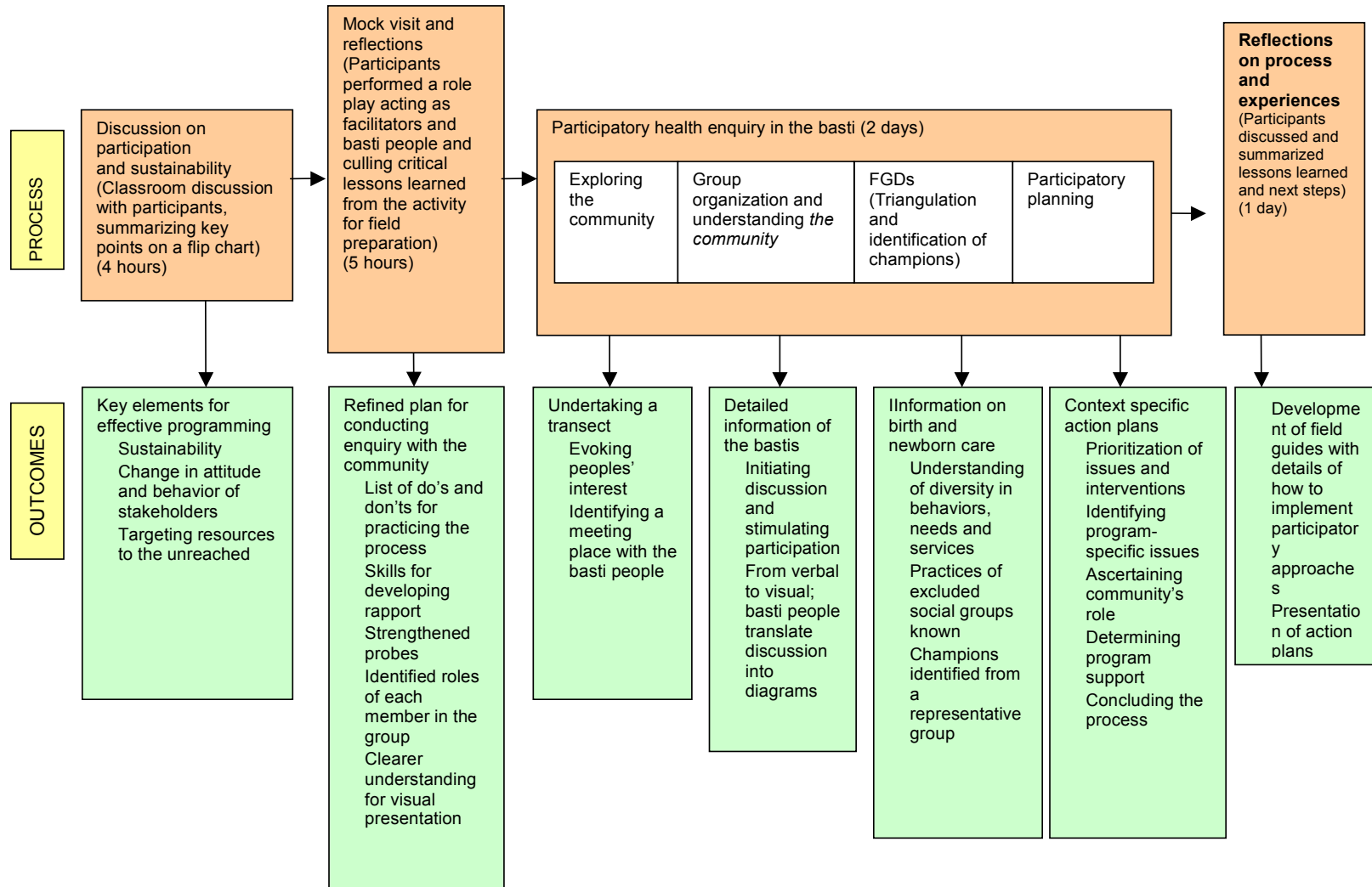
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<sup>4</sup> After the program orientation session, the 40 participants were divided into two groups for the field visits, reflection and action planning.

Table 4.1: Workshop design

| <b>Phase</b> | <b>Day</b> | <b>Activity</b>  |
|--------------|------------|--|
| I            | 1          | Program orientation for all participants to develop a common understanding of the Indore Urban Health Program  |
|              |            | Technical information on newborn care to guide the community enquiry process   |
|              | 2          | Introduction to participatory processes; mock exercise to practice and understand the basics of participation  |
| II           | 3-5        | Field visit to apply participatory approaches to conducting a community enquiry on newborn care for NGO participants from BGMS and CECOEDECON and their respective CBOs                  |
|              | 6          | Reflections on the field visit and formulation of the action plans   |
| III          | 7-9        | Field visit to apply participatory approaches to conducting a community enquiry on newborn care for NGO participants from IDSS, Balnikatan Sangh and Pushpkunj and their respective CBOs |
|              | 10         | Reflections on the field visit and formulation of the action plans   |

Figure 4.1: The process and broad outcomes of the workshop



## 5 . Group Discussion: Effective Programming through Participation

Go to the people,

Live with them,

Learn from them,

Start with what they know,

And build with what they have

Lao Tsu – 700 B.C.

Representatives from NGOs, lead CBOs and EHP initiated thinking and reflection on the concepts of participation and sustainability. Since this diverse group had different levels of experience in project implementation and management, it was necessary that all the different stakeholders develop a common understanding of the basics of participation and development before they began the community enquiry process.

## Typology of participation

Participation is a fundamental process within a group. Levels and degrees of participation vary, and it can be difficult to achieve participation in its true sense in the community. A typology of participation was developed by Pretty et al.<sup>5</sup>

### **Passive participation**

People participate by being told what is going to happen or has happened.

Participation in information giving

People participate by answering questions posed by extractive researchers using questionnaires or similar approaches.

### **Participation by consultation**

People participate by being consulted; external people listen and define both problems and solutions.

### **Participation for material incentives**

People participate by providing resources (e.g., labor) in return for material incentives.

Functional participation

People participate by forming groups to meet predetermined objectives related to the project.

### **Interactive participation**

People participate in joint analysis, which leads to action plans and the formation of new local institutions or the strengthening of existing ones.

### **Self-mobilization**

People participate by taking initiative independent of external institutions to change systems; they develop contacts for resources and technical advice but retain control over resources.

The objective in the Indore effort was to instil ownership of the project in the program partners and in the community (or self-mobilization as described above).

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<sup>5</sup> Pretty J et al. (1995). *A Trainers Guide for Participatory Learning and Action*. IIED Participatory Methodology Series. London: IIED.

## 5.1. Attributes of a successful project

The discussion started with defining what constitutes a successful project, which participants eventually described as follows:

- It should be sustainable, meaning that without external support the partners should be able to continue the project.
- It should bring about a change in behavior among participants and project facilitators, and the changed behavior should reflect equity among different stakeholders.
- It should be time limited, having certain targets, namely, physical, financial and social. The success will greatly depend on whether the project has achieved the above targets by maintaining quality and effectiveness.
- It should be built on the participation of the project partners, having shared responsibilities and a belief that “they too have capacities to bring change.”

## 5.2. Sustainability as a key component of effective programming

Following the discussion, the participants discussed the concept of sustainability and made the following observations.

- The project processes should focus on removing dependency on outside resources.
- The emphasis of the project facilitators should be on identifying and developing leaders, raising awareness, and ensuring that the ownership of and responsibility for project processes and outcomes remains with the partners.
- Participation of the project partners is crucial and critical in determining whether the project can become sustainable.
- The resources that the participants have and those that are delivered by the project need to be properly utilized.

The above discussions provided the framework for further analysis and reflection. Any interventions should be designed in terms of achieving the “big picture,” which is sustainability of the processes and outcomes.

## 5.3. Participation is key to sustainability

The workshop participants then worked on developing a common understanding of the fundamentals of participation and identified key directions for effective participatory programming:

- Planning, implementing and evaluating the processes and outcomes should be undertaken jointly with project partners.
- Solutions and interventions should be needs-based and identified in partnership with project participants.
- Project facilitators, donors and outside agencies should realize that the project is “theirs” (the community’s) and not “ours.”
- It is important for the program partners to have “dreams” and the project should help partners achieve these dreams.
- It is important that project facilitators are polite, build relationships with different groups, not have biases and are ready to understand different views and perspectives of participants.
- It is important to be in a learning mode and ready to challenge the outsiders’ dominant behavior. Accepting that that project partners have the solution is a key step in achieving participation.
- The facilitators should always be asking: “Whose need are we discussing and addressing?” This helps determine whether the needs being met are those of the donors or implementers or those of the partners. This also helps to distinguish whether the need is of the elite groups, “sitting in the front,” or those who are poor and vulnerable and “sitting at the back.”

### Summary of discussion outcomes

These discussions were the beginning of an important learning cycle. The participants identified sustainability, participation/responsibility sharing and change in behavior as critical elements of a successful program. The participants developed a common understanding of the essence of participation in theory and practice. At the end of these discussions, the workshop participants in different working groups made plans to put into practice some of the above concepts and principles with the communities in different slums.

## 6. Mock Visit and Reflections

A day prior to the field visit the participants performed a role play enacting the role of the facilitators and possible responses of the basti people.

### **Role plays in theory and practice**

In role plays, participants use their own experiences to enact a real life situation. When done well, role plays increase the participants' self-confidence, give them the opportunity to understand or even feel empathy for other people's viewpoints and situations, and usually lead to practical solutions or guidelines. Role plays are good energizers<sup>6</sup>, are useful for exploring and improving interviewing techniques and for examining the complexities and potential conflicts of group meetings. The process also helps the facilitator obtain feedback from the group.

Each group consisted of one facilitator, one reporter and 4-5 respondents/participants. For each group one representative from the EHP team provided guidance and technical support wherever necessary. As the discussion progressed, the participants developed skills in implementing the participatory approach, and some maps and diagrams emerged that provided insights on the benefits of using these and other visual aids as techniques for collecting information and planning community-specific programs.

The exercise helped strengthen the plan for conducting the community enquiry by:

- creating a list of do's and don'ts for practicing the process
- sharpening skills for developing rapport
- strengthening the use of probing questions
- defining roles for each member in the group
- increasing awareness of the use of visual aids

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<sup>6</sup> Pretty et al.



## 7. Participatory Processes: Methods and Techniques

All the teams had detailed discussions on how to approach the community, the steps to be followed in collecting data, different tools that can be used for collecting data from the slum community, and the lessons learned. Each group ensured that data collection did not become an end in itself. It was also stressed that participants should realize that communities have a better understanding of their issues and have the capacity to solve their own problems, with outsiders acting as facilitators and catalysts. Local solutions, it was emphasized, solve local problems best. The need for *unlearning* that we outsiders know everything was the central theme of this learning exercise.

It was noted that the selection of facilitators is critical in conducting the process effectively and keeping it truly participatory. The desired orientation and attributes of facilitators were described as follows:

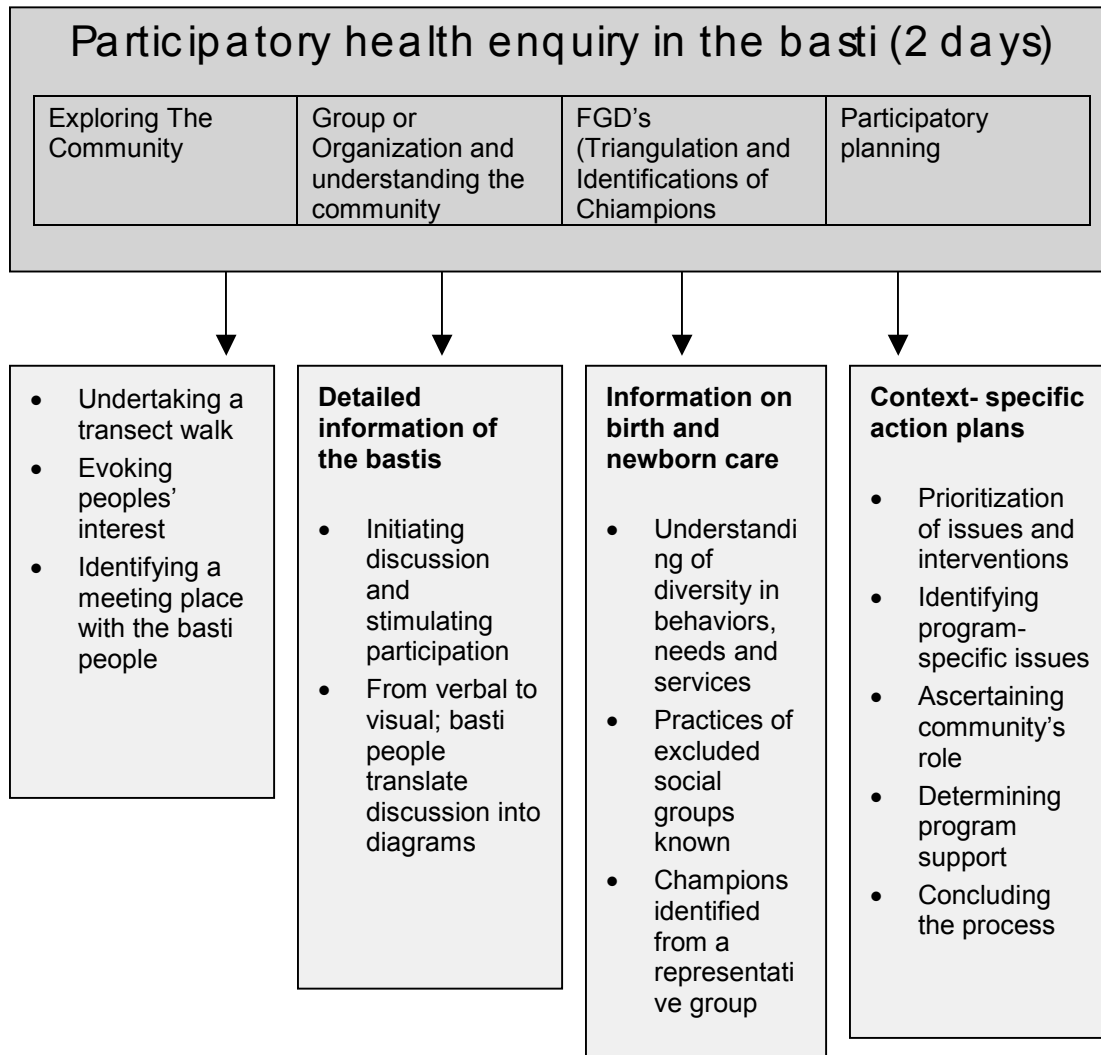
- knowledgeable about the topic but not necessarily experts
- fluent in the language spoken by the participants and in which discussions will be conducted
- capable of establishing rapport with others
- good listeners
- having respect for others opinions<sup>7</sup>

Interestingly, the methodology was not predetermined by any of the groups. The objectives rather than the techniques remained the main focus. Consequently, different pathways emerged leading to the common goal of achieving participation in the community enquiry process.

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<sup>7</sup> Aubel J. (1994). *Guidelines for studies using the group interview technique*. Training papers in population and family welfare education in the work setting: Paper No. 2.

A common framework of the overall process was developed next, setting out four steps that need to be taken to conduct a participatory community health enquiry and planning exercise.



## 7.1. Step 1: Exploring the community basti

A transect walk was undertaken to explore the basti as well as evoke people's curiosity to move out and initiate discussions with the facilitator. This provided the facilitator with an opportunity to learn some of the following from curious onlookers: their place of origin, how long the basti has been present in the area, the major occupations, approximate number of households, and major elements of the child health situation in the basti.

Through the transect walk and house visits, community members belonging to the identified target group—pregnant women, mothers of newborns, lactating women, community members who influence family decision making—were requested to join for a meeting at a place in the basti that they considered appropriate for discussion.

## 7.2. Step 2: Group organization and understanding the community

The facilitator engaged in a discussion with the community men who gathered at the meeting site to help them understand the overall purpose of the program and the immediate purpose of the visit. The purpose of the visit was to eliminate anxiety and possible interference in the process and also to encourage the men to participate in the process so that it would be more representative.

The group slowly seated themselves on mats laid out on the meeting site by women and children and started discussing various issues.

## 7.3. Initiating discussion and stimulating participation

### **Factors affecting participation**

Participation does not mean being present or speaking. Silent members could also be participating by listening very carefully. Attention should also be given to those who are “there but not there,” those who are indifferent or uninvolved, as they can potentially influence the group. Factors that affect participation are presented below:

The focus or task of the group. Is it of interest, importance and relevance?

The physical atmosphere. Is it comfortable physically, socially and psychologically?

The psychological atmosphere. Is it accepting, non-threatening?

Members personal preoccupations. Are there any distracting thoughts on their minds?

The level of interaction and discussions. Is adequate information provided to everyone so they can understand? Is it a level everyone understands?

Familiarity between group members. Do group members know each other from before?<sup>8</sup>

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<sup>8</sup> A manual for participatory training methodology in development. *Published by Society for Participatory Research in Asia PRIA (1995).*

After a brief introduction of the participants and a description of the purpose of the program, the facilitators sought the resident's views on issues pertinent to the basti. The group voiced concerns on sanitation and cleanliness, limited access to welfare schemes, and the cost of health care.

The facilitator attempted to shift the group's focus towards issues that are most critical, and especially those where community members could take the initiative with minimal outside support and contribute on their own to improving the basti. The discussion eventually focused on good health as the outcome of any activity whether it was improving sanitation or getting access to benefit schemes. The group members reached a consensus that child health and related issues of service delivery and utilization were of critical importance to them.

The group decided it needed a method of documenting its health needs and actions and decided to follow up on this. The facilitators asked the group to suggest a method of describing their community in such a manner that all present could see and understand it similarly; the group, being quite mixed with respect to literacy, needed a method that did not require any textual explanation. This discussion eventually led to the idea of preparing a map of the basti. A couple of women made a hesitant start on chart paper. Then a few enthusiastic young men and boys came forward to describe the basti via a map, and a completed map soon emerged. (It should be noted that communities from different bastis adopted different techniques for mapping such as using charts and sketch pens, rangoli colors, chinks, etc.)

### **From verbal to visual; basti people translate discussion into diagrams**

There are important contrasts between visual and verbal modes of communication as presented in the table below. It is important that the participants discuss these differences and appreciate the use of pictorial representations, though creating them may be time consuming.

Table 7.1: Comparing the verbal and the visual<sup>9</sup>

| <b>Category</b>                                      | <b>Verbal</b>                 | <b>Visual</b>                            |
|--|-------------------------------|--|
| Investigator's mode and role                         | Probing investigator          | Facilitator and catalyst                 |
| Local person's mode and role                         | Reactive respondent           | Creative analyst and presenter           |
| Aim  | Extraction of information     | Generating local analysis                |
| Local people's awareness of investigators            | High                          | Low                                      |
| Degree of eye contact                                | High                          | Low                                      |
| The medium and material chosen by...                 | Investigators                 | Local people                             |
| Information flow                                     | Sequential                    | Cumulative                               |
| Accessibility and stability of information to others | Low and transient             | High and semi-permanent                  |
| Responsibility for cross-checking                    | Appropriated by investigators | Rests with local people and team members |
| Ownership of information                             | Appropriated by investigators | Shared; can be owned by local people     |



Maps prepared on mud floor using chalk and rangoli powder in Rishi nagar and Ekta nagar

<sup>9</sup> Chambers R. (1992). *Rural Appraisal: Rapid, relaxed and participatory*. IDS Discussion Paper 311. Brighton, UK: IDS.

## Enhancing participation by use of local resources/materials

Local people tend to hesitate in going ahead with the mapping process. Illiteracy is put forth as a reason for this, especially in a community where most people are not literate. The hesitation may be more pronounced when chart papers and colorful sketch pens are used, as the participants in most cases are first time users. But the same people are willing to show what their locality looks like by drawing some major landmarks with a twig on the ground. This turns out to be an important argument in favor of using local material and doing the initial mapping on the ground. At the same time, some community people may find the use of pen and pencil more exciting because of the novelty associated with it. The facilitator has to decide on what material to use based on the situation. With a bit of persuasion and, in worst cases, some initial prompting, the mapping process will take off. Then the process can be handed over to the local people<sup>10</sup>.

### 7.4. Step 3: Focus group discussions

After the map was drawn, the facilitators asked whether key health service providers could be indicated on the map. The basti map was then transferred (more neatly) onto another sheet so as to leave space around the basti limits to be able to indicate the health providers located nearby. The group then began describing all the health



service providers, such as government, private, basic/primary, and specialty services. All these were indicated on the map with appropriate symbols. Once the service providers were identified, the group discussed issues related to preference, frequency of use, cost of treatment, distance for each service provider, etc.

As the communities started valuing their involvement in the entire process, members came

forward with methods to depict information with little stimulation from the facilitators. In Ekta nagar, for example, when the women's group was asked to depict pregnancy-related complications, Nisha took the lead and initiated a body mapping exercise without any prompting from the facilitator, and other women soon joined in.

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<sup>10</sup> Kumar S. (2002). *Methods for Community Participation. A complete guide for practitioners.* Published by Intermediate Technology Development Group Publishing.

Teams decided to work in small groups of people of different clusters so as to have a better understanding of the situation and triangulate the information obtained from the above exercise. This helped validate (and correct if required) information from small groups representing different *mohallas* (parts of the slum) in an efficient manner. Triangulation also enabled filling information gaps, reaching the unrepresented groups and understanding the diversity in behaviors, needs and service use.

Because triangulation allowed for better representation of different sections of the community, leaders could be identified from these sections and were not limited to the more vocal or powerful community members. The champions who thus emerged were the ones who could make a difference to the entire community and move it together as a unit rather than keep it fragmented.

## 7.5. Step 4: Participatory planning

### Community based participatory research

Participants in community-based participatory research do more than merely give informed consent; they share their knowledge and experience and help to identify key problems to be studied, formulate research questions in culturally sensitive ways, and use study results to help support relevant program and policy development or social change.<sup>11</sup>

### **Prioritization of issues and interventions and identifying program-specific issues**

The discussions and visual presentations (regarding the major health resources and facilities) led to a clear understanding of health resources and practices in the community for both the facilitators and the community members. The community people were able to discuss the optimal practices related to child health (with some assistance from the facilitator) and classify their current practices as harmful and not harmful. They could also identify the practices most closely related to child survival and prioritize/keep these for promoting child health. Their priorities were immediate care of newborn, including provision of warmth and colostrum feeding, and immediate referral of complicated cases. (Findings are detailed in Section 9).

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<sup>11</sup> Green L, Mercer S. (2001). "Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities?" *Am J Public Health*, 91:1926-1929.

## **Ascertaining the community's role and determining program support**

The community members could identify their roles in motivating the community to avail themselves of existing services and making representation to the Municipal Corporation for sanitation services. At the same time, they realized the need to have trained health volunteers equipped with information and selected material for providing counseling and curative services. There was keen interest in learning more about policies and health programs most relevant to their situation that the program could support.

## **Concluding the process**

The information obtained via various participatory techniques was reviewed with the participants, and they provided confirmation of the findings by writing their names or placing initials on the map. The facilitators enquired about any issues of specific interest to the community for discussions. The time and venue for the next meeting were set, and at the end of each day, the team met together to compile the information collected. The team shared their experiences and documented the lessons that they learned during the day and planned what needed to be done the following day.

### **When things did not work**

*What happened when NGO and CBO were not at par or equal partners?*

In some groups, CBO representatives had very little exposure to improved ways of working with the community and saw themselves as merely "carrying forward" the tasks handed over to them by the NGOs. Where the idea of partnership between the NGOs and CBOs was weak, the facilitators decided, in agreement with the NGO representatives, that the focus of this community enquiry process would be to train the CBO representatives in the idea of partnership and how this could be taken forward. The implication of this approach was that the focus shifted from developing understanding of community perspectives and practices on MCH to making the CBOs aware of the "dos and don'ts" of the participatory process. As a result of all this, there were a number of discussions between the NGO and CBO representatives on how this partnership could be developed to the level where the NGO and CBO can emerge as equal partners.

## 8. Reflections and Lessons Learned

The reflections and lessons learned from the team's field experience have been classified as those pertaining to implementing and those pertaining to applying the participatory approach. Through these daily reflections, the NGOs and CBOs came up with answers to the various "hows" of the participatory approach, such as: How to organize people? How to initiate a discussion? How to probe and triangulate to verify information? How to encourage participation?

### 8.1. Implementing the participatory approach

It is important to reach out to different segments of a basti, especially when the basti has a very heterogeneous composition. The perceptions and practices of any one segment cannot be generalized to others. In a slum where there are more than one ethnic/social group, it is important to interact with each separately. Transect walks help identify the different groups of people in the basti, and interactions with different segments in separate groups help facilitators understand the different perspectives.

- Lessons:
1. The huts and houses on the main streets, which are the ones facilitators often interact with first, are usually the more well-off families and not representative of the poorer sections.
  2. During the first few interactions with a large group, it is usually the more vocal people who express their opinions, while others remain quiet and still others are not even present. It is important to get input from those who are not outspoken and those who do not attend meetings to get a more complete picture of the varying extent of deprivation within the slum.

Try to contact as many basti people as possible before initiating the enquiry to avoid a feeling of discrimination or of being "left out."

- Lessons:
1. The entry of outsiders into the basti evokes curiosity and may also lead to a feeling of intrusion in some cases. It is important that the purpose of the outsider's visit is known to the basti people and that nobody is discouraged from approaching the outsiders.

2. Children are good guides to navigating the slum inroads and to reach as many people as possible.

Participants in the meetings should be predominantly from the target group so that their experiences are known directly rather than from other informants who may not be as familiar with their issues and practices. Community members tend to open up readily when facilitators approach them in a friendly manner, with an obvious desire to learn and not as authority figures. At times, however, the community may be hostile due to previous unpleasant experiences with outsiders.

- Lessons:
1. In situations where the community is hostile (see box below) it is important to give a patient hearing to the basti people to let them vent their anger; at times this allows community members to bring up issues that may be important for guiding the program and prioritizing interventions.

### When things did not work

*What happened when one participatory approach was ineffective?*

NGO-CBO participants prepared to conduct a mapping exercise to identify key service providers in a more vulnerable section of Professor colony occupied predominantly by rag pickers and roadside beggars. A great deal of time was spent trying to convince the basti people to gather at a place for discussion. Those who came forward initially and settled down became impatient while waiting for the group to organize. Once organized, the group did not exhibit much interest in the mapping process; their hesitation in presenting their information in visual form was evident and persistent despite the encouragement provided by the facilitator. Instead, they continued discussing health-related issues with the facilitator. The facilitator quickly decided not to impose the mapping exercise on the group and simply let the discussion continue, thereby capturing all the issues pertinent to the objective of the enquiry.

All participants should be involved in the process; if the group is too large then form subgroups to engage all the participants before or during the process of enquiry.

- Lessons:
1. In a large group if subgroups are not formed promptly or if equal attention is not provided to all participants, then there is a tendency for the group to disperse or lose focus and engage in other discussions.

It is important to have a male member in the facilitators' group to respond to the queries of men and boys and capture their interest. Otherwise the men may disrupt the enquiry and keep women from participating.

Begin the enquiry with a general discussion to generate people's attention and interest, and only after rapport has been established, should you proceed to more specific issues. A socio-demographic profile of the basti is a good way to initiate discussions. Use real examples to stimulate people to think about issues when they are unable to progress further in a discussion, such as narrating an incident of an obstetric complication from a nearby basti.

- Lessons:
1. Talking about the death of an infant or loved one is difficult for most people. It may be easier to begin by asking people to talk about a similar situation from another basti, which not only generates empathy and a feeling of “I am not alone,” but may also encourage them to think more about their own situation and bring up important concerns.
  2. Often community women (and even men) may take a few minutes to understand a question or statement and not respond right away. Continue to use nonverbal communication (eye contact, smiling) and let people take time to think. Often this pause is vital and may be followed by very useful information; note also that the response after the pause, whether verbal or only nonverbal, may be quite revealing.

The enquiry should end with a review of the discussion findings and confirmation by the participants to ensure accuracy. One method is to make a list of group participants to record their presence. Any maps that are drawn should preferably remain with the community in a location decided upon by the participants. There are experiences from other projects to support this practice and the need to systematically and regularly update the maps to make them a useful monitoring tool.<sup>12</sup>

Finally, the facilitators should always remember that participatory approaches are intended to be flexible and should be modified based on the local situation and circumstances. Facilitators should not go into an enquiry with rigid notions about how to proceed; the process should evolve as the community desires without deviating from the overall objectives of the enquiry.

## 8.2. Applying the principles of the participatory approach

The following lessons were learned about applying the principles of the participatory approach:

1. Participatory approaches enable the facilitators to gather more information from a wide spectrum of participants in a shorter period of time.
2. Participants’ attention can be focused for a longer period by engaging them in activities such as sketching and drawing, rather than merely conducting group discussions.
6. Detailed information can be obtained on a specific topic of discussion by probing the reasons for each response.

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<sup>12</sup> Bhatia et al. (2001). Resource and social mapping ...and beyond. Experiences in the maternal and infant survival project. CARE – MP.

5. Frequent interactions with community members help develop rapport and confidence and thereby diminish inhibitions in discussing even more personal issues such as miscarriages, contraception, etc.

Participation is a powerful tool to guide programming

### **Lessons learned on the communication process**

- Learn to listen.
- Pay attention to nonverbal communication: "Eyes can be very expressive."
- Be at the community's level; demonstrate respect and equality.
- Derive questions from answers.
- Do not suggest or recommend. Pose questions, encourage thinking and discussion; do not put ideas into people's heads, draw them out.
- Do not cut off discussion on issues of interest to the community even though they may not be pertinent to the enquiry.
- In the presence of a dominating participant, don't forget the other participants.

## 9. Community Enquiry Findings

Community enquiry was undertaken as a part of practicing the participatory approach in six bastis: Professors Colony (two clusters), Shanti nagar, Ekta nagar, Shiv nagar, and Pushpa nagar.

### 9.1. Community profile

*Professors Colony:* The slum exists as two distinct clusters: Professors Colony (150-170 households) and Vidya Nagar (170-200 households). The inhabitants are migrants from the Nimmad region who settled in the basti 25-30 years back in pursuit of better livelihood opportunities. The community is heterogeneous with respect to caste and occupation. Commonly pursued occupations include working as domestic help, daily wage laborer, and rag pickers. A tribal segment of the basti is involved in tattooing, body piercing and snake charming. The general hygiene and sanitation prevailing in the basti are poor. The major problems identified by the slum people are lack of drinking water and no place for defecation. The nearest government school is situated at a distance of 5 kms in Sindhi Colony, and there are two private schools within 1 km of the slum area.

*Shanti nagar:* Shanti nagar is a large basti consisting of approximately 1,000 households. Initially located in the heart of the city, it was relocated 15 years ago to the present peripheral location. Migrants from Khar and Nimmad inhabit this slum. Inadequate sanitation and water supply constitute the major concern of the basti dwellers.



Slum settlements of Shanti nagar basti

*Ekta nagar:* Ekta nagar is a peripheral slum consisting of about 100 households. There is a fairly equal distribution of tribal and nontribal population. Basti people are involved in selling plastic articles, broom making and working as daily wage laborers. An AWC is situated in the slum and is the hub of informal education, group meetings and food distribution. The critical problems of basti dwellers pertain to limited access to health facilities and inadequate sanitation facilities.

*Shiv nagar:* This slum was resettled twelve years back and is home to migrants from Khar and Nimmad. There are approximately 600 households. Dwellers are occupied mainly in informal labor.

*Pushpa nagar:* The slum is located in Ward Number 5, which is the biggest municipal ward in Indore and is underserved with respect to government health facilities. This area has come up in the last 15-20 years with the migration of informal sector workers from Uttar Pradesh (UP) and Bihar.

## 9.2. Current practices

At the community level, the problems pertaining to birth and newborn care are not one dimensional (exclusively biological) but integrated with a range of complex sociocultural and economic issues. In slum situations where the population is heterogeneous (geographically and socioeconomically), merely understanding the sectoral problems and provision of corresponding services will not address some of the more deep-rooted problems that exist and which were identified during the community enquiry process.

Information collected on a range of maternal and newborn health practices and perspectives was compiled from individual basti reports. Key findings from the community enquiry were grouped according to issues as detailed below.

### Service providers

#### Preventive services

- An antenatal care service that includes TT immunization and receipt of iron and folic tablets is available primarily from private practitioners and PHCs.
- The ANMs (health worker from the health department) cover only two of the six bastis where the enquiry was held.
- Certain providers are unique to a basti, such as the voluntary health providers at the church in Shanti nagar and the nurse at the civil dispensary in the Holkar Science College near Professors Colony whom pregnant women approach for primary health care.

- Basti people approach PHC for childhood immunization; very few use private practitioners for childhood immunization

#### Delivery-related services

- A majority of deliveries are conducted at home by untrained traditional birth attendants.
- In case of complications, the family members take the pregnant women to the nearby private hospital or nursing home.
- In cases of delayed labor, private practitioners are approached for inducing labor; but delivery still occurs at home due to monetary reasons.

#### Curative services

- The commonly used health facilities for protracted illnesses include MP government hospital and GPO hospital.

#### Preference for treatment seeking

- A majority of the people approach private providers due to quick and promising relief. The total expenditure inclusive of consultation and other services amounts to Rs. 30-100 depending on the severity of disease.
- Some people prefer to use the PHC because of the low cost of treatment as only a Rs. 5 receipt is required.
- In case of an emergency basti people prefer the Maharaja Yashwantrao (MY) government hospital due to its casualty facilities

### Birth preparedness

#### Normal delivery

- No prior arrangements are made for transport as most deliveries are at home.
- The expense incurred in a home delivery is generally met from household savings. At times the *dai* is rewarded in kind (rather than cash) in the form of bangles or clothing.

#### Complicated delivery

- Very few families make prior monetary arrangements to counter emergency situations. In most cases money is borrowed from money lenders or employers at interest rates varying from 10-25%. Self-help Groups (SHG) provide loans at the rate of 2% in bastis where they are active.

- A health provider is generally not identified beforehand (to minimize the time spent in deciding the most appropriate provider or facility) and there is a resulting delay in getting the necessary service.
- Transport arrangements are also not arranged prior to an emergency, which may lead to delays in reaching the facility.

#### Preparedness for the newborn

- People from two bastis reported keeping washed sun-dried cotton clothing on hand for wrapping the baby.
- People from selected bastis reported certain modifications in the dwelling place such as layering of the floor with a mixture of cow dung and sand with the objective of sanitizing the area.
- No provision is made to regulate the temperature of the room and keep it warm or at a temperature appropriate for the newborn to be placed in.

## Delivery and newborn care related practices

#### Delivery care

- The five cleans of delivery are followed stringently by trained *dais*. However, in most cases the *dais* are untrained and considered mainly for their experience in conducting deliveries.
- Generally a new, but non-sterile thread, is used for cord tying. The use of a new blade to cut the cord is widely prevalent, though in certain sections an old knife or glass was being used for the purpose. Groundnut oil or talcum powder may be applied on the cord with the view that it hastens drying of the cord.

#### Newborn care

- Newborns are given a bath immediately after birth with warm water.
- Colostrum is discarded continuously for the first three days and breastfeeding is initiated three to five days post delivery.

## Identification of complications and subsequent actions

#### Pregnancy and delivery related

- Women identified anemia, night blindness, dispositioning of the fetus in the womb, weakness and giddiness as signs of complication during pregnancy.

- Malpresentation and premature rupture of the uterus were identified as danger signs pertaining to delivery.
- Treatment is sought from private practitioners and/or hospitals during severe complications.

#### Newborn related

- Basti people identified low birth weight, pneumonia, no crying and jaundice as complications of the newborn.
- If the child does not cry, some people try to warm the child by burning cowdung cakes and placenta.

#### Roles and responsibilities of family and community

- The tasks involved during pregnancy and delivery are considered the women's domain. The mother-in-law, sister-in-law and elderly neighbors assist in all pre-arrangements—such as arranging for clean clothes, layering of the floor with cowdung paste—and even conduct delivery in the absence of the *dai*.
- Men may make financial and transport arrangements in emergency situations.

#### Community expectations

- Basti people were keen to gain information on practices to improve the health and nutrition of women and children.

## 9.3. Barriers, facilitators and options

Table 9.1: Barriers, facilitators and options

| S.No | Issues                                |              |   | Options   |
|------|---------------------------------------|--------------|---|---|
| 1    | Family and Individual Level           | Facilitators | <ul style="list-style-type: none"> <li>Willingness to spend on health services</li> <li>Keen desire to be more informed about practices and government provisions</li> </ul>  | - Identifying motivated individuals; training them on health- and development-related government schemes  |
|      |                                       | Barriers     | <ul style="list-style-type: none"> <li>Low literacy levels compounded by low awareness levels</li> <li>Traditional taboos and beliefs</li> <li>Preference for home deliveries</li> <li>Alcoholism</li> </ul>  | Develop clear understanding of beliefs/taboo; distinguish these as harmful, beneficial or neutral. Address the harmful practices in a community-specific manner |
| 2    | Infrastructure and Access to Services | Facilitators | <ul style="list-style-type: none"> <li>Presence of qualified medical practitioners</li> <li>Community's linkage with the providers</li> </ul>   | Use of the relationship with the private providers and the community to improve health-related practices  |
|      |                                       | Barriers     | <ul style="list-style-type: none"> <li>Proximity of the untrained <i>Dai</i></li> </ul>   | Training of identified TBAs   |
| 3    | Social Environment                    | Facilitators | <ul style="list-style-type: none"> <li>Communities have some form of organization</li> </ul>  | Institution building; strengthening and widening their role   |
|      |                                       | Barriers     | <ul style="list-style-type: none"> <li>Presence of moneylenders which prevents people from making advance savings</li> </ul>  | Sustainable health funds and self-help groups   |
| 4    | Exclusion                             |              | <ul style="list-style-type: none"> <li>discrimination of certain segments and consequent inequity based on caste, religion and class</li> <li>Service provision restricted to dwellings on or near the main road of the basti</li> <li>Local leaders are not from a representative population of the basti</li> </ul> |   |

### 9.3.1. Family and individual level: discussion

#### Barriers

- Low literacy levels compounded by low awareness levels culminate in an attitude of resignation towards one's situation and apathy to change. In communities where there is an AWC (Anganwadi Center) or an ANM, the general awareness of maternal and new born health issues is higher than in communities who do not have these services.
- Traditional taboos and beliefs. One tribal community in Professor colony considered immunization to be culturally unacceptable and of no value. A possible option here is to develop a clear understanding of the beliefs and taboos and distinguish these as harmful, beneficial or neutral, and then address the harmful practices in a community-specific manner.
- There is a preference for home deliveries due to traditional factors, proximity and low cost. Home deliveries are conducted by untrained *dais*, and consequently may not be clean and there may be no way to handle complications.
- Alcoholism among the male members of the communities emerges as a major barrier to optimal practices as it lowers the confidence levels of women.

#### Facilitators

Willingness to spend on health services.

- Keen desire to be more informed about practices and government provisions. A possible option here is to identify motivated individuals and train them in health- and development-related government schemes (such as *vidhwa* pension, *yojna*, *balika samridhi* and *matritva yojna*) and provisions. Similar trainings could be given to the same or a different set of volunteers on health practices and issues.
- The presence of supportive husbands who may become role models for the others. An option here would be to identify sympathetic males who can support and adopt healthy behaviors pertaining to the care of pregnant women and newborns and thereby become role models for other basti men.
- The ability of community members to identify complications during pregnancy and of the newborn. During the discussions on complications related to pregnancy and the newborn (using a timeline technique), women in Professor colony were able to identify premature labor, bleeding and malpresentation as pregnancy- and delivery-related complications, and low birth weight, lethargy, the inability to cry, pneumonia and jaundice as complications of the newborn.

## 9.3.2. Infrastructure and access to services: discussion

### Barriers

- Proximity of the untrained *dai*, which prevents the people from seeking delivery care outside the community. Possible options here include:
  1. Training of identified TBAs in:
    - a) appropriate delivery and newborn care practices
    - b) early identification of danger signs of the mother and newborn and appropriate action
    - c) counseling skills
  2. Encouraging *dais* to improve the quality of their services by:
    - a) adopting appropriate hygiene (e.g., provision of DDK if possible)
    - b) initiating the process of timely contact so the *dai* can provide effective counseling

### Facilitators

- The presence of qualified medical practitioners in the vicinity of the basti, and people's faith in, rapport with and level of comfort with them for health services. At least one service provider was relatively affordable.
- A community's linkage with the providers to the extent that they adapt to the community's expectations; for example, in cases of delayed labor at least two providers administer an injection to induce labor and let the delivery be conducted at home. An option here is to use the relationship between the private providers and the community to improve health-related practices, such as encouraging providers to counsel mothers and families on particular behaviors.
- Monthly visits by the ANM. These can be modified (frequency, timing and locations within the basti) to suit the requirements of basti members since many mothers and caretakers are employed and unavailable in the morning or on the specific days when the ANM visits. More appropriate times can be established to improve service coverage, and the ANMs can also be trained to provide more complete ANC.
- The presence of less utilized health facilities such as the civil dispensary, a stone's throw away from Professors Colony. An option here would be to explore non-

utilized service providers, such as the civil dispensary at the Holkar Science college, sensitizing them to basti needs and providing adequate encouragement.

### 9.3.3. Social environment: discussion

#### Barriers

- The presence of moneylenders which prevents people from making advance savings for possible complications. An option here is to create mechanisms to develop sustainable health funds and self-help groups.

#### Facilitators

- Communities have some form of organization, at times static and at other times volatile and active. The lesson is that it is important to understand this process (what exists and the reasons for it) and develop plans to strengthen the organization of the communities. There are various experiences all across India where models of good community organization have been established and lessons can be learned and incorporated in this project. A strategic plan can be developed based on these lessons learned suited to the needs of the community.

### 9.3.4. Exclusion: discussion

- Diversity of the community with respect to caste, class and geographic origin may lead to discrimination against certain segments and consequent inequity.
- Within the slum, houses on the main street, which are generally occupied by the more influential members of the basti, are frequented by the health providers (such as the ANM) while the more distant houses remain unattended.
- Community leaders and more vocal representatives are generally able to represent the relatively better-off families, who have some access to education, some level of general awareness and access to other facilities. The poorest do not have a voice and remain excluded.



# 10. Summary and Emerging Issues

## 10.1. Why do we need to use the participatory community enquiry approach?

Community participation expands the impact of health programs by contributing resources, increasing service utilization and facilitating preventive activities, while at the same time enhancing the community's self-respect and ability to control its environment. Specifically, community participation can:

- **Increase community self-reliance:** The movement towards increased community autonomy may be manifested by self-reliance in ideas and initiatives, in funding and control or in materials and manpower.
- **Increase service utilization:** Community participation in project planning and implementation can promote the attitudinal and behavior changes necessary for improved health conditions.
- **Facilitate behavior change:** Community participation can promote attitudinal and behavior changes necessary for improved health conditions.
- **Encourage government support:** Community involvement can help promote continued government support and the essential "political will" needed over the long term for project success.
- **Provide much greater use of substantive community resources (e.g., traditional medicine) and knowledge (best time and place for service delivery), some of which may be unknown to people outside the community.**
- **Create more culturally appropriate services and facilitate service coverage.**

An important element of any successful project is sustainability, and the participation of project partners is critical in determining this.

## 10.2. Who are the project partners?

The project partners include the NGOs, CBOs, and the communities who can best identify and analyze their needs as well as formulate methods to meet the set objectives.

## 10.3. How can participatory community enquiry help in achieving program objectives?

The main objectives of the Indore urban health program are:

- Increased coverage of services and adoption of key health behaviors in neonatal survival, age-appropriate immunization, diarrhea prevention and control and other child health priorities. Participatory enquiry enables identification of current practices/service coverage, barriers and facilitators associated with it—“Local problems have local solutions”—and provides a forum for community members to identify realizable options together. It helps people move from individualism to togetherness.
- Improved capacity of CBOs, NGOs, private and public sector health providers in health behavior promotion and building partnerships. Stimulating community participation is a skillful process which can be mastered only by constant interaction with the community and thorough understanding of its needs, and participatory enquiries greatly enhance this process. Participatory enquiry may increase a sense of ownership amongst the community, leading to the forming of new community-based organizations and strengthening the cohesiveness of existing ones. Also the community’s perceptions of an organization or a provider provide insights into the quality of effort invested by them, how they need to address people’s needs and areas where they need to improve.
- Better targeted policies and increased allocation of resources for urban slum health. A motivated community is a powerful tool to overcome the biggest hurdles in the way of development. Through participatory community enquiries, communities can seek information on relevant policies and determine the deficiencies in the reach of key policy benefits. A well-conducted enquiry provides pertinent issues to the policymakers to formulate specific policies and goals for target groups.

## 10.4. Emerging issues

### *Community-based organizations (CBOs) as the building blocks for community development*

A number of slums have community-based organizations, and some of them will be working as partners in this project. This is a resource that the project has and which can be used not only to improve the implementation of the processes in the communities where they exist but also in other communities. The CBOs need exposure, training and other capacity development, and some of the representatives can very well act as volunteers for other slum communities.

### *Government facilities: possibilities for a strengthened partnership*

It is a fact that the government has a role to play; it is not only a resource but is also constitutionally mandated to provide services to the poor.

### *Strengthening the Anganwadi centers*

In some communities, AWC exist and play an important role in the life of community members. Providing improved skills on a range of social and technical issues can help to increase the efficiency of these workers.

### *Private sector services (for-profit and not-for-profit services)*

Private providers are critical in providing health care to slum dwellers as they are often the most accessible and basti people have developed immense faith in them. There may be a possibility of training the nonqualified providers and maximizing the benefit of their association with basti dwellers by promoting them as counselors on issues such as immunization and newborn care.

### 10.4.1. Looking to the community

Communities play an important role during the delivery and post-delivery period and provide a range of support to family members. There is general awareness among community members that problems exist and that there is a need to address them. There was a case in one basti where each household in a particular locality in the slum contributed Rs. 100 to construct a cement road. This example illustrates how important it is for the project to identify the circumstances where communities come together to provide help and how this community binding can be strengthened.



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# Annex 1.

## Probes on newborn care for guiding the facilitator on conducting the participatory community health enquiry and planning

The table below provides the thematic areas for discussion on newborn care, the issues that need to be investigated/discussed within each item, i.e., the probes and the possible participatory method/s that can be employed to garner this information.

| Thematic areas  | Probes  | Tools to be used  |
|---|---|---|
| <p><i>Service Providers:</i> their availability and quality of service provided</p> | <p>i. Identifying health facilities/ service providers in and around the area – both utilized and non utilized</p> <p>Who are the health service providers in and around your bastis?</p> <p>Are they all approached in case of illness/ medical emergency?</p> <p>ii. Identifying the types of services provided: antenatal, delivery, and post-natal care. Further, identifying what activities are performed for each of these and the need for such services.</p> <p>For what type of services are the providers approached? (Curative/Preventive)</p> <p>For each type of service what is the treatment advised or action taken by the provider?</p> | <p>Institutional mapping (a technique whereby the basti is sketched on the floor or paper using suitable material ie coloured pens, chalk or any locally available material)</p> <p>Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family who influence decisions on selecting service providers such as husband or mother in law may also be included in the group</p> <p>Matrix Ranking: For ranking service providers with respect to the quality of service on a 2 x 2 matrix</p> |

|  |   |   |
|--|---|---|
|  | <p>iii. Defining the quality of services</p> <p>How much time does it take to receive service once you reach the facility or provider?</p> <p>Do you have a fixed provider? Is there a particular reason for selecting him?</p> <p>What is the cost of seeking treatment?</p> <p>How would you describe the provider's behavior? Would you revisit him/her?</p> <p>iv. Analyzing accessibility of services:</p> <p>Who gets these services, who doesn't get them?</p> <p>What are the difficulties in receiving these services?</p> |   |
| Birth preparedness and contingency readiness   | <p>i. Identifying costs involved in home/ hospital delivery</p> <p>ii. Planning for resources</p> <p>What arrangement is made for transport, money and escort in case of emergency? Are these pre decided?</p> <p>Who is looked upon for help- family members/ relatives, neighbors or other community members?</p> <p>Do you have a health fund? If yes how does it operate?</p> <p>Do people approach moneylenders for monetary support? What interest rate do they charge?</p>   | Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family who influence decisions on cost of health services and arrangement of resources such as husband or mother in law are also included in the group |
| Preferences for place and provider of delivery | Influencing factors for determining the place of delivery   | Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family   |

|                                       |   |   |
|---------------------------------------|---|---|
|                                       | <p>Following reasons can be investigated:</p> <p>a) Who does the delivery and what is their availability or location vis a vis the client?</p> <p>b) Quality of services – how long does it take to receive service ones you reach the health facility or the provider? How is the health staff's behavior; are they friendly and approachable? Etc.</p> <p>c) Preparations made by the family members. Preparations made by the providers (practice of 5 cleans of delivery – clean surface, clean hands, clean blade, clean cord and clean cord tie)</p> <p>d) Costs involved in availing the health services</p> | <p>who influence such decisions eg. husband or mother in law are also included in the group</p>   |
| Roles of family and community members | <p>i. Roles of family members/husband during pre natal, delivery and post natal care.</p> <p>ii. Roles of community during pre natal, delivery and post natal.</p>  | <p>Focus Group Discussion (FGD) with pregnant women, elderly ladies of the community, Trained/Traditional Birth Attendant and husbands of pregnant women.</p>   |
| Complications                         | <p>i. Discussing complications for mothers: pre natal, delivery and post natal</p> <p>ii. Types of complications of new born (In the first month of life)</p> <p>iii. For each: identifying causes, service provider most often contacted and reasons for this, costs involved etc</p>  | <p>Identify the complications, list them down using a Problem–Action-Analysis tool ie analyzing the pros and cons of the actions (the purpose is to understand how specific complications are handled in the community; which measures are beneficial and which are dangerous/ harmful)</p> <p>OR</p> <p>Seasonality: Chart of pregnancy,</p> |

|                  |   |  |
|------------------|---|--|
|                  |   | for every 3 months and possible complications  |
| Family practices | <p>i. Understanding practices followed by the pregnant mother: pre natal, during delivery and post delivery [Practices related to work pattern (breast feeding especially post delivery), food habits, rituals followed]</p> <p>ii. Practices with the new born: colostrum and breast feeding, providing warmth, attending to the new born, rituals followed. Family practices during sickness, gender preferences etc.</p> | <p>Seasonality with 9 month chart and an additional 3 month to identify post delivery</p> <p>x</p> <p>For each month, food habits, work pattern, rest and support</p> <p>Focus Group Discussion (FGD) with pregnant and mother's of newborns. Members of the family who have a role in these activities are also included in the group</p> |

## Annex 2.

### Probes on understanding hygiene and sanitation related behaviors

The table below provides the thematic areas for discussion on hygiene and sanitation related behaviors and the issues that need to be investigated/discussed within each theme. This section aims to provide probes for facilitation on health issues beyond newborn care for ease of the user in applying participatory approaches for gaining insight other health issues such as hygiene and sanitation

| Thematic areas                | Probes   |
|-------------------------------|--|
| <b>Safe disposal of feces</b> | <ul style="list-style-type: none"><li>• What is the most common place of defecation in the basti for adults? (private toilet, public toilet, open air)</li><li>• Where do children defecate (probe: in households having toilets, in households not having toilets)?</li><li>• What do people do with feces of children who do not use toilets (probe: how long does the feces lie in the surroundings, where do they dispose the feces)?</li><li>• Are there any public toilets?</li><li>• Are they being used? By how many households? Why not( probe; mechanism for maintenance in place)?</li><li>• Do any households have private or shared toilet facilities? Many, just a few or none?</li><li>• What would be the preference for sanitation facilities in the basti/household?</li></ul> |

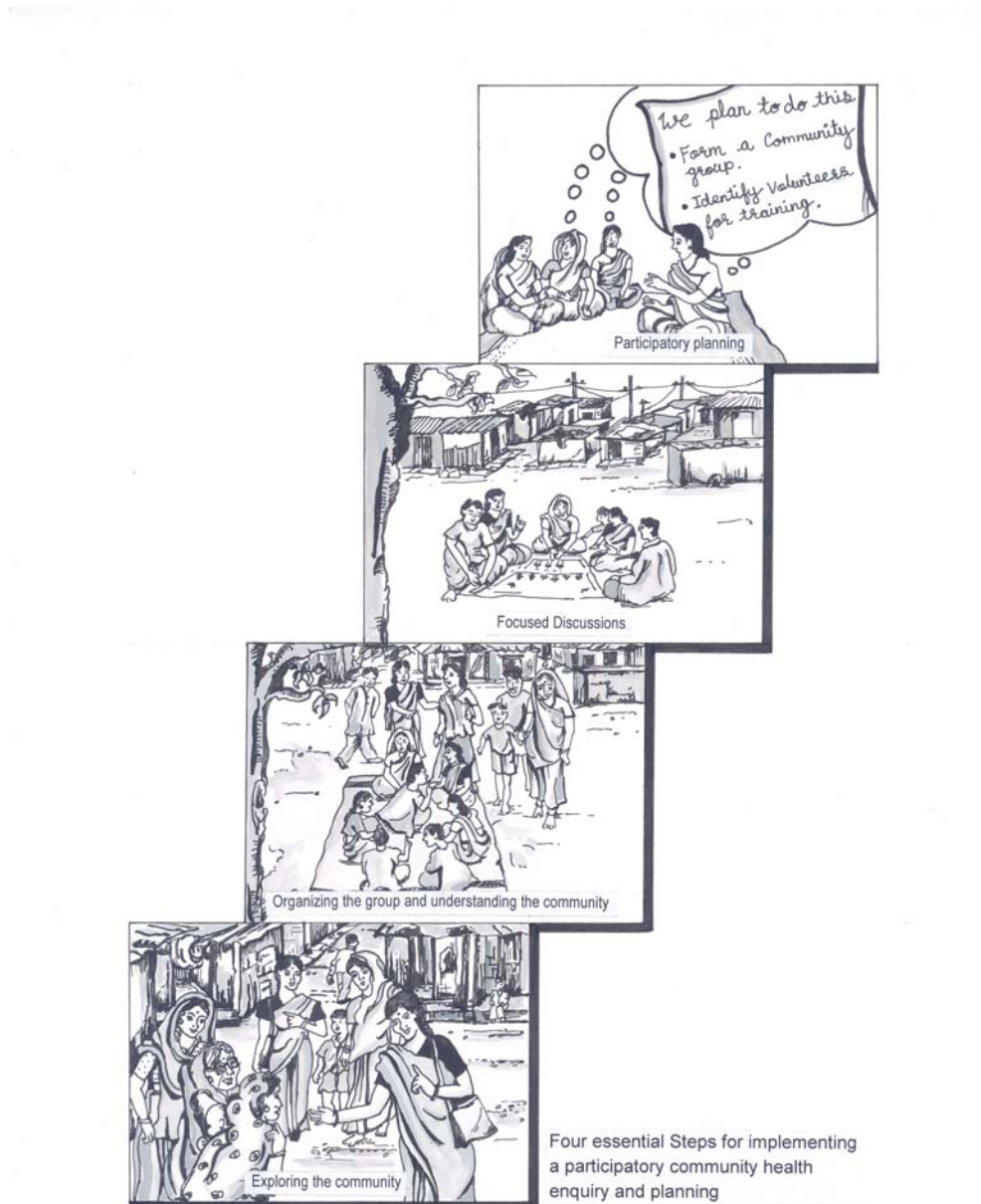
|   |  |
|---|--|
| <p><b>Safeguarding household drinking water from fecal contamination and treatment before use</b></p> | <p>Source of drinking water</p> <ul style="list-style-type: none"> <li>• What are the basti's sources of drinking water?</li> <li>• Is this the same source as water for other uses (bathing, washing clothes)?</li> <li>• If not, what other sources are there?</li> <li>• Is the water supply adequate for drinking and other purposes?</li> <li>• If not, what is the water primarily used for?</li> </ul> <p>Safeguarding water from contamination</p> <ul style="list-style-type: none"> <li>• What kind of water do people consider good to drink?</li> <li>• What do people think makes water dirty or unfit to drink?</li> <li>• Can drinking water make you sick?</li> <li>• Do you know of any illnesses that come from drinking water?</li> <li>• How do people store drinking water in the household? Describe or show containers (<i>probe: use of narrow neck containers etc</i>).</li> <li>• How do you take out drinking water from the container (<i>probe: long handle container, not dipping fingers etc</i>)</li> <li>• Do children have access to household drinking water (<i>probe: is containers kept at an elevated surface and covered</i>)?</li> <li>• If not, how do they get their drinking water?</li> <li>• Do people separate drinking water from water for other uses?</li> </ul> <p>Treating drinking water</p> <ul style="list-style-type: none"> <li>• Do households use any methods to treat water before drinking? What are they?</li> <li>• What methods do you know about to treat household drinking water to make it safe to drink?</li> <li>• Does anyone use chlorination/filtering to treat water?</li> </ul> |
|---|--|

|  |   |
|--|---|
| <p><b>Wash hands with soap at critical times using correct technique</b></p> | <ul style="list-style-type: none"> <li>• Do people consider it important to wash hands? Why or why not?</li> <li>• What do people in the basti use to wash hands? Water? Soap?</li> <li>• How many people use soap to wash hands? All, many, some, a few?</li> <li>• Is soap available and affordable? To all or just a few?</li> <li>• When do people wash hands [probe: after contact with feces (after defecating, disposing off child's feces, washing child's bottom), before contact with food (before preparing food, before serving food, before feeding, before eating)]?</li> <li>• Where do people wash their hands in the household?</li> <li>• Is there a special place for hand washing? Is soap and water kept there?</li> </ul> |
| <p><b>Protect food from flies, dirt and spoilage</b></p>                     | <ul style="list-style-type: none"> <li>• How is food stored in basti homes?</li> <li>• Do people cover their food?</li> <li>• Do you protect your food in other ways? What ways?</li> <li>• How do you handle uncooked and cooked food (<i>probe: washing of fruits before eating, washing vegetables before cooking, serving with clean spoons, ladles etc</i>)</li> </ul>   |
| <p><b>Some related questions</b></p>   | <ul style="list-style-type: none"> <li>• Do small children get diarrhea often? How often? Once a week, once a month, less, more? More prevalent in any particular months?</li> <li>• What do people in the basti think causes diarrhea?</li> <li>• What do most people do when their child has diarrhea?</li> <li>• Do you know of any ways to prevent diarrhea?</li> <li>• Are there any schools in the basti?</li> <li>• Do the schools have water? Toilets?</li> <li>• What do you do with your garbage?</li> <li>• Where do you go for advice about staying healthy?</li> <li>• Where do you go to seek care when a child has diarrhea?</li> </ul>  |



# Annex 3.

Diagram of the steps involved in a Participatory Community Health Enquiry.



Participatory Community Health Enquiry and  
Planning in Urban Slums  
A Field Guide for Facilitators

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This field guide is a documentation of the lessons learned and experiences of the participants and the community during a ten-day workshop and follow up action in the field post workshop.

We express sincere gratitude and heartfelt thanks to the Non-government Organizations and Community Based Organizations of Indore for their whole hearted and enthusiastic participation in making this participatory learning effort successful.

It was an enriching experience to talk to the men, women and children in the different slums that we visited and discuss their understanding and perspectives on health related issues. Their enthusiasm and keenness to share their feelings and experiences was encouraging for the entire participant group.

Our heartfelt gratitude to the key resource person, Mr. Utpal Moitra (Senior Social Scientist, with 16 years experience in participatory planning, monitoring and evaluation in South and South-East Asia) for his dedication and openness in sharing his experiences, skills and knowledge with the participants. We value the contribution of EHP colleagues Rajeev Nambiar, Sandeep Kumar, Tasneem Khorakiwala, Amit Bhanot and Shweta for their untiring and persistent support in conducting this workshop. Suggestions from and comradeship of Mr. Kukreja, Sanjeev Upadhyaya, Anju Dadhwal, Praveen Jha, Mani Gupta, Gunika Dua and Pooja Sharma have been of immense value.

We look forward to comments and suggestion from users of this guide, which will enable this process to be enriched and increase it's applicability in different cultural contexts.

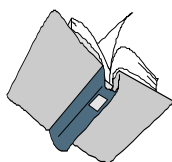
Siddharth Agarwal

Arti Bhanot



# Preface

## Is this guide for you?



This guide has been written for people working with slum communities to facilitate sustainable improvement of child health with the involvement of the communities—people such as:

- Project managers, technical advisors of Urban Health Programs
- Field Implementers of Urban Health Programs
- CBOs, local community leaders
- Researchers interested in program process

## How can this guide help you?



This guide will help you get answers to **WHYs**, **WHATs** and **HOWs** of participatory community health enquiry and Planning (PCHEP)?

What is PCHEP and what are the different types/forms of PCHEP?

What are the benefits of using PCHEP?

What benefit will using PCHEP give one for achieving the program objective of sustained improvement in child health?

How to use this approach?

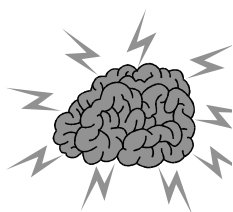
How to facilitate the community to prepare an action plan for themselves using this approach?

How to analyze and present the findings?



Is there any other WHAT, HOW OR WHY COMING TO YOUR MIND? Quickly SCRIBBLE IT DOWN in the box<sup>1</sup>.

## How to use this guide



This guide is not like a recipe instruction book. It is more a description of a suggested approach that the EHP team has used and found useful. The approach is flexible and needs to be adapted, experimented with and evolved over time and with use. The more you use this approach the more it gets strengthened with your experience. Use this guide as a source of ideas for working with the community. This guide plants the seeds of ideas for understanding and implementing PCHEP. **Since every situation is different there is no rigid formula or “blue print” that will work everywhere.** So please look-out for important TIPS, learn from the experiences of others and through your creativity and experience you will surely be able to adapt the approach to respond better the operating context.

Most examples used in this guide are those of experiences of EHP/India in using this approach in the slums of Indore. However, one can adapt this methodology to the village setting and elsewhere as well.

### **This guide is divided into VII sections**

**Section I** will introduce you to the typology of participation. It will help you understand the need for using participatory community enquiry

As you move on to **Section II**, you will read about participatory community enquiry and the different methods we can use to facilitate such an enquiry

**Section III** presents the use of PCHEP in EHP’s context. **Section IV** encompasses the suggested steps to follow in PCHEP. It talks of various methods you can use at various stages. A systematic procedure of writing a succinct report of the information

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<sup>1</sup> Please retain this question till you read the entire guide. If you obtain the answer, that is fine; if you do not and still have the question, please send a comment. This will help in enriching the guide.

gathered is presented in **Section V**. Tips for stimulating discussion and facilitation in a group are detailed in **Section VI**.

Finally, **Section VII** orients you in preparing a TOT for facilitating a PCHEP workshop.

# Section 1

## Typology of Participation

Go to the people,  
Live with them,  
Learn from them,  
Start with what they know,  
And build with what they have

Lao Tsu – 700 B.C.

Participation is a fundamental process within a group because many of the other processes depend upon participation of the various members. Levels and degrees of participation vary. In its true sense is difficult to achieve in the community.

Let's understand the various types of participation<sup>2</sup>:

### ***Passive participation***

People participate by being told what is going to happen or has happened.

e.g.: Teacher –student interaction

### ***Participation in information giving***

People participate by answering questions posed by extractive researchers.

e.g.: Researcher gathering information using a questionnaires or interview

### ***Participation by consultation***

People participate by being consulted; external people listen and define both problems and solutions.

e.g.: Medical professional conducting a case history

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<sup>2</sup> Pretty J et al (1995). A Trainers Guide for Participatory Learning and action, IIED Participatory methodology series. IIED, London

### ***Participation for material incentives***

People participate by providing resources (e.g. labour) in return for material incentives.

e.g.: Food for work programs where disaster affected people participate in retrieval and reconstruction process in exchange for food

### ***Functional participation***

People participate by forming groups to meet predetermined objectives related to the project.

### ***Interactive participation***

People participate in joint analysis, which leads to action plans and the formation of new local institutions or the strengthening of existing ones.

### ***Self-mobilization***

People participate by taking initiatives independent of external institutions to change systems. Develop contacts for resources and technical advice, but retain control over resources. It emphasizes that communities have improved and have better understanding of the issues and have the capacities to solve their own problems, with outsiders acting as facilitators and catalysts

e.g.: Community assessing their needs and preparing action plans on their own with little facilitation from outsiders

Participation does not mean just physical presence or that everyone speaks. Silent members could be listening very carefully. What needs to be identified and tackled are the members who are “**there but not there**” those who are indifferent or uninvolved as they can potentially damage the group.

# Section II

## Participatory Community Health Enquiry and Planning (PCHEP)

Participatory community enquiry is an empowering process that enables the community to analyze the prevailing situation, identify gaps, barriers and facilitators and potential options to overcoming gaps

### **What is participatory community enquiry?**

- It is guided by principles of mutual respect and equality between participants.
- It starts from the positive and constructive rather than from problems helps to encourage an attitude of self-reliance and collective action rather than dependence.
- Special attention is given to hearing and prioritizing the voices of the poorest and most vulnerable.
- The investigation is linked to action and decision making in order to justify resources diverted from implementation.
- It is linked to an ongoing learning process and contributes to developing capacities and networks.<sup>3</sup>
- The need for unlearning that we outsiders know everything is the central theme of the entire process of this learning exercise.
- Participants' attention is focused for a longer duration by engaging them in activities such as sketching and drawing, rather than merely conducting group discussions
- Detailed information is obtained on a focused topic of discussion by probing the reasons for each response

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<sup>3</sup> Mayoux L (2003). Empowering enquiry. Enterprise impact news.

- The objectives rather than the techniques remain the main focus.

### **Why do we need to use participatory community enquiry approach?**

Community participation expands the impact of health programs by contributing resources, increasing service utilization and facilitating preventive activities, while at the same time enhancing the community's self respect and ability to control its environment. Specifically, community participation can:

- Increase community self-reliance: The movement towards increased community autonomy may be manifested by self-reliance in ideas and initiatives, in funding and control or in materials and manpower.
- Increase service utilization: Community participation in project planning and implementation can promote the attitudinal and behaviour changes necessary for improved health conditions.
- Facilitate behaviour change: Community participation can promote attitudinal and behaviour changes necessary for improved health conditions.
- Encourage government support: Community involvement can help promote continued government support and the essential "political will" needed over the long term for project success.
- Contribute unique knowledge and resources: a participatory approach can result in much greater use of substantive community resources (e.g., Traditional medicine) and knowledge (e.g., best time and place for service delivery) some of which may be unknown to people outside the community.
- Create more culturally appropriate services and facilitate service coverage.
- An important element of a successful project is sustainability and participation of project partners is critical in determining this.

# Section III

## PCHEP in EHP India's Indore Urban Health Program

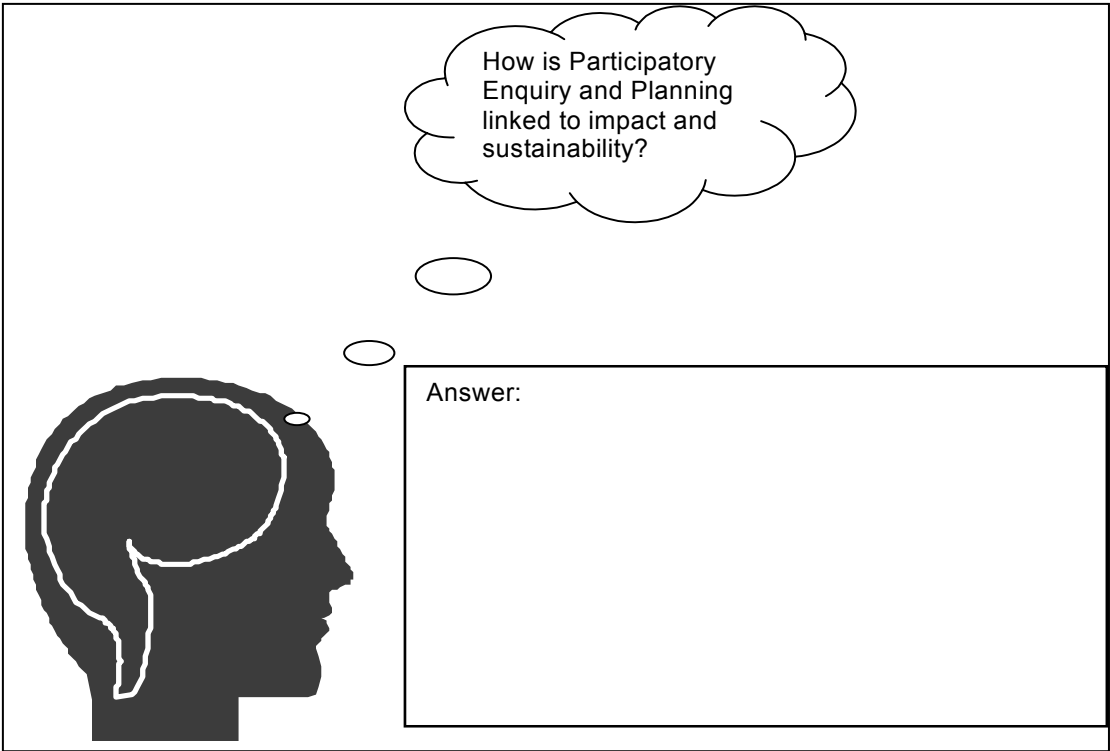
How can participatory community enquiry help in achieving program objectives?

The main objectives of the EHP/Indore Urban Health Program are:

- Increased coverage of services and adoption of key health behaviors in neonatal survival, age appropriate immunization, diarrhea control and other child health priorities
- Improved capacity of CBOs, NGOs, private and public sector health providers in health behavior promotion and building partnerships
- Better targeted policies and increased allocation of resources for urban slum health

“Local problems have local solutions”— Participatory enquiry enables identification of current practices/service coverage, barriers and facilitators associated with it and provides a forum for community people to identify realizable options together. It helps them to rise from individualism to togetherness.

A motivated community is a powerful tool to overcome the biggest hurdles in the way of its development. Through participatory community enquiries **communities can seek information on relevant policies and determine the deficiencies in the reach of these policy benefits**. A well conducted enquiry provides pertinent issues to the policy makers to formulate “target group” and “target goal” specific policies.



How is Participatory Enquiry and Planning linked to impact and sustainability?

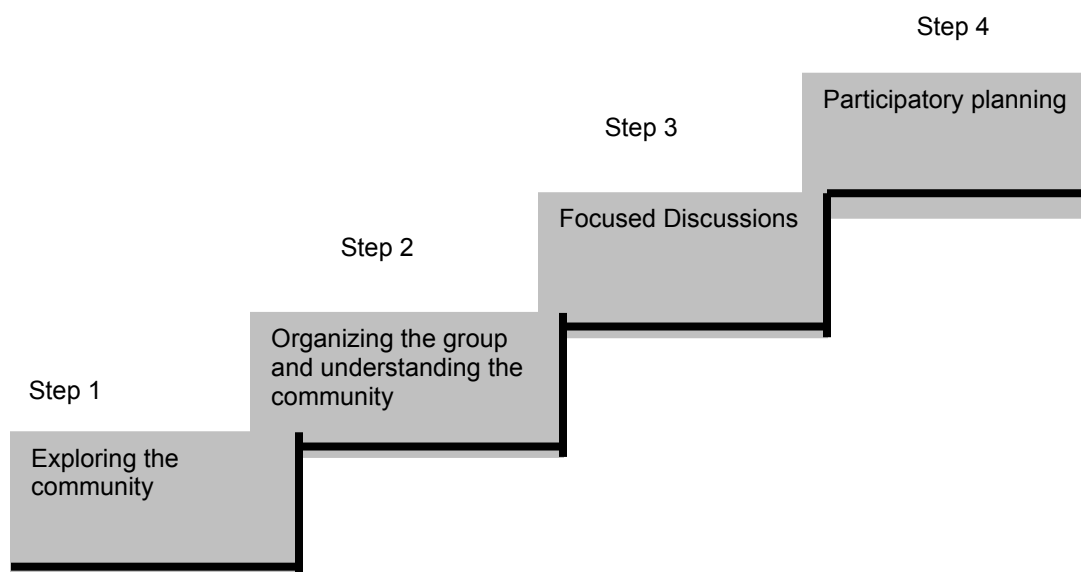
Answer:

# Section IV



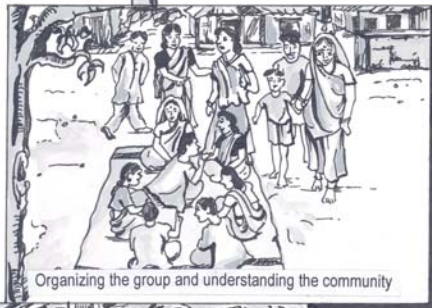
## Four essential Steps for implementing a participatory community health enquiry

There are 4 steps one needs to take to conduct a participatory community health enquiry. These steps are diagrammatically represented below:



Each of these steps is important. However depending on the purpose of the project one can choose the steps one wants to start with.

Each of these steps will now be discussed in detail.

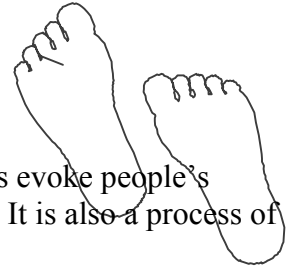


Four essential Steps for implementing a participatory community health enquiry and planning

Walk About ⇒ Observe ⇒ Ask

## Defining the purpose of your transect

A transect walk can be undertaken to explore the basti as well as evoke people's curiosity to move out and initiate discussion with the facilitator. It is also a process of rapport formation with the community you intend to work with.



## Preparation

Think about issues that concern your program, which you can gather from this observatory walk.

Few ideas are given below:

- How long has the basti been in the present area?
- Common occupations
- Caste divisions
- Approximate number of households
- Population density
- Environment cleanliness
- Broad issues of concern
- Meeting place in the basti which is considered appropriate for discussion



*Note: if the facilitators are already familiar with the basti, then the transect could focus on learning more about a specific cluster or issue and on mobilizing people to ensure representation from all clusters.*

Prepare a checklist of these issues on a plain sheet as given below:

|   |
|---|
| Name of the person who took the transect: |
| Name of the Basti                         |
| Date of the visit                         |

| Issue | Information gathered |
|-------|----------------------|
|       |                      |
|       |                      |
|       |                      |

Such a checklist would prevent you from missing out on any information you need for your program.

## During the transect

Directions to carry out an effective transect:

- Take a slow walk down the path of the selected community with a community member/volunteer or adolescents. Children are good guides to navigate the slum inroads and reach to as many people as possible
- While walking make careful observations on the conditions of the homes and ask questions mentioned in the preparation section.
- Remember it's an observatory walk: Listen through your eyes. **Observation**<sup>4</sup> allows you to learn of the things that program participants may be unwilling to talk, and thus you will get personal knowledge and direct experience in understanding and interpreting the situation being observed.

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<sup>4</sup> Ganguly KK. Qualitative research: A tool in community based health care studies: some issues. Indian J Public health 2000; 44:52-57.

- Make sure you cover the basti completely. It is generally seen that the community resides in clusters divided on the basis of class, caste and occupation. Transects in each of these clusters will enable you to hear voices of all members of the community.
- Keep noting all the information you gather for further discussion with the community members during group discussions.
- Entry of outsiders into the basti evokes curiosity and may also lead to a feeling of intrusion in some cases. It is important that the purpose of the outsider's visit is informed to the basti people and nobody is restrained from questioning.
- Write up information gathered from conversation, make case studies, and quote the people you meet.
- What can makes your effort effective and useful:
  - *Rapport formation*: This is your first entry point in the community you intend to work with. Not only are you observing but everyone is observing you too. Try not to reflect that you are different from them.
  - Your tone should be very humble and respectful.
  - *Be simple and have fun*: No matter how sophisticated you might be in the world of management simplicity does matter. Your checklist should be in your mind ... be a friend, genuinely interested in listening. Let the conversation flow and enjoy the experience.
  - *A genuine interest in people, their lives and activities is an attitude that is good for absorbing<sup>5</sup> and imbibing*. It helps the programmer gather fascinating and useful insights.

After the transect:

- Fill in all the information you gathered in your prepared checklist
- Point out information issues/gaps or contrasting opinions
- After the transect you should be able to find a meeting place and stimulate interest of the people to come for a discussion.

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<sup>5</sup> Russel Bertrard. The Conquest of Happiness: .....

### 1 Organizing the group

- Through the transect and house visits community members belonging to the identified target group should be requested by the facilitator to join for a **discussion** at the site of the “meeting” to help them understand the overall purpose of the program and the immediate purpose of the visit.
- The facilitator can engage in a discussion with the community men who collect at the site of the “meeting” to help them understand the overall purpose of the program and the immediate purpose of the visit. This eliminates anxiousness and possible interference in the process; it may also encourage them to participate in the process making it more representative.

### 2. Set the climate

- Once the group slowly settles down on the “meeting” site and start discussing sundry issues, talk about familiar things; talk about general things/issues (e.g., about the children in school-dress, and what they learned that day) to make people feel comfortable. Be relaxed, direct and confident.
- Have the participants introduce themselves with relevant information (age, occupation, number of children and age, etc).

### 3. Initiating a discussion

Discuss the purpose of your visit:

- Say —“You may have noticed that we have been coming to your basti to understand from you the problems related to infant and maternal health nutrition in your basti. Our organization wishes to work with you towards improvement of child health in your community. Do you feel it would be useful to talk about child health issues to better understand the difficulties experienced by the residents of the basti?”
- Allow the participants to think, talk among themselves and patiently wait for them to respond ... appreciate their answer ... If its No ... maybe they do not want to discuss these issues...probe on why they do not want to do so...you may want to understand why and which issues they feel are the priority issues ... If they say yes ... continue

### 4. Identify and prioritize relevant issues from what the slum people say:

- Probing Questions:

Probing questions vary according to the objective of the exercise.

A general list<sup>6</sup> for child health objective is presented below. You can modify it according to the objectives of your enquiry and select appropriate/pertinent issues from this list.

- **Occupation:** Where do poor people live? What are their major occupations?
- **Caste/ religious/other social groups:** How many different caste groups are there? Where do they live?
- **Government institutions:** Where are the government institutions like municipal ward office, zonal office, etc.?
- **Health facilities/provider:** Govt. Health Centre, Private doctor, Anganwadi Centre, Charitable Dispensary, etc.?
- **Welfare workers:** Where do the TBAs, private doctors and traditional healers reside? How many are there? Where do the AWW and AWH reside? Enquire about: Sources, quality of service providers, preference, frequent use, cost of treatment, distance for each service providers.
- **Schools/educational institutions:** Is there any school? Where is it located? Do all children go to school? Who do not go to school? A large chunk? Why?
- **Religious buildings:** Are there mosques, temples and churches? Where are they located? What and when are the local festivals?
- **Centre point for activities:** Where do people normally gather for activities? Where do men gather? Where do women gather?
- **Facilities available in slum:** Water, sanitation, personal cleanliness?
- **Community Based organizations:** Women's group, youth clubs?

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<sup>6</sup> Adapted from CINI (2000). Positive Deviance in early Childhood Care. An Action Project in West Bengal. A manual for facilitators

## AN EXAMPLE FROM PARTICIPATORY COMMUNITY ENQUIRY AT INDORE SLUMS

In Indore, the facilitators asked the community group to suggest a method of describing their community in such a manner that all present can see and understand it similarly. This discussion slowly led to the idea of preparing a map of the basti. A couple of women made a hesitant start on a chart paper. Slowly a few enthusiastic young men and boys came forward to describe the basti via a map and the map soon emerged (It may be noted that communities from different bastis adopted varying techniques for mapping such as charts and sketch pens, rangoli colors, chalks etc.). Following this, the facilitators suggested whether key health service providers could be indicated on the map. The group then began describing all the health service providers, namely, government, private, basic/primary, more specialty services, etc. All these were indicated on the map using indicative symbols.

**NOTE:** The maps should preferably remain with the community, in a location decided upon by the participants. There are experiences from other projects to support this and the need to systematically and regularly update the maps to make it a useful monitoring tool.<sup>7</sup> [A smaller version of the map/diagram on a regular A-4 size paper is handy for reports and reproduction].

## VISUAL ENQUIRY

### Stimulating participation through Mapping

Local people tend to hesitate in going ahead with the mapping process. Illiteracy is put forth as a reason for this especially in a community where most people are not literate. In case of hesitation, people might be more comfortable to draw and describe what their locality looks like by drawing some major landmarks with a twig on the ground (or any other local material). However, in some cases the use of charts and colorful sketch pens may meet initial hesitation. Often it might soon lead to an excited and fascinated group happily drawing away on paper. Thus, depending on the response, the facilitator could pursue either method. The activity could also begin with local material and then move to paper. With a bit of persuasion and, in worst cases, some initial prompting, the mapping process will take off. Then the process can be handed over to the local people<sup>8</sup>.

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<sup>7</sup> Bhatia et al. Resource and social mapping ...and beyond. Experiences in the maternal and infant survival project. CARE – MP (1999)

<sup>8</sup> Kumar S (2002). Methods for Community Participation. A complete guide for practitioners.

Table 2: Comparing the verbal and the visual<sup>9</sup>

| Comparing the verbal and visual                      | Verbal                        | Visual                               |
|--|-------------------------------|--------------------------------------|
| Investigator's mode and role                         | Probing investigator          | Facilitator and catalyst             |
| Local person's mode and role                         | Reactive respondent           | Creative analyst and presenter       |
| Aim  | Extraction of information     | Generating local analysis            |
| Local people's awareness of investigators            | High                          | Low                                  |
| Degree of eye contact                                | High                          | Low                                  |
| The medium and material chosen by                    | Investigators                 | Local people                         |
| Information flow                                     | Sequential                    | Cumulative                           |
| Accessibility and stability of information to others | Low and transient             | High and semi permanent              |
| Responsibility for cross checking with               | Appropriated by investigators | Local people and team members        |
| Ownership of information                             | Appropriated by investigators | Shared; can be owned by local people |

**Notes for the facilitator:** The group of participants should run this exercise; the resulting map is the map of the community, as the group perceives it. Use symbols indicating specific resources. The facilitator can make a legend. The recorder can take note of participant's comments as they progress through the activity.

**Step 3: Understand issues related to maternal and child health situation**

- Now to gather information after the mapping is over it would be useful to collect target groups for gathering information regarding the maternal and child health issues through a focus group discussion.
- You can do a social influence analysis to understand from the community which family member and/or community members are influences of these practices.

## Before conducting a Focus Group Discussion (FGD)

### Step 1: Conduct role analysis

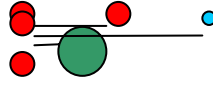
An example: Role analysis in the context of birth preparedness

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<sup>9</sup> Chambers R (1992). Rural appraisal: Rapid, Relaxed and Participatory. IDS Discussion Paper 311. IDS, Brighton, UK.


- E.g.: ask the group – “Who conducts the delivery in your community? Are there any more people involved? Is the mother-in-law involved? And who? Any one else?. Free list all the responses. Now ask – “Who is most and least involved in this process.” Ask the group – “ Is there a way to rank the people who are involved in the process in order of their contribution in the process.” They may come up with making circles, or putting stones/twigs, etc. The people who the group mentions are involved in the delivery process will form your target group for focused discussion.
- You will come up with an analysis as depicted in Table 3 if the group uses stones to define target groups.

Table 3: Role analysis on birth preparedness

| Aspect             | Involvement   | Target group  |
|--------------------|---|---|
| Birth Preparedness |  | Pregnant women in their third trimester of pregnancy          |
|                    |   | Mother-in-laws of women in their third trimester of pregnancy |
|                    |   | Husbands pregnant women in their third trimester of pregnancy |

Hence for birth preparedness pregnant women, mothers in law and Husbands would become your target group

Step 2: A probe list can be prepared to ask questions. One such list on newborn care is depicted in Annex 1.



Sometimes in a slum there are more than one ethnic/social groups. The perceptions and practices of any one segment cannot be generalized. Hence, it is important to interact with each segment separately. For this, it would be wise to work in small groups of people of different clusters so as to have better understanding of the situation and triangulate the information obtained from the above exercise especially when the basti has a very heterogeneous composition. This would help validate (and correct if required) information from small groups representing different mohallas (parts of the slum) in an efficient manner.

Example:

The huts/houses on the main streets, which are the ones that one often interacts with first are often the more well off families (more powerful, so better located) and not representative of the still poorer sections.

## During a Focus Group Discussion

**Team:** One facilitator and One Recorder

- Steps to follow for facilitating an effective and complete GD are given in Section V.
- Recorder should keep notes by topic and write down all participants' responses under the topic heading. Starting from the left of the facilitator and going clockwise around the room, the recorder can prepare a "socio-gram" for recording this information.

Notes for the facilitator:

- Intervene to reorient discussions that get off track and do not enrich the topic at hand
- Each participant should be encouraged to take an active part. Many people are hesitant to speak in public and are accustomed to a lecture format
- At the first few interactions with a large group, one witnesses a situation where the more vocal people express their opinion, while some remain quiet or are absent. It is vital to hear the voices of the quieter or absent sections to understand the varying extents of deprivation within the slum.
- Facilitators should encourage participation by:
  - Remembering that participants are adults who, regardless of their education and professional training, have rich life experiences that should be recognized and built on
  - Making it clear that participating in this learning process is a step toward creating more participatory relationships in the work and life of each participant
  - Emphasizing from the beginning that the training is designed to produce new ideas, approaches, and practices.
- TIPS on NONVERBAL COMMUNICATION

The following "SOLER" behaviours<sup>10</sup> tend to demonstrate the fact that you are listening. Use them as a "baseline" for monitoring your own behaviour:

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<sup>10</sup> Source: Egan, G(1990) the skilled helper(4<sup>th</sup> edn), Brooks/Cole Pacific Grove,CA

- Sitting squarely (relaxed, at ease and in no hurry)
  - Open position (openness to listening)
  - Leaning forward (express genuine interest)
  - Eye contact (attentiveness)
  - Relaxed and comfortable (adapted completely to the environment)
- At times the community may be hostile even when approached pleasantly due to previous unpleasant experiences with outsiders.

#### Lessons:

- In situations where the community is hostile, it is important to give a patient hearing to the basti people to vent their anguish; at times it may lead to emergence of issues that may be important for guiding the program and prioritizing interventions.
- In the group, if a person starts speaking on any subject, who is different from the subject matter being discussed, listen to his/her views patiently.
- Identify champions that could make a difference to the entire community and move it together as a unit rather than keep it fragmented.
- The enquiry should be concluded with a review of the discussion findings and confirmation of the same by the participants, to ensure accuracy of the obtained information. One method may be to record the names of the participant group on the chart/paper to indicate their participation.

Notes for the recorder: Recording information appropriately using a sociogram

Topic of discussion: Birth preparedness

Group Profile

Group: Pregnant women (6)

Age: 15-24

Occupation: Housewife

## Theme 1: Identifying and establishing contact with a trained birth attendant

| Person | Response |
|--------|----------|
| S1     |          |
| S2     |          |
| S3     |          |
| S4     |          |
| S5     |          |
| S6     |          |

### After conducting the FGD

Immediately after the session the facilitator and recorder should:

- A. Review the notes for clarity and understanding
- B. Compare and record observations about the group not readily clear from the notes
- C. Prepare a summary of the GD: free list the responses according to the themes and semi-quantity the responses<sup>11</sup>.

#### Step 4: Participatory planning

### What is participatory planning?

Participants of a community based participatory research give more than informed consent; they share their knowledge and experience in helping to identify key problems to be studied, formulate research questions in culturally sensitive ways and

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<sup>11</sup> Dobe M. Optimal Infant feeding in rural areas- the missing agenda for communication needs. Indian Journal of Public Health, 2002; 36(4): 145-50.

use study results to help support relevant program and policy development or social change<sup>12</sup>.

| Steps  | Themes   | Content  |
|--------|--|--|
| Step 1 | Interpreting visual representations and GD findings                                | The discussions followed by visual presentations would lead to a clear understanding of health resources and practices in the community to both the facilitator and the community people. Ask the community people to discuss the optimal practices related to child health and delineate their current practices as harmful and non-harmful   |
| Step 2 | Identifying priority issues  | <i>Facilitate the group to identify the practices most closely related to child survival</i>   |
| Step 3 | Prioritization of issues and interventions and identifying program specific issues | <p><i>Say-“Can you think of a good way to describe that which priority issue is the most important to you in order of magnitude beginning with the biggest. (They might end up sketching chapattis (or some thing similar) of diff sizes and so on; OR they might do something we do not even know as a method today)</i></p> <p>(Be patient: stimulated appropriately and patiently, communities identify appropriate objectives and are able to prioritize effectively)</p>  |
| Step 4 | Stimulate thinking:  | <p>Ask-“Do you feel the need for some effort and perhaps for collective action?”</p> <p>(Allow the participants to think, talk among themselves and patiently wait for them to respond.... appreciate their answer...If its No...may be they do not want to discuss these issues...probe on why they do not want to do so...you may repeat step 4 again...to understand which issues they feel are the priority issues...If they say yes...continue)</p> <p>Use live examples to stimulate people to think about issues when they are unable to progress further on a discussion e.g. narrate an incident of an obstetric complication from a nearby basti</p> <p>NOTE:</p> <p>Talking about death of a baby or any near one is a disturbing and difficult process for any individual. Consequently, people avoid discussion about the same. However a live example of a similar situation from another basti generates empathy and a feeling of “I am not alone” which may encourage them to think and discuss the issue.</p> |

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<sup>12</sup> Green L, Mercer S. Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities? Am J Public Health. 2001;91:1926-1929

|        |   |  |
|--------|---|--|
| Step 5 | Ascertaining community's role and determining program support | <p>Now discuss about each prioritized behaviour as in the example 1</p> <p>Facilitate communities (and families and individual) cultivate a sense of control over factors that impact shaping of their future. Help them see or sense the power they have over individual factors through experience</p> <p>Example 1: suppose the first issue the community prioritized is exclusive breast-feeding (EBF) till about six months (ideal behaviour)</p> <p>What can be done that allows mothers to practice EBF?<br/>(What messages be framed so that the community perceives the BENEFIT)</p> <p>Who to motivate? (Primary, secondary, tertiary audience)</p> <p>What channels and language to use?</p> <p>What activities to use to promote EBF?</p> <p>Do we need someone's help for this purpose? (Dividing roles and responsibilities)</p> <p><u>Lesson:</u> In Indore, the community people could identify their roles in motivating the community to avail existing services, make representation at Municipal Corporation for availing sanitation services etc. Concomitantly, they realized the need to have trained health volunteers equipped with information and selected material for providing counseling and curative services.</p> |
| Step 6 | Preparing an action plan                                      | <p>Prepare action plan on the basis of issues, which arose from the group discussion</p> <p>Prepare action plan according to the Basti structure.</p> <p>Remember present situation of the Service providers in the slum</p> <p>Prepare work plan on the basis of quality of service provider.</p> <p>Prepare action plan on the availability of the resources. e.g. Training of untrained Dais (birth attendants)</p>   |



# Section V

## Reporting, Analyzing, Summarizing

Reporting format for the community enquiry findings

| PARTICIPANT PROFILE  |  |
|--|--|
| TOTAL NUMBER OF PARTICIPANTS<br>IN THE ENTIRE PROCESS            |  |
| <b>Number of men</b>   |  |
| <b>Number of women</b>   |  |
| <b>Number of pregnant women</b>                                  |  |
| <b>Number of women with children less than<br/>1 year of age</b> |  |
| BACKGROUND INFORMATION   |  |
| <b>Name of Basti</b>   |  |
| <b>No. of Households</b>   |  |
| <b>Names of Different Caste / Groups</b>                         |  |
| <b>Occupation</b>  |  |
| <b>Electricity</b>   |  |
| <b>Water Facility</b>  |  |
| <b>Community/Individual sanitation facilities</b>                |  |
| <b>Disposal of Refuse</b>  |  |
| <b>Means of Communication</b>                                    |  |
| <b>Health Service Providers in the basti</b>                     |  |
| <b>Health Service Providers outside the basti</b>                |  |
| <b>Local leaders / CBO</b>                                       |  |

| KEY FINDINGS FROM COMMUNITY ENQUIRY ON SERVICE PROVIDERS |           |                 |            |
|--|-----------|-----------------|------------|
| Service Providers  |           |                 |            |
| Names of institutions/<br>providers                      | Antenatal | During Delivery | Post Natal |
| 1  |           |                 |            |
| 2  |           |                 |            |
| 3  |           |                 |            |

|  |           |                 |            |
|--|-----------|-----------------|------------|
| * In cases of delayed labor the private practitioners administer injections to induce labor. However, delivery is conducted at home for monetary reasons |           |                 |            |
| <b>Order of preference for health seeking</b>  |           |                 |            |
|  | Antenatal | During Delivery | Post Natal |
|  |           |                 |            |
|  |           |                 |            |
|  |           |                 |            |
| <b>Cost of Treatment</b>   |           |                 |            |
| 1.   |           |                 |            |
| 2.   |           |                 |            |
| 3.   |           |                 |            |

|  |                       |            |            |          |           |
|--|-----------------------|------------|------------|----------|-----------|
| <b>KEY FINDINGS ON BIRTH PREPAREDNESS, COMPLICATIONS, FAMILY ROLES AND PRACTICES</b> |                       |            |            |          |           |
| Issues   | At 3 months Pregnancy | 3-6 months | 6-9 months | Delivery | Postnatal |
| Preparedness   |                       |            |            |          |           |
| Complications  |                       |            |            |          |           |
| Co-operation (from family)   |                       |            |            |          |           |
| Practices  |                       |            |            |          |           |

|   |                                       |              |  |                |
|---|---------------------------------------|--------------|--|----------------|
| <b>Summarizing the findings: Barriers, Facilitators and Options</b> |                                       |              |  |                |
| <b>S.No.</b>  | <b>Issues</b>                         |              |  | <b>Options</b> |
| 1   | Family and Individual Level           | Facilitators |  |                |
|   |                                       | Barriers     |  |                |
| 2   | Infrastructure and Access to Services | Facilitators |  |                |
|   |                                       | Barriers     |  |                |

| Summarizing the findings: Barriers, Facilitators and Options |                    |              |  |
|--|--------------------|--------------|--|
| 3  | Social Environment | Facilitators |  |
|  |                    | Barriers     |  |
| 4  | Exclusion          |              |  |

# Section VI

## Suggestions and Tips for facilitators of PCHEP

### Are you a good facilitator?

- You need to be knowledgeable about the topic but need not be expert
- You need to be fluent in local language spoken by the participants and in which discussion should be conducted
- You need to be capable of establishing rapport with others
- Being a good listener and respect for others opinions<sup>13</sup> is important. You need to pay attention to nonverbal communication: “eyes can be very expressive.” Good Listening entails: not interrupting people, asking for clarification, asking questions and maintaining an open mind<sup>14</sup>
- Be at the communities level—respect and equality

### Factors affecting participation:

- The content or task of the group—is it of interest, importance and relevance?
- The physical atmosphere—is it comfortable physically, socially and psychologically?
- The psychological atmosphere—is it accepting, non threatening?
- Members personal preoccupations—are there any distracting thoughts on their minds?
- The level of interaction and discussions—is adequate information provided to everyone to understand? —Is it a level everyone understands?

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<sup>13</sup> Aubel J (1994). Guidelines for studies using the group interview technique. Training papers in population and family welfare education in the work setting Paper No. 2.

<sup>14</sup> Bhatia AK, Sarasua I and Agarwal S. Resource and Social Mapping and beyond. Experiences in the maternal and Infant Survival Project. CARE M.P. 1999.

- Familiarity between group members—do group members know each other from before?<sup>15</sup>
- The attitude, skill and preparedness of the facilitators.

## How to facilitate?

- Derive questions from answers.
- Do not suggest or recommend. Pose questions, encourage thinking and discussion—do not put ideas into peoples heads, draw them out.
- Do not escape discussion on issues of interest to the community even though they may not be pertinent to the project.
- In presence of a dominating participant do not lose focus of the other participants.
- Often community women (and even men) may take a few minutes in understanding a question or statement and not respond instantly or not respond at all. Continue to use nonverbal communication (eyes, smile) and wait (let people take time to think). Often this pause is vital and the response (after the pause of 3-7 min.) may be verbal or only nonverbal. Use whatever response to continue the communication.

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<sup>15</sup> A manual for participatory training methodology in development PRIA, 1995.

## Suggestions for facilitating a good FGD

### **Step 1: Start with an Introduction**

Give the Facilitator's and Observer's name.

### **Step 2: Give purpose of FGD**

We wish to learn from you what preparedness is made for birth in your community and your opinion on the same.

### **Step 3: Mention that there are no right and wrong answers**

We would just like to know about your opinions on this subject. There are no right or wrong answers to any of the questions. This is no test. We just want to learn from you.

### **Step 4: Give length of time the FGD would take**

The discussion would take about an hour.

### **Step 5: Inform them about talking to one another**

As we will be discussing about each of your experiences, it will be important that we do not talk at once because we will want to hear each other so we should not talk together. Every body should participate and every body will be given a chance to put forth their views. If you have any queries they would be addressed at the end.

### **Step 6: Explain note taking confidentiality**

Observer/reporter's will be writing down some of the things that we will be saying so we can remember later. Does anyone object? We are the only ones who will know your names, we will not use any names in our reports.

### **Step 7: Check understanding and clarify**

Do you all understand what I have said? Do you all have any questions?

It is important to have a male member in the facilitators group to attend to the queries of the curious men/boys and capture their interest. They may otherwise disrupt the enquiry and prevent women from participating.

### **Step 8: Participants introductions (Warm up)**

Please introduce yourselves and tell us the trimester of pregnancy you are in.

### **Step 9: Lets begin**

We would start by sharing what preparations each of you have made for delivery and newborn care. Follow the questions given in the FGD guidelines.

### **Step 10: Ensuring participation**

All participants should be involved in the process; if the group is too large then form subgroups to engage all the participants before or during the process of enquiry.

Lessons:

In a large group if sub groups are not formed promptly or equal attention is not provided to all participants then there is a tendency for the group to disperse or lose focus and engage in other discussions.

### **Step 11: Give a Summary**

Mention main themes discussed and participant's responses. Ask, is there anything else that we talked about that I forgot to mention?

### **Step 12: End with a Closure**

Thank you for your time. Do you have any questions that you would like to ask? I am not sure that I will be able to answer all of them, but I will try (Record all questions. Do not lecture).

# Section VII

## Using this guide for a TOT for facilitators for conducting a participatory community enquiry

Suggested Framework for Planning and Design of a PCHEP Workshop with focus on newborn care

- Program orientation for all participants to develop a common understanding of the Health Program (Day 1, 2 hours)
- Technical information on newborn care (technical area prioritized by the program partners for capacity building) to guide the community enquiry process (Day 1, 3 hours)
- Discussion on general principles of participation (Day 1, 2 hours)
- Introduction to participatory processes- mock exercise to practice and understand the basics of participation (Day 2)
- Field visit to apply participatory approaches for conducting community enquiry on newborn care for NGO participants and their respective CBOs (Days 3 and 4, Group 1; Days 6 and 7, Group 2)\*
- Reflections on the field visit and formulation of the action plans (Days 3, 4 and 5, Group 1; Days 6,7 and 8, Group 2)

\* After the program orientation session the participants can be divided into two groups for the field visits, reflection and action planning so that each group has no more than 6–8 members for efficient learning

# Post Script



## How this guide came about

A ten-day workshop on participatory community health enquiry was held in Indore with the NGO-CBO partners from March 20-30, 2003. The purpose of this workshop was to enhance the program partners' skills in conducting a participatory community enquiry with accurate triangulation and reporting of findings, outlining and documenting a process through which the community takes ownership of the program objectives and process, prioritizing interventions based on community needs and planning subsequent actions. This workshop was designed specifically for guiding the urban health program in the slums of Indore with its limited access and availability of health care facilities.

The team enjoyed this learning experience. This field guide is a documentation of the lessons learned during this ten-day workshop. It evolved from the experience of the participants and the community during the workshop. The processes and principles that emerged from this exercise and which are documented may be replicated/adapted by program planners/managers/implementers functioning in a similar scenario.

This guide is a result of insights of many people: Non-government Organizations and Community Based Organizations of Indore, Mr. Utpal Moitra, EHP colleagues Rajeev Nambiar, Sandeep Kumar, Tasneem Khorakiwala, Amit Bhanot and Shweta Suggestions from and comradeship of Mr. Kukreja, Sanjeev Upadhyaya, Anju Dadhwal, Praveen Jha, Mani Gupta, Gunika Dua and Pooja Sharma.

# Annex 1. Probes on newborn care for guiding the facilitator on conducting the participatory community health enquiry and planning

The table below provides the thematic areas for discussion on newborn care, the issues that need to be investigated/discussed within each item, i.e., the probes and the possible participatory method/s that can be employed to garner this information.

| Thematic areas  | Probes  | Tools to be used  |
|---|---|---|
| <p><i>Service Providers: their availability and quality of service provided</i></p> | <p>i. Identifying health facilities/ service providers in and around the area – both utilized and non utilized</p> <p>Who are the health service providers in and around your bastis?</p> <p>Are they all approached in case of illness/ medical emergency?</p> <p>ii. Identifying the types of services provided: antenatal, delivery, and post-natal care. Further, identifying what activities are performed for each of these and the need for such services.</p> <p>For what type of services are the providers approached? (Curative/Preventive)</p> <p>For each type of service what is the treatment advised or action taken by the provider?</p> | <p>Institutional mapping (a technique whereby the basti is sketched on the floor or paper using suitable material ie coloured pens, chalk or any locally available material)</p> <p>Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family who influence decisions on selecting service providers such as husband or mother in law may also be included in the group</p> <p>Matrix Ranking: For ranking service providers with respect to the quality of service on a 2 x 2 matrix</p> |

|  |   |   |
|--|---|---|
|  | <p>iii. Defining the quality of services</p> <p>How much time does it take to receive service once you reach the facility or provider?</p> <p>Do you have a fixed provider? Is there a particular reason for selecting him?</p> <p>What is the cost of seeking treatment?</p> <p>How would you describe the provider's behavior? Would you revisit him/her?</p> <p>iv. Analyzing accessibility of services:</p> <p>Who gets these services, who doesn't get them?</p> <p>What are the difficulties in receiving these services?</p> |   |
| Birth preparedness and contingency readiness   | <p>i. Identifying costs involved in home/ hospital delivery</p> <p>ii. Planning for resources</p> <p>What arrangement is made for transport, money and escort in case of emergency? Are these pre decided?</p> <p>Who is looked upon for help- family members/ relatives, neighbors or other community members?</p> <p>Do you have a health fund? If yes how does it operate?</p> <p>Do people approach moneylenders for monetary support? What interest rate do they charge?</p>   | Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family who influence decisions on cost of health services and arrangement of resources such as husband or mother in law are also included in the group |
| Preferences for place and provider of delivery | Influencing factors for determining the place of delivery   | Focus Group Discussion (FGD) with pregnant and lactating women. Members of the family   |

|                                       |   |   |
|---------------------------------------|---|---|
|                                       | <p>Following reasons can be investigated:</p> <p>a) Who does the delivery and what is their availability or location vis a vis the client?</p> <p>b) Quality of services – how long does it take to receive service ones you reach the health facility or the provider? How is the health staff's behavior; are they friendly and approachable? Etc.</p> <p>c) Preparations made by the family members. Preparations made by the providers (practice of 5 cleans of delivery – clean surface, clean hands, clean blade, clean cord and clean cord tie)</p> <p>d) Costs involved in availing the health services</p> | <p>who influence such decisions eg. husband or mother in law are also included in the group</p>   |
| Roles of family and community members | <p>i. Roles of family members/husband during pre natal, delivery and post natal care.</p> <p>ii. Roles of community during pre natal, delivery and post natal.</p>  | <p>Focus Group Discussion (FGD) with pregnant women, elderly ladies of the community, Trained/Traditional Birth Attendant and husbands of pregnant women.</p>   |
| Complications                         | <p>i. Discussing complications for mothers: pre natal, delivery and post natal</p> <p>ii. Types of complications of new born (In the first month of life)</p> <p>iii. For each: identifying causes, service provider most often contacted and reasons for this, costs involved etc</p>  | <p>Identify the complications, list them down using a Problem–Action-Analysis tool ie analyzing the pros and cons of the actions (the purpose is to understand how specific complications are handled in the community; which measures are beneficial and which are dangerous/ harmful)</p> <p>OR</p> <p>Seasonality: Chart of pregnancy,</p> |

|                  |   |  |
|------------------|---|--|
|                  |   | for every 3 months and possible complications  |
| Family practices | <p>i. Understanding practices followed by the pregnant mother: pre natal, during delivery and post delivery [Practices related to work pattern (breast feeding especially post delivery), food habits, rituals followed]</p> <p>ii. Practices with the new born: colostrum and breast feeding, providing warmth, attending to the new born, rituals followed. Family practices during sickness, gender preferences etc.</p> | <p>Seasonality with 9 month chart and an additional 3 month to identify post delivery</p> <p>x</p> <p>For each month, food habits, work pattern, rest and support</p> <p>Focus Group Discussion (FGD) with pregnant and mother's of newborns. Members of the family who have a role in these activities are also included in the group</p> |

## Annex 2. Probes on understanding hygiene and sanitation related behaviors

The table below provides the thematic areas for discussion on hygiene and sanitation related behaviors and the issues that need to be investigated/discussed within each theme. This section aims to provide probes for facilitation on health issues beyond newborn care for ease of the user in applying participatory approaches for gaining insight other health issues such as hygiene and sanitation

| Thematic areas                | Probes   |
|-------------------------------|--|
| <b>Safe disposal of feces</b> | <ul style="list-style-type: none"> <li>• What is the most common place of defecation in the basti for adults? (private toilet, public toilet, open air)</li> <li>• Where do children defecate (probe: in households having toilets, in households not having toilets)?</li> <li>• What do people do with feces of children who do not use toilets (probe: how long does the feces lie in the surroundings, where do they dispose the feces)?</li> <li>• Are there any public toilets?</li> <li>• Are they being used? By how many households? Why not( probe; mechanism for maintenance in place)?</li> <li>• Do any households have private or shared toilet facilities? Many, just a few or none?</li> <li>• What would be the preference for sanitation facilities in the basti/household?</li> </ul> |

|   |  |
|---|--|
| <p><b>Safeguarding household drinking water from fecal contamination and treatment before use</b></p> | <p>Source of drinking water</p> <ul style="list-style-type: none"> <li>• What are the basti's sources of drinking water?</li> <li>• Is this the same source as water for other uses (bathing, washing clothes)?</li> <li>• If not, what other sources are there?</li> <li>• Is the water supply adequate for drinking and other purposes?</li> <li>• If not, what is the water primarily used for?</li> </ul> <p>Safeguarding water from contamination</p> <ul style="list-style-type: none"> <li>• What kind of water do people consider good to drink?</li> <li>• What do people think makes water dirty or unfit to drink?</li> <li>• Can drinking water make you sick?</li> <li>• Do you know of any illnesses that come from drinking water?</li> <li>• How do people store drinking water in the household? Describe or show containers (<i>probe: use of narrow neck containers etc</i>).</li> <li>• How do you take out drinking water from the container (<i>probe: long handle container, not dipping fingers etc</i>)</li> <li>• Do children have access to household drinking water (<i>probe: is containers kept at an elevated surface and covered</i>)?</li> <li>• If not, how do they get their drinking water?</li> <li>• Do people separate drinking water from water for other uses?</li> </ul> <p>Treating drinking water</p> <ul style="list-style-type: none"> <li>• Do households use any methods to treat water before drinking? What are they?</li> <li>• What methods do you know about to treat household drinking water to make it safe to drink?</li> <li>• Does anyone use chlorination/filtering to treat water?</li> </ul> |
|---|--|

|  |   |
|--|---|
| <p><b>Wash hands with soap at critical times using correct technique</b></p> | <ul style="list-style-type: none"> <li>• Do people consider it important to wash hands? Why or why not?</li> <li>• What do people in the basti use to wash hands? Water? Soap?</li> <li>• How many people use soap to wash hands? All, many, some, a few?</li> <li>• Is soap available and affordable? To all or just a few?</li> <li>• When do people wash hands [probe: after contact with feces (after defecating, disposing off child's feces, washing child's bottom), before contact with food (before preparing food, before serving food, before feeding, before eating)]?</li> <li>• Where do people wash their hands in the household?</li> <li>• Is there a special place for hand washing? Is soap and water kept there?</li> </ul> |
| <p><b>Protect food from flies, dirt and spoilage</b></p>                     | <ul style="list-style-type: none"> <li>• How is food stored in basti homes?</li> <li>• Do people cover their food?</li> <li>• Do you protect your food in other ways? What ways?</li> <li>• How do you handle uncooked and cooked food (<i>probe: washing of fruits before eating, washing vegetables before cooking, serving with clean spoons, ladles etc</i>)</li> </ul>   |
| <p><b>Some related questions</b></p>   | <ul style="list-style-type: none"> <li>• Do small children get diarrhea often? How often? Once a week, once a month, less, more? More prevalent in any particular months?</li> <li>• What do people in the basti think causes diarrhea?</li> <li>• What do most people do when their child has diarrhea?</li> <li>• Do you know of any ways to prevent diarrhea?</li> <li>• Are there any schools in the basti?</li> <li>• Do the schools have water? Toilets?</li> <li>• What do you do with your garbage?</li> <li>• Where do you go for advice about staying healthy?</li> <li>• Where do you go to seek care when a child has diarrhea?</li> </ul>  |

# Annex 3: Sample Report of PCHEP Process (Professors' Colony in Indore)

| <b>PARTICIPANT PROFILE</b>                               |  |
|--|--|
| TOTAL NUMBER OF PARTICIPANTS<br>IN THE ENTIRE PROCESS    |  |
| Number of men  |  |
| Number of women  |  |
| Number of pregnant women                                 |  |
| Number of women with children less than<br>1 year of age |  |
| <b>BACKGROUND INFORMATION</b>                            |  |
| Name of Basti  | Professor Colony   |
| No. of Households  | 350  |
| Names of Different Caste / Groups                        | Nimad (SC and ST)  |
| Occupation   | Domestic help (mainly women), daily wage labourers, snake charming, body piercing, rag picking |
| Electricity  | Available in some areas  |
| Water Facility   | Two sources of water (irregular supply)  |
| Community/Individual sanitation facilities               | Absent   |
| Disposal of Refuse                                       | Dumping behind the house and no further process is available.                                  |
| Means of Communication                                   |  |
| Health Service Providers in the basti                    | 2 Dai (Untrained), ANM visits the Basti.   |
| Health Service Providers outside the basti               | Private and public   |
| Local leaders / CBO                                      | Vaishnavi SHG  |

| <b>KEY FINDINGS FROM COMMUNITY ENQUIRY ON SERVICE PROVIDERS</b>   |  |  |            |
|---|--|--|------------|
| Service Providers   |  |  |            |
|   | Antenatal  | During Delivery  | Post Natal |
| Choithram Hospital  |  |  |            |
| M.Y.hospital  |  |  |            |
| G.P.O. Urban Clinic   |  |  |            |
| Sindhi Colony P.H.C.  |  |  |            |
| Private Doctors   |  |  |            |
| Dr. (Mrs.) Saluja   | Yes  | Yes*   | Yes        |
| Dr. Satwani   | Yes  | No   | Yes        |
| Dr. Geeta Sharma  | Yes  | No   | Yes        |
| AWC   | -  | -  | -          |
| ANM   | Yes  | No   | Yes        |
| Dai   | Yes  | Yes  | No         |
| <i>* In cases of delayed labor the private practitioners administer injections to induce labor. However, delivery is conducted at home for monetary reasons</i> |  |  |            |
| <b>Order of preference for health seeking</b>   |  |  |            |
|   | Antenatal  | During Delivery  | Post Natal |
| Private practitioners   | Yes  | <b>Yes</b>   | Yes        |
| Sindhi Colony P.H.C.  | Yes  | -  | Yes        |
| Dai   | Yes  | Yes  | -          |
| ANM   | Yes  | -  | Yes        |
| MY hospital   | -  | -  | Yes        |
| <b>Cost of Treatment</b>  |  |  |            |
| 1. Sindhi Colony PHC  | Rs 5/- for registration receipt                          | -  | -          |
| 2. Dai  | -  | As per the choice of the family from Rs50/- to Rs100/-                         | -          |
| 3. Private practitioners  | Rs 30/- to Rs 100/- (varying with the type of treatment) | Only introduce injection before delivery Rs15/- each visit + injection charges | -          |

## FINDINGS ON BIRTH PREPAREDNESS, COMPLICATIONS, FAMILY ROLES AND PRACTICES

| Issues                | At 3 months Pregnancy         | 3-6 months  | 6-9 months              | Delivery  | Postnatal   |
|-----------------------|-------------------------------|---|-------------------------|---|---|
| Preparedness          | Nil                           | TT, IFA   | TT, IFA                 | <ul style="list-style-type: none"> <li>• Information to dai</li> <li>• Clothes for baby</li> <li>• Hot water</li> <li>• New Blade</li> <li>• Colored thread</li> </ul>  | Mother nutrition  |
| Complications         | Vomiting, Weakness, Giddiness | -   | Swelling of extremities | Malpresentation, lethargy, inability to cry, jaundice   |   |
| Support (from family) | -                             | Husband arranges for food, may help in household chores | -                       | Relatives, neighbors (female) and male members of the family  | Mother-in-law / mother  |
| Practices             | Routine                       | Routine   | Routine                 | <ul style="list-style-type: none"> <li>• Kadha to mother</li> <li>• New blade for cutting cord</li> <li>• Coloured thread as cord tie</li> <li>• House floor layered with cowdung paste</li> <li>• Dai contacted at time of delivery</li> <li>• Financial assistance from moneylenders at time of emergency (interest rate of 10-25% )</li> </ul> | <ul style="list-style-type: none"> <li>• If baby not weeping burn the placenta</li> <li>• <i>Gud</i> water to baby</li> <li>• Baby bathed immediately</li> <li>• No breast feeding up to three days</li> <li>• Colostrum discarded continuously for 3 days</li> <li>• Haldi and oil, applied on cord for early healing</li> </ul> |

## **ANALYSIS OF FINDINGS (Barrier and Facilitators)**

### **BARRIERS**

- Low literacy levels compounded by low awareness levels.
- Traditional taboos and beliefs eg. One tribal community in the basti considered immunization to be culturally unacceptable and of no value.
- Untrained Dais-Non usage of sterile thread for tying the cord and non practice of other delivery cleans other delivery cleans.
- Presence of money lenders which prevents people from making advance savings for possible complications.
- Proximity of the untrained Dai, which prevents the people to seek delivery care outside the community.
- Alcoholism emerges as a major barrier to optimal practices due to lower confidence level of women.
- Diversity of the community may lead to discrimination of certain segments and consequent inequity

### **OPTIONS**

A range of options exists to address the above barriers and some of them are discussed here.

Training of identified TBAs on:

- appropriate delivery and newborn care practices as she is the first contact;
- early identification of danger signs of mother and newborn and appropriate action and
- counseling skills ( if they could be enrolled as health volunteers )

Encourage dais to improve quality of services by

- adopting appropriate hygiene (eg. provision of DDK if possible)
- initiating the process of timely contact so that she can provide effective counseling

Evolving mechanisms to develop sustainable health funds and self help groups.

Develop clear understanding of beliefs and taboos and distinguish these as harmful, beneficial and neutral.

### **FACILITATORS**

- Presence of qualified medical practitioners in the vicinity of the basti and peoples faith among the same for receiving health services.
- Communities linkage with the providers to the extent that they adapt to the communities expectations for example, in situations of delayed labor at least two providers administer an injection to induce labor and let the delivery be conducted at home .
- Monthly visits by the ANM which may be modifiable (frequency, timing and appropriate locations within the basti) to suit the requirement of the basti members

- Presence of less utilized civil dispensary, stone throw distance away
- Willingness to spend on health services.
- Keenness to be more informed about practices and government provisions.
- Presence of some supportive husbands who may become role models for the others.
- Ability of community members to identify complications during pregnancy and of the newborn.

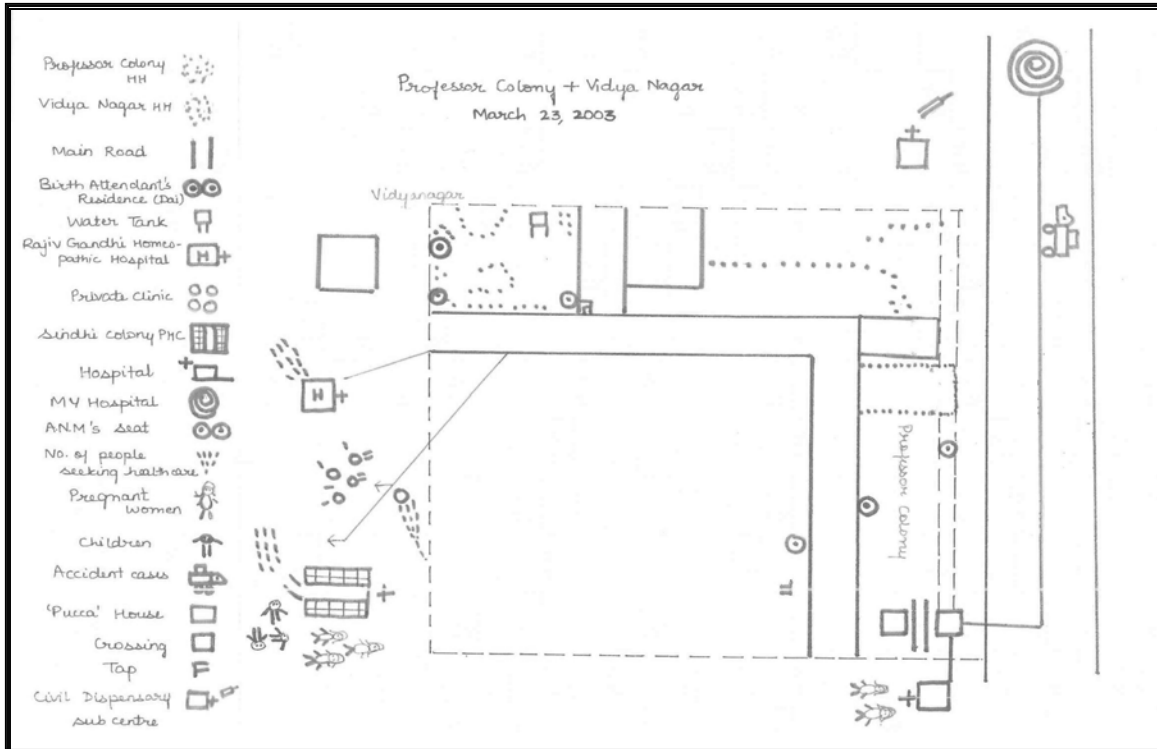
#### **OPTIONS**

- Utilization of the relationship with the private providers and the community to improve health related practices eg. they can be motivated to counsel mother/families on particular behaviors.
- Assess most appropriate and effective time and mechanisms ( eg. 1 hour each in 3-4 clusters) for improving service coverage by the ANM and capacity building of ANM eg. through provision of material to provide complete ANC.
- Exploring non utilized service providers (eg Civil dispensary located at Holkar Science college), sensitizing them to basti needs and providing adequate stimulation.
- Identify efficacious male members who can adopt behaviors pertaining to care of pregnant women and newborn; thereby become role models for the basti men.
- Identifying motivated individuals and training them on health and development related government schemes (eg. vidhwa pension yojna, balika samridhi and matritva yojna) and provisions. Similar trainings to the same or different set of volunteers on health practices and issues.

# Annex 4: Sample Action Plan for April-June, 2003 (Professors' Colony in Indore)

- A. To understand the basti, to know about all the Class/cluster (Mohalla) of the slum.
  - 1. According to different cluster and class conduct small group meetings and prepare one or multiple map
  - 2. Conduct continuous meetings in the slum to develop confidence of the community
- B. With the help of Basti CBO promote healthy practices (behaviours)
  - 1. With the help of basti people, identify volunteers
  - 2. Identified volunteers will be selected by Women's Group on the basis of the Mohalla/Class/ability & credibility in the community
  - 3. Motivate people to form new groups
  - 4. Identify pregnant women and child bearing mothers with the help of volunteers
  - 5. Organize meetings with CBO /Volunteers and Health service providers
  - 6. Make efforts with CBO, volunteers and health service providers for regular health check-up and complete immunization for pregnant women and children
  - 7. Counselling for pregnant women and child-bearing mothers
- C. Training
  - 1. Provide training to CBO and volunteers according to health, Government policies and our objectives
  - 2. Training for untrained Dais (birth attendants)
- D. Cleanliness & Hygiene
  - 1. Prepare map with 2- 3 options with the community participation for toilet construction and will be submitted to the related Officer of the Municipal Corporation

2. Identify and implement the ideas/ inner feelings of the people about cleanliness and hygiene.



Map depicting health service providers for the slum dwellers of Professors' colony



# Annex 5: Different methods adopted in Participatory Community Enquiry

## Participatory Learning Methods<sup>16</sup>

It is a systematic, semi-structured approach of understanding community situations with the participation of the people and through the eyes of the people. It gives the researcher a clue to the way people think. It is an appraisal of what people truthfully feel and opine. Being qualitative, rapid and participatory in nature it gives people choices and leaves decision making to them. The mode used is friendly inquiry and not lecture mode.

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<sup>16</sup> Chambers R, Joseph S, Humbert B and Mascarenhas J. A workshop on participatory learning methods. Myrada, Talavadi Project, Bangalore (Karnataka) 1990.

Table 1: PRA methods for sensitizing and mobilizing the communities<sup>17</sup>

| Methods            | Description   | Potential uses in Nutrition Situation Assessment   |
|--------------------|---|--|
| Community Mapping  | Community members draw a map of their community, including geographical features and other resources  | Ice breaker<br>Identifying community resources   |
| Seasonal calendars | Identifies activities, problems and opportunities taking place throughout the year; shows how things change throughout the year   | Household food security<br>Food prices<br>Work patens water availability<br>Disease patterns   |
| Venn diagrams      | A social (organizational) data gathering tool shows how institutions in the community are linked using circles and a map  | Identifying potential organizations and structures that can be involved in solutions to priority problems  |
| Three pile sorting | Pictures are sorted into categories such as good (beneficial), neutral and bad (harmful) practices; facilitated discussions of reasons why and how to move from harmful to positive practicing/categories | Categorized foods<br>Categorized practices<br>Identifying ways to move forward from bad to neutral to positive practices or situations<br>Identifying locally feasible solutions to problems |
| Pocket Voting      | Simple method for collecting opinions on problems, causes and solutions   | Causes of malnutrition<br>Health problems<br>Priorities in the community   |
| Transect Walks     | They are observatory walks or treks across any given area.  | Transects help outsiders see at a close range several items of interest and relevance which they would otherwise miss.   |

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<sup>17</sup> Developing an Integrated Nutrition Program through Assessment, analysis and Action: A trainer's guide. The university Cape and the Academy for Educational Development (AED), 1998 (draft)

|                        |  |  |
|------------------------|--|--|
| Matrix Sorting         | Method of ranking alternatives according to community determinant criteria; useful in process of building consensus to move forward  | Prioritizing actions and solutions   |
| Story with a gap       | Before and after scenes are given and community members are asked how to move before to the after; a pre-planning tool   | Hygiene conditions/ behaviours<br>Sanitation conditions/ behaviours<br>Feeding behaviours  |
| Community Action Plan  | A plan developed with/by the community   | Defines the way forward  |
| Focus Group Discussion | A Group of 8-12 people participating in a guided discussion on a given issue/ for a period of 1 – 1 1/2 hour in room or closed area.<br><br>Participants are homogenous in nature, in terms of age, sex, or positions held in the family | Understanding the beliefs and perceptions behind the practices in a short duration of time |



# Glossary

|                                    |   |
|------------------------------------|---|
| ANM (Auxiliary Nurse Midwife)      | She is trained nurse involved in provision of primary health care services such as immunization, counselling on pregnancy and infant care, contraception etc. through facility based as well as out reach activities  |
| AWC (Anganwadi center )            | It is the focal point for delivery of services under the national program of Integrated Child Development Services Scheme. Services include behaviour change activities targeted at pregnant and lactating women, non formal education for children up to 6 years, distribution of food supplements etc |
| CBO (Community Based Organization) | It is a group of 5-6 members of a slum community with common values of slum improvement. They have focussed activities towards identified objectives generated from the need of the community   |
| DDK (Disposable Delivery Kit)      | The kit consists of essential materials required to conduct a delivery such as soap, new blade, sterilized thread, gauze to ensure practice of delivery cleans  |
| EBF (Exclusive Breast Feeding)     | The practice of providing only breast milk to the infant till completion of 6 months of age   |
| Municipal ward                     | Smallest unit of administration under the municipal corporation of the city   |
| Quack doctors                      | Unqualified providers of health services, claiming to be medical professionals  |
| Sociogram                          | A technique of recording information of a group discussion where each member is designated an initial and information provided by him/her is noted against it   |
| TBA (Traditional Birth Attendant)  | A women from the slum skilled in conducting deliveries though may not have received certified training to do so   |

TOT (Training of Trainers)

Process of training identified resource persons who would further conduct trainings for front line workers for skill enhancement and information dissemination