Formative Research

A guide to support the collection and analysis of qualitative data for integrated maternal and child nutrition program planning

care

CARE is a humanitarian organization leading the fight against global poverty. CARE places special focus on working alongside women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. As part of its mission, CARE works with survivors of war and natural disasters to help people rebuild their lives.

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Forward

This guide will provide anyone with the basic information and tools they need to conduct and analyze qualitative research. It will be most useful for people who are planning programs to improve maternal and infant and young child nutrition combined with programming around improved household food security. Formative research teams should include members with experience with nutrition programming, research, and social and behavior change. Prior experience with qualitative research is not required or assumed.

Although the methods reviewed in this guide are focused on infant and young child feeding (IYCF), maternal nutrition, and food security, they can be applied to numerous topics. Research should be planned carefully to collect only essential data.

This guide focuses on qualitative methods. Many nutrition projects conduct qualitative research to develop more effective programming. Qualitative methods are particularly suited to asking *why*, *how,* and *under what circumstance things* occur and thus, can help identify underlying reasons for behaviors. Additionally, qualitative research can be key in explaining the results of findings from quantitative surveys.

This guide has been purposefully kept brief so not to be overwhelming. The format of this toolkit lends itself to being flexible. The activities can be used individually or in conjunction with other activities. Each activity is contained in its own module and each of the modules contains an overview of the activity being discussed, step-by-step instructions on how to collect data using the activity, and instructions on how to do basic qualitative data analysis.

The goals of the guide are to:

- Define the key problems in maternal and child nutrition and feeding practices and local food insecurity
- Provide an introduction to conducting formative research
- Familiarize users with qualitative methods
- Offer step-by step instructions on how to plan, conduct, and analyze formative research
- Complement other qualitative formative research guides that exist.

The following resources were reviewed when designing this guide. Repeat of information contained in the reviewed guides has been kept to a minimum.

1. *Analyzing Qualitative Data.* Ellen Taylor-Powell and Marcus Renner (2003). University of Wisconsin-Extension, Cooperative Extension, Madison, Wisconsin. This resource can be downloaded free of charge at: http://learningstore.uwex.edu/pdf/G3658-12.pdf
2. *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development. This resource can be downloaded free of charge at: http://www.globalhealthcommunication.org/tools/58/
3. *Formative Research: Skills and Practice for Infant and Young Child Feeding and Maternal Nutrition* by AED/ LINKAGES India. (2003). This publication can be downloaded free of charge from http://www.linkagesproject.org/media/publications/Training Modules/Formative_Research_Module_2-23-04.pdf
4. *How to Conduct a Food Security Assessment.* (2006, 2ND Ed.). International Federation of Red Cross and Red Crescent Societies, Geneva. This publication can be downloaded from www.ifrc.org

5. *Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health & Social Analysis Action*. (2007). Barton, T., Rubardt, M., Reilly, J. Cooperative for Assistance and Relief Everywhere, Inc. (CARE). This publication can be downloaded from www.care.org/reprohealth
6. *Methodological Guide: Participatory Appraisal of Nutrition and Household Food Security Situations and Planning of Interventions from a Livelihoods Perspective.* (2003). Karel Callens, K., & Bernd S., FAO. This resources can be downloaded free of charge at: http://www.fao.org/docrep/006/ad694e/ad694e00.htm
7. *Qualitative Research Methods: A Data Collector's Field Guide*. (2005). Natasha Mack, Cynthia Woodsong, Kathleen M. MacQueen, Greg Guest, & Emily Namey. Research Triangle Park, NC: Family Health International. This publication can be ordered from publications@fhi.org
8. *Qualitative Methods in Public Health: A Field Guide for Applied Research* (2004).Priscilla R. Ulin, Elizabeth T. Robinson, Elizabeth E. Tolley. John Wiley & Sons.
9. *The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011). This resource can be downloaded free of charge at: www.iycn.org
10. *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance. This publication can be downloaded from www.aidsalliance.org
11. *Training in Qualitative Research Methods: Building the Capacity of PVO, NGO, and MOH Partners;* and *Qualitative Research Methods: A Data Collector's Field Guide.* Adapted by: The CORE Group Social and Behavior Change (SBC) Working Group This publication can be downloaded at: http://www.coregroup.org/storage/documents/Workingpapers/qrm_complete.pdf

References to these resources are made in the footnotes where applicable.

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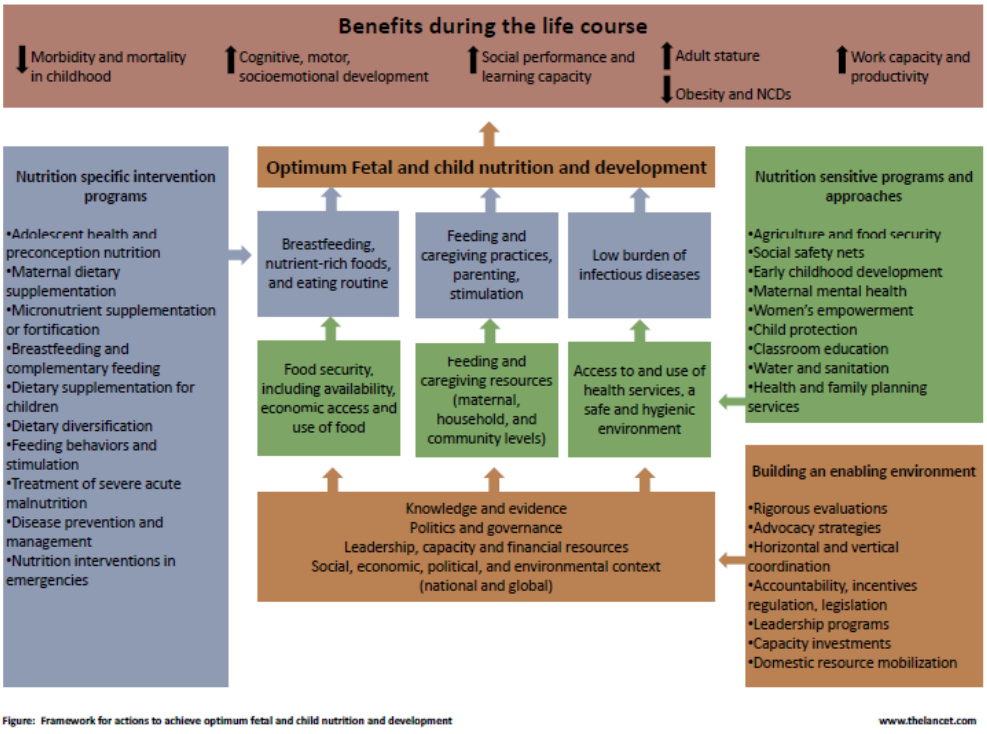
INTRODUCTION: MATERNAL & CHILD NUTRITION

Maternal and child nutrition during the first 1,000 days – from conception through the age of two – shapes a child's future. Women's nutrient needs increase during pregnancy and lactation. Some of the increased nutrient requirements protect maternal health while others affect birth outcome and infant health. If the requirements are not met, the consequences can be serious for women and their infants. With adequate nourishment in the earliest years of life, children have an opportunity to grow, learn, become productive adults and break the cycle of poverty. That is why it is critical to act early, before a child suffers irreversible damage from malnutrition. Many lives can be saved through low-cost measures to improve nutrition early in life. Interventions that begin during pregnancy and continue through a child's second year show the greatest potential for preventing the devastating effects of malnutrition.[1]

The framework in Figure 1[2] was developed for the 2013 *Lancet* series on maternal and child nutrition. It outlines the dietary, behavioral, and health determinants of optimum nutrition, growth, and development, and how they are affected by underlying food security, caregiving resources, and environmental conditions, which are in turn shaped by economic and social conditions, national and global contexts, capacity, resources, and governance.

Figure 1. Framework for actions to achieve optimum fetal and child nutrition and development[3]



[1] Bhutta, et al. (2008). What works? Interventions for Maternal and Child Undernutrition and Survival. *The Lancet.*
[2] Black RE, Victora CG, Walker SP, and the Maternal and Child Nutrition Study Group. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet.*
[3] Source: Maternal and Child Nutrition, Executive Summary of *The Lancet* Maternal and Child Nutrition Series, p. 2. This summary can be downloaded free of charge at: http://www.thelancet.com/series/maternal-and-child-nutrition

Key cultural factors that impact maternal and child nutrition

Not highlighted on the *Lancet* framework, but important to consider when developing maternal and child nutrition programming is the role culture plays on food and feeding practices. Culture may be defined as the set of rules and norms that are used to guide behavior or a group of people.[4] Every cultural setting maintains multiple concepts about how foods, including breastmilk, should be categorized. [5] These systems of categorization, in turn, are commonly invoked when making decisions about food selection, preparation, serving, and consumption.

Infant and young child feeding practices are thought to be highly culturally scripted (e.g., Blurton Jones, 1986; Sellen & Smay, 2001) such as when nonhuman milks and other liquids should be provided, when animal-source foods should be provided, when solid foods should be introduced and what food pregnant and lactating women should and should not eat. When women grow up in rural subsistence communities where breastfeeding is practiced in the open and has no stigma attached to it, and where birth rates are high, a young girl or woman will have observed thousands of hours of child care in action. This process of observation may lead to the formation of cultural models of infant feeding that can affect behavior."[6] In regards to maternal nutrition, cultural rules and systems relating to food selection, allocation, and consumption commonly take the form of foods that are to be avoided or preferentially consumed by all or by segments of a cultural group (i.e., pregnant and/or lactating women). Thus, culturally, specific maternal and child feeding models should not be overlooked during the formative research phase because they may form the basis from which deviations in practices might be occurring.

In any given community there are various ways of understanding and negotiating the meanings of nutrition and health and the values that are deeply connected with them. These systems often remain hidden unless one specifically examines what it means to be healthy, what it means to be ill, and how people approach health and illness. Formative research can help build interventions from the vantage point of cultural members, highlighting their voices through the expression of problems, the prioritization of problems, and the development of solutions. The emphasis is on creating opportunities for dialogue that bring out meanings of heath and illness articulated through the voices of cultural communities otherwise marginalized and silenced and then developing programs that incorporate culturally adapted approaches.

Constraints to Improving maternal and child feeding practices and household food security

The many constraints or issues that reduce the likelihood of families adopting better maternal and child feeding behaviors can vary tremendously according to culture, geography, social, economic, and other family and community factors, there are some common issues that arise regardless of the context. Constraints can be classified as environmental or attitudinal constraints (Griffiths, 1993). Environmental factors include the unavailability or seasonal variation in the availability of certain foods, the need to work outside the home, a scarcity of cooking fuel, or misinformation about child feeding given by health care professionals. Attitudes that prevent improvements in child feeding (in particular) are numerous. They will vary by culture, but certain issues are common:

- Perceived insufficient quantity or quality of breast milk
- Perceived inability of child to swallow or digest particular foods/preparations
- Lack of maternal self-confidence or feelings of powerlessness in the face of resistance from the child
- Perception of time constraints for food preparation and feeding

[4] Gittelsohn, J. & Vastine, A. (2003). Social cultural and household factors impacting on the select allocation and consumption of animal source foods: Cultural knowledge and application. *The Journal of Nutrition*.
[5] Gittelsohn, J. & Vastine, A. (2003). Social cultural and household factors impacting on the select allocation and consumption of animal source foods: Cultural knowledge and application. *The Journal of Nutrition*.
[6] Hadley, Patil, C.L., Gulas, C. (2010). Social Learning and Infant and Young Child Feeding Practices Testing Hypotheses about the Transmission of Child Feeding Information in Tanzania. *Current Anthropology*,

- Increase frequency of breastfeeding and decrease other foods and liquids for infants under six months
- Traditional rules for food distribution within the family
- Fear of spoiling the child with too much food or special foods.[7]
- Maternal undereating to prevent the child growing too large in utero and fear of obstructed delivery
- Food taboos for pregnant and lactating women and children under two

Food taboos, preferences and consumption patterns have an impact on the nutritional status and frequently have a gender dimension. These factors should be addressed if they hinder healthy dietary practices (e.g. the tendency of women to eat smaller portions than other household members in some countries).

Furthermore, as seen on the framework from the *Lancet* series, IYCF and maternal nutrition practices are affected by household food security/access to food. Households are food secure when they have year-round access to the amount and variety of safe foods their members need to lead active and healthy lives.[8] Complex relationships between agriculture, food, gender norms, and livelihood impact food and nutrition security, particularly of women and children.[9] [10]

Also, many of the constraints to improving child feeding practices arise from inadequate attention to the needs and roles of women, resulting in inadequate care for pregnant and lactating women, lack of education, poor self-confidence, low economic status and a work load that allows little time for modifying practices to improve nutrition. To be effective, programs to improve child feeding may have to address a range of factors affecting the caregiving environment and dynamics of the household."[11]

In summary, maternal and child nutrition are complex issues. Completing a comprehensive situational analysis and formative research are critical for program planning and implementation. Success in programming depends on overcoming the many barriers that lead to poor nutritional outcomes, with the most vulnerable people (women and children) facing the most challenges.

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[7] Designing by Dialogue, p. 2.9 – 2.10
[8] World Food Summit, 1996
[9] Hoddinott, J. (2011). *Agriculture ,health and nutrition: Toward conceptualizing linkages.* 2020 Conference Brief, IFPRI, Washington, DC.
[10] Meinzen-Dick, R., Behrman, J., et al. (2011). *Gender: A key dimension linking agriculture programs to improved nutrition and health.* 2010 Conference Brief, IFPRI, Washington, DC.

[11] Designing by Dialogue, p. 2.3

Additional information on Items to consider during the initial literature review and common perceived problems and key beliefs and attitudes related to IYCF maternal nutrition and food security can be found in Appendix 1 and 2. This information should be reviewed before starting formative research.

FORMATIVE RESEARCH: AN OVERVIEW

Formative research is a critical activity in the process of developing program strategies, especially those involving approaches to change behavior to prevent malnutrition.

"Formative research looks at the community in which an organization is implementing or plans to implement program activities, and helps the organization to understand the interests, characteristics, and needs of different populations and groups in their community. Formative research is research that occurs before a program is designed and implemented, or while a program is being implemented to help "form" or modify a program. Formative research should be an integral part of developing programs or adapting programs, and should be used to help refine and improve program activities."[12]

Formative research can provide insight on: what motivates or inhibits the optimal practice of the most critical (or least practiced) behaviors in households; perceptions about these practices; and possible ways to facilitate new or improve current practices.[13]

Formative research is a general term describing investigations conducted for program design and planning. Methods may be quantitative or qualitative; those described in this manual are mostly qualitative.

Formative research can help to:

- Narrow and describe the target population
- Select a specific behavior for the target population to change
- Identify the factors which influence the target population's behavior
- Develop activities for the intervention.

Formative Research and its role in planning Social and Behavioral Change Communication and Activities

Formative research is one of the most important elements of facilitating the design of programs and services. It can help refine messages to be more effective for change and generally leads to more effective social and behavior change communication and activities[14] by ensuring that communications and activities are targeted, tailored, feasible and acceptable to the local population.

[12] Quote from: *Formative Research: Skills and Practice for Infant and Young Child Feeding in Maternal Nutrition* (LINKAGES), p. 4.

[13] *The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011).

[14] Social behavior change communication and activities is a set of planned set of messages and activities that aim to foster positive behaviors; encourage sustainable individual, community and societal changes in behavior; and maintain optimal behaviors.

Qualitative and quantitative formative research data can be collected on a wide range of topics including knowledge and awareness, skill level, demand for products and services, perception of service delivery, current practices, attitudes, perceived social norms and power relationships, self-efficacy, and self-esteem.

Key to effective social and behavior change messages, materials and activities is knowing exactly who your target and influencing audiences are and looking at everything from their point of view.

One of the biggest mistakes made when formulating a SBC strategy is that staff will hypothesize why their target audience behaves the way they do instead of verifying the target audiences' beliefs, attitudes, intentions and behaviors through research. **DON'T GUESS!!!** Base decisions on evidence, not conjecture, and keep checking.

The difference between quantitative and qualitative research

In the next sections the general differences in quantitative and qualitative research will be discussed along with how these methods differ in terms of questions they can address, tools and sampling.

Qualitative research

Qualitative research draws out the deeper motivations of participants through conversation. It is used to better understand an issue from the perspective of the local population. It is especially effective in examining complex relations between (1) personal and social meanings, (2) individual and cultural practices, and (3) the material environment or context. Additionally, it provides insight into the often contradictory behaviors, beliefs, opinions, emotions, and relationships of individuals and can be effective at identifying factors such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research issue may not be readily apparent.[15]

The strength of qualitative research lies in its ability to provide descriptions of *how* and *why* people believe the things they do and *why* they behave the way they do. When planning health programming it is critical to understand people's reasons for behaving the way they do.

That is why conducting qualitative research is important for health programming. It can help people get in touch with deeper motivations, help them find ways to express themselves, motivate them to do so and help researchers to interpret what comes out.

Quantitative research

Quantitative research is "explaining phenomena by collecting numerical data that are analyzed using mathematically based methods (in particular statistics)."[16] Nutritional assessments completed at baseline or endline of a project are typically quantitative.

The key difference between quantitative and qualitative research is the type of data that is collected. For example, questionnaire surveys (a quantitative research method) are appropriate to use when you want to answer *what* or *how many.* Qualitative methods on the other hand, are more appropriate to use when you want to examine *why* and *how*. Another big difference is in their flexibility. Qualitative methods are typically more flexible – that is, they allow greater spontaneity and

[15] Qualitative Research Methods: A Data Collector's Field Guide. (2004).
[16] Aliaga and Gunderson (2000).

adaptation of the interaction between the researcher and the study participant. Overall, the differences between quantitative and qualitative research methods include[17]:

- Their analytical objectives
- The types of questions they pose
- The types of data collection instruments they use
- The forms of data they produce
- The degree of flexibility built into study design
-

Table 1. The difference between quantitative and qualitative research methods

Qualitative Methods	Quantative Methods
Methods include partiicpatory activitties such as social mapping and other methods such as focus group discussions and individual interviews	Surveys, structured interviews, observation, and reivew of records or documents for numeric informaton
Primarly inductive process used to formulate theory or hypothesis	Primarily deductive process used to test pre-specified concepts, constructs, and hypotheis that make up a theory
More subjective: describes a problem or condition from the point of view of those experencing it	More objective: provides observed effects (Interpreted by researchers) of a program or a problem or condition
Text-based	Number based
More in-depth information on a few cases	Less in-depth but more breadth of information across a large number of casses
Unstructured or semi-structured response options	Fixed response options
No statistical tests	Statistical tests are used for analysis
Can be valid and reliable: Largely depends on skill and rigor of the researcher	Can be vaild and reliable: Largely epends on on the measurement device or the instrument used
Time expenditure lighter on the planning end and heavier during the analysis phase	Time expenditure heavier on the planning phase and lighter on the analysis phase
Less generaalizable	More generalizable

Sampling

The other difference between quantitative and qualitative research is how participants are sampled. Deciding who will participate in the research and which methods to use are important elements of the formative research planning process. In both quantitative and qualitative research related to maternal and child nutrition, the goal is to choose respondents who can provide the most accurate and useful information about practices, who or what influences those practices, or who or what needs to be considered in facilitating change in the practices. A "good" sample is one that is representative of the population from which it was selected. In global maternal and child nutrition project research, the most common research participants are caregivers, husbands/fathers, grandmothers, community health workers, midwives, traditional healers, Ministry of Health staff, religious leaders and other community leaders.

[17] Adapted from Qualitative Research Methods: A Data Collector's Field Guide. (2004).

In **quantitative** research, the sample size is the number of people or households selected to participate in the research. Regardless of the specific techniques used for sampling for quantitative research, the steps in sampling are essentially the same: identification of the population, determination of the required sample size, and selection of the sample.

In **qualitative** research, sample sizes, which may or may not be fixed prior to data collection, depend on the resources and time available, as well as the study's objectives, how alike the research participants are to the target population for the project.

For the purpose of this guide and conducting formative research on maternal and child nutrition, we suggest using purposive sampling. Purposive sampling means deliberately choosing a site or participants due to the qualities the participant possesses (for instance, a mother in the implementation area that has a child under two years of age).

"It is also important to point out that in purposive sampling you are also sampling individuals that differ enough to provide you heterogeneity of perspectives -- so that you don't miss a critical population's perspective -- for example work in India may purposively sample individuals from across the various castes to ensure that their perspectives are represented; in Guatemala you would be purposive in your sampling to include both indigenous and non-indigenous groups; or in Kenya you may want to include respondents of varying levels of food insecurity to identify how each group copes with child feeding in light of different food access situations."[18]

Purposive sampling is a nonrandom technique that does not need a set number of sites or participants. Simply put, the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience. It does *not* mean choosing a site or a participant just because it is convenient for the research team. Site and participant selection is an important step; choosing inappropriate sites or participants can bias the research findings."[19]

Because a purposive sample is not random, it is not representative in the statistical sense. It is not valid to apply statistical tests to results based on a purposive sample.

Purposive Sampling Example

During a final evaluation of a maternal and child nutrition project in Sierra Leone, mothers with children under two in the implementation area were sampled based on their participation, or lack of participation in CARE's project activities. CARE wanted to research project participants versus project non-participants' attitudes towards infant and young child feeding practices.

[18] Amy Webb Girard

[19] *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development, p. 4.16

DEVELOPING & PLANNING FORMATIVE RESEARCH

Formative research typically has three phases and each phase has multiple steps. Table 2 lists the phases and specific steps of conducting formative research from start to finish. Unlike quantitative research, designing a carrying out qualitative research is rarely a linear process because qualitative methods allow us to rethink and modify elements of the design even as the data are emerging. Thus, all the steps are interdependent and overlapping. Nevertheless, before starting qualitative research there are steps that should be taken to ensure that the right data are collected.

In this section, each step in **Phase 1 - developing and planning formative research** is outlined. The steps for **Phase 2- data collection**, are provided in each of the individual research activity modules and; each step in **Phase 3- analyzing, using, and reporting formative research** are either discussed in the individual module or are covered at the end of this guide, right after the modules containing the research activities.

Table 2. Formative research phases and methods[20]

Phase 1	Step	Developing and planning formative research	Where this information is found in this guide
Review existing data and information and design the formative research		1. Define the research problem(s) and purpose 2. Create a draft conceptual framework **3.** Gather, review, and summarize available relevant qualitative and quantitative research reports.[21] See **Appendix 1** for a list of items to consider when reviewing key documents. You can find a list of common perceived problems and key beliefs and attitudes related to IYCF and maternal nutrition in **Appendix 2** 4. Identify gaps in data and information 5. Develop research questions 6. Select and adapt research methods to answer the research questions	See pages 12 - 18
Design and plan the data collection		7. Select the sample and 8. Select and train the research team	See pages 18 - 21
Phase 2		**Formative research data collection**	
Collect data	1.	2. Collect data on practices, problems, attitudes and beliefs, etc. 3. Collect advice on how to solve problems 4. Obtain opinions from target audience members and other key stakeholders	Detailed instructions on how to collect data using specific methods are provided for each research activity. See individual modules for

[20] Table adapted from table found in Designing by Dialogue p. 1.4

[21] Gather information on nutrition-related issues such as food security, feeding practices, dietary intakes, beliefs, attitudes, motivations, constraints from surveys; qualitative and quantitative studies; national and regional data; local experts; program documents. Specifically the topics should cover: prevalence and patterns of undernutrition; likely causes of undernutrition (such as inadequacies of food security, care, environmental conditions, or health); which demographic characteristics (i.e., ethnic group, rural or urban residence, region) are likely to have the strongest effect on child nutritional status and on feeding practices; current child feeding practices and problems; reasons for current practices and possible constraints and motivations for changing behavior; individuals, services, and media that may influence child feeding; locally available and affordable foods and their nutritional value; experience, and effectiveness of previous programs to improve maternal and child nutrition and household food security.

			instructions.
Phase 3		**Analyzing, using and reporting formative research**	
Analyze data	1.	2. Interpret the findings from individual sessions 3. Triangulate all qualitative findings with quantitative data (baseline survey if there is one)	See individual research modules See page 112
Use and report the results		3. Integrate all the information collected and analyzed during phases 1 and 2 into one document. Share and discuss the document. 4. Apply research results to program planning. Develop the program strategy, SBC strategy, and communications plan	See pages 112 - 113

Steps in Phase 1- Developing and Planning Formative Research

Step 1. Define the research problem(s) and purpose: For the purpose of this guide, the research problems are what motivates the most critical IYCF and maternal nutrition behaviors in communities and households; perceptions about these practices; and possible ways to facilitate new or improve current practices.

The specific research objectives include:

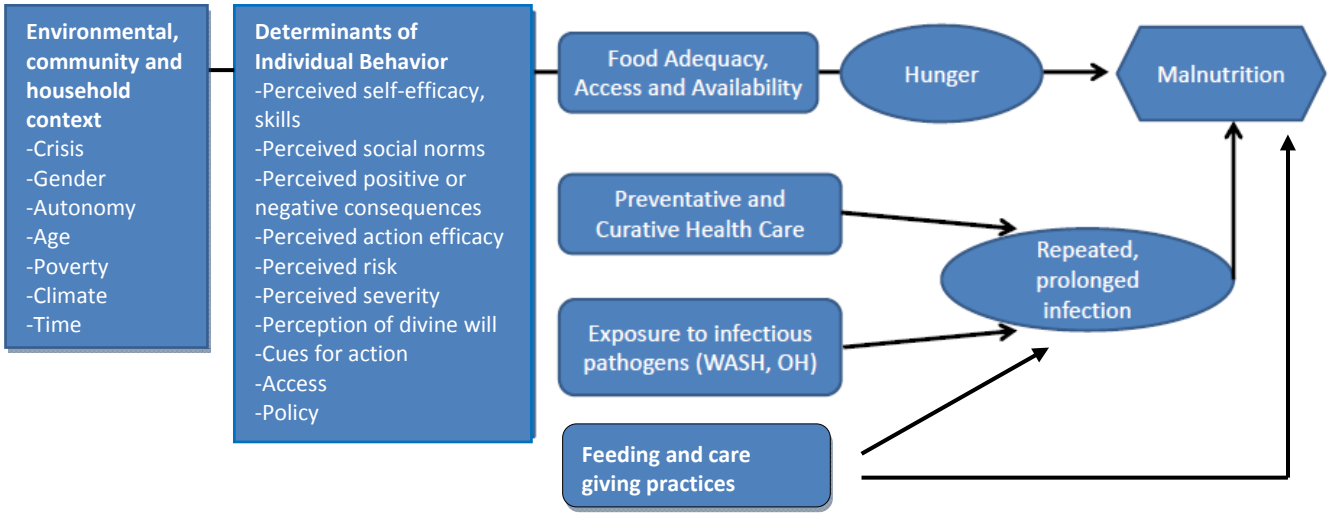
1. To explore the barriers and promoters of behavior related to maternal and young child nutrition
2. To identify resources and factors that influence optimal IYCF and maternal nutrition practices and household food security
3. To identify people that influence optimal IYCF and maternal nutrition practices and household food security
4. To explore how household food security, source of family income, and work-related migration fluctuates during the course of the year
5. To explore the workload challenges people (mothers, fathers, and frontline health/ nutrition workers) face and how both might interfere with optimal IYCF and maternal nutrition and programming
6. To explore household level decision-making and who makes decisions regarding maternal and child health and nutrition practices
7. To explore how equity, gender, and power relations affect women's decision-making and autonomy and ultimately health and nutrition practices.
8. IYCF and maternal nutrition practices
9. To assess the level of knowledge, perceptions, and issues associated with complementary feeding and maternal nutrition
10. To explore community-driven strategies which can help address the causes of malnutrition and food insecurity
11. To describe how household food security affects IYCF and maternal nutrition practices
12. To gain a deeper understanding of the causes and effects of food insecurity and malnutrition in the community

Step 2. Create a draft conceptual framework to keep your formative research focused on the research objectives. A conceptual framework is a set of related ideas behind the research design. It may be a simple list of concepts and their possible associations or a more elaborate schematic diagram of key influences, presumed relationships, and possible outcomes of the research problem. “Most qualitative researchers start with a set of thoughtfully defined concepts and tentative

associations as they design the research and begin to work with study participants. As the study progresses, concepts and their relationships become clearer, articulated in the participant's voices."[22]

Keep the conceptual framework somewhere convenient so that you can refer to it often when conducting your formative research so that you can continually examine assumptions and methods in light of new evidence. **Figure 1** provides a sample conceptual framework you could use for formative research on IYCF, maternal nutrition practices, and household food security.

Figure 2. Conceptual framework of food security, hunger and malnutrition[23]



Step 3. Gather, review, and summarize available relevant qualitative and quantitative research reports. Before conducting formative research it is important to be clear on what information and data exists and what information and data are missing. See Appendix 1 for a list of items you should be sure to consider during the literature review. Try and find qualitative research reports that have been conducted in the area you will be implementing in. Review these reports to gain insight on the social, political, and economic factors associated with maternal and child malnutrition and household food insecurity. Crosscheck the existing location specific qualitative research with the existing quantitative research. Quantitative information can reveal much about the determinants of malnutrition and aid in guiding the formative research.[24] Review quantitative reports (e.g., agency reports, project/program evaluations, etc.) and journal articles to help identify any gaps in information about IYCF and maternal nutrition practices, food security, and other relevant topics in the area you are working.[25] Sources of data on key areas outlined in Figure 2 related to malnutrition include:

[22] Ulin, P.R., Robinson, E.T., Tolley, E.E. (2005). Designing the study. p. 37. In *Qualitative methods in public health: A field guide for applied research* (1st ed.) Jossey-Bass,
[23] Conceptual framework adapted from a conceptual framework provided by Dr. Amy Webb Girard, Assistant Professor, Rollins School of Public Health, Emory University.
[24] *The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011).
[25] Relevant journal articles and project documents can be found at:

Demographic Health Surveys (DHS); Multiple Indicator Cluster Surveys (MICS); the World Health Organization database on vitamin and mineral deficiencies; and USAID's Knowledge, Practice and Coverage (KPC) Surveys. Additionally, the Food and Agriculture Organization (FAO) of the United Nations provides country-level statistics related to food and agriculture. Table 3 on the following page outlines the indictors for food security, undernourishment/ chronic hunger and malnutrition.

Step 4. Identify gaps in data and information.

After reviewing the key sources of data, start to make a list of the things you don't know. For instance, data might indicate that mother express and colosturm and feed baby pre-lactals Quantitative data can help guide formative research. Do not spend time collecting formative research data on those practices already practiced by >80% of mothers. Research shows that it is much more difficult to change practices of the remaining 20%. (Please note an exception to this rule would be for disease eradication and immunization campaigns. For either disease eradication or immunization, you would want optimal practices to reach 100%.) Use Table 3 to compare quantitative data across many sources. By filling out this table you will be able to quickly review and compare data on key indicators.

Table 3. Metrics for measuring food security and nutritional status[26]

Measure	Definition	Indicators	Methods
Food Security	Regular physical / economic / access to adequate food	Household food energy nutrient; dietary diversity; % expenditures on food; depth of energy/ nutrient deficiency; coping practices	HH income / expenditures; Individual food consumption surveys; HH food security scales; qualitative assessments
Undernourishment / chronic hunger (FAO)	Food energy deprivation	The number of people who do not consume the minimum daily energy/ nutrient requirement	National per capita dietary energy supply (food balance sheets); HH income / expenditures surveys; Individual food consumption surveys
Malnutrition	Physical manifestations of food insecurity / hunger	Underweight Stunted Wasted Anemia prevalence Night blindness Micronutrient deficiencies Overweight/Obesity	Anthropometry; Clinical and biochemical assessments

- Multidisciplinary journals: www.ingentaconnect.com.
- National Library of Medicine: http://gateway.nlm.nih.gov.gw/Cmd.
- International Information Support Center: www.asksource.info/databases.html.
- All United States Agency for International Development-funded project reports and documents: http://dec.usaid.gov
- Google Scholar: http://scholar.google.com/

[26] Table 2 provided by Dr. Amy Webb Girard, Assistant Professor, Rollins School of Public Health, Emory University.

Go back and review your research objectives. Ask yourself what information is missing from your literature review and what you need to answer to fulfill your research objectives. Research objectives have been developed for this guide and can be found on Table 6.

You should conduct formative research to fill gaps in data, not to collect more of the same data.

Table 4. Example comparison table of key IYCF, maternal nutrition and food security indicators across quantitative tools

INDICATORS	Source 1 %	Source 2 %	Source 3 %
1. Anthropometric Indicators			
Wasting			
Underweight			
Stunting			
Low birth weight			
2. IYCF Indicators			
Early/immediate initiation of breastfeeding (1 hour)			
Early initiation of breastfeeding (1 day)			
Initiation of breastfeeding (2 days)			
Newborn given colostrum			
Pre-lacteal drinks given to infants in the first three days of life			
Exclusive breast feeding under six months			
Non-exclusive breastfeeding under six months			
Continued breastfeeding 6 – 11 months			
Continued breastfeeding at 1 year (12 -15 months)			
Continued breastfeeding at 2 years (2- 23 months)			
Introduction of solid, semi-solid or soft foods for infants 6 – 8 months			
Minimum Dietary Diversity for children 6 – 23 months			
Minimum meal frequency for children 6 - 23 months			
Minimum acceptable diet for children 6 – 23 months			
Consumption of iron-rich or iron-fortified foods for children 6 -23 months			
Bottle feeding			
4. Maternal nutrition indicators			
Maternal anemia			
Maternal micronutrient adequacy			
Nutritional status of non-pregnant women- underweight			
5. **Household food security indicators**			
Food insecure households			
Household income expenditures			
Dietary Diversity			

Step 5. Develop the research questions. Table 5 provides sample research objectives and corresponding questions that are appropriate for qualitative research.

Step 6: Select and adapt research methods to answer the research questions. A variety of research methods and activities are available for collecting information on maternal and child nutrition and household food security. Some methods and activities are better suited to certain research questions than others. Methods and activities should be selected based on the kind of information that is needed. Thus, once you have outlined your research objectives and questions, pick the method(s) and activities that will yield the richest information. This guide does not adequately cover all qualitative methods and activities; nevertheless, a few activities have been selected to cover each of the objectives research questions developed for this guide. Table 5 provides an overview of the activities in this guide.

Step 7: Select the sample. One of the most common sampling strategies in qualitative research is called purposive sampling.[27] With purposive sampling, participants are selected according to preselected criteria relevant to a particular research question.

"The most common groups of participants for infant and young child feeding and maternal nutrition and household food security formative research are:

- **Pregnant and lactating women/ Caregivers** (usually segmented by the age of their youngest child and/or by environmental and cultural factors such as rural or urban location, access to markets, ethnic group, religious group).
- **Husbands/fathers** of the young children, depending on their involvement in child rearing. Fathers rarely prepare food, but may have major control over food distribution in the family and the mother's mobility outside the home or community. They may play an important role in cultivation of food crops and raising animals and may purchase some or all of the family food. Fathers often influence mothers' food selection, preparation, and feeding practices, particularly when the child is ill.
- **Grandmother** of the young children, particularly grandmothers living in the same household of the target audience. As the managers of indigenous knowledge systems that deal with the development, care and well-being of women and children, grandmothers are expected to advise and supervise the younger generations.
- **Health workers in the community** who might be involved in child health such as the volunteer health workers or midwives, or traditional healers.
- **Other influencing Individuals in the community**, such as religious leaders, community leaders.
- **Farmers and food sellers**

It is also important to **segment participants**. A population segment is a group of people sharing similar characteristics that affect the topic being researched. The more that participant groups and the geographic areas where the research will take place can be further defined by environmental and cultural factors important in maternal and child nutrition, the easier it will be to interpret and learn from the findings. When identifying which of these criteria should be applied, ask whether, for example, people with different religious beliefs feed their children differently on a regular basis. If yes, the different religious groups need to be included in the sample. If not, no distinction is needed.

[27] Qualitative Research Methods: A Data Collector's Field Guide. (2004).

Typical factors that aid in defining segments include:

- Rural or urban location[28]
- Highland, lowland, or coastal area
- Market accessible, market non-accessible
- Ethnic groups
- Religious groups

Finally, segmenting the categories of research participants (caregivers, grandmothers, traditional birth attendants, etc.) according to additional criteria will further aid in interpreting the results of the research. For example, the research might segment caregivers using the following criteria:

- **Nutritional or health status of the children**: Caregivers with well-nourished children, caregivers with malnourished children or sick children.
- **Age of the youngest child***:* Families with infants in important age groupings for feeding practices: 0–5 months, 6–8 months, 9–11 months, and 12–23 months.[29]
- **Mother's work status***:* Caregivers working inside the home for remuneration, those working outside the home for remuneration, or not working for remuneration.
- **Family socioeconomic status***:* Caregivers who are marginalized by socioeconomic class or caste, those who are not.
- **Mother's experience***:* First-time mothers, experienced mothers.
- **By practice***:* Mothers who are breastfeeding, those who are not."[30]

"Create segments *only* when groups differ so much that different activities, messages, and/or communication strategies are required to reach them. Choosing *too many segments* increases the complexity, duration, and cost of the research. Do not collect detailed information on more groups than the program itself can target with tailored actions."[31]

[28] The sites should be representative of the program area in terms of socio-economic status, access to health care and other services, food availability, and other characteristics that are likely to affect the recommendations or the way the program will be delivered.

You can segment caregivers by the age of their children for instance:

- Zero to less than six months (when exclusive breastfeeding is recommended)
- Six to less than nine months (a period of high risk for infection and malnutrition, when infants begin to need complementary foods)
- Nine to less than 12 months (when children are introduced to a greater variety of foods)
- 12 to less than 18 months (when children are able to walk and often are considered ready for a transition to the family diet)
- 18 to less than 24 months (when children need even greater quantities of nutrient-dense foods)

The age groups may be divided differently to reflect culturally relevant practices. For example, if there is a local ceremony at 10 months to mark a milestone in children's lives, this may be a more appropriate break point than the nine months cut-off suggested above. It may be possible to narrow the overall age range or reduce the number of groups, depending on the local situation and the scope of the program.

[30] *The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011), pp. 5 – 6.

[31] *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development, p. 4.10

In summary:[32]

- Select two or three sites that are representative of each population segment. So for example if there are five population groups there should be at least 10-15 sites. Although research sites may be selected purposively, individuals in those sites should be selected randomly.
- Decisions about sample size must be taken in light of time and budgetary constraints.
- Because there is no statistical process for calculating the sample size, during the research the team may decide *not to interview* the entire sample, if interviews after a certain point stop yielding new and useful information. This also depends on time and budgetary resources.
- Alternatively, the team may decide to *add interviews* of a certain type of respondent on the basis of early findings.

Step 8. Select and train the interviewers/ facilitators based on specific needs of the formative research. There are several characteristics to look for in the research team members such as:[33]

- Previous field experience
- Fluency in the local language(s)
- Ability to establish rapport with strangers, converse naturally, and put people at ease so that they can express themselves freely
- Good listening skills
- Awareness of own nonverbal reactions, using body language to project positive responses
- Ability to interpret and explore what people say in light of the research questions, versus rote response
- Ability to project enthusiasm and genuine interest in others
- Ability to observe and record situations without judging or distorting
- Ability to convey warmth and empathy with different types of people
- Maturity, ability to handle difficult situations that may arise during fieldwork.
- Comfort in discussing maternal health, child care, child illness, and child feeding issues. (While men and women are potential team candidates, women are usually more at ease when talking with women about these issues.)
- Ability to analyze a situation, think critically, and write adequately.

The number of interviewers/ facilitators needed to conduct the formative research depends on several things. For many of the activities, as long as you have a tape recorder and/ or a camera to record the data, at a minimum you will need someone to act as a facilitator. However, it is optimal to have at least one more person who can take notes as well as act as "crowd control" when need be. Other things to consider are:

1. The number of activities you will be conducting
2. "The amount of time available for completion of the research. If time is short and the sample is large, it is advisable to have several teams working simultaneously, thereby increasing the number of research assistants needed for data collection and for supervision.
3. The accessibility and distance between sites affects the plan: if sites are very far apart, it may make sense to send separate teams to different sites rather than have one team travel long distances between sites.
4. The various research methods also require different staff numbers and qualifications (e.g., having a trained and skilled focus group facilitator can make a difference in the quality of data) and different amounts of time to complete.

[32] *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development, p. 4.17

[33] Adapted from list found in *Qualitative Methods in Public Health: A Field Guide for Applied Research* (2004).Priscilla R. Ulin, Elizabeth T., Robinson, Elizabeth E. Tolley. John Wiley & Sons, p. 119.

All of these decisions have salary, accommodation, and transport implications.

Field supervision is critical to the effective performance of the team.

1. It is essential that someone be responsible for logistical issues such as transport, scheduling, and making sure that research assistants have what they need to conduct the research.
2. At the same time, oversight of sample selection and careful review of the data collected is an important determinant of data quality.
3. Daily supervision is necessary to catch errors or incompleteness of data, so that field workers can revisit households or individuals to correct any problems. Supervisors can hold daily debriefs with team members to discuss findings emerging from the day's sessions as well as to have the notetaker provide feedback on how the sessions went and to troubleshoot for how to improve the sessions.[34]
4. If teams are working in widely separated sites, additional supervisors are needed." [35]

Budgeting Time and resources

The estimates provided on Table 5 are recommended as guidelines to assist in calculating the number of field interviews and time required to conduct the research. Ideally, all group activities should include a facilitator **and** a note-taker; whereas individual activities such as interviews may only require the interviewer.[36] Furthermore, in locations where populations are very dispersed, it may not be possible to conduct more than one or two activities per day and time estimates should be increased accordingly. Obviously the more activities you do and the larger the sample, the more time and resources it will take to complete the formative research.

[34] Amy Webb Girard

[35] *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz, (1997). Academy for Educational Development, p. 4.20

[36] Amy Webb Girard

Table 5. Time estimates for various research activities included in this guide

Activity	Average time it takes to run the activity	# of interviewers/facilitators	Optimal group size or sample
Barrier Analysis	Approximately 20 minutes per participant 1 – 2 days per topic	4 - 6	90 participants per topic = 45 Doers and 45 Non-Doers
Gendered Resource Mapping	45 minutes to one hour	1 - 2	8 – 12 participants
Social Network (relationship) Mapping	45 minutes to one hour	1 - 2	8 – 12 participants
Seasonal Calendar	45 minutes to one hour	1 - 2	8 -12 participants
Daily Activity Chart	30 minutes to an hour	1 - 2	2-7 participants
Typical Man / Woman	one and a half hours	2 - 4	8-12 women and 8- 12 men
Local Food Assessment	Several hours	1- 2	0 participants
Card Sorting	one hour	1 - 2	1 -5 participants
Ten Seed Technique	30 to 45 minutes	1 - 2	5 – 30 participants
SWOC Analysis	one hour	1 - 2	5 - 8 participants
Problem Tree	½ hour to 45 minutes	1 - 2	5 – 8 participants
Problem Wall and Solution Tree	one hour	1 - 2	14-30 participants
Force Field Analysis	½ hour to 45 minutes	1 - 2	8- 12 participants
Individual Interview	1 hour	1 - 2	1 participant
Focus Group Discussion	1 hour 1 - 2 per day	1 - 2	6-10 participants

EFFECTIVLY FACILATATING QUALITATIVE RESEARCH

Facilitating qualitative research activities can be challenging. The facilitator is responsible for moving the discussion of each group along and for keeping the discussion on topic. A good facilitator should be skilled at creating a discussion in which he or she participates very little. In this regard, the facilitator should stress the value of participants' contributions to the study and emphasize the facilitator's own role as a learner rather than a teacher. Facilitators also need to be skilled at directing the discussion at a pace that allows all questions to be addressed thoroughly. Having these skills depends on your familiarity with the research objective and question guide, flexibility, ability to monitor and gauge the tone of the discussion, and ability to make quick judgments about when and how to interject.[37]

[37] *Qualitative Research Methods: A Data Collector's Field Guide*. (2005).

Remember, qualitative tools differ from quantitative tools. In essence, the facilitator is the tool in qualitative research and the guides they use are just that – guides. Qualitative guides are often much more open ended and flexible than surveys and they require substantially more probing and engagement with the participants. Facilitators need to guide participant's discussion with gentle steering back on topic as necessary.

Traits and skills needed to be an effective facilitator

Ideally, facilitators and notetakers should be:

- Trusted by members of the community
- Speak the same language
- Understand the culture
- Willing and interested to learn from people
- Of the same age and gender
- Committed to addressing issues in community
- Has basic knowledge of issues community faces
- Can work respectfully with marginalized groups
- Skilled in facilitating discussions
- Literate, so they can record information

The best facilitators have the ability to quickly create an atmosphere that is positive, relaxed, and mutually respectful. They treat participants as experts while remaining in control of the session. The best facilitators also demonstrate a neutral attitude and listen more than speak.

Active Listening[38]
Active listening is more than just hearing what others say. It involves listening in a way that communicates respect, interest and empathy. These three emotions can be conveyed through both verbal and non-verbal communication.

Examples of **verbal cues:**
"Mm hmmm...."
"Yes, I see..."
Repeating what the person has just said

Examples of **non-verbal cues: Not interrupting the speaker**
Leaning forward
Giving eye contact to the person speaking (unless rude to do so in the culture)

Some common errors that facilitators can make include the following:[39] (list not applicable to barrier analysis interviews)

- Allowing one or two participants to dominate the discussion or not enabling quiet participants to speak.
- Remaining too long on a topic, continuing to repeat questions even after participants have nothing additional to say
- Using the same words to repeat a question instead of probing what has just been said or noticing new ideas and asking participants to elaborate

[38] *Empowering Communities: Participatory Techniques For Community-Based Program Development. Volume 1: Trainer's Manual and Volume II: Participant's Handbook*. FHI 360.

[39] *Qualitative Methods in Public Health: A Field Guide for Applied Research* (2004), pp. 247 -248.

- Interrupting people who begin to express a different point of view by repeating the original question as if the speaker were not addressing it.
- Accepting comments on what people should do without probing what they actually do and why there is a difference
- Not probing the logical conclusions of ideas (See list of probing questions in Appendix 11)
- Not probing assumptions to see where they come from? (See list of probing questions in Appendix 11)
- Letting a good question drop if it is not answered immediately
- Failing to explore vague or nonspecific terms or to clarify language expressions that may not be familiar to the researchers
- Asking leading question that might bias the answers for example, “Don’t you think that…? Or “Would you agree that…?”

Every group research activity you conduct will be a unique experience, not only because what the participants say will be different each time, but also because the group dynamics will vary according to the personalities and moods of the people who attend. Some groups will have a gregarious tone to them, and others a serious or quiet tone. Whatever the case, your goal should be to keep the discussion moving along, with as many people participating as possible.

Avoiding common pitfalls

Interviewer bias – As much as we like to think that we are all open minded and objective, everyone is biased. Sometimes your opinions about a topic, participant or your mood can interfere with your interpretation of the data. Try to remain as objective as possible regardless of your personal bias:

- Preconceived notions on a topic (or lack thereof)
- Discomfort with certain topics or opinions on a topic (MANGE YOUR DISCOMFORT)
- Mental and/or physical exhaustion
- Bad or contrary mood

Correcting misinformation – It can be tempting to want to correct misinformation during an interview or activity, but correcting participants can cause them to lose face in front of their peers and may discourage them from participating.

Using Creative Approaches

Some groups may be composed of only women or only men. Other groups can be mixed, although issues related to power dynamics may be more noticeable in mixed groups. Some participants can at times dominate the discussion for various reasons. These participants should be filtered out of the group as soon as possible so that they don’t have the opportunity to monopolize the conversation. Participants who may be prime candidates for being filtered out include community leaders, moneylenders, landlords, or others with authority. When authority figures are present other participants might not want to disagree with them even if they have a different opinion. It is good to have an extra person on your research team that can deal with crowd control or authoritative participants. If you do run across a participant that is dominating a conversation or an authoritative participant that is creating a bias, a good option is to have a person from the team pull them out of the group and do an impromptu interview with them.

In some circumstances it is appropriate to consider creative approaches to focus groups in order to meet research needs. For instance, young mothers might feel too shy to participate fully. Elders in some societies are shown respect by not being interrupted, which makes them a challenging group for the facilitator to manage. In some cultures, people are not accustomed to expressing their opinions. Under such circumstances, it is appropriate to find an approach that will give insight into the participants' personal attitudes and experiences without threatening their comfort or privacy.

Here are some ideas.

- **What was said in other groups-** As long as you are not going to be "outing anybody" Play tape excerpts from one group to another. This is particularly good when there are people who defer to each other, rather than confront each other. For example, people usually won't argue with real, live experts. But if you play tape excerpts, people will tell you exactly what they don't like about what the experts are saying.

- **Screen-** Anybody ever try to solicit participants for a focus group discussion for 8 10 people (maybe the CHW was finding volunteers for you) and half the village showed up? As you know in qualitative research, we are usually not trying to get a statistically representative sample of the universe. Maybe you are trying to zero in on a particular segment of the target audience, such as positive deviants, or you are looking for creative ideas. Once I had half the village show up to a FGD I was holding and I had all of them play a game with me to divide them further. For instance, I said, "*I want to find a mother who…. Any of the mothers that fit the statement should raise their hands*. I was able to come up with a couple different groups with mothers, grandmothers, and fathers and collect some really insightful data.

- **Afterthoughts-** Typically after a FGD I like to stick around at the end. People will tell you things privately that are very valuable.

- **Informality-** A style of extremely informal, relaxed playfulness, coupled with a professional seriousness of purpose (they are not the contradictions that so many people think) works best for most facilitators. Often the worst facilitating style is one of formality, especially among inherently formal people like religious leaders and medical experts. These are exactly the kinds of people who want and need the excuse to loosen up a little and willingly do so if given permission by the example of the facilitator. Be sure to sit or stand at the same level of the participants, it can really make them feel more comfortable with you from the start.

- **Fun**- Anything that you can do which will make the group fun will tend to increase the feeling of psychological safety. People reveal more when they are relaxed and having a good time, as long as the facilitator does not trivialize the proceedings with gratuitous nonsense.

- **Make it a group** - It's not really a group until the participants start talking to each other. Encourage interaction. When that fails, insist on it. Ask, as your first question, something which requires interaction, such as *I'd like you all to figure out among yourselves what is the most effective course of action in the following circumstance*. or, *Figure out among yourselves three reasonable ways to proceed in these conditions, and the pros and cons of each. I'll sit back and listen for awhile*. This will help break out 'serial interview mode.'

- **Eyes closed-** Ask the participants to close their eyes and imagine the last time they did the behavior you are interested in, used a product, or encountered a certain type of situation. The very act of closing their eyes in front of each other and then sharing an experience with each other will go very far in getting them to share private thoughts.

- **Natural surroundings-** The more natural and more informal the surroundings the better. It helps people relax. Meet the participants in the waiting room, kid with them, get to know them, make them feel welcome. When you get into the room, have them help you rearrange the furniture for the activity. For instance, have them help you move the table(s) against the walls and sit in a circle. You've then already formed a group, performed a common task, and established an atmosphere of relaxed informality.

Common mistakes to avoid in matching information needs with collection methods include:

- Using a method based on what the researcher is familiar with rather than choosing one (or more) based on the information needed/research questions.
- Many types of qualitative research activities do not allow for 'honest' answers about practices, as participants are often reluctant to describe what they do in front of people they know, or they will mimic what others say. For instance focus groups are good methods for discussing notions of child raising, beliefs about the properties of foods, what usually happens in the community and ideas about what might or might not be acceptable to change and why, but don't use them to gather information about daily child feeding practices. Use an individual interview or survey instead.
- Asking key informants such as nurses and community leaders to provide information on caregiver practices. They cannot speak for caregivers about what they do and why; their answers would be speculative and uninformative.
- Thinking that baseline or quantitative surveys in which information is collected on prevalence of certain practices or beliefs provide insight into practices. These surveys lack insight into why, or how, precisely certain practices are followed.
- Assuming that defining current behaviors and determinants will lead to answers about the feasibility of potential changes or new practices. The determinants of current behaviors are not necessarily determinants of new behaviors. Rather, they are merely a starting point for defining what and how a practice might be modified."

RESEARCH ACTIVITES INCLUDED IN THIS GUIDE

A variety of research activities are provided in this guide to ensure that different points of view are explored and to cross-check the data obtained. The activities have been purposively selected and adapted to collect data around feelings, attitudes, values, and beliefs related to IYCF, maternal nutrition, and household food and nutrition security. Most of the activities are very visual in nature and because of this, allow for literate and illiterate people to participate as equal partners and contribute meaningfully to the discussion.

The activities in this guide are designed to:

- Encourage people to share information, ideas, concerns and knowledge
- Support learning in a group
- Help people to communicate effectively
- Make it easier for the facilitator to manage group dynamics
- Collect data that is practical and relevant
- Invite the participants to take control of the learning and sharing process

The selected activities are examples and not a comprehensive list. You can use the activities listed in this guide as is, or adapt them to your needs. There are a plethora of other activities you can use to conduct qualitative research. You are not limited to using just the example activities outlined in this book. The activities in this guide are divided into seven sections.

Barrier Analysis- Helps to identify behavioral determinants (reasons that promote or hinder behaviors), so that effective messages, strategies and activities can be developed.

Mapping- Will provide an overview of how local services and social capital affect the community, households, and individuals. The three activities covered in this guide include:

- Community Mapping
- Gendered Resource Mapping
- Social Network Mapping

Time Analysis- The following two tools will provide insight on how household food security changes over time and how people spend their time over the course of a day.

- Seasonal Calendar
- Daily Activity Chart

Linkages and Relationships- The following activity will provide a greater understanding of how gender norms may affect nutrition and feeding behaviors.

- 'Typical' Father/Mother/Grandmother

Prioritization/ Quantification- The following two activities will sort, count, measure, and rank how malnutrition and food security issues affect people.

- Card Sorting
- Ten Seed Approach

Action Planning- The following four activities can be used to help make programming plans that will help address the cause and effects of malnutrition and food security.

- SWOC Analysis
- Problem Wall and Solution Tree
- Force Field Analysis
- Local Food Assessment

Experiential- Will provide a deeper understanding of the causes and effects of malnutrition and food security and behavior around IYCF and maternal nutrition practices. The following two activities will be used to explore and gather data not collected using the other participatory activities.

- Individual Interview
- Focus Group Discussion

Please note there are no rules about which activities to use for an issue, but some do work better than others for certain objectives and research questions. Please consider using activities besides focus group discussions for formative research. Rich data can be obtained using other activities that may be easier to facilitate.

Some activities work best with people who share the same characteristics, for example, people of the same gender, age group, status, etc. Some research activities work better in large groups, others in smaller groups. As a general rule, activities that require a lot of detailed analysis, or are of a very personal nature, are best used in small groups. Additionally, you need to think about how much time you have to facilitate the group. Some tools can deal with lots of issues at once, while others concentrate on just one issue in depth. Think about your objective, get creative, experiment, and see what works.

Table 6 outlines each activity included in this guide along with an objective, corresponding research question and explanation of what it is used for.

Table 6. Research activities according to the research objectives and questions

Activity	Objective	Corresponding research question	Use to:
Barrier Analysis	To explore the barriers and promoters of behavior related to maternal and young child nutrition.	What are the determinants of behavior related to specific IYCF and maternal nutrition practices?	Determine key reasons why people are or are not doing a behavior (behavioral determinants). Helps with planning messages and activities.
Gendered Resource Mapping	To identify resources and services in a community and who use them.	What agricultural resources and services are available to women as opposed to men in a community? What income generation opportunities exist for women as opposed to men? What social service programs are available to women as opposed to men in the community? (If relevant) Where can women go without permission from family members as opposed to where men can go?	Show the resources and services available in a community, and who can access/ use them. Resource maps can also show what resources and services different people need but are unable to access. Can help to start identifying strategies for increasing access to existing resources and services. Can also capture where and from whom people seek information and advice on the particular health problem and why they use these information sources.
Social Network (relationship) Mapping	To identify people that influence optimal IYCF and maternal nutrition practices and household food security.	What supportive relationships exist in the community and/ or household? Who are the people in the community/ and or household that influence nutrition practices? Who makes decisions regarding maternal and child nutrition and household food security?	Show relationships that are important to a person (or family); what kind of support the relationships offer; how information is shared or not shared; who is involved in decision making, and provide insight on the divisions and isolation within a community.
Community Mapping	Identify where the participants live, work, socialize and where they access services.	(See expanded list in the module) What places do the participants go to often and why do they go there? What is considered the poor area of the community? What is considered the wealthy area of the community? Is the number of households growing or shrinking in each of these areas? Why is that happening? What are the social structures and institutions found in the community?	Identify key locations in a community and who does and does not access / have access to these locations / resources
Daily Activity Chart	To explore the workload challenges people (mothers, fathers, and frontline health/ nutrition workers) face and how both might interfere with optimal IYCF and maternal nutrition and programming.	What activities do mothers, fathers, and frontline health/nutrition workers spend their time doing during the course of a day? What are the factors that influence these differences? What are the problems and obstacles faced by different people? What are important times of the day when people have free time to access services or participate in activities?	Show how people spend their time over the course of a day. This activity will also provide insight on the time and effort people spend of different activities and the choices people make. From a programming standpoint, it will identify when people are free to participate in program activities.

Activity	Objective	Corresponding research question(s)	Use to
Seasonal Calendar	To explore how household food security, source of family income and work-related migration fluctuates during the course of the year.	How does household food security fluctuate during different seasons during the year? How does source of family income fluctuate during the year? How do work-related migration patterns fluctuate during the year? What are the relationships between different patterns of change?	Diagram the changes over the period of 12 months and identify the changing availability of food, or income, work and migration patterns. Can identify when people may be particularly vulnerable. Important to determine because it will indicated the times of the year when people are available for involvement in programming and community action.
Typical Father/ Mother/ Grandmother	To explore how equity, gender, and power relations affect IYCF and maternal nutrition practices.	What gender roles, qualities and behaviors are expected from the 'typical' father/mother/grandmother particularly around child care and being a father/mother/grandmother in a given community and what happens if they don't' follow them?	Identify the gender roles, qualities, and behaviors expected of 'typical' father/mother/grandmother and explores what happens if fathers/mothers/grandmothers do not do what is expected of them.
Local Food Assessment	To gain a better understanding of the food that is available in the local markets, kiosks, stores, and fields and what is accessible to the target population.	What food is available in the local markets, kiosks, stores, and fields, and how accessible and expensive is it?	Gain a better understanding of the food that is available in the local markets and the accessibility and cost.
Card Sorting	To count, measure, and rank perceptions and explore people's priorities	What food is available and being consumed by pregnant and lactating women and infants and young children and why? Specifically, what foods are important and acceptable for children 6 -23 months to eat? What foods are important and acceptable for pregnant women to eat? What foods are important and acceptable for lactating women to eat? What foods should children 6 -23 months never eat? What foods should pregnant women never eat? What foods should lactating women never eat? What foods are reserved for men to eat? What foods are always available in the community? What foods are seasonal? What foods are too expensive to eat on a daily basis?	Organize information; determining what criteria are most important to the participant; determine the similarity and differences between certain items, terms and concepts and ; learn about food proscriptions and prescriptions for pregnant and lactating women and children 6 -23 months old.
Ten Seed Technique	To determine people's perceptions of how important factors related to health, nutrition and food security are and how much more important they are relative to the other factors.	This activity can be used for a variety of things including trends analysis, seasonality diagramming, livelihood analysis, etc.. The results can be used for action, community development and program planning.	Determine the way people see themselves in relation to others or which (or whether) one factor is more important and how much more important a factor is in relation to other reasons given.
Activity	**Objective**	**Corresponding research question(s)**	**Use to**
SWOC Analysis	To explore community-driven strategies which can help address the causes of	What are the strengths, weaknesses, opportunities and constraints (SWOC) of food and nutrition programming.	Aid in program planning.

	malnutrition food insecurity .		
Force Field Analysis	To examine what factors and persons prevent women from getting enough food and rest when they are pregnant and what factors and persons can help women get enough food and rest when they are pregnant.	What factors and/ or persons prevent women from getting enough food and rest when they are pregnant? What factors and/or persons can help women get enough food and rest when they are pregnant?	Identify the moral, legal, and cultural factors that could constrain or facilitate adoption of the behavior. Identify and estimate the strength of 'supporting' factors and the strength 'resisting' factors around an issue.
Problem Wall and Solution Tree	To describe how household food security affects IYCF and maternal nutrition practices and identify potential solutions to food insecurity at the household level.	How does household food security affect IYCF and maternal nutrition practices in the family?	Identify problems and solutions related to a particular topic.
Individual Interview	To better understand meanings, values and perceptions related to maternal and child nutrition.	Various questions covering an assortment of topical areas. See Appendix 9.	To better understand a person's attitudes, beliefs and perceptions regarding a particular issue. Interviews can be conducted with mothers, fathers, government officials, local health service personnel, traditional healers, community leaders (elected or self- appointed), local shop owners, and members of nongovernmental organizations. Individual interviews can be used to explore local experiences and cultural traditions, identify the feelings and understanding of different individuals about a topic and help identify priorities for action.
Focus Group Discussion	To identify the key factors and people that influence maternal and child nutrition and health.	Various questions covering an assortment of topical areas. See Appendix 10.	Can be used to explore local experiences and cultural traditions, identify the feelings and understanding of different groups about a topic and help identify priorities for action. FGDs are NOT used to gain insight on individual practices.

BARRIER ANALYSIS[40]

Objective:	To explore the barriers and promoters of behavior related to maternal and young child nutrition.
Use to:	Determine key reasons why people are or are not doing a behavior (behavioral determinants). Helps with planning messages and activities.
Time frame:	Research on one specific behavior can be done using a barrier analysis with a team of 2-4 people in two days. A larger group of data collectors are able to conduct more barrier analyses in about the same amount of time. On average, each survey takes about 10- 15 minutes for a participant to fill out. Use different participants for each barrier analysis you conduct.
Materials needed:	Pen/pencil, copies of surveys, flipchart, calculator and notepad for analysis, and a copy of the consent and debriefing scripts
Ideal workspace:	a quiet, private setting to administer survey
Number of participants:	A Barrier Analysis requires a sample size of 45 Doers and 45 Non-Doers in order to find statistical significance. Nevertheless, if time and money are limited or the number of "Doers" (the people doing the optimal behavior) are hard to come by, smaller sample sizes can be used. If that is the case, your results won't be statistically significant, but you will be able to get an idea of what is determining the behavior and the data will help you to determine what other qualitative research is needed as a follow-up.

Background

The Barrier Analysis is a rapid assessment tool used to better understand how to successfully promote behavior change by identifying the most important barriers and promoters of behaviors. The method consists of "a survey that focuses on identifying what is preventing the priority group from adopting the behavior."

To identify the key barriers, the priority audience is asked a series of questions to identify up to 12 potential determinants of behaviors that can block or help people take action. There are four Determinants that should always be explored and eight others that may be useful to explore. The questions identify what the respondent perceives are the key benefits (positive consequences) of an action. These can then be used as 'promoters' for use in health communications and social and behavior change activities. The results of the questions are compared amongst groups of people who are:

- "Doers"- people who have already adopted the new behavior and;
- "Non-Doers"- people who haven't yet adopted the new behavior.

[40] The information contained in this module was adapted from: 1) *Barrier Analysis Facilitator's Guide: A Tool for Improving Behavior Change Communication in Child Survival and Community Development Programs* by Thomas P. Davis Jr. (2004). Washington, D.C.: Food for the Hungry. Copies can be downloaded free of charge from http://www.coregroup.org/resources/core-tools ; the *Designing for Behavior Change Curriculum (*2013) that was developed by the CORE Group, Social and Behavior Change Working Group. Copies of this curriculum can be downloaded free of charge from http://www.coregroup.org/storage/Tools/DBC_Curriculum_111113.pdf and *A Practical Guide to conducting Barrier Analysis* (2013) that can be downloaded free of charge from http://www.fsnnetwork.org/behavior-bank Text in quotation marks was copied verbatim from those guides.

By comparing these two groups we can see which behavioral determinants seem to be the most important.

Important determinants that influence behavior:[41]

The Four Most Powerful Determinants

These Determinants should always be explored by conducting formative research (e.g., Barrier Analysis). They are more commonly found to be the most powerful for health and nutrition behaviors.

1. Perceived self-efficacy/skills- An individual's belief that he or she can do a particular behavior given his or her current knowledge and skills; or in other words, the set of knowledge, skills, abilities and the confidence necessary to perform a particular behavior. For instance, if a person thinks that an action is very difficult to do, he/she may not do it." For instance, a mother might not feel confident that she can grow a variety of foods in her backyard.

2. Perceived social norms - The perception that people important to an individual (e.g., family members, neighbors) think that he or she should do the behavior. There are two parts to social norms: who matters most to the person on a particular issue, and what he or she perceives those people think he or she should do. For instance, if a child's grandmother influences the child's mother a lot, and believes that colostrum is bad for the baby, the mother may not engage in early initiation of breastfeeding and give the newborn another liquid instead. If we do not convince the grandmother of the importance of giving colostrum to newborns, then we may not be able to convince the mother to try it. Social norms can also influence optimal practice. If a person thinks that other people will think bad of them if they defecate in an open field, they might use a latrine instead (if that is what everybody else is doing- or they think that is what everybody else is doing.)

3. Perceived positive consequences- What positive things a person perceives (or thinks) will happen as a result of performing a .

4. Perceived negative consequences- What negative things a person thinks will happen as a result of performing a Behavior

Note: Answers to questions about perceived positive consequences or perceived negative consequences in a Barrier Analysis or Doer/Non-Doer Study may reveal advantages (benefits) and disadvantages of, attitudes about, and perceived positive and negative attributes of the behavior.

Other Key Determinants

5. Access - The degree of availability (to a particular audience) of the needed products (e.g., fertilizer, insecticide-treated bed nets, condoms) or services (e.g., veterinary services, immunization posts) required to adopt a given behavior. Includes an audience's comfort in accessing desired types of products or using a service. Includes issues related to cost, gender, culture, language, etc.

6. Cues for action/reminders - The presence of reminders that help a person remember to do a particular behavior or remember the steps involved in doing the behavior. An example might be

[41] For more information on the determinants see pp. 85- 87 of *Designing for Behavior Change Curriculum (*2013) that was developed by the CORE Group, Social and Behavior Change Working Group. Copies of this curriculum can be downloaded free of charge from http://www.coregroup.org/storage/Tools/DBC_Curriculum_111113.pdf

pictorial instructions on an oral rehydration solution (ORS) packet showing how to correctly prepare it, a sticker with the steps on how to plant a particular type of seed

7. Perceived susceptibility/risk - A person's perception of how vulnerable they feel to the problem. If people think that they cannot get a particular disease, or have a particular problem, they often will NOT take action to prevent it." Examples: Does a mother that thinks her child will not get sick if she does not wash her hands with soap and water before preparing food, before eating, and before feeding young children? Do people feel that it is possible that their crops could have cassava wilt?

8. Perceived severity - Belief that the problem (which the behavior can prevent) is serious If people do NOT think that a problem or disease is serious or annoying they may not take action to prevent it. The thing that is most important is NOT if the problem is, in fact serous, but if the person THINKS that the problem is serious. Examples: A farmer may be more likely to take steps to prevent growth of mold on stored harvest if he perceives it to be a serious problem that could cause harm; a mother may be more likely to take her child for immunizations if she believes that measles is a serious disease.

9. Perceived action efficacy -The belief that by practicing the behavior one will avoid the problem, that the behavior is effective in avoiding the problem Example: If a person sleeps under a mosquito net, he or she will not get malaria. Another example might be a mother believing that the breasts make as much milk as the baby takes—if baby takes more, the breasts make more (the breast is like a "factory"—the more demand for milk, the more supply).

Note: Perceived susceptibility, perceived severity, and perceived action efficacy relate to the problem, NOT to the behavior. If people think the preventative action you are promoting does not work to prevent the problem or disease, then they probably will not do it."

10. Perceived divine will - A person's belief that it is God's will (or the gods' will) for him or her to have the problem and/or to overcome it. In other words, a person's belief that God (or the gods) is responsible for the problem.

11. Policy -Laws and regulations that affect behaviors and access to products and services. Examples: The presence of good land title laws (and a clear title) may make it more likely for a person to take steps to improve his or her farm land; a policy of automatic HIV testing during antenatal visits may make it more likely for women to have HIV testing. Policies often affect enablers and barriers (the things that make it easier or more difficult to do a behavior).

12. Culture - The set of history, customs, lifestyles, values and practices within a self-defined group. Culture may be associated with ethnicity or lifestyle, such as "gay" or "youth" culture and often influences perceived social norms.

Barrier Analysis is often used at the start of a behavior change program to help determine key messages and program activities. It can also used during ongoing programming to address behaviors that are largely not adopted by a community, despite repeated efforts to encourage the behavior.[42].

[42] "A Behavior is…
- - An Action
- - Observable
- - Specific (time, place, quantity, duration, frequency)
- - Measurable
- - Feasible

A common question: Quantitative or qualitative? Barrier Analysis is both qualitative and quantitative. It has open-ended elements that help us to describe how the two groups think (which makes them qualitative in nature), but it also has quantitative elements (e.g. the comparison) which allow us to say which differences are important. Since neither tool measures prevalence of a particular belief, most people do not think of it as quantitative; however, quantitative information is being collected (e.g., what was said).

Once a behavior and accompanying target group is chosen, a questionnaire is crafted to include questions in each determinant category. Additionally, the survey will include a key behavior question that determines whether the respondent is practicing the behavior (a Doer) or not practicing the behavior (a Non-Doer). Surveys should be conducted as individual interviews.

Example research question

What are the determinants of behavior related to specific IYCF and maternal nutrition practices?

Steps to follow

There are seven steps involved in conducting Barrier Analysis. In this module, we use the example behavior of exclusive breastfeeding.

Before collecting data

Step 1: Define the Goal, Behavior and Target Group. The goal is usually general and the behavior should be specific so that it can be determined clearly whether someone is or is not practicing the behavior. The target group is your audience of people whose behavior you want to better understand (and change). In our example, these are:

- Goal: to improve child nutrition
- Behavior: to increase the number of infants who are exclusively breastfed up to 6 months of age
- Target Group: lactating mothers

Step 2: Develop the behavior question. The behavior question is used to distinguish if the respondent is or is not practicing the chosen behavior. For our example barrier analysis on exclusive breastfeeding, there are actually three questions to ask to determine whether a mother is a Doer or a Non-Doer.

1. How old is your infant? _____ (for this particular question only interview mothers with children 7-9 months. Sometimes it is hard to remember behaviors long after you have performed them).

2. Did you exclusively breast feed your child (meaning, did you feed your infant ONLY breastmilk between birth and six months)? _____Yes (Doer) _____No (Non-Doer)

3. Did your infant have anything to eat or drink apart from breastmilk during the first six months of life?_____Yes (Non-doer) _____No (Doer)

Step 3: Develop questions about determinants. Barrier analysis questions can be developed by completing the following sentences.

Determinants	Example Barrier Analysis Questions
Perceived Positive Consequences	What are the advantages/ benefits of…? What are (or would be) the advantages/benefits of using organic fertilizer on your maize crop? What are (or would be) the advantages/benefits of exclusively breastfeeding your child under 6 months of age?
Perceived Negative Consequences	What are the disadvantages or negative consequences of…?
Perceived Social Norms	Who would approve / support you if…? Who would discourage you from…? Is[insert behavior here] an acceptable behavior in your community? Do (or would) most of the people you know approve of your decision to…?
Self Efficacy	What would make it easier for you to…? What makes it difficult? Do you have the knowledge and skills necessary to…?
Perceived Susceptibility	How likely is it that your baby will become malnourished in the next year? Would you say it is very likely, somewhat likely or not likely at all? Do you think you may lose a good portion of crop during the coming year due to rats or insects?
Perceived Severity	How serious is it when...? How serious a problem is it if your crops become contaminated with aflatoxin? How serious a problem is malnutrition in children compared to other problems that they could get?
Perceived Action Efficacy	Can [doing this behavior] do [this]? Would giving only breast milk to your child help him or her avoid getting diarrhea?
Cues for Action	Can you remember to…? How easy is it to remember the date and location of the monthly seedling distribution? How difficult is it to remember the date of the immunization post where you need to take your child for vaccines?

Perceived Divine Will	Is it God's will that… Do you think that God (or the gods) want(s) you to burn your fields after the harvest? Is it God's will that infants get diarrhea and other illnesses?
Access	How difficult is it for you to get the materials needed to …? How difficult is it for you to get to the local clinic when your child has diarrhea? How well are you treated when you visit that clinic?
Policy	Are there any laws or policies that make it more likely that you will get your child immunized?
Culture	Are there any cultural rules/taboos against use of organic fertilizer? Are there any cultural rules/taboos against early initiation of breastfeeding?

Here is an example set of barrier analysis questions on exclusive breastfeeding. The first three questions verify whether or not the participant is a Doer or a Non-Doer.

1. How old is your infant? _____ (for this particular question only interview mothers with children 7-9 months. Sometimes it is hard to remember behaviors long after you have performed them).

2. Did you exclusively breast feed your child (meaning, did you feed your infant ONLY breastmilk between birth and six months)? _____Yes (Doer) _____No (Non-Doer)

3. Did your infant have anything to eat or drink apart from breastmilk during the first six months of life?_____Yes (Non-doer) _____No (Doer)

4. What are the advantages/benefits of feeding your baby only breast milk for the first 6 months?

5. What are the disadvantages or negative consequences (inconveniences) of feeding your baby only breastmilk for the first 6 months?

6. Who would approve/support you if you gave only breast milk to your infant during the first 6 months?

7. Who would discourage you from giving only breast milk?

8. Is giving only breast milk an acceptable behavior in your community?

9. What would make it easier for you to give only breast milk to your infant less than 6 months?

10. What makes it difficult?

11. If your baby ate or drank things other than breast milk in his first 6 months do you think s/he would get sick?

12. How serious is it when infants get sick or have diarrhea?

13. Can giving only breast milk prevent your infant from getting diarrhea and other illnesses?

14. How difficult is it for you to remember to give only breastmilk to your infant?
15. Can you remember not to give other things?

16. Does God approve of you exclusively breastfeeding?

Step 4: Take care of data collection logistics. In this step, you choose the communities and respondents that will be targeted to collect the Behavior Analysis (where you may find Doers & Non-Doers); seek authorization from appropriate gate keepers (communitychief, clinic managers, etc.); practice interviewing colleagues using the questionnaire; make sufficient copies of the questionnaires and arrange transportation to the interviewing locale.

During data collection

Step 5: Collect field data. In this step, you will administer the doer/non-doer surveys in your selected communities with your selected respondents. It the person you interview does not pass the screening questions, then you have to go find another respondent. Also you need to monitor how many Doers and NonDoers you have interviewed as you go along. The aim should be to collect interviews from 45 Doers and 45 Non-Doers so that you may successfully compare answers in these two groups.) Be sure to read the consent script (See Appendix 3 for an example) before administering the survey.

After collecting the data

After completing the survey read the debriefing script (see Appendix 3 for an example). Steps 6 and 7 address how to analyze your doer/non-doer surveys and then use your results.

Step 6: Organize and analyze the results. Once you have your completed surveys, you'll begin to review and organize your data. You and your team will begin by reviewing the surveys and capturing the most common responses for each question. Here are some specific steps to follow:

a) Divide the questionnaires into two stacks: 1) people who responded that they did the behavior (doers) and 2) people who said they did not do the behavior (non-doers).
b) Clearly mark each questionnaire with a "D" for doer or a "ND" for non-doers.

c) Keep stacks separated and divide each stack among staff who will help record and calculate the responses.
d) Develop a coding guide that includes all questions in the questionnaire. Record the most common responses under each question.

Table 7: Example of Blank Coding Guide

	DOERS (n=45)		NON-DOERS (n=45)	
		%		%
Question 7. Who would discourage you from giving only breast milk?				

e) Display the Coding Guide/Tally Sheet (use Flip chart paper) for everyone to see. Explain that the team will now jointly tabulate by hand, all of the results of the survey they conducted. Ask for a volunteer to help you calculate percentages.

Start with the first question. Ask the participants to look at the questionnaires in front of them and read (silently) the responses, looking for similar responses. Ask participants to say out loud any response that more than one respondent mentioned on their questionnaires. Then ask if any other participants' surveys have similar responses (have them indicate by a show of hands). Agree on a shortened wording of the response - the code - and which other similar responses should be included under this "code."

Write the common responses on separate lines of the Tally Sheet under the corresponding determinant question creating a shortened version of the response. (E.g. Answers to the question, "Who would discourage you from giving only breastmilk to your baby?" might be: "mother-in-law, husband, other relative, health clinic staff, religious leader; etc.").

Table 8: Example of Coding Guide with Codes

	DOERS (n=45)		NON-DOERS (n=45)	
		%		%
7. Who would discourage you from giving only breast milk to your baby?				
Mother-in-law	𝍸 𝍸 𝍸 𝍸 𝍸	55	𝍸 𝍸 𝍸 𝍸 𝍸	60
Husband				
Other relative				
Health clinic staff				
Religious leader				

Once all of the most common responses to the determinant question have been written in the first column (on the left), ask each participant to read the responses on the questionnaires in front of him/her and to tell you, by show of fingers, how many **Doers** responded with the same or similar response. For each same or similar response put a tick mark in the tabulation column under **Doers**.

Do the same for **Non-Doers**. (If a team member finds an “other” response, write the response on that line and add a tick mark in the appropriate column - Doer or Non-Doer - of the Tally Sheet.)

DO NOT offer responses that were written down for a different question even if they seem relevant to the one being tallied.

(f) Based on the total number of Doers and Non-Doers calculated at the beginning of the session, calculate the percentages for each common response given and record this on the flip chart before going on to the next determinant question.

(g) Repeat this process until all of the responses to each of the determinants have been coded and tallied for both Doers and Non-Doers and a percentage calculated. Make sure to record doer responses and non-doer responses in separate columns so you can compare the responses.

(h) When all questionnaires have been tabulated, calculate the percentages for each possible response. To do this, write down the total number of tick marks for each response and divide by the total number of doers or non-doers. For example in the table below, 27 doers responded that one an advantage to feeding their baby only breast milk for the first six months was that it is convenient out of 45 total doers. 27 divided by 45 and multiplied by 100 = 60%.

Table 9: Example of Coding Guide with Ticks and Percentages

	DOERS (n=45)		NON-DOERS (n=45)	
		%		%
4. What are the advantages/benefits of feeding your baby only breast milk for the first 6 months?				
Convenient	卌 卌 卌 卌 卌 ||	60	卌 卌 卌 卌 卌	55
Does not cost any money				
Keeps baby healthy				

(i) Once all percentages have been calculated, look for five or six of the biggest differences in percentage points between the doer responses and non-doer responses. **You are looking for a difference of at least 20 percentage points.**[43]

Important!

a. If percentage points are not very different between the 2 groups, then that item is not likely to be a determinant of the behavior for this target group.
b. If percentage points are radically different, this item is very likely to be a determinant of the behavior for this target group.
c. Knowledge about the health benefits of a behavior will often be similar for doers and non-doers and therefore, is often not a practical focus for an intervention.

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[43] Please note there is an excel sheet to gather significance. Here's the link to the latest BA tabulation table: http://www.caregroupinfo.org/docs/BA_Tab_Table_Latest.xlsx

Here's the link to the latest instructions on using it: http://www.caregroupinfo.org/docs/BA_Analysis_Excel_Sheet_Tab_Sheet_Explanation_Latest.doc

(j) Summarize your results in a table similar to the one pictured in Table 10. Under column 1, list the responses for each determinant and then report the percentages of Doers and Non-Doers in columns 2 and 3. In column 4, the implications column, categorize to what degree (H=high, M=medium, L=low) each of the responses are. A response is considered a 'high priority' if there is a significant difference between Doers and Non-Doers ($\geq$ 20 point split), and if an activity your project could do is likely to change the situation. So for instance, on Table 10 you will notice that that there is a 37 percent difference between Doers and Non-Doers regarding the perceived positive consequences of exclusive breastfeeding. 52 percent of Doers (mothers who exclusively breastfeed) compared to 15 percent of Non-Doers (mothers who don't exclusively breastfeed) indicate that a positive consequence of exclusive breastfeeding is a delay in pregnancy for the first six months after giving birth.[44] This response is considered a 'high priority' because of the large difference between the Doers and Non-Doers and because the project could potentially promote lactational amenorrhea (LAM) as a natural birth control method. A response would be considered 'medium priority' if there is a 10 – 19 percent split and a 'low priority' if there is a $\geq$9 percent split between the Doers and Non-Doers.

Please note that the direction of the split can change the interpretation of the results. If NoN-Doers are higher on a positive behavior (like self efficacy) than Doers, then you ignore the results because they are not relevant. However, if Non-Doers are higher on a negative characteristic like (negative consequences) than you can interpret this as a barrier that needs to be overcome.

Step 7: Use the results. Results from the barrier analysis can be used to inform your behavior change messages and strategies. For example, results can be used to:

- Promote and advertise advantages of a behavior
- Minimize things that make it difficult to do a behavior
- Help target audience develop skills to overcome the things that make the behavior difficult
- Adapt program design based on priority determinants, activities, and messaging
- Increase support of the behavior among people who disapprove
- Identify people who are advocates of the behavior so that they can be asked to give testimonies about the behavior

[44] Lactational amenorrhea (LAM) is the natural postnatal infertility that occurs when a woman is amenorrheic (not menstruating) and fully breastfeeding. LAM is 98% - 99.5% effective during the first six months postpartum if the following conditions are met:

- Breastfeeding must be the infant's only (or almost only) source of nutrition. Feeding formula, pumping instead of nursing and feeding solids all reduce the effectiveness of LAM.
- The infant must breastfeed at least every four hours during the day and at least every six hours at night.
- The infant must be less than six months old.
- The mother must not have had a period after 56 days post-partum (when determining fertility, bleeding prior to 56 days post-partum can be ignored).

Source: Planned Parenthood.

Table 10: Example Summary of Findings – Exclusive breastfeeding

Research findings	Doers %	Non-doers %	Implications	High priority	Medium priority	Low priority
Perceived positive consequences of exclusive breastfeeding						
Convenient	90	83	Small difference			*
Does not cost any money	95	92	Small difference			*
Keeps baby healthy	80	60	Possible difference		*	
Can delay pregnancy for the first six months	52	15	Difference- Educate on LAM	*		
Perceived negative consequences of exclusive breastfeeding						
Takes a lot of time	62	85	Difference- work on time management and expression of breastmillk	*		
Sometimes it hurts	25	47	Difference- work with mothers on positioning and attachment	*		
Baby can still be thirsty	27	30	Small difference			*
Perceived self-efficacy regarding exclusive breastfeeding						
Know how to properly attach baby to breast so they get enough milk	80	50	Difference- work with mothers on positioning and attachment	*		
Know how to express breastmilk	65	45	Possible difference		*	
Know how to cup feed	60	40	Possible difference		*	

You may decide to complete the Designing for Behavior Change (DBC) Framework[45] (see Appendix 4) for the high priority behaviors[46] your program will target. The DBC framework will help you think about all the different things that need to be considered when designing/reviewing a behavior change strategy. For instance, it will help you decide what key factors must be addressed through your activities. Which activities you will you use to address the priority and influencing groups and what indicators you will monitor during the life of your project.

The FSN Network has a behavior bank where you can see more examples of Barrier Analysis surveys. Go to: http://www.fsnnetwork.org/behavior-bank

[45]For more information on the DBC framework see the *Designing for Behavior Change Curriculum (*2008) that was developed by the CORE Group, Social and Behavior Change Working Group. Copies of this curriculum can be downloaded free of charge from http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

COMMUNITY MAPPING[47]

Objective:	Learn where the participants live, work, socialize and where they access services.
Used to:	Identify key locations in a community.
Timeframe:	45 minutes to 1 hour
Materials needed:	Flipchart paper, colored pens or markers, tape, pad of paper for note-taking, a voice recording device, a camera to take a picture of the map with
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper
Number of participants:	5-8

Background

A community map is a map showing important places in a community. These maps can indicate the location of houses, food production and gathering sites, sites for collection of fuelwood, sites for food distribution, water sources and health facilities, churches, or temples, markets, and so on.

Community mapping is useful to:

- Explore what people like about their communities and what people's concerns are about their communities and what they would like to change.
- Indentify services and resources available in a community, and gaps in services
- Highlight different groups' views. For example, a group of young women might draw different things on a map of the same area compared to a group of older women.

Example research questions

- What are the approximate boundaries of the community with regard to social interaction and social services?
- What is considered the poor area in the community?
- What is considered the wealthy area of the community?
- Is the number of households growing or shrinking in each of these areas? Why is that happening?
- What are the social structures and institutions found in the community?
- What religious groups are found in the village? Where are the different religious groups living?
- What ethnic groups are found in the village? Where are the different ethnic groups living?
- Which are the female headed households and where are they located?
- What places do the participants go to often and why do they go there?
- What services (e.g., health, agriculture, education, etc.) are used by the participants?
- What gaps in services exist?
- What places can women go as opposed to men?

[47] This module adapted from *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p 44.

- What resources are abundant?
- What resources are scarce?
- Does everyone have equal access to land?
- Do women have access to land?
- Do the poor have access to land?
- Who makes decision about land allocation?
- Where do people go to collect water?
- Who collects water?
- Where do people go to collect firewood?
- Who collects firewood?
- What kind of development activities do you carry out as a community? Where?
- What resource do you have most problems with?

Steps to follow

Before mapping:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (communitychief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a map with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During mapping:

1. Divide large groups into smaller groups. There should be about 5-8 participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men, etc.

2. Distribute markers and paper to the participants.

3. Provide directions for the exercise to the participants.
Ask the participants to work in a small group to draw a map of their community (where they live, work, socialize and access services). Have the participants add places that are in their communities such as markets, places of worship, non-governmental and governmental organizations, people or services that are available to the community when they are needed. Resources can also mean: roads, houses, health facilities (health posts, pharmacies, hospitals, clinics, growth monitoring locations, etc.), schools, water wells, factories, rivers, midwives, social workers, teachers, doctors, and so forth. Ask the participants to identify the various community resources by name or with a symbol. Add more paper as the map grows. Also ask the participants to indicate the places where they get information on IYCF and maternal nutrition and agriculture, participate in savings and loans groups on their map by marking it with a symbol of their choice. For the example a star has been used in the example map in Figure 10.

If the participants have never seen a map, explain that you are asking them to imagine how their village/district would look to a bird flying over it, and draw that image on paper. Reassure the participants that things do not have to be drawn exactly as they are in their community – the map is only to get a general idea of what the village/district looks like.

Different participants may draw very different maps of the same area, and that is fine, it reflects their different views of the community and the topic discussed.

If the group has trouble getting started, suggest that they begin by marking where they are right now on the map.

Be careful not to direct what is being drawn on the map and how it is being presented.

4. Once the group has finished their map, lead a group discussion that explores issues of access to resources. Ask probing questions to draw out more information from the map. Use the questions in the analysis section below to help guide the discussion.

After the mapping exercise is over:

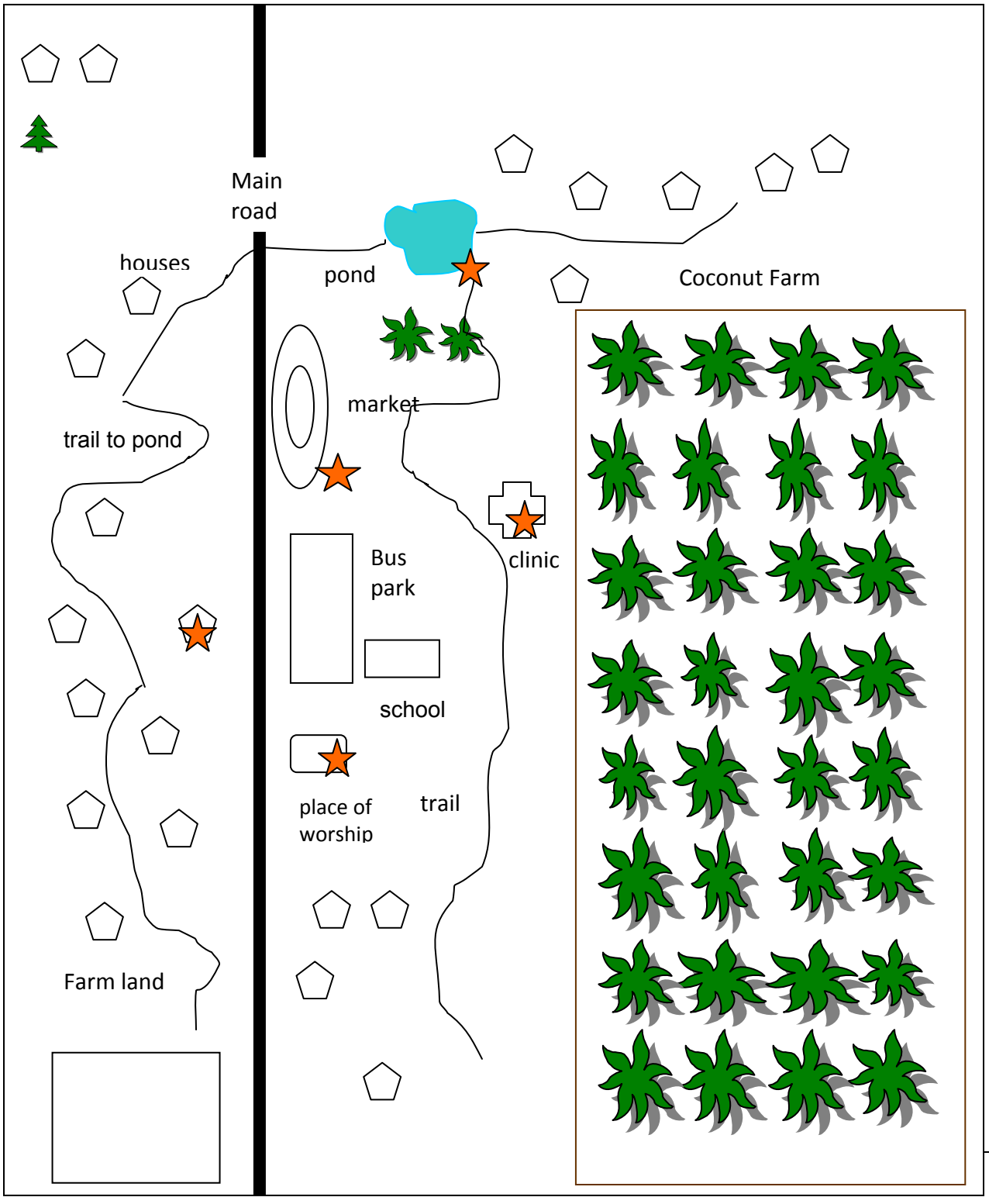
Take a photograph of finished maps and leave the paper copy with the community if they would like to keep it.

1. Write up notes from session. The facilitator is expected to take brief notes during each community mapping session. Be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the facilitator should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the maps and the write ups and write a brief summary. For your summary answer the following questions:

- Where do participants often go and why?
- What services / resources are used by the participants? What resources do women use? What resources do men use?
- What gaps in services / resources exist in the community?
- What are the key concerns and priorities of the participants?
- If several maps of a particular community were drawn, what common themes exist between all the maps? What is different?

Figure 10. Example community of a map



This is a place where pregnant and lactating women can get information about ICYF and rMN

GENDERED RESOURCE MAPPING[48]

Objective:	To identify resources and services in a community and who uses them.
Use to:	Gendered resource maps can be used for multiple purposes and they don't have to be used just to compare and contrast the differences between males and females. They can show the resources and services available in a community, and who can access and use them (for instance, men, women, adolescents, older people, varying castes, ethnic groups, varying religions, etc.). Additionally, they can show what resources and services different people need, but are unable to access, and can help identify where and from whom people seek information and advice on the particular health problem and why they use these information sources. Lastly, gendered resource maps can be used to help develop strategies for increasing access to existing resources and services.
Timeframe:	45 minutes to one hour depending on how many maps are completed.
Materials needed:	Flipchart paper, colored pens or markers, tape, pad of paper for note-taking, voice recording device, camera to take picture of finished activity, and a copy of the consent and debriefing scripts
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper
Number of participants:	8-12

Background

A gendered resource map is used to show important places in a community- for example, places of worship, markets, health services, schools, bars, places where people meet, place where people socialize, and so on and who uses them. For example, this type of map can identify what resources women use as opposed to men, or what resources women can access as opposed to men.

Gender resource mapping is useful to:

- Provide a non-threatening way to start a discussion about sensitive subjects such as gender norms, discrimination, or women's empowerment
- Understand the reasons why some people have access to resources and services and some people do not
- Start to identify strategies for increasing access to existing resources and services

Example research questions

For the purpose of this guide, we are going to focus on gender versus other differences (e.g., age, varying castes, ethnic groups, varying religions). The example questions are as follows:

- What agricultural resources and services are available to women as opposed to men in a community?
- What income generation opportunities exist for women as opposed to men?
- What social service programs are available to women as opposed to men in the community?

[48]The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 50.

- (If relevant) Where can women go without permission from family members as opposed to where men can go?

There should only be one research question per map.

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a map with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups**.** There should be about 8- 12 participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men, adolescent boys.

3. Distribute markers and paper to the participants.

4. Provide the following directions to the participants.
   1. First, ask the participants to agree who to show on the map (for example a women) and identify the research question.
   2. Have the participants draw the person in the center of the map.
   3. Ask the participants to agree what resources and services to show on the map- for example, resources and services women use in connection to income generation. Explain that resources could be the market, place of worship, non-governmental and governmental organizations, roads, houses, health facilities, health posts, pharmacies, hospitals, clinics, extension workers, schools, banks, mills, cell phones, water wells, factories, rivers, midwives, social workers, teachers, doctors, growth monitoring locations, etc. Ask the participants to identify the various community resources by name or with a symbol.
   4. On the left side of the person, show the resources and services that the person uses at the moment.
   5. On the right side of the person, show the resources and services that exist in the community, but which the person does not use now.
   6. Underneath the person, show additional resources and services that are needed. These can be resources that the community can provide or which need to come from outside.
   7. Discuss and compare what is shown on the different maps and how the situation can be improved.

Reassure the participants that things do not have to be drawn well. The process is more important than the artwork.

Different groups of participants may draw very different maps of the same area, and that is fine, it reflects their different views of the community and the topic discussed.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

5. Record and take notes on what is being said while the participants are creating each map. The conversation that participants have while making a map is often as important as the map itself.

6. Lead a group discussion about the map**.** Ask probing questions to draw out more information from the map(s). If more than one map was drawn, point out similarities and differences among them. Facilitate a discussion with the group. Use the analysis questions below as a guide for the group discussion.

After the session is over:

Read the debriefing script (see Appendix 3 for an example).

Thank the participants for their contributions. Take a photograph of the map and leave the map with the community if they would like to keep it.

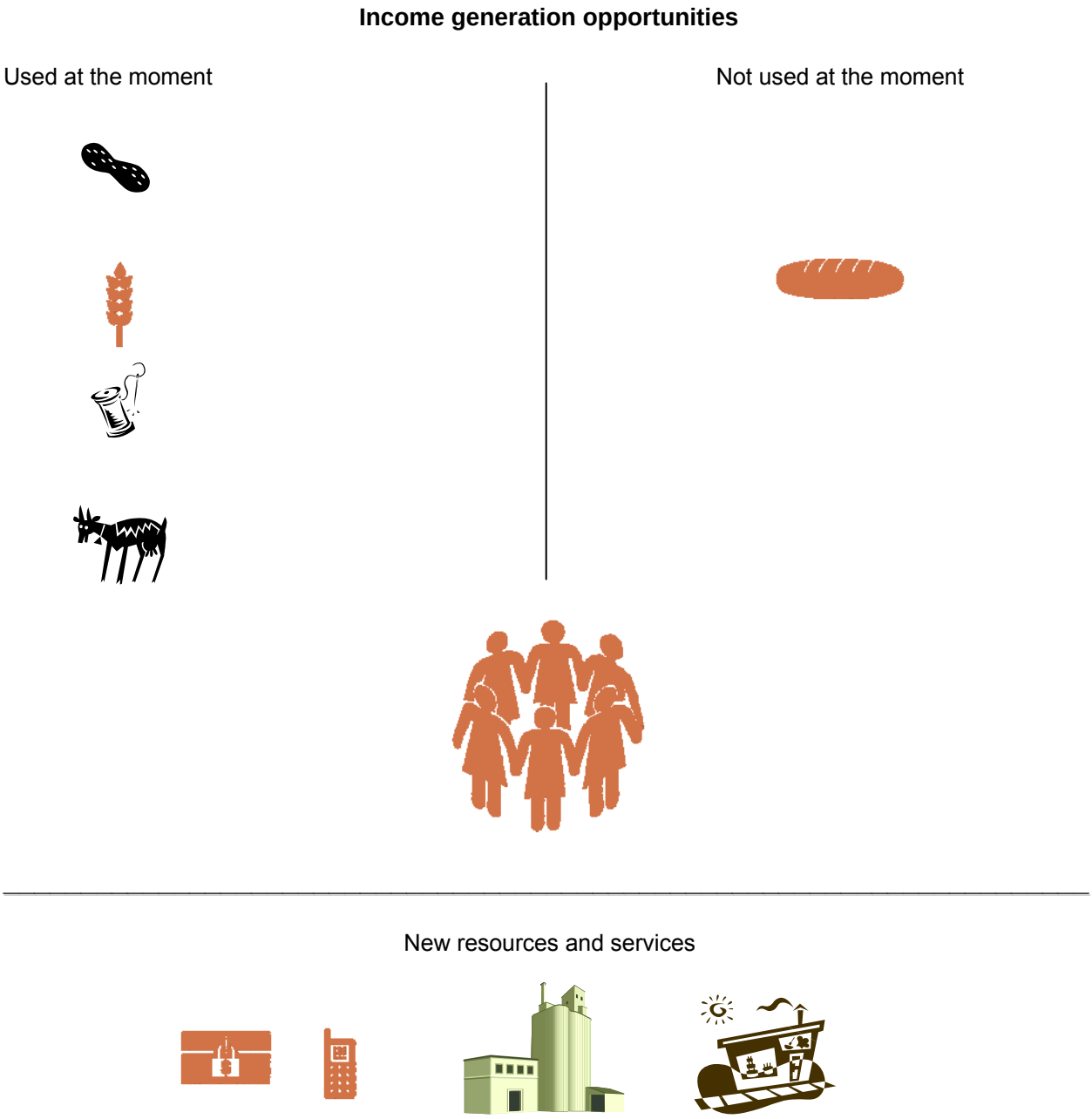
1. Write up notes from session. Tape record the session if possible, if not, the facilitator (or a note taker should take brief notes during each mapping session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the facilitator and/ or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the maps and the write ups and write a brief summary. Remember, the discussion the group has while they are creating a map is just as important as the map itself. Be sure to analyze the discussion as well. For your summary answer the following questions:

- What resources and services are available to different people and who uses them? For example, what resources and services are available to women? Which are available to men? Can all women and all men use these resources?
- What are peoples' perceptions about the available resources? Are the resources adequate for the community's needs?
- What are the reasons why some people have access to resources and services and some people do not?
- Did key themes exist between all the maps? Did the participants agree with one another when they were drawing the map? What differences of opinions between group members occurred.
- What strategies for increasing access to existing resources and services came out of the session?

Another way to do resource mapping is by adding them to community maps. "A community map is a map showing important places in a community – for example, churches or temples, markets, health services, schools, bars, place where people meet, places where people socialize, and so on."[49]

Figure 3. Example gendered resource map- Income generation opportunities exist for women



[49] *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 44.

SOCIAL NETWORK (RELATIONSHIP) MAPPING[50]

Objective:	Create a map that shows what relationships are important to a particular group.
Used to:	To explore social relationships in a community
Timeframe:	45 minutes to one hour
Materials needed:	Flipchart paper, colored pens or markers, tape, voice recording device, and a camera to take a photograph, and a copy of the consent and debriefing scripts
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper
Number of participants:	8-12

Background

Social maps are diagrams that show relationships that are important to a person (or family or peer group). During a social mapping exercise, participants are asked to identify what they consider to be sources of social and institutional support within their community. This activity is also a good way for development workers to obtain valuable information regarding resources that are already present in the community, as well as get a sense of what additional resources might be needed. The tool is particularly sensitive to the composition of the participating group.

Social network maps are useful to:

- Explore relationships within a community
- Understand what is important about these different relationships- for example, do these relationships provide practical help, emotional support, or information?
- Understand how people communicate within a community, and how information is shared (not shared)
- Explore how different people (or groups) are involved in decision-making
- Explore the benefits and risks of different relationships
- Understand divisions and isolation within a community- for example, do women and men spend most of their time away from each other?

Example research questions

- What supportive relationships exist in the community in regards to maternal and child health and nutrition?
- What supportive relationships exist in the community in regards to household food security?
- Who are the people in the community that influence nutrition practices?
- Who makes decisions regarding food security?

[50] The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 60.

- How do people communicate within the community (or not) about health and development issues? What people in the community are left out of community activities or who do the community members lack a relationship with?

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a map with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups**.** There should be about 8- 12 participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men, adolescent boys.

3. Distribute markers and paper to the participants.

4. Provide the following directions to the participants.

1. Ask the participants to agree whose relationships to map. For example the relationships of a 'typical' young mother in the community. Ask the group to draw the person in the middle of the page.
2. Ask the participants to draw all the people (or households, groups, churches, temples, and so on) with whom they have important relationships on the map. Use lines to indicate relationships. Use different colored lines, or lines made from different objects to show different kinds of relationships- for example, 'helping' relationships, friendships, business relationships and so on.
3. Instruct the participants to use distance between people and the person cared for on the map to show the importance of the relationship- the closer to the person, the more important

Different groups of participants may draw very different maps of the same area, and that is fine, it reflects their different views of the community and the topic discussed.

5. Lead a group discussion about the map. Once the group is finished making the map, ask probing questions to draw out more information from them. If more than one map was drawn, point out similarities and differences among them. Explore how circumstances affect a person's social network. For example, how is the social network map of a young mother different from a grandmother? How does a women's social network change when they get married? Why are some people/organizations closer to the person in the center of the map than others? See the list of questions related to the analysis section for additional questions. Facilitate a discussion with the group. Use the analysis questions below as a guide for the group discussion.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

6. The note taker is expected to take brief notes during the social mapping session. Be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participants' non-verbal behaviors and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

After the session is over:

After completing the survey read the debriefing script (see Appendix 3 for an example).

Thank the participants for their contributions. Take a photograph of the map and leave the map with the community if they would like to keep it.

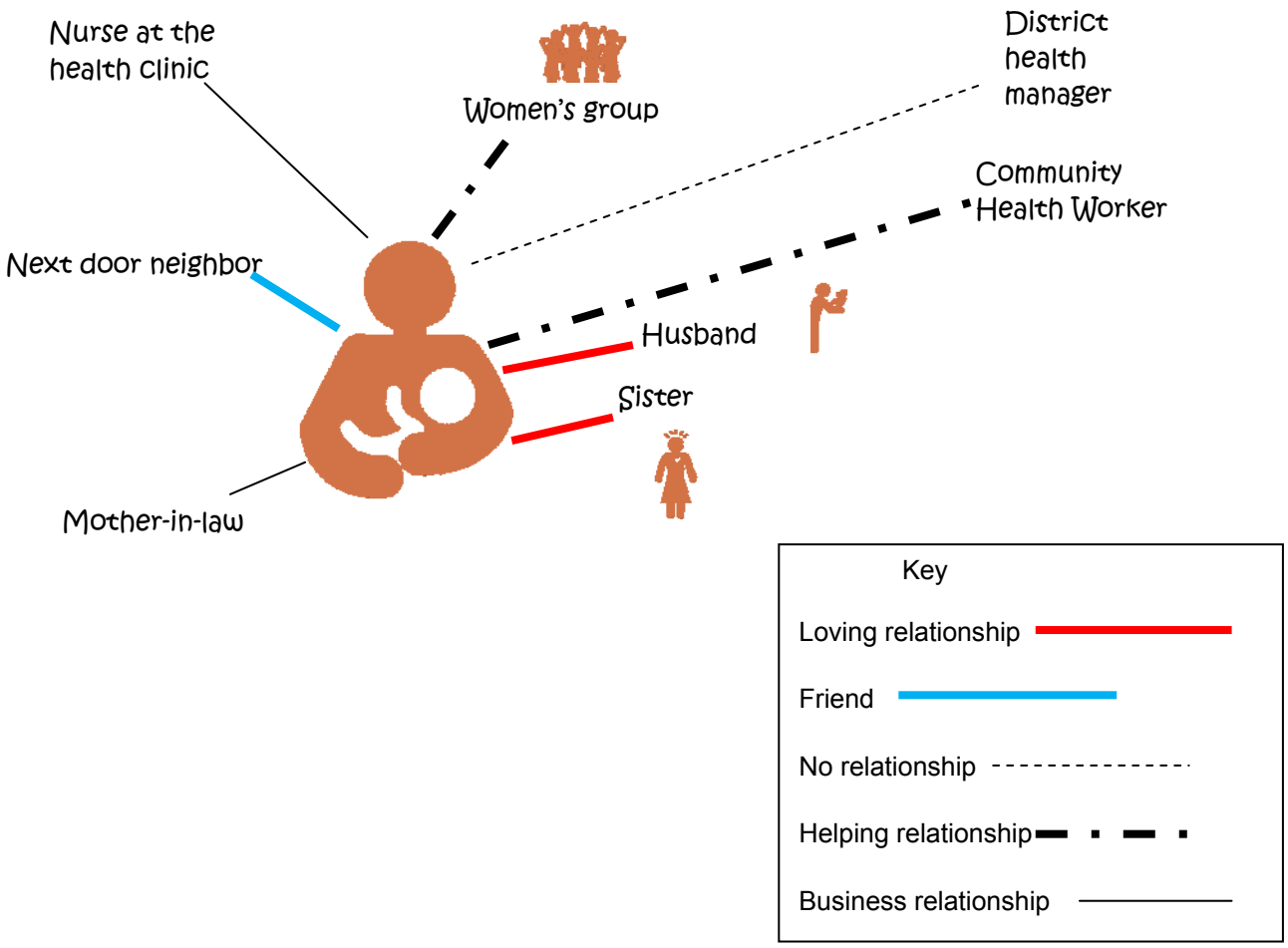
1. Write up notes from session. Tape record the session if possible, if not, the facilitator (or a note taker should take brief notes during each mapping session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the facilitator and/ or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the maps and the write ups and write a brief summary. Remember, the discussion the group has while they are creating a map is just as important as the map itself. Be sure to look analyze the discussion as well. For your summary answer the following questions:

- Who in the community offers the participants support and information?
- What sources of information do women trust the most? Why?
- How do people communicate within a community, and how is information shared (or not shared)? Who shares with who and why?
- How are decisions made in the community around maternal and child health and nutrition and household food security? Who makes those decisions and why?
- What relationships do the participants benefit the most from? What relationships do the participants benefit the least from? Why?
- Who are the people in the community with very few relationships and why?

An example map is provided in Figure 4. This map shows the people who influence a young women's decision to practice exclusive breastfeeding. In particular who offers support to her to practice exclusive breastfeeding and who does not?

Figure 4. Example A: Social relationship map of the people that influence young women to exclusively breastfeed.



DAILY ACTIVITY CHART[51]

Objective:	To explore the workload challenges people (mothers, fathers, and frontline health/ nutrition workers) face and how both might interfere with optimal IYCF and maternal nutrition and programming
Used to:	Show how people spend their time over the course of a day. This activity will also provide insight about the time and effort people spend on different activities and the choices people make. From a programming standpoint, it will identify when people are free to participate in program activities.
Timeframe:	45 minutes to one hour
Materials needed:	Flipchart paper, colored pens or markers or seeds, tape, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper
Number of participants:	2 -7

Background

Daily activity charts show how people spend their time over the course of a day. They can help the population clarify their roles, identify problems and help the community assess the feasibility of possible solutions. Different time charts can be drawn up as needed according to gender, main occupation or age, and according to the time of year.

Daily activity charts are useful to:

- Explore and compare how different people spend their work and leisure time
- Discuss the roles and responsibilities of different types of people
- Explore the factors that influence the differences between different types of people
- Understand the problems and obstacles faced by different people
- Identify important times of the year- for example, times when people are particularly busy or vulnerable to food shortages
- Plan activities by helping to identify the best time to work with particular groups

Example research questions

- For each person, how is his or her time divided?
- What is the difference between the women's and the men's and girl's and boy's charts?
- Who has the heaviest workload?
- Who has time for rest and leisure?
- What are the factors that influence these differences?
- What are the problems and obstacles faced by different people?
- When is the best time for program activities?

[51] The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 70 and *Guidelines for Participatory Nutrition Projects, Chapter 2: Participatory appraisal of community food and nutrition*, FAO, Agriculture and Consumer Protection Department. This document is a available for download at: http://www.fao.org/docrep/V1490E/v1490e02.htm

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a daily activity chart with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups. There should be about 8- 12 participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men, adolescent boys, religious leaders, community health workers, etc. You can ask women and men to draw their own activity chart or alternatively, you can have them draw each other's activity chart. This is a good way to open up discussion about how women and men see each other's situation.

3. Distribute markers and paper to the participants.

4. Provide the following directions to the participants.
   1. Have the group decide whether to show time in hours or as parts of the day- for example, morning, afternoon, evening.
   2. Have the participants agree whose daily activities to chart. Participants can make daily activity charts for themselves or for other types of people they know of in the community. It is often interesting to understand how people perceive other people's roles and responsibilities. The activities should represent an average day.
   3. Have the participants list the daily activities on the chart at the appropriate times.
   4. If the participants are interested, they can expand the daily activity charts into weekly activity charts. Weekly activity charts may be useful if there is a weekly routine to people's lives, such as employment or religious activities that programming activities need to be planned around.

5. Record and take notes on what is being said while the participants are creating the activity chart. The conversation that participants have while making an activity chart is often as important as the chart itself.

6. Lead a group discussion about the activity chart. Discuss what is shown on the charts. Compare the charts for different types of people. Use the analysis questions below as a guide for the group discussion. You can also ask the participants to place beans or other objects (stones, stacks, etc.) next to the activity or activities that take up the most time and discuss this.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

After the mapping exercise is over:

After completing the survey read the debriefing script (see Appendix 3 for an example).

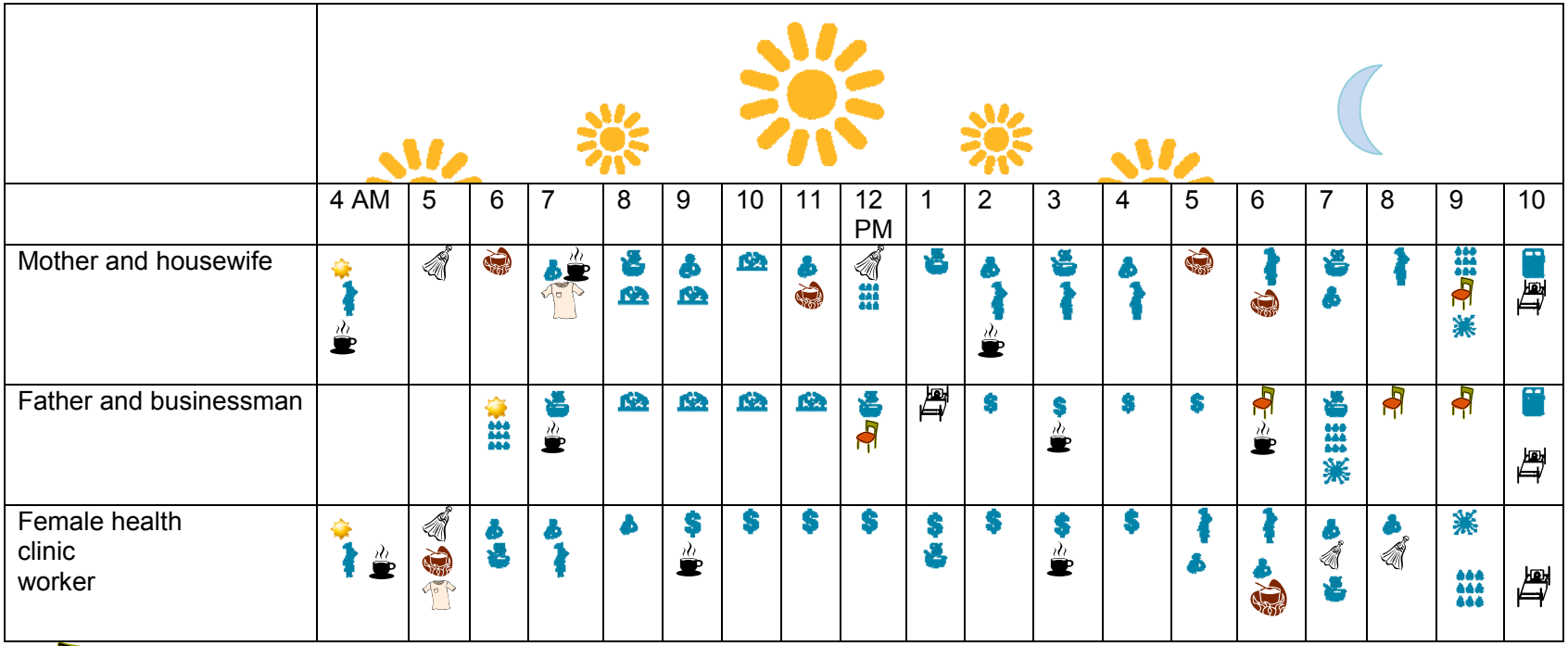
Thank the participants for their contributions. Take a photograph of the activity chart and leave the activity chart with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the facilitator (or a note taker should take brief notes during each mapping session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the charting exercise. Notes taken during the charting exercise do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the activity chart(s) and the write ups and write a brief summary. Remember, the discussion the group has while they are creating a map is just as important as the map itself. Be sure to analyze the discussion as well. For your summary answer the following questions:

- How do different people spend their work and leisure time?
- What are the roles and responsibilities of different types of people?
- What factors influence the differences between different types of people? For example, do young mothers have less leisure time than older mothers?
- What problems and obstacles do different people face in their daily lives?
- What important times of the year occur in the community? For example, are there times when people are particularly busy or vulnerable to food shortages?
- What is the best time to work with mothers, fathers, grandmothers, religious leaders, community health workers, health facility workers?

Figure 6. Daily activity chart showing how a housewife, businessman and health care worker spend their day.



SEASONAL CALENDAR[52]

Objective:	To explore changes over a course of the year that might affect IYCF and maternal nutrition as well as household security.
Used to:	Diagram the changes over the period of 12 months and identify the changing availability of food, or income, work and migration patterns, etc. Seasonal calendars can also identify when people may be particularly vulnerable. These various factors are important to consider when designing a program.
Timeframe:	45 minutes to one hour
Materials needed:	Flipchart paper, colored pens or markers, tape, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper
Number of participants:	8 -12

Background

Seasonal calendars can be prepared by specific groups in the community (e.g. mothers of children under two, farmers, landless laborers, community leaders). The topics can include weather, religious and social activities, cropping patterns, food availability, economic activities, price of foods, cash flow in and out of the house, expenditures planned, common illnesses, migration, labor demand (in particular for women), etc., and show how these change during the year. Calendars help clarify seasonal constraints on adequate nutrition (nutritional stress periods) and constraints on solving them.

Calendars will be useful to refer back to during the selection of activities when establishing their timing and phasing. They can also help identify time-dependent opportunities, such as when new crops could be grown. Comparison of calendars drawn up by different population groups may reveal differences in perception and can lead to useful discussions and new information.[53]

Seasonal calendars are useful to:

- Identify seasonal patterns of change, for example, changing availability of resources, such as food or income, work and migration patterns
- Explore relationships between different patterns of change, for example, the relationship between income levels and movements
- Identify when people may be particularly food and nutrition insecure

[52] The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 76.
and Guidelines for Participatory Nutrition Projects, Chapter 2: Participatory appraisal of community food and nutrition, FAO, Agriculture and Consumer Protection Department. This document is a available for download at: http://www.fao.org/docrep/V1490E/v1490e02.htm

[53] *Guidelines for Participatory Nutrition Projects, Chapter 2: Participatory appraisal of community food and nutrition*, FAO, Agriculture and Consumer Protection Department. This document is a available for download at: http://www.fao.org/docrep/V1490E/v1490e02.htm

- Explore seasonal patterns of well-being and hardship and how different people are affected. For example, when do people have the most income? When do people have free time? When are people more vulnerable to illness?

Example research questions

- How does household food security fluctuate during different seasons during the year?
- How do work-related migration patterns fluctuate during the year?
- What are the busiest months of the year?
- At what time of the year is food scarce?
- How does income vary over the year for men and women?
- How does expenditure vary over the year for men and women?
- How does rainfall vary over the year?
- How does the availability of potable water vary over the year?
- How does availability of livestock forage vary over the year?
- How does availability of credit vary over the year?
- At what time of the year are which holidays?
- When do women carry out most of the agricultural work carried and what work is done when?
- When do men carry out most of the agricultural and what work is done when?
- What non-agricultural work do women carry out and when?
- What non-agricultural work do men carry out and when?
- What is the most appropriate season for additional activities for men and women?
- What time constraints exist and for what reason?
- What are the relationships between different patterns of change?

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a seasonal calendar with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups. There should be about 8 - 12 participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men, adolescent boys.

3. Distribute markers and paper to the participants. Alternatively, beans or seeds can be used instead of having the participants draw. A lot of seeds placed on a month will indicate an increase while a decrease can be indicated by just a few beans.

4. Provide the following directions to the participants.

1. Discuss what calendar and seasonal landmarks are used locally- for example:
    - Weather/ seasons
    - Religious/ social/ National holidays or events
    - Economic activities
    - Work cycles/ Periods of intense work
    - Migration
    - Common illnesses
    - Cash flow
    - Crops/ Food availability
    - Locally available food
    - School schedule

   Have the participants draw a horizontal calendar line (from left to right) making seasonal landmarks.
2. Have the participants agree on what activities, events or problems are going to be discussed and mark changes in these along the calendar line. See suggested research questions on the previous page.
3. Suggest that the participants may find it easier to start discussing general issues such as climate, economic activity, and income.

Reassure the participants that things do not have to be drawn well. The process is more important than the artwork.

Different groups of participants may draw very different maps of the same area, and that is fine, it reflects their different views of the community and the topic discussed.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

5. Record and take notes on what is being said while the participants are creating the calendar. The conversation that participants have while making a calendar is often as important as the calendar itself.

6. Lead a group discussion about the map. Ask probing questions to draw out more information from the calendar. If more than one map was drawn for the same community, point out similarities and differences among them. Facilitate a discussion with the group. Use the analysis questions below as a guide for the group discussion.

<u>After the session is over:</u>

After completing the survey read the debriefing script (see Appendix 3 for an example).

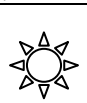
Thank the participants for their contributions. Take a photograph of the calendar and leave the calendar it with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the facilitator (or a note taker) should take brief notes during each calendar session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the calendar making session. Notes taken during the calendar making session do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the maps and the write ups and write a brief summary. Remember, the discussion the group has while they are creating a seasonal calendar is just as important as the map itself. Be sure to analyze the discussion as well. For your summary answer the following questions:

- What are the seasonal patterns of change in relation to food security, family income and work-related migration during the year?
- When do people have the most income? When do people have free time? When are people more vulnerable to illness?
- What are the relationships between different patterns of change, for example, the relationship between income, food access and consumption or the rainy or dry season and food consumption.
- When are people food and nutrition insecure?

Figure 5. Seasonal calendar identifying food insecurity and other time-dependent factors in a community in Sierra Leone

January	February	March	April	May	June	July	August	September	October	November	December
Weather											
											
Religious and Social Activities											
	 National holiday		 National holiday				Eid-Ul-Fitr		Eid-Ul-Adah		Christmas
Economic Activities											
											
Common Illnesses											
 coughing			 diarrhea				 coughing	 Malaria	 diarrhea		 colds
Cash flow											
											
Food availability											
 Rice											
Locally gathered food											
Rice, Broad beans, Groundnut, Millet, Sorghum, Maize, Sesame, Yams, Palm oil, Coco yam, Cassava, Potato, Pumpkin, Meat, Fish; Fruits-Oranges, Pawpaw, Breadfruit, Plum, Lime, Banana					Hunger gap			Rice, Wide roots, Maize, Cassava, Okra, Palm oil, Cucumber, Pumpkin, Beans, Garden Eggs, Fruits-Oranges, Lime, coconut, Meat, Fish, Spinach			

'TYPICAL' FATHER/ MOTHER/ GRANDMOTHER[54]

Objective:	To explore how equity, gender roles, and power relations affect IYCF and maternal nutrition practices
Used to:	Identify the roles, qualities, and behaviors expected of 'typical' father/ mother/ grandmother and explore what happens if a woman or man does not do what is expected of them. This tool is particularly useful for exploring issues such as vulnerability, power, and cultural traditions.
Timeframe:	One and a half hours
Materials needed:	Flipchart paper, colored pens or markers or seeds, tape, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see and write on the flipchart paper and for the combined group (up to 24 participants) to come together for a discussion
Number of participants:	8-12 women and 8- 12 men in same sex groups

Background

"Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female at a particular point in time."[55] This tool involves participants drawing and describing the 'typical' father/ mother/ grandmother and identifying the gender roles, qualities and behaviors expected of them. It involves exploring what happens if a woman or man does not follow the typical gender roles.

This activity helps to:

- Provide a non-threatening way to identify the different roles, qualities, and behaviors expected of fathers and mothers, especially as they relate to maternal nutrition and child feeding practices
- Explore where those roles, qualities and behaviors come from and the pressures associated with them
- Identify what happens if people do not follow the expected roles, qualities, and behaviors
- Explore what roles, qualities, and behaviors could change and how that can be done

Example research questions

- What roles, qualities and behaviors are expected from the 'typical' father/ mother/ grandmother particularly around child care and being a mother/father in a given community?
- What happens if people don't follow them?

[54] The information contained in this module was adapted from the following two sources, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 88 and *Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health.* (2007), CARE, p. 57 -61.
[55] *Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health.* (2007). CARE, p.58

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice running a session on gender boxes with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

Please note that you will need two note takers for this activity because there will be one female and one male group meeting simultaneously before the group comes back together for a discussion.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups. There should be about 8- 12 participants per group. Form women-only and men-only groups. The female and male participants need to sit in separate locations for the first part of the group and then come together for the second part of the group.

3. Distribute markers and paper to the participants.
Please note: If you conduct this activity with low-literacy populations (if they can't write or draw these roles, you might need to have a note taker do it for them

4. Provide the following directions to the participants.

1. Ask the participants to think about the first words that come to mind when they hear the words "man." Write down "FATHER" at the top of the sheet of paper and then put the responses from the group below. Repeat this for the word "MOTHER" and "GRANDMOTHER."
2. When the lists are complete, ask participants if any of the roles can be reversed.
    - Can any of the "father" words also describe mothers?
    - Can any of the "mother" words also describe fathers?
    - Can any of the "father" or "mother" words also describe grandmothers?
    - What are the things that fathers, mothers and grandmothers can do exclusively?
    - Can a mother make decisions about household finances and resources? Can a mother own land? Can a mother move about the community without a chaperon? Can a mother have a job outside the home? Can a mother object to any directive that the father or grandmother give her? Etc.
    - Can a father cook for the family? Can a father clean the house? Can a father help look after the children? Can a father let his wife make decisions for the family? Can a man be fair? Etc.
    - Can a grandmother make decisions on how household finances can be spent? Is a grandmother's suggestions supposed to be followed no matter what? Is a grandmother typically more powerful than a husband when it comes to how children should be fed and cared for?
    - Who has more power over a mother? Her husband or her mother/ mother-in-law?

3. Ask the participants to draw a 'typical' father, mother and grandmother near the representative list of words.

5. Record and take notes on what is being said while the participants are listing what a typical father/mother/grandmother are like and while they are drawing. The conversation that participants have while completing this exercise is often as important as the finished product.

6. Display the sheets of paper so that others can see.

7. Bring the male and the female groups back together and lead a group discussion. Ask the participants to review each other's words and drawings. Initiate a discussion with the group about what they think of each others' words and drawings. Ask some or all of these questions as a starting point; ask additional probing questions as appropriate. You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group. Encourage debate within the group and be ready to spend some time discussing the issues that arise. This is a good way to open up discussion about how women and men see each other's situation.

- What is correct about the list of words? About the drawings?
- What is surprising or unexpected?
- What pressures do women and men face to act the way a 'typical' father or mother should act?
- Where does that pressure come from?
- What happens if the 'typical' father/mother/ grandmother does not behave how society expects?
- How does gender affect child care?
- What are the advantages of people following and not following gender roles in relation to child care?

<u>After the exercise is over:</u>

After completing the exercise read the debriefing script (see Appendix 3 for an example).

Thank the participants for their contributions. Take a photograph of the typical father/mother/grandmother lists of words and drawings. Leave the paper with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the facilitator (or a note taker should take brief notes during each session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the exercise. Notes taken during the exercise do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the activity chart(s) and the write ups and write a brief summary. Remember, the discussion the group has while they are creating a map is just as important as the map itself. Be sure to analyze the discussion as well. For your summary answer the following questions:

- What are the gender roles, qualities and behaviors expected of fathers, mothers and grandmothers in the community?
- How do roles, qualities and behaviors affect child care?
- Where do these roles, qualities and behaviors come from?
- What pressure do people feel to follow gender roles?
- What happens if people do not follow the expected roles, qualities and behaviors?
- What roles, qualities, and behaviors did the participants identify that need to be changed? List any ideas the participants had on how to change roles, qualities, and behaviors.
- What vulnerabilities do mothers face?
- What cultural traditions strengthen roles, qualities, and behaviors expected of fathers, mothers and grandmothers?

Figure 7. A 'typical' mother, father and grandmother

MOTHER

Nurturer
In the home
Passive
Kind
Subordinate
Obedient
Tolerate
Illiterate

Talkative
Beautiful
Sexy
Gentile
Jealous
Child care
Cannot own land
Limited mobility
Must seek permission

No sex before marriage- Virtuous
Does all the housework, collects water and firewood
Cooks all the food
Has no control over family finances or household resources
Makes limited decisions about household affairs

FATHER

Selfish
Dominant
Power
Brave
Main source of financial support and protection for the family
Highest social status in the family
Makes decisions about family finances and household resources
Has little parental involvement
Rarely at home
Has girlfriends- Unfaithful
Drinks alcohol
Can own land

Lazy
Violent
Strength
Loud
Mobile
Can do as he pleases

GRANDMOTHER

Dominant
Powerful
Bossy
Loud
Mobile
Makes decisions about small purchases for the household
Is very involved in helping to raise the children
Is at home most of the time
Does some housework, collects water and firewood

LOCAL FOOD ASSESMENT[56]

Objective:	To gain a better understanding of the food that is available in the markets, kiosks, stores, and fields in the community and what is accessible to the target population.
Use to:	Determine what food is available in a given community, in what quantities, the price of the food items and what food is available during particular growing seasons.
Timeframe:	As much time as needed
Materials needed:	A camera, consent form for food market analysis , food market survey and a pen
Ideal workspace:	Places where food is sold
Number of participants:	1-2 data collectors

Background

A local food assessment is a simple and quick way to determine what food is available in a given community, in what quantities, the price of the food items and what food is available during particular growing seasons. The assessment can also be used to determine whether the food that is available has been locally grown on farms or home gardens, and/or locally manufactured, or whether is has been imported to the community via commercial markets or as food aid.

Local food assessments are useful to:

- Assess the availability and access to specific food items in a community and how it fluctuates during the year
- Identify main food commodities available and in demand on markets

How the data from the local food assessment will be used for programming

The data and photographs collected during the analysis can be used for the card sorting exercise (see the next module in this guide) which will provide a better understanding of the availability of foods as well as the behaviors revolving around dietary diversity and food consumption of pregnant and lactating women and infants and young children.

You might want to conduct several assessments during the course of a project.

[56] The following section was adapted from, *How to Conduct a Food Security Assessment.* (2006, 2ND Ed.). International Federation of Red Cross and Red Crescent Societies, Geneva. This publication can be downloaded from www.ifrc.org

Steps to follow

Before the data collection:

1. Locate and select data collectors.

2. Define a region to analyze. A region should be identified based on geographic boundaries, budget and the amount of time available to conduct the market analysis.

3. Identify markets, stores, kiosks and fields within the community. This can be done through community mapping, transect walks, and observation and interviewing of residents of the region determine the most popular shopping areas.

4. Pick the markets, stores, kiosks and fields for the assessment. Based on resources and time available for the assessment, pick a representative variety of food establishments (large and small markets, stores, kiosks and fields). Be sure that all of the food categories will be covered by the establishments that are chosen.

5. Visit the establishments to obtain consent from owners and/or managers to conduct the survey. Take the provided consent script (see Appendix 5) stating the purpose of the survey and ask participants whether they agree to participate. Be sure to state that names and prices will not be published and all information collected will remain confidential, we do not intend to disrupt the flow of business, and that we may like to meet with the owner or manger for five minutes after the survey for any follow-up questions.

6. Set a time and date for the visit. For stores, be sure to set a time and date when most, if not all, foods will be available for sale (i.e. after shipment and stocking). For markets, arrive early in the day to ensure that most/all products will be available to be analyzed.

During the data collection:

1. Fill out the local food assessment sheet (see Appendix 6). Walk down the aisles and be sure to record all fresh fruits and vegetables, all bread cereal and grain products, all fresh dairy products, all fresh meat and fish products, any available breast milk substitutes and a few of the most popular snack foods.

2. Take pictures of the individual food items.

3. Follow up with owners/managers and thank them for allowing you to conduct the analysis and ask any questions. Most importantly find out if any major products are missing from the store on this particular day, why and for how long.

After the session is over:

1. Compile the food market assessment sheets and write a brief summary.

CARD SORTING[57]

Objective:	To count, measure, and rank perceptions and explore people's priorities.
Timeframe:	1 hour
Materials needed:	Pre-made food cards, pens, paper, data collection forms, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see the cards
Number of participants:	1 -5

Please note that for this activity you will need to make food cards ahead of time.

Background

Card sorting is a simple way to organize information. During a card sorting session, participants are asked to sort cards with images into piles so that each pile consists of items that are considered similar to one another.

Card sorting is useful for:

- Organizing information
- Determining what criteria are most important to the participant
- Determining the similarity and differences between certain items, terms and concepts
- Learn about food proscriptions and prescriptions for pregnant and lactating women and children 6 -23 months old.

[57] The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance.

Example research questions

- In broad terms, what food is available and being consumed by pregnant and lactating women and infants and young children and why?
- Specifically, what foods are important and acceptable for children 6 -23 months to eat?
- What foods are important and acceptable for pregnant women to eat?
- What foods are important and acceptable for lactating women to eat?
- What foods should children 6 -23 months never eat?
- What foods should pregnant women never eat?
- What foods should lactating women never eat?
- What foods are reserved for men to eat?
- What foods are always available in the community?
- What foods are seasonal?
- What foods are too expensive to eat on a daily basis?

Steps to follow

Before the card sorting activity:

1. Create food cards. One option to create food cards that are appropriate for the community you are working in is to go to the local market and ask permission to take photographs of all the available food. Each food item should be photographed individually. The photograph can then be turned into a card with a number on the back of the card. Each card should be assigned a number. This number will be recorded on the card sort data collection form by the note taker and later used for data analysis. See an example card in Appendix 7. Make multiple decks and make sure that the same items are in each deck and assigned the same number. Create a master list of all the foods and the numbers assigned to the food item.

2. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice making a map with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the card sort:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups. Card sorting works best with smaller groups of people. There should be no more than five participants per group. Form the groups based on common groups in the community, young mothers, older women, adolescent girls, young fathers, older men.

3. Place the all the cards on a table face up so that they can be seen by all the participants. The participants will remove the food cards that are not relevant for each card sort.

4. Now ask the participants to sort the cards into different categories. Suggested categories are listed below. Probe on why these foods should / should not be eaten.

- Foods that are given to infants as soon as they are born
- Foods that are important and acceptable for children 6 -23 months to eat
- Foods that are important and acceptable for pregnant women to eat
- Foods that are important and acceptable for lactating women to eat
- Foods young children ages 6 -23 months should never eat
- Foods pregnant women should never eat
- Foods lactating women should never eat
- Foods that are reserved for men to eat
- Foods that are always available in the community
- Foods that are seasonal
- Foods that are too expensive for the family to eat on a daily basis
- What foods are modern foods? What foods are traditional foods?

Once the participants are finished sorting the cards, ask them to discuss what is in the category and why.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

Ask the participants if they have suggestions for further card sorts they would like to do. Allow the participants to complete any additional card sorts that they are willing to do. Be sure to record the data.

Instructions for the note taker. **In addition to taking notes during the card sorting exercise,** the note taker is responsible for filling out a card sort data collection form for each category of food asked about (see Appendix 8 for a blank form). For accuracy, the note taker should write down the card number versus the name of the food on the card sort data collection form.

Table 11: Example card sort data collection form that has been filled out

Category of card sort	Card number	Notes
Foods that are important and acceptable for pregnant women to eat	2 17 3 12 7 5 9 10 25 27 29	Mostly carbohydrates
Foods that are reserved for men to eat	6 26 1 19 13 18	Mostly animal source foods
Foods that are seasonal	21 28 10 4 5 12	Mostly fruits and vegetables
Foods not eaten by pregnant women	8 5 12 23	There was a lot of discussion about the consumption of wild animals and what they can do to the fetus,

After the card sorting exercise is over:

After completing the survey read the debriefing script (see Appendix 3 for an example).

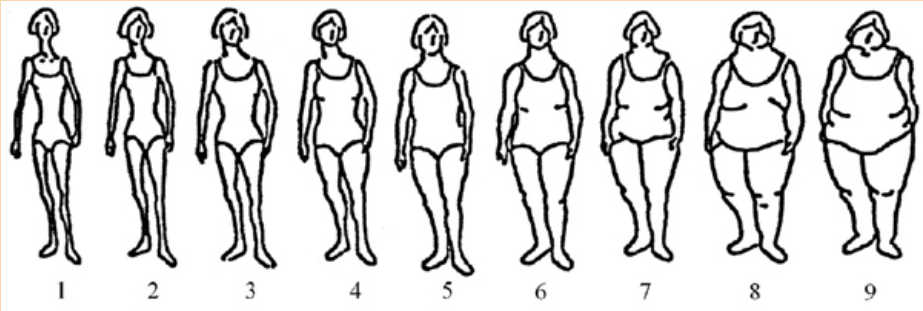
Thank the participants for their contributions. Take a photograph of each card sort.

1. Write up notes from the session. Tape record the session if possible, if not, the facilitator (or a note taker should take brief notes during each sorting session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the sorting exercise. Notes taken during the sorting exercise do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

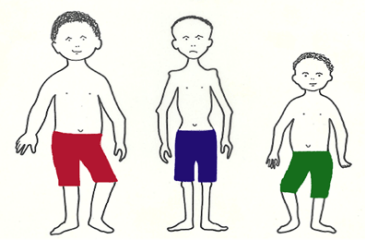
2. Analyze the card sort forms and write a brief summary. Remember, the discussion the group has while during the sorting exercise is just as important as the end result so be sure to analyze the discussion as well. For your summary answer what is in each category and why. The person doing the analysis will need to consult the master list to find out what food item was assigned what number. Staple the summary and the data analysis forms together.

OPTIONAL EXERCISE: Card sorting activity on perceptions related to maternal and child nutrition.

You will need to create a set of cards with images of nonpregnant women, pregnant women and children under five that are a mixture of underweight, overweight and optimal weight and from different wealth strata (ultra poor, poor and wealthy). You would need to make these cards in country. The images can be photographs you take or drawings from a local artist.



Example images of non-pregnant women



Example images of normal weight, underweight and stunted children

Have the participant(s) look at the cards and pick out which ones best represent their answer to the following questions.

1. Which women would you categorize as healthy?
2. Which women would you categorize as not healthy?

Observe where they put their cutpoints in terms of women's size in relation to health. Then ask:

3. Which one of these women would you trust to give you advice about how to feed your child?
4. Which one of these women takes the best care of her children?
5. Which one of these women do you think is able to exclusively breastfeed their child?
6. Which child would you categorize as healthy?
7. Which child would you categorize as not healthy?

TEN SEED TECHNIQUE[58]

Objective:	To determine people's perceptions of how important factors related to health, nutrition and food security are and how much more important they are relative to the other factors.
Used to:	This activity can be used for trends analysis, seasonality diagramming, livelihood analysis, expenditure analysis, problem analysis, disease incidence, rapid food security status assessments, gender disaggregation, and district level planning.[59] The results can be used for action, community development and program planning.
Timeframe:	1 hour
Materials needed:	Seeds or stones, flipchart paper, colored pens or markers, audio recording device and camera to take a photograph, set of questions to ask, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see the stones
Number of participants:	5 – 30 participants

Background

The ten seed analysis has been used in child survival and other health programs for looking at issues such as equity, gender and power relations, the causes of illness in the community, health seeking behavior, child spacing beliefs and many other topics that are pertinent to health and development programming. It is useful in gathering qualitative information on various issues, identifying reasons for behaviors, and/ or prioritizing issues. It can be especially useful in gauging the way people see themselves in relation to others. The ten seed analysis is a very visual activity, and because of this, it allows for literate and illiterate people to participate as equal partners and contribute meaningfully to the discussion. The small number of seeds (10) forces participants to make a choice in allocating seeds to categories and enables them to make reasonable comparisons and come up with approximate percentages. If the number of seeds allocated to one of the categories changes, the amount of seeds in other categories automatically changes as well. This can prompt a lively and sometimes heated conversation during the activity. The resulting visuals are easy to explain, understand, and discuss.

The ten seed technique helps to:

- Identify behaviors and the reasons behind them
- Determine how important factors are and which (or whether one is more important) and how much more important they are relative to the other factors
- To understand the local perceptions
- Map vulnerable households

[58] This section adapted from *The Ten Seed Technique*. (2002). Ravi Jayakaran. This guide can be downloaded for free at: http://ravijayakaran.com/books.htm

[59] See pages 7 – 9 of *The Ten Seed Technique* for further details on these activities.

Example research questions

A ten seed analysis can be used to research a broad variety of subjects limited only by the imagination. Example questions are provided for health, nutrition and food security below.

- What are the commonly seen health problems in the community?
- What problems are specific for children, adults and women?
- For each group (children, adults and women) what the health problems are the most critical?
- What health problems are caused by malnutrition?
- Why does malnutrition exist in the community?
- What do people in general do to treat these problems?
- What types of households are affected by nutrition related problems?
- Why do these households have the nutrition-related problems that were mentioned?
- What are the major health problems during the different seasons?
- What are the most important constraints to achieving good health?
- How are the constraints to health overcome?
- Who makes the decisions in the household with regard to health or responding to health problems?
- What resources are needed to prevent health problems from recurring?
- What resources are needed to prevent nutrition problems from recurring?
- What foods are commonly eaten during the different seasons?
- When are there shortages and why?
- What are the most important constraints to achieve food security?
- How do different people cope?
- How and by who are decisions made with regard to achieving food security or responding to problems of attaining food security?
- How are resources allocated to achieving food security?
- How are resources reallocated in case of food insecurity?
- What measures are taken and what resources are needed to prevent food security problems from recurring?

An example ten seed analysis is provided after the directions.

Steps to follow

Before the ten seed analysis:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice facilitating a few ten seed sessions with colleagues so that he/she is familiar with the process. The facilitator should ensure that no participant dominates the conversation and that everybody gets an equal opportunity to participate. Before going to session be sure to organize the supplies you will need and arrange transportation to the community.

During the ten seed analysis:

1. Read the consent script. See Appendix 3 for an example. Give an explanation of the ten seed activity to the participants. Explain that the purpose of this exercise is to understand and learn from the participants about their perspectives on the topics that will be discussed during the activity.

2. Divide large groups into smaller groups**.** This activity works best with 8 – 10 participants. Gender specific or mixed groups can be formed. Participants should be long-standing members of the community, be knowledgeable, and be honest. They should represent a cross section of the community in terms of age, sex, ethnicity, or other locally relevant distinctions (caste, productive orientation, etc.). Power dynamics may be more noticeable in mixed groups especially if authoritative figures (e.g., community leaders, moneylenders, and landlords) are present.

3. Give the group ten seeds. For the first round of questions explain that the ten seeds represent the entire community. Tell the participants that they will be asked to1) develop categories for the questions posed and then 2) allocate seeds based on how many in their community they think would fall into each category

4. Pose a broad question to the group and then ask the participants to move the seeds around into groups representing the topic being discussed. The participants can write or draw images on the flip chart paper to represent the different categories and then place the seeds on the flip chart paper. The way the seeds are allocated will indicate how the community views itself. Have the group practice moving the seeds around to a couple of board questions before moving on to more specific or sensitive questions

5. Observe the reactions of the participants. There are sometimes very different opinions about the number of seeds to be assigned to different segments. Facilitators should watch the reactions of the participants to determine whether there may be some divergent views, and then ask those participants who may have a different opinion to share their reasoning.

6. Take notes. The discussion that takes place during the activity are just as revealing as the final position of the seeds- if not more so. Be sure to take notes during the session or audio record the session if you can.

7. Ask the group follow-up questions**.** Once the group has reached consensus on the arrangement of the seeds, ask the participants to describe the arrangement, and why they classified the seeds the way they did. One way to follow-up is to ask the same type of question in a different way, such as “Where do the families below the poverty line seek health care? And similarly, “Where do the families at or above the prosperity line see health care?” Alternatively, you can ask non-directive questions to seek additional information. See a list of non-directive questions in Appendix 11 to help with clarification. Once the moving around of seeds stops with unanimous agreement, the information and the outline of the seeds can be recorded on a sheet of flip chart paper.

8. If a topic can be further classified, ask the group to continue to divide up the seeds accordingly. Sometimes the broad categories can have subcategories that are significant. If so, ask the group follow-up questions. As the questions and answers become more complex, facilitators need to be sure to have clear and easy ways of explaining what they want the participants to respond to. You might need to help define concepts like ‘prosperous’ ‘less prosperous,’ ‘poor’ and ‘ultra poor.’

Unlike an individual interview or focus group discussion, the facilitator does not have to have all the questions prepared before the group meets.

If you prepare a set of rigid questions ahead of time you might miss out exploring dimensions and perspectives outside of your own experience and understanding and will end up reestablishing your own prior assumptions and perspectives. Prepare a few questions ahead of time that you would like

to ask, but also be flexible and think of questions as the activity unfolds. You are seeking the participants' perspectives, not justifying your own hunches.

Another way to clarify the participants' perspectives is by incorporating drawings on the flip chart paper. For instance, attitudes about different factors can be expressed by drawing a smiling face to represent the supportive or positive attitude, an angry face to show a negative attitude, and an expressionless face to show a neutral attitude.

After the activity is over:

After completing the ten seed analysis read the debriefing script (see Appendix 3 for an example).

Thank the participants for their contributions. Take a photograph of all the ten seed analyses that were drawn on flip chart paper and leave them with the community if they would like to keep them.

1. Write up notes from the session. Tape record the session if possible, if not, the note taker should to take brief notes during the session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the activity. Notes taken during the ten seed analysis do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the notes and ten seed analysis tables and write a brief summary. Summarize the main points of the discussion. Remember, the discussion the group has while completing the ten seed analysis is just as important as the end result so be sure to analyze the discussion as well. For your summary answer the following questions:

- What criteria were brought up and discussed?
- Were there any disagreements?
- Did everyone participate?
- What were some of the issues that should be explored further?

A complementary activity you might consider doing in conjunction with a ten seed analysis is a community map. A community map can provide further detail on which households fall into which categories or identify where key resources are in the community.

Example ten seed session on food security, nutrition and health

You can use a ten seed analysis to look at each of the dimensions of food security: availability, access, asset creation, and usage to identify what dimensions are critical to the food security of the families in the community.

For example, start with general questions about the community to make the participants feel at ease with the process. Ask about things that the participants are familiar with such as:

- What types of crops are grown in the community?
- What types of animals are raised in the community?
- What type of food is imported?
- What type of food is exported?

- What types of work do people from the community do?
- What portion of the community migrates for work?

Then move into more specific questions about household food security in the community. The participants should come up with their own categories but the facilitator might need to help guide them. For instance, you could ask the participants to categorize households by their ability to secure food.

For the example in Table 12 participants were asked, "If your seeds represent the entire community then how many community members would be in each category?"

Table 12. Household food security status as an indicator of vulnerability in community X

Number of seeds	Vulnerability status	Description
	Prosperous	Those who have enough food and can lend food
	Less prosperous	Those who face food shortages for one to two months a year
	Poor	Those who face food shortages for three to five months a year
	Ultra poor	Those who face food shortages from six to 12 months a year

Table 12 shows that the majority of people in this community face food shortages. From here you could continue to examine why households are food insecure. For instance, you could ask, "What food is available year round in the community?"

Table 13. Types of food available throughout the year

Number of seeds	Food available year round
	Animal source foods
	Fruits and Vegetables
	Rice
	Other

As you can see from Table 13, availability is not a significant problem in this community. The next question you could ask could be centered on access. For instance, “How do the different households obtain their food?”

Table 14. Access to food by the four groups

Number of seeds	How food is obtained	Vulnerability status
	Buy their food	Prosperous
	Buy some food and needs to grow some food	Prosperous and less prosperous
	Needs to grow most of their own food	Poor
	Needs to grow food, receive food aid	Ultra poor

Table 14 shows that there are significant differences between the four groups in terms of access. Not everyone could always afford to buy food – some had to grow their own food and some received food aid.

You can also use a ten seed analysis to find out how food is distributed within a family. Do this by asking, “If the 10 seeds represent the total amount of food available to the family, how is the food distributed among family members? Each of the seeds need to be distributed into one of four categories.”

Table 15. Access to food by the four groups

Men 	Women 
Boys 	Girls 

Table 15 displays the same levels of inequality based on gender and not necessarily on food security status indicating the value place on males in relationship to females.

SWOC ANALYSIS[60]

Objective:	To identify the strengths, weaknesses, opportunities and constraints (SWOC) of food and nutrition programming.
Used to:	Aid in program planning and implementation
Timeframe:	1 hour
Materials needed:	Flipchart paper, colored pens or markers or seeds, tape, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts.
Ideal workspace:	Enough space for all participants to see the flipchart paper
Number of participants:	5- 8 people

Background

This research tool uses a matrix to encourage discussion about the strengths, weaknesses, opportunities and constraints of a particular issue.

Using a SWOC analysis helps to:

- Identify and review the strengths and weaknesses of a behavior, situation, or organization
- Decide whether an individual or a group has the ability to carry out a behavior or project
- Look at the impact that the introduction of a program may have on a given population
- Have participants identify their own nutrition-related problems and major constraints to adequate nutrition
- Have participants prioritize their food and nutrition problems
- Show the strengths, weaknesses, opportunities and constraints of different prevention, care and support projects and programs

Example research questions

The example SWOC analysis described in this module will be used to provide information on the strengths, weaknesses, opportunities and constraints of providing food and nutrition programming to target populations in a given community. This information will aid in program planning and implementation. For the example SWOC analysis outlined in this module, the research questions are:

- What are the nutrition-related problems and major constraints to adequate nutrition in the community?
- What are the perceived strengths and weaknesses of CARE's programming in the community? What priorities do the participants have around food and nutrition programming?
- What have been the strengths, weaknesses, opportunities and constraints of previous food and nutrition programs in the community (if applicable)?

[60] The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, pp. 214 – 215.

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (NGO staff, village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice running a SWOC analysis with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

During the session:

1. Read the consent script. See Appendix 3 for an example.

2. Divide large groups into smaller groups. "A SWOC analysis is best done by smaller groups. When working with larger groups, divide participants into smaller groups of five to eight participants. Each small group can then work on different topics- for example, different activities, organizations or situations, or one group identifies strengths, one weakness, one opportunities and one constraints. The groups can then share their analysis with each other." Form women-only and men-only groups or mixed groups.

2. Provide the following description to the participants.

1. Discuss the meaning of the words with the participants:

- ***Strengths***- the factors that strengthen an individuals' or families' ability to provide adequate food and nutrition to pregnant and lactating women and children between birth and 23 months. For example, good basic and support services (health care, agricultural services) provided by the government, non-governmental organizations (NGOs) or community based organizations (CBOs).

- ***Weaknesses-*** the weak points that limit an individuals' or families' ability to provide adequate food and nutrition to pregnant and lactating women and children between birth and 23 months. For example, the poorest families may not be reached by services.

- ***Opportunities-*** the positive opportunities that exist for individuals or families to provide adequate food and nutrition to pregnant and lactating women and children between birth and 23 months. For example, an increase of nutrition expertise at district level that aims to improve the quality of community activities.

- ***Constraints-*** the things that are, or will get in the way of an individuals' or families' ability to provide adequate food and nutrition to pregnant and lactating women and children between birth and 23 months. For example, a drought, a small household income, or poor soil.

3. Distribute markers and paper to the participants. Have the participants draw a matrix with two rows and two columns (see Table 16). Have them write or draw symbols for the heading in each box in the matrix.

Table 16. Example of SWOC analysis on exclusive breastfeeding

Strengths +	Weaknesses -
• Breastfed children are more resistant to disease and infection early in life as compared to formula-fed children • Do not need to have access to clean water to breastfeed • Cheaper than buying formula • When a woman gives birth and breastfeeds her baby exclusively and on demand, she can delay becoming pregnant again[61]	• Breastfeeding is time consuming • Breastfeeding takes a lot of energy for the body to make milk, so the mother may often feel tired • Mothers feel anxiety and frustration while trying to learn how to breastfeed
Opportunities 	**Constraints** 
• Community has a baby friendly hospital nearby • Religious advisor supports exclusive breastfeeding • Breastfeeding advocates try to persuade policy-makers to pass legislation to make all hospitals in the country baby friendly	• Inappropriate distribution of infant formula by inexperienced charities in the area • Some believe that women cannot produce enough milk to breastfeed alone • Mothers lack of adequate food which compromised their nutritional statuses

4. Have the participants discuss each box of the SWOC analysis. The facilitator should lead the participants in a discussion about the strengths, weaknesses, opportunities and constraints of food and nutrition programs. Draw or write items in the appropriate box. After each box has been filled in the facilitator should ask the participants the following additional questions:

- What are the nutrition-related problems and major constraints to adequate nutrition in the community?
- What priorities do the participants have around food and nutrition services/programming?
- How can the participants make use of the strengths, reduce the weaknesses and constraints, and make use of the opportunities to achieve their priorities?

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

<u>After the SWOC analysis is over:</u>

[61] Lactational amenorrhea (LAM) is the natural postnatal infertility that occurs when a woman is amenorrheic (not menstruating) and fully breastfeeding

After completing the survey read the debriefing script (see Appendix 3 for an example).

Thank the participants for their contributions. Take a photograph of the SWOC analysis and leave the SWOC analysis with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the note taker should take brief notes during the session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the SWOC analysis. Notes taken during the SWOC analysis do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the SWOC analysis and write a brief summary. Summarize the main points of the discussion. Remember, the discussion the group has while completing the SWOC analysis is just as important as the end result so be sure to analyze the discussion as well. For your summary answer the following questions:

- What are the perceived strengths, weaknesses, opportunities and constraints of food and nutrition related services in the community?
- What are the nutrition-related problems and major constraints to adequate nutrition in the community?
- What priorities do the participants have around food and nutrition services/programming?
- How can the participants make use of the strengths, reduce the weaknesses and constraints, and make use of the opportunities to achieve their priorities?

FORCE FIELD ANALYSIS[62]

Objective:	To examine what factors and persons **prevent** women from getting enough food and rest when they are pregnant and what factors and persons **can help** women get enough food and rest when they are pregnant?
Use to:	See the positive or negative sides to a situation and identify who or what may help a group reach a goal
Timeframe:	One hour
Materials needed:	Flipchart paper, markers, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts
Ideal workspace:	Enough space for all participants to see the flipchart paper
Number of participants:	8 - 12

Background

A force field analysis looks at who or what can help bring about change. These are the 'supporting' factors. It also looks at who or what may prevent change. These are the 'resisting' factors. A force field analysis also looks at the strength of 'supporting' factors and the strength of 'resisting factors.

Using this activity helps to:

- See the positive and negative sides to any situation
- Identify the real issues which may prevent a group from reaching its goal
- Identify who or what may help a group to reach a goal

Example research questions

- What factors and/or persons prevent women from getting enough food and rest when they are pregnant?
- What factors and/or persons can help women get enough food and rest when they are pregnant?

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (NGO staff, village chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice running a SWOC analysis with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

62 The information contained in this module was adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 188.

During the session:

1. Read the consent script. After completing the survey read the debriefing script (see Appendix 3 for an example).

2. Explain the purpose of the activity. Explain the difference between 'supporting' factors (things that can help bring about change) and 'resisting' factors (things that may prevent change from happening).

3. Draw the force field as a vertical wavy line. Label the space on the left 'supporting factors'. Label the space on the right 'resisting factors' (see example on the next page).

4. Introduce the topic that will be discussed- "Who or what can bring about change around providing pregnant women with enough food and rest? Who or what may prevent change?"

5. Have the group discuss the supporting factors and resisting factors. In relation to the example research question, a supporting factor might be antenatal counseling whereas a resisting factor might be economic conditions that force pregnant women to work long hours.

6. Have the participants each draw or write one supporting and resisting factor card. Tell the participants that each card should only have one factor or person listed.

7. One-by-one ask each participant to share with the group what their cards say and discuss the strength of the factor on the card.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

8. Place each card on the force field. Draw a line from the center of the force field to each factor. The longer the length of the line, the stronger the factor. The shorter the line, the weaker the factor. See Figure 8.

9. When all the supporting and resisting factors have been placed on the force field, facilitate a discussion with the group on what the force field shows. For example, how can the group build on the supporting factors? What can the group do to overcome the resisting factors? Which resisting factors are within the group's control? Which factors are outside the group's control?

Participants may find it difficult to be open about supporting or resisting factors. A participant may not want to identify a person or group who is a resisting factor. Try to build an atmosphere without blame when using this tool, to help participants talk openly.

After the session is over:

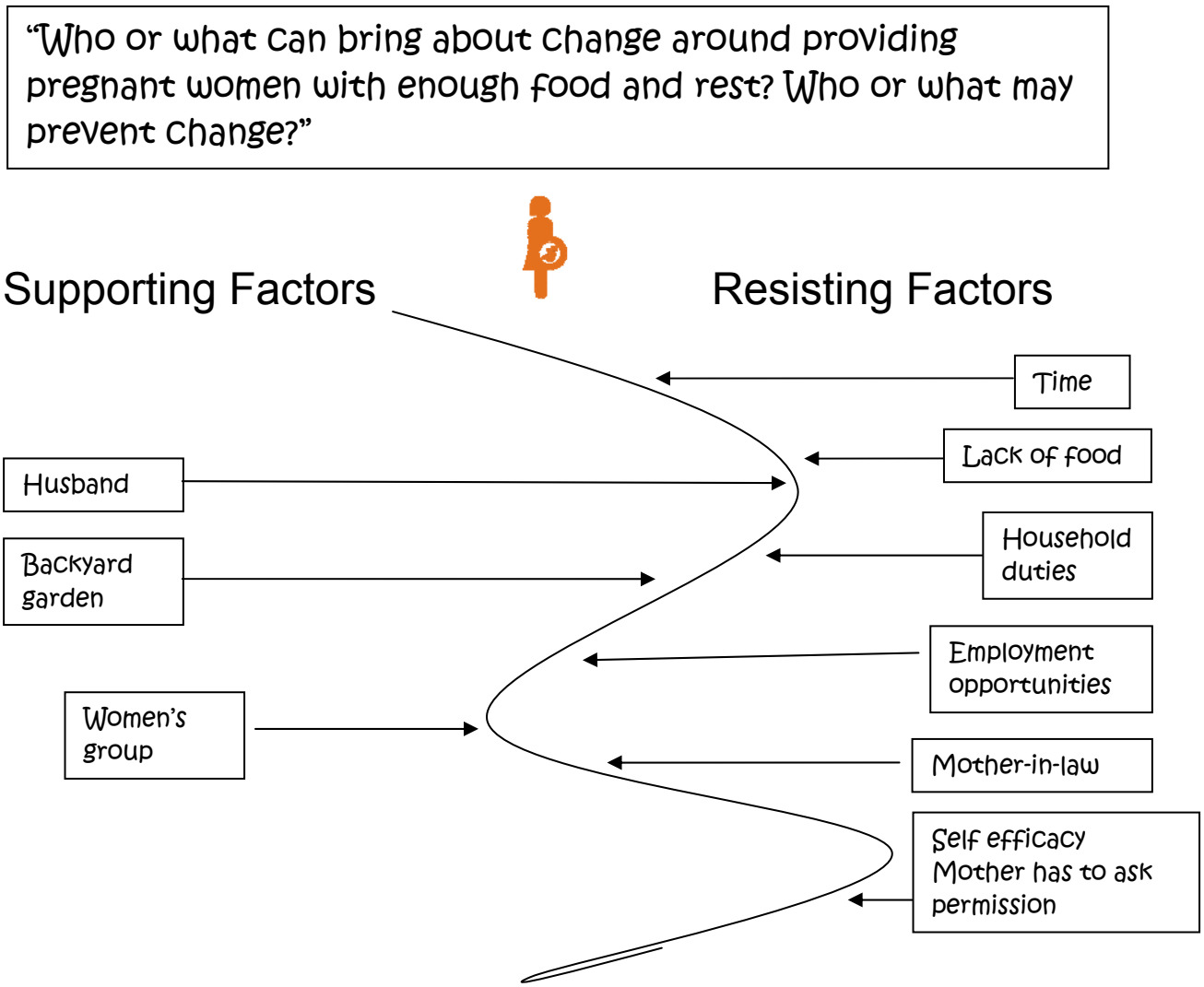
Thank the participants for their contributions. Take a photograph of the force field analysis and leave the force field analysis with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the note taker should to take brief notes during the session. The note taker should be sure to record all discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the session. Notes taken during the force field analysis do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the force field analysis and write a brief summary. Summarize the main points of the discussion. Remember, the discussion the group has while completing the force field analysis is just as important as the end result so be sure to analyze the discussion as well. For your summary answer the following questions:

- What factors and/or persons prevent women from getting enough food and rest when they are pregnant?
- What factors and/or persons can help women get enough food and rest when they are pregnant?
- What suggestions did the group come up with on how to build on the supporting factors?
- What suggestions did the group come up with on how to overcome the resisting factors?
- Which resisting factors are within the group's control?
- Which factors are outside the group's control?

Figure 8. Force field analysis showing the supporting and resisting forces related to maternal health and nutrition



PROBLEM and SOLUTION TREE [63]

Objective:	To identify and analyze how household food security affects IYCF and maternal nutrition practices and identify potential solutions to food insecurity at the household level
Use to:	Identify problems, the causes, and the solutions related to a particular issue
Timeframe:	1 -2 hours
Materials needed:	Flipchart paper, copy paper, scissors tape, markers, voice recording device and camera to take a photograph, and a copy of the consent and debriefing scripts
Ideal workspace:	Enough space for all participants to see the flipchart paper
Number of participants:	5 – 30 participants

Background

This is an activity that works well with large groups of people in public places. It involves identifying.

The problem and solution tree is a tool that can be used to explore problems, the causes and effects of problems and solutions to a problem. See Figure 9 for an example. This activity will help participants think about the underlying social and cultural factors that lead to negative outcomes and to develop actions to address these factors.

Using a problem and solution tree helps to:

- Provide a visual and non-threatening way to look closely at problems
- Identify the main causes and effects of the problem
- Identify the social and cultural factors that can constrain optimal behavior
- Begin to identify what can be done to address the cause and reduce the effects
- Group together similar problems that may have the same solution as a possible way forward in the community

Example research questions

- What are the main causes of household food insecurity in the community?
- What effect does household food insecurity have on maternal and child nutrition?
- What can be done to address the cause of household food insecurity and reduce maternal and child malnutrition?

63 The information contained in this module were largely adapted from, *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance, p. 202.

Steps to follow

Before the session:

1. Take care of the data collection logistics. Specifically: What day? What place? What time? What participants? Seek authorization from appropriate gate keepers (community chief, clinic managers, etc.); decide what field staff will act as the facilitator and have the designated facilitator practice running a problem wall/ solution tree session with colleagues so that he/she is familiar with the process; organize supplies you will need, and arrange transportation to the community.

2. Cut up lots of square and 'leaf' shaped pieces of paper. Make the leaves of paper one color and the squares of paper two different colors. One color of square paper will represent the root causes of the problem the other will represent solutions

During the session:

1. Prep for the session. Cover a wall with paper. Put markers and tape nearby so that the participants will be able to stick the leaves on the tree

2. Start the session.

1. Read the consent script. See Appendix 3 for an example.

2. Ask the group to draw a tree and write or draw the issue to be discussed on its trunk. Reassure the participants that the tree does not have to be drawn well. The process is more important than the artwork.

3. Then ask the participants to think of things that may be at the cause(s) of the problem and write them on squares of paper and stick them at the roots of the tree.

4. Select one of the main causes. Ask, 'Why do you think this happens?' This question will help participants identify the 'secondary' cause. Draw or write the 'secondary causes on pieces of square paper below the other causes at the root of the tree. Repeat this process for each of the other main causes.

5. Then ask the participants to group similar causes.

6. Once the causes of the problem are identified, ask the participants to group similar causes together.

7. Then ask the participants to identify the effects of the problem and place them in the tree branches.

8. Now ask the participants to consider the causes and think of solutions to them. Invite people to write solutions on the pieces of paper and stick these near the causes they could potentially address.

9. Facilitate a discussion about what the problem tree shows. Ask the following questions:

- What problems are caused by food insecurity in the community? How do the causes and effects relate to each other? What are the root causes of the problem
- How does household food insecurity affect IYCF and maternal nutrition?
- What are some potential solutions to food insecurity at the household level? Which solutions would be easy to do and which would be difficult to achieve?

4. Record and take notes on what is being said while the participants are creating the problem and solution tree. The conversation that participants have while making a problem tree is often as important as the finished product.

You can find a list of non-directive questions and comments for use in participatory activities in Appendix 11. These phrases will aid in eliciting further information from participants and help keep the conversation flowing in the group.

After the session is over:

After completing the exercise read the debriefing script (see Appendix 3 for an example).

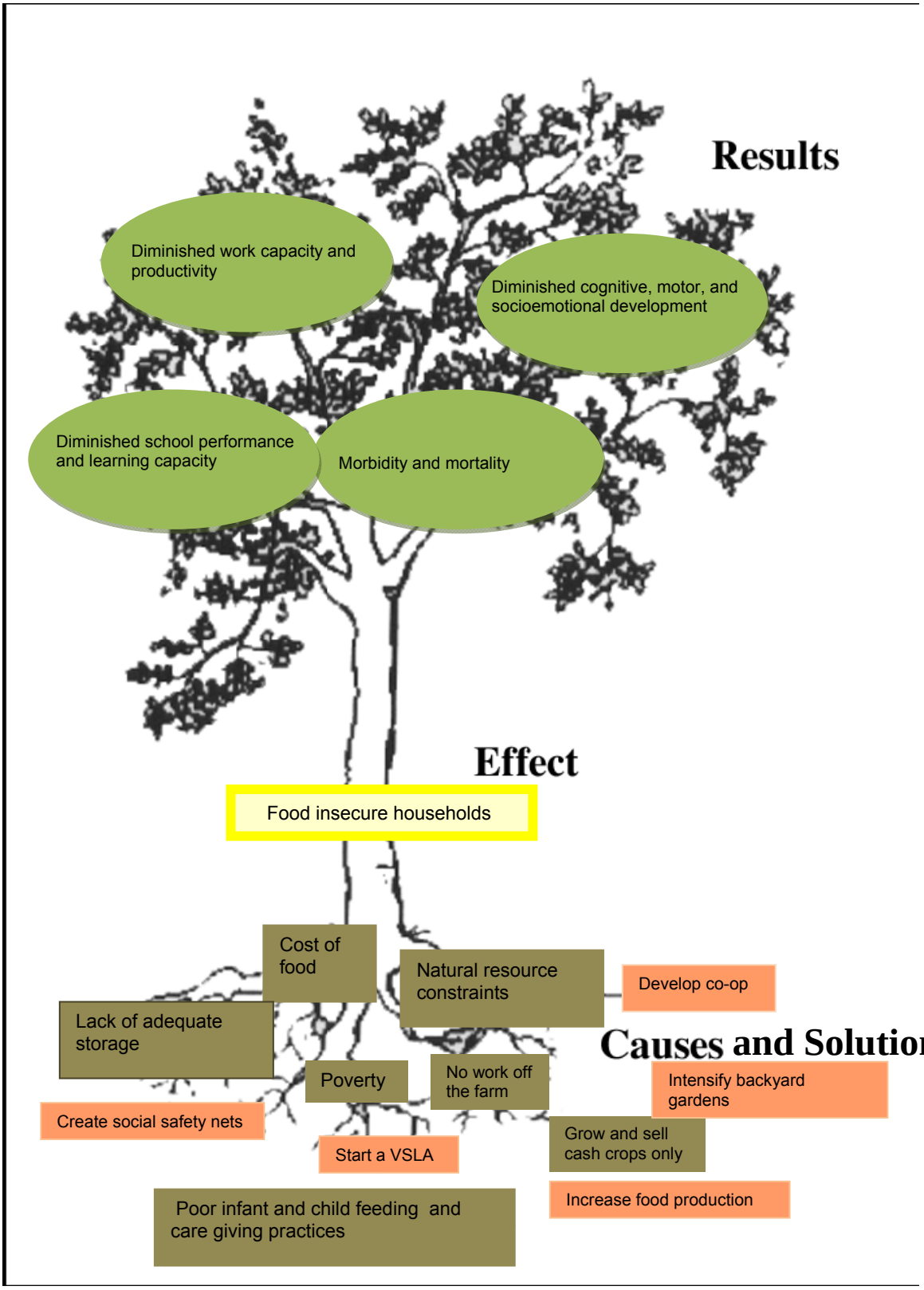
Thank the participants for their contributions. Take a photograph of the problem and solution tree and leave the display with the community if they would like to keep it.

1. Write up notes from the session. Tape record the session if possible, if not, the facilitator (and/ or a note taker should to take brief notes during each mapping session. The note taker should be sure to record discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior and interactions with one another during the charting exercise. Notes taken during the session do not need to be detailed; however, in order to capture all the information, the facilitator and/or note taker should expand their notes following the exercise. Notes should be expanded as soon as possible, preferably within 24 hours.

2. Analyze the problem and solution trees and the write ups and write a brief summary. Remember, the discussion the group has while they are creating the problem wall and solution tree is just as important as the map itself. Be sure to analyze the discussion as well. For your summary answer the following questions:

- What problems are caused by food insecurity in the community? How do the causes and effects relate to each other? What are the root causes of the problem
- How does household food insecurity affect IYCF and maternal nutrition?
- What are some potential solutions to food insecurity at the household level? Which solutions would be easy to do and which would be difficult to achieve?

Figure 9. Example Problem and Solution Tree



KEY INFORMANT INTERVIEW

Objective:	To identify the key factors and people that influence maternal and child nutrition and health
Use to:	Gather detailed information on local and cultural traditions, identify the feelings and understanding of different individuals about a topic and help identify priorities for action.
Timeframe:	1 hour
Materials needed:	Notepads and pens to record key points of the interview, audio recording device, interview guide, and a copy of the consent and debriefing scripts
Ideal workspace:	A quiet, private setting
Number of participants:	1

Background

Key Informant Interviews (KIIs) are a qualitative research technique that involves conducting intensive individual interviews. An individual interview is used to gather detailed information on local and cultural traditions, identify the feelings and understanding of different individuals about a topic and help identify priorities for action. Individual interviews are usually conducted face-to-face with one participant who has knowledge and/or experience with a given topic and can speak about general community beliefs and practices.

Key informant interviews can help to:

- Research very sensitive issues that participants may not want to discuss in a group
- Seek responses that won't be influenced by peers (like they would be in a focus group discussion)
- Identify issues for quantitative surveys
- Clarify quantitative survey results, crosscheck data
- Generate ideas for programs, campaigns, or materials
- Pretest communication materials, concepts, or messages
- Improve products or services

Typically, key informant interviews last no more than one hour. If more time is needed, a second interview should be scheduled.

How key participant interview data are used

After all the interviews have been conducted, responses to each question can be analyzed to capture the most important themes emerging across the set of interviews. Data from the key informant interviews can be used to plan and implement programming.

Objectives of the KIIs included in this guide

1. To understand the strategy and operation of each agency or community group, specifically each group's:
    a) Priorities
    b) Promotion activities
    c) Staffing
    d) Support and supervision structure
    e) Community reach
2. To gather information on how agencies and groups communicate and work together.

Steps to follow

Before the individual interview:

1. Decide who will act as the individual interviewer. Interviewers are responsible for facilitating the individual interviews, asking all questions listed in the interview question guide, and keeping the interview going. Interviewers should have interpersonal skills, social and conversational skills and be knowledgeable about the research topic. Additionally, interviewers should be prepared to conduct the interview, be ready to listen to the participant and able to keep a neutral attitude. The interviewer will also be expected to take brief notes during each interview.

The interviewer should try to learn everything the participant can share about a given topic by posing questions without judgment, listening attentively to responses, and asking follow-up probing questions based on those responses.

ESSENTIAL CHARACTERISTICS
OF INTERVIEWERS

Demonstrates respect
Develops rapport
Uses appropriate, non-threatening question forms
Pays attention to non-verbal behavior
Listens more than talks

2. Decide who will act as note takers. The role of the note taker is to observe and record what the participants say and how they behave. After the individual interview is over, the note taker will summarize their notes alongside the interviewer. It is a good idea to have a note taker especially if the interview is not audio recorded. This will allow the interviewer to concentrate on asking appropriate questions.

3. Decide on logistics.
Specifically: What day? What place? What time? How long? Who the participants will be?

4. Design interview guide. Example interview guides for key informants important for maternal and child nutrition can be found in Appendix 9 of this guide.

Interview guide

A guide should be developed to conduct key participant interviews. Although the guide is designed to help the interview flow easily, you do not have to follow the exact order of questions; nevertheless, it is important to try to cover each question thoroughly. Each question is designed to elicit specific information. Probe each topic as necessary to get sufficient information. If you need to, take notes on your guide as a reminder to return to a question or address an issue further. Take advantage of natural shifts in the interview as they relate to questions in the interview guide. If an individual's comments do not pertain to the research focus, look for opportunities to steer the conversation back to the topic. If you find that a question is out of place or interviewees have a hard time answering a particular question, change the guide to correct the problem.

All the questions used during the individual interview should be "open-ended," meaning they will require more than a "yes" or "no" response. If you do ask a question and the participant does not provide you with much information use a 'probe' to encourage them to share more. Probes are neutral questions, phrases, sounds, and even gestures interviewers use to encourage participants to elaborate on their answers and explain why or how. See Table 18 for examples of probes.

7. Practice and pilot test the interview guide. Interviewers should familiarize themselves with the questions before interviewing people. Another important element to the interview preparation is the implementation of a pilot test. The pilot test will help determine if there are flaws, limitations, or other weaknesses within the interview design and will allow the team to make necessary revisions prior to the implementation of the study. A pilot test should be conducted with participants that have similar interests as those that will participate in the implemented study. The pilot test will also assist the researchers with the refinement of research questions

<u>During the individual interview:</u>

1. Recruit individuals to be interviewed.
Be strategic and identify and gain access to those who can teach you the most about your topic. A few characteristics of a good participant include: they willingly volunteer information; they are knowledgeable about the topics of interest; and they are currently involved in or recently experienced the topic/activity of interest.

2. Read the consent script. An example consent script is provided in Appendix 3. Explain why you are conducting the interview and ask the participants whether they agree to participate. This is called 'informed consent.' Informed consent can be granted both in written and verbal form. Please make sure to **obtain verbal informed consent from each participant BEFORE the interview.**

3. Ask the interview and probe questions.

4. Take notes during the interview. During the interview, you can write your notes on the question guide or in a notebook. Record all discussions, debates, disagreements, key phrases and terminology in the local language. Notes taken during an interview will not be detailed because conversations may move fast between the interviewer and the participant; however, note any inconsistent comments or vague or cryptic comments and probe for understanding.

5. End interview by giving clear indication that it is coming to a close (examples):

a) *It is about time to finish this interview, is there anything else you want to tell me? Is there anything you feel is important for me to know?*

b) *Thank you very much for talking to me today. Your time is very much appreciated and your insights have been very helpful.*

Be sure to:

- Give the participant the opportunity to ask questions
- Clarify any misinformation expressed by participants during the interview (only if you are knowledgeable on the subject). However, please note that an individual interview is not intended to be a health education session
- Read the debriefing script

Table 17. Examples of Probes

Direct probes:

- "What do you mean when you say . . .?"
- "How did this happen?"
- "How did you feel about . . .?"
- "Can you tell me more?"
- "I'm not sure I understand_____. . . .Would you explain that to me?"
- "How did you handle _____?"
- "How did _____ affect you?"
- "Can you give me an example of _____?"

Indirect probes:

- Neutral verbal expressions such as "uh huh,""interesting," and "I see"
- Verbal expressions of empathy, such as, "I can see why you say that was difficult for you."
- Mirroring technique, or repeating what the participant said, such as, "So you were young when you had your first child?"
- Culturally appropriate body language or gestures, such as nodding in acknowledgment.
- The silent probe – Allow for 5 seconds of silence before saying anything -- often that alone prompts more discussion on the part of the participant -- though they should be used sparingly because they can come off as awkward or threatening.

Try not to prompt interviewees by asking, "Why?" or saying, "That is good, can you tell me more?" Questions and the way you ask them can make participants pull back, or get them into self-justification mode. "Why?" makes people defensive so try to ask "What about …" instead. Alternatively if you say, "That's good" participants might shut down, presumably because when you don't say it again, you are implying "That's bad." Try to stick to non-directive prompts. See Appendix 15 for a list of non-directive questions and prompts.

5. End the interview by giving a clear indication that it is coming to a close. An easy script to follow could go something like this…

> *It is about time to finish this interview, is there anything you else want to tell me? Is there anything you feel is important for me to know?*
>
> *Thank you very much for talking to me today. Your time is very much appreciated and your insights have been very helpful.*

Also be sure to:

- Give the participant the opportunity to ask questions.
- Clarify any misinformation expressed by participants during the interview (only if you are knowledgeable on the subject). However, please note that an individual interview is not intended to be a health education session.
- Read the debriefing script. (A copy of this script can be found in Appendix 3).

After the interview

1. Be sure to write down identifying information (who, where, when the interview took place) on the hard copy of the interview notes. Add identifying information or an identification (ID) number to each interview.

2. Transcribe or expand your notes. Transcription is time-consuming.[64] Depending on the purpose of the research and your resources, you may choose to make a summary of what people said and analyze that, transcribe only certain parts of an interview that are important, or transcribe everything. If you were able to audio record the session than transcribe notes from the interview. Directions on how to transcribe are provided.

[64] "Transcribing a typical single interview takes several hours and can generate 20-40 pages of single spaced text. Transcripts and notes are the raw data of the research. They provide a descriptive record of the research, but they cannot provide explanations. The researcher has to make sense of the data by sifting and interpreting them" (Pope,C., Ziebland, S., Mays, N. (2000). Analysing qualitative data. BMJ, 320, p. 114).

How to transcribe an interview

Type the conversation as is. Don't try to change an interviewee's word choices or grammar. This will take away from the authenticity of the interview.

Pause the recording every so often. By pausing, you can think back on what you've already heard and write down any general key points. You can also rewind to repeat any passages you misunderstood or couldn't hear.

Leave out phrases such as "um" or "uh". Only use words and phrases that best convey the conversation.

Use proper line spacing, paragraphs, quotation marks and lower case and upper case letters. Format the report as you would any professional work. If you are asked to provide the transcript for any reason, you'll be able to do so quickly, without having to go back and work on it further.

Place activities into brackets. If the phone rings, type, [phone rings]. If there are unintelligible parts of the conversation, add [??] or [unclear].

Use dashes for pauses, interruptions and incomplete sentences.

If you were unable to audio record the interview, then expand your notes after the interview is finished. It is impossible to recall any discussion in full, and important points may be lost if the notes are not expanded soon after the interview. Therefore, in order to capture all the information, the interviewer and note taker should expand their notes following each interview, preferably within 24 hours, while the interview is still fresh in the note taker's memory. Try not to complete another interview without expanding your notes. Note any discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior. The interviewer and note taker should review the notes together to verify the information.

In summary, immediately after the interview (interviewer & note taker)

- Label each summary / transcript – ID number, date, name / id of interviewer / notetaker's name
- Conduct debriefing session between interviewer and note taker
- Note themes, hunches, interpretations, and ideas
- Compare and contrast this interview to other interviews
- Label and file field notes
- Discuss any changes that should be made in the interview guide

2. Analyze the data[65]

Once you have the field notes / summaries / transcriptions from all the individual interviews you will be ready to analyze the data.

Some important definitions to know before getting started include:

[65] This section was adapted from Ellen Taylor-Powell and Marcus Renner (2003). *Analyzing Qualitative Data.* University of Wisconsin-Extension, Cooperative Extension, Madison, Wisconsin. This resource can be downloaded free of charge at http://learningstore.uwex.edu/pdf/G3658-12.pdf

- **Codes:** Codes are labels to lines of text that are assigned so that the researcher can group and compare similar or related pieces of information.
- **Themes:** Themes in qualitative data analysis are patterned responses or categories that show up in the data
- **Iterative process:** A process for arriving at a decision or a desired result by repeating rounds of analysis

There are three ways to categorize narrative data- using *preset* or *emergent* categories or a combination of the two. With preset categories you start with a list of themes or categories in advance, and then search the data for these topics. Alternatively with emergent categories, the themes or categories emerge from the data and are defined after you have read through the data. Since only an example individual interview guide has been provided and there is no way to know in advance what you would specifically like to research, the instructions below provide steps to take to categorize narrative data using emergent categories. The steps are as follows:

Step 1: Get to know your data

1. Review the research objectives and questions.

2. Reread your notes thoroughly and carefully and look for emerging themes. Good analysis depends on understanding the data. For individual interviews you will need to read and re-read the field notes and the summaries until you are intimately familiar with the content. Write down any impressions you have as you go through the data. Write themes down.

3. Decide whether the data are of sufficient quality to analyze and what level of investment is warranted. If not, don't waste the resources it will take to analyze the data.

Step 2: Focus the analysis

4. Decide whether to focus your analysis by question, topic, time period or event, or by group. How you focus your analysis depends on the purpose of the evaluation and how you will use the results. If you focus by topic, time period or event you will look at how groups (mothers, fathers, religious leaders, health service staff, etc.) responded to each question or topic, or for a given time period or event. Alternatively, you can organize the data from a group and analyze it as a whole.

Step 3: Categorize the information

5. Go through data again and sort data by themes. Identify themes or patterns such as: ideas, concepts, behaviors, interactions, incidents, or terminology or phrases used. Main themes may be broken into subcategories. This allows for greater discrimination and differentiation. For example, for a question about benefits of mother-to-mother support groups, data within the theme of benefits to self might be broken into a number of sub categories. See Table 19 for an example

6. Develop codes. Create abbreviated codes of a few letters that represent the themes or patterns. For example, food shortage (FS); breastfeeding (BF); diarrhea (Dia); tradition (T); religious belief (RB), disease (Dis), etc. You will use the same codes for all the data.

7. Go back through the data and add codes to individual lines of texts. Your initial list of themes may change as you work with the data. This is an iterative process meaning you will

arrive at a decision by repeating rounds of analysis. You may have to adjust the definition of your themes, or add codes as needed- don't force new findings into existing codes if they don't fit. Continue to build themes and code the text until no new themes or subcategories are identified. Add as many themes as you need to reflect the nuances in the data and to interpret data clearly.

Coding can be a fairly labor-intensive process depending on the amount of data you have. It involves reading and re-reading the text and identifying coherent themes and then going back and coding the data.

Step 4: Interpret the data

8. Use your themes and connections to explain your findings. As you organize the data into themes- either by questions, topics, time period or event, or by the different groups- you will begin to see patterns and connections both within and between the themes.[66] You may be interested in summarizing the information pertaining to one theme or capturing the similarities or differences in people's responses. Develop a list of key points or important findings you discovered as a result of categorizing and sorting your data.

As you go through the data, try and answer the following questions:

a) What new things did you learn?
b) What does all this mean?
c) What are the key ideas being expressed within the theme?
d) What are the similarities and differences in the way people responded
e) How many times did a particular topic or issue come up?
f) What is really important? What will those who use the results of the evaluation be most interested in knowing?

Additionally, as you read through the data, notice whether certain topics keep being said, whether certain topics evoke stronger emotion, whether the participants share more personal information about certain topics more than others or if two or more themes occur together consistently (whenever you find one, you find the other) and make note of these things. Notes can be put on the summary tabulation sheet. See Table 19 for an example. Take note of the following:

Extensiveness and frequency: Some topics are discussed more by participants (extensiveness) and also some comments are made more often (frequency) than others. These topics could be more important or of special interest to participants. Also, consider what was not said or received limited attention. Did you expect but not hear certain comments?

[66] For example you could compare breastfeeding patterns by area, nutritional status, illness status, and child care patterns, or cultural patterns. If you were interpreting by cultural patterns you should pay attention to beliefs or terms that are mentioned frequently and explain common practices. Many cultures have a set of beliefs related to the child's ability to chew, swallow, and digest foods, and these beliefs affect the timing, type, and dilution of foods that are offered. From a programming standpoint, the purpose of collecting this information is to discover whether these beliefs affect people's willingness to change feeding behaviors (AED/ LINKAGES p. 41). If you were interpreting the data by population you could determine if the responses from influential people are consistent with what mothers say, and the extent to which these people influence mothers and others in the household and community (AED/LINKAGES p.41).

Intensity: Occasionally participants talk about a topic with a special intensity or depth of feeling. Sometimes the participants will use words that signify intensity or tell you directly about their strength of feeling. Intensity may be difficult to spot with transcripts alone because intensity is also communicated by the voice, tone, speed, and emphasis on certain words. Individuals will differ on how they display strength of feeling and for some it will be a speed or excitement in the voice whereas others will speak slowly and deliberately.

Specific information (Specificity): Responses that are specific and based on personal experiences should be given more weight than responses that are vague and impersonal. To what degree can the participant provide details when asked a follow up probe?

Relationships: Two or more themes occur together consistently in the data. For example new mothers consistently list mother-in-law as a trusted source of information about how to feed infants and young children. Such connections are important to look for because they can help explain why something occurs.

Step 5: Report findings

9. Create a summary of what you found. An easy way to summarize the results is to create a summary tabulation table like the one in Table 19. Summary tables can present responses to a question, topic, time period or event or by different groups. Use quotes taken from the data to illustrate the themes if possible. Be sure to keep track of the source of the information of the quotes (individual, site and date).

Table 18. Example summary tabulation table analyzed by question

Question	Themes and codes	Quotes	Notes
What makes a quality mother-to-mother support group?	relevance (RE); participation (Part); good (GO) facilitator (FAC); content (CO); respect (RES); timing (TM)	*"A good facilitator is necessary. She must be knowledgeable and respect us." 23/05/ 2013; Mother, age 23, Community A* *"The group needs to focus on topics that are relevant to us." 24/05/2013; Mother, Age 18, Community B*	When mother participants talked about 'good' facilitators they shared a lot of detailed information on how the facilitator behaves.
What is the benefit of mother-to-mother support groups?	Benefits to self: knowledge (KNOW); self-efficacy (SE); skills (SK); social capital (SC); comfort (COM); no benefit (NB) Benefits to facilitator (BFAC) Benefits to family (BEF) Benefits to community (BCOMM)	*"Previously, before the support group, I would give my children warm water after delivery. Now I don't because of what I learned in the mother-to-mother support group in our community. Now I give breast milk and only breast milk until the child is six months old. After the child exceeds six months, I introduce complementary foods. I learned how to prepare the right complementary food from the group." 30/05/2013; Mother, Age 19, Community C* *"There is no benefit for me." 04/05/2013; Mother, Age 28, Community C*	The theme that mother-to-mother support groups are of no benefit was raised a lot by (mother) participants.
What would you change about the mother-to-mother support group	timing (TM); location (LOC) incentives (IN); topics (TOP); facilitator (FAC); teaching style (TS)	*"It would be better if the group could meet in the early afternoon when it is too hot to work in the fields and before our husbands come home." 19/05/2013; Mother, Age 28, Community A* *"Currently we meet in the courtyard of the group's leader but she lives far away from the rest of us. I would like it if we could meet closer to town." 020/05/2013; Mother, Age 28, Community B*	Mother participants very concerned about the distance and the amount of time they spend traveling to get to the mother-to-mother support groups.

FOCUS GROUP DISCUSSIONS[67]

Objective:	To better understand meanings, values and perceptions relating to a particular issue
Use to:	Can be used to explore local experiences and cultural traditions, identify the feelings and understanding of different groups about a topic and help identify priorities for action. FGDs are NOT used to gain insight on individual practices.
Timeframe:	1-2 hours
Materials needed:	Notepads and pens to record key points of the discussion, audio recording device, FGD guide and a copy of the consent and debriefing scripts
Ideal workspace:	A quiet, private place with enough space for all participants to gather comfortably, preferably in a circle.
Number of participants:	6 -10

Background

A focus group discussion (FGD) is a loosely structured discussion among six to ten individuals that is used to gather information on a particular research or program topic. A facilitator, who guides the discussion, encourages participants to talk freely and reveal their thoughts and feelings about the research topic. FGDs are repeated with several groups of similar makeup until the discussions no longer reveal anything new and relevant to the research.[68]

Much like individual interviews, this method uses prepared open-ended questions to encourage discussion. The questions are asked in order to get a better understanding of people's thoughts and feelings regarding a particular issue.

FGDs are ideally suited for exploring the complexity surrounding feeding practices, food choices and other lifestyle behaviors within the context of lived experience. Do not ask sensitive questions during a FGD. Sensitive questions should be asked during individual interviews.

Focus group discussions can help to:[69]

- Identify issues for quantitative surveys
- Clarify quantitative survey results, crosscheck data
- Generate ideas for programs and social and behavior change communication and activities
- Pretest communication materials, concepts, or messages
- Improve products or services

[67] The following section was largely adopted from materials developed for The Community Tool Box (for more information go to: http://ctb.ku.edu); the CORE Group's manual, *Training in Qualitative Research Methods: Building the Capacity of PVO, NGO, and MOH Partners*; and *Formative Research: Skills and Practice for Infant and Young Child Feeding and Maternal Nutrition* developed by AED/ LINKAGES.
[68] Debus, M. (1998). Handbook for excellence in focus group research. Washington, DC: Academy for Educational Development.
[69] BASICS and HealthCom. (1995). A toolkit for building health communication capacity. Washington, DC: Academy for Educational Development.

Possible topics that can be explored during focus group discussions related to nutrition programming:

- Food preparation and usage
- Diseases, causes, and cures
- Health problems facing women and girls
- Perception of nutritional status
- Perceptions of child growth and development
- Gender norms around nutrition for pregnant and lactating women
- Food taboos
- Nutrition and food access, availability, and coping mechanisms
- Nutrition and other services for women and children
- Infant and young child feeding practices
- Health-seeking behavior
- Sources of information on child feeding (mass media, family member, health personnel)

FGDs are NOT a health education session or a time to disseminate information.

FGDs typically last about an hour to two hours long. The focus group is usually made up of six to ten participants who are of similar social status, sex, age, marital status and education; nevertheless, rich data can be gathered from a group as small as three people. The focus group will be run by a facilitator. The facilitator's job is to ask questions, keep the participants on topic and share their perceptions of the FGD with the note taker after the session. The note takers job is to take notes and observe the interactions between the participants and afterward, write a brief summary of the discussion.

Focus group discussions can provide a non-threatening way to explore issues, norms, emotions and cultural traditions. FGDs can be used in conjunction alone or in conjunction with participatory research activities (Like the ones in this guide!). Data from the FGDs can be used to help plan program interventions by revealing knowledge, attitudes, and practices. This data will help identify priorities for action.

A word of caution

The focus group technique was developed as a way of getting beneath the surface, to have people talk openly. The open-ended interaction of focus groups is supposed to lead to stimulation of thoughts and emotions, the revelation of material which is not ordinarily forthcoming in an individual interview. Nevertheless, facilitating a focus group is hard work and requires a skilled facilitator. If lead by in inexperienced or unskilled facilitator, focus groups can lead to data that are clear-cut, simple, unambiguous and wrong. The reasons people behave a certain way is often complex and the data you collect should reflect this. If you are new to facilitating focus groups try some of the other activities in this guide first or add an activity into a focus group discussion to help get the conversation started.

Example research areas included in this guide

The example focus group guides in Appendix 10 are intended for use with community leaders and health service providers as well as with mothers of children under two years of age. There are many more questions in the guides than would be possible to ask in a single FGD. You should develop and tailor FGD guides for your specific research needs.

FGD guide for community leaders and health service providers
Research area 1: Introductory questions about the community
Research area 2: Diseases, causes, and cures
Research area 3: Health problems facing women and girls
Research area 4: Perceptions of nutritional status
Research area 5: Changing nutrition and food access, availability and coping mechanisms
Research area 6: Nutrition Services for women and children
Research area 7: Other services for women and children
Research area 8: Specific questions for health service providers
FGD guide for mothers of children under two years of age
Research area 1: Introductory questions about the community
Research area 2: Diseases, causes and cures
Research area 3: Health problems facing women
Research area 4: Health problems facing children under two
Research area 5: Changing nutrition and food access, availability and coping mechanisms
Research area 6: Food preparation and usage
Research area: 7 Caring capacity

Please note the guides provided are just examples. You should develop and tailor a guide for your specific research needs.

Steps to follow

Before the focus group:

1. Define research objectives. In order to design an efficient research plan, research objectives must first be defined based on the overall goals of the program and the findings from the review of existing information.

2. Develop research questions. Research questions should be developed based on the information gaps identified by completing the initial analysis or by other participatory activities. What is the key information that needs to be gathered in order to plan interventions and develop messages?

3. Select the FGD research team. Decide what field staff will act as the focus group facilitator. Facilitators are responsible for leading the focus group discussion, asking all questions listed in the focus group question guide, keeping the discussion on track, and encouraging all participants to contribute. Facilitators need to be aware of how much they talk. They should not be dominating the conversation, or be a focal point of the conversation. The group should do 95 percent of the talking.

ESSENTIAL CHARACTERISTICS
OF FGD FACILITATORS

Demonstrates respect
Develops rapport
Uses appropriate, non-threatening question forms
Pays attention to non-verbal behavior
Listens more than talks
Encourages equal contribution from all participants

Decide what field staff will act as the note taker. The role of the note taker is to observe and record what the participants say and how they behave during the FGD. After the FGD, the note taker will and facilitator should meet and discuss their observations of the FGD. The note taker should then summarize the FGD.

4. Decide on logistics.
Specifically: What day? What place? What time? How long? Who the participants will be?

5. Design the FGD guide. Example FGD guides for community leaders, health clinic staff and pregnant or lactating women can be found in Appendix 10 of this guide. Please note that the guides provided are quite lengthy and would make for a very long interview. Pick only the most relevant questions for your needs. FGDs should not last longer than two hours.

Focus group discussion guide

A guide should be developed to conduct the focus group discussion. Although the guide is designed to help the conversation flow easily, you do not have to follow the exact order of questions; nevertheless, it is important to try to cover each question thoroughly. Each question is designed to elicit specific information. Probe each topic as necessary to get sufficient information. If you need to, take notes on the guide as a reminder to return to a question or address an issue further. Take advantage of natural shifts in the focus group discussion as they relate to questions in the FGD guide. If the conversation the participants are having does not pertain to the research focus, look for opportunities to steer the conversation back to the topic. If you find that a question is out of place or participants have a hard time answering a particular question, change the guide to correct the problem.

All the questions used during the FGD should be “open-ended,” meaning they will require more than a “yes” or “no” response. If you do ask a question and the participants do not provide you with much information use a non-directive question to encourage them to share more. Non-directive questions are neutral questions, phrases, sounds, and even gestures facilitators can use to encourage participants to elaborate on their answers and explain *why* or *how*. See Appendix 11 for examples of non-directive questions for use in focus groups.

It is typically better to ask a non-directive question than to ask “Why?” This is because “Why?” often makes people defensive, and although the answers you get back can be plausible and convincing, they often are rationalizations rather than the real reasons. For example, say you ask a mother about early initiation and she tells you that she expresses and discards the colostrum because it is “poisoned” or “infected.” Your natural tendency as a facilitator may be to ask her why she thinks that. Nevertheless, mothers may not be eager to tell you that they are fearful that their family and

community will shun them, that they feel acutely uncomfortable about defying their mother-in-law and instead take the easier course of following her advice and discarding the colostrum, or they might say that they don't feel comfortable doing anything different from what the overwhelming majority of other mothers are doing, even if they know it isn't right. So instead of asking the mother, why she thinks colostrum is infected, try asking her a non-directive question to elicit further details such as, "tell me more about that…" or "what do other women think about colostrum?"

6. Practice and pilot test the FGD guide. FGD facilitators should familiarize themselves with the questions before facilitating a FGD. Another important element to FGD preparation is the implementation of a pilot test. The pilot test will help determine if there are flaws, limitations, or other weaknesses within the FGD guide design and will allow the team to make necessary revisions prior to the implementation of the study. A pilot test should be conducted with participants that have similar interests as those that will participate in the implemented study. The pilot test will also assist the researchers with the refinement of research questions.

During the FGD:

1. Select the FGD participants. Be strategic and identify and gain access to those who can teach you the most about your topic. A few characteristics of a good participant include: they willingly volunteer answers; they are knowledgeable about the topics of interest; and they are currently involved in or recently experienced the topic/activity of interest.

For the activities listed in this guide you should use a purposive sample meaning participants are selected because they serve a very specific need or purpose. It can be helpful to consult with local people who are active in or have connections to the type of people you would like to participate. They may be able to offer ideas about how to gain access to the population, how best to approach people, and possible obstacles to recruitment.

> Have you ever tried to solicit participants for a focus group discussion (maybe the community health worker was finding volunteers for you) and half the community showed up all at the same time? If that happens to you try playing a spontaneous game of "segment the audience" to divide the crowd into manageable groups of participants. To do this, ask the larger group to divide into smaller groups based on questions you ask them. For instance, "Who in this group has ever breastfed a child?" Who in this group has a backyard garden?" "Who in this group raises animals? Who in this group is a father? Etc. After you have divided the larger group into smaller groups you can arrange a time to hold a FGD or other participatory activity with them. By doing this it will convey that you think what they have to say is important and you might be able to collect rich data.

Each focus group should be formed of participants that are similar in age, gender, and experiences. This should make the participants more comfortable talking to the facilitator and each other.

2. Decide on the seating arrangements. Participants should be seated in a manner that encourages involvement and interaction. A circle works best for this. A circle arrangement makes it possible for the facilitator and other participants to all make eye contact with each other. Be sure to avoid designating status with the seating arrangement. For instance, participants seated closest to the facilitator may appear to be more important and so the facilitator may need to make sure they do not try and lead the discussion.

3. Thank the participants for coming and read the consent script. An example consent script is provided in Appendix 3. Explain to the participants the purpose and format of the FGD. Tell the participants that you have a list of questions that you would like them to respond to. Tell the participants they should speak freely with one another in response to each question and what others have to say as long as they feel comfortable doing so. Additionally, explain that you are there to gain from the participants' own knowledge about the research topic, not to dispense advice. Assure the participant that there is no right or wrong answers; it is their personal opinions and perspectives that are of interest to the study.

4. Ask all questions listed in the FGD guide. Examples of multiple sets of FGD questions can be found in Appendix 9. For an hour long FGD you should only have about ten questions plus probes.

5. Take notes. During the FGD, you can write your notes on the question guide or in a notebook. Record all discussions, debates, disagreements, key phrases and terminology in the local language. Notes taken during an FGD will not be detailed because conversations may move fast between the participants; however, note any inconsistent comments or vague or cryptic comments and probe for understanding.

6. End the FGD by giving a clear indication that it is coming to a close. An easy script to follow could go something like this…

> *It is about time to finish this discussion, is there anything any of you want to share? Anything you feel is important for me to know?*
>
> *Thank you very much for participating in this discussion today. Your time is very much appreciated and your insights have been very helpful.*

Be sure to:

- Give the participants the opportunity to ask questions.
- Clarify any misinformation expressed by participants during the FGD (only if you are knowledgeable on the subject). However, please note that an FGD is not intended to be a health education session.
- Read the debriefing script. (A copy of this script can be found in Appendix 3).

After the FGD

Immediately after the FGD (facilitator & note taker)

- Add identifying information or a identification (ID) number to each FGD.
- Conduct debriefing session between facilitator and note taker Note themes, hunches, interpretations, and ideas
- Compare and contrast the FGD to other FGDs
- Label and file field notes
- Discuss any changes that should be made in the FGD guide taking into account new issues that are raised that require further investigation.

Soon after the focus group

- Transcribe the taped discussions. Decide ahead of time whether verbatim transcriptions are needed or just extensive notes with a few verbatim comments inserted.
- Prepare a summary of the individual focus group in a question-by-question format with amplifying quotes
- Share the summary for verification with the facilitator for verification purposes

1. Transcribe or expand your notes. Transcription is time-consuming.[70] Depending on the purpose of the research and your resources, you may choose to make a summary of what people said and analyze that, transcribe only certain parts of an interview that are important, or transcribe everything. Directions on how to transcribe are provided.

How to transcribe a FGD

Type the conversation as is. Don't try to change an interviewee's word choices or grammar. This will take away from the authenticity of the interview.

Pause the recording every so often. By pausing, you can think back on what you've already heard and write down any general key points. You can also rewind to repeat any passages you misunderstood or couldn't hear.

Leave out phrases such as "um" or "uh". Only use words and phrases that best convey the conversation.

Use proper line spacing, paragraphs, quotation marks and lower case and upper case letters. Format the report as you would any professional work. If you are asked to provide the transcript for any reason, you'll be able to do so quickly, without having to go back and work on it further.

Place activities into brackets. If the phone rings, type, [phone rings]. If there are unintelligible parts of the conversation, add [??] or [unclear].

Use dashes for pauses, interruptions and incomplete sentences.

If you were unable to audio record the FGD, then expand your notes right after the FGD is finished. It is impossible to recall any discussion in full, and important points may be lost if the notes are not expanded soon after the interview. Try not to complete another FGD without expanding your notes. Note any discussions, debates and disagreements, key phrases and terminology in the local language. Also record the participant's non-verbal behavior. The facilitator and note taker should review the notes together to verify the information.

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2. Analyze the data[71]

Once you have the transcriptions or field notes / summaries from all the FGDs you will be ready to analyze the data.

Some important definitions to know before getting started include:

- **Codes:** Codes are labels to lines of text that are assigned so that the researcher can group and compare similar or related pieces of information.
- **Themes:** Themes in qualitative data analysis are patterned responses or categories that show up in the data
- **Iterative process:** A process for arriving at a decision or a desired result by repeating rounds of analysis

There are three ways to categorize narrative data- using *preset* or *emergent* categories or a combination of the two. With preset categories you start with a list of themes or categories in advance, and then search the data for these topics. Alternatively with emergent categories, the themes or categories emerge from the data and are defined after you have read through the data. Since only an example focus group discussion guides have been provided and there is no way to know in advance what you and your team would specifically like to research, the instructions below provide steps to take to categorize narrative data using emergent categories. The steps are as follows:

Step 1: Get to know your data

1. Review the research objectives and questions.

2. Reread your notes thoroughly and carefully and look for emerging themes. Good analysis depends on understanding the data. For FGDs you will need to listen to audio recordings (if there are any) and/ or read and re-read the field notes / summaries until you are intimately familiar with the content. Write down any impressions you have as you go through the data. Judge whether or not the data are worthy of transcription and analysis. Start to write themes down.

3. Decide whether the data are of sufficient quality to analyze and what level of investment is warranted. If not, don't waste the resources it will take to transcribe and analyze the data.

Step 2: Focus the analysis

4. Decide whether to focus your analysis by question, topic, time period or event, or by group. How you focus your analysis depends on the purpose of the evaluation and how you will use the results. If you focus by topic, time period or event you will look at how groups (mothers, fathers, religious leaders, health service staff, etc.) responded to each question or topic, or for a given time period or event. Alternatively, you can organize the data from a group and analyze it as a whole.

[71] This section was adapted from Ellen Taylor-Powell and Marcus Renner (2003). *Analyzing Qualitative Data.* University of Wisconsin-Extension, Cooperative Extension, Madison, Wisconsin. This resource can be downloaded free of charge at http://learningstore.uwex.edu/pdf/G3658-12.pdf

Step 3: Categorize the information

5. Go through data again and sort data by themes. Identify themes or patterns such as: ideas, concepts, behaviors, interactions, incidents, or terminology or phrases used. Main themes may be broken into subcategories. This allows for greater discrimination and differentiation. For example, for a question about benefits of mother-to-mother support groups, data within the theme of benefits to self might be broken into a number of sub categories. See Table 20 for an example.

6. Develop codes. Create abbreviated codes of a few letters that represent the themes or patterns. For example, food shortage (FS); breastfeeding (BF); diarrhea (Dia); tradition (Tra); religious belief (RB), disease (Dis), etc. You will use the same codes for all the data.

7. Go back through the data and add codes to individual lines of texts. Your initial list of themes may change as you work with the data. This is an iterative process meaning you will arrive at a decision by repeating rounds of analysis. You may have to adjust the definition of your themes, or add codes as needed- don't force new findings into existing codes if they don't' fit. Continue to build themes and code the text until no new themes or subcategories are identified. Add as many themes as you need to reflect the nuances in the data and to interpret data clearly.

Coding can be a fairly labor-intensive process depending on the amount of data you have. It involves reading and re-reading the text and identifying coherent themes and then going back and coding the data.

Step 4: Interpret the data

8. Use your themes and connections to explain your findings. As you organize the data into themes- either by questions, topics, time period or event, or by the different groups- you will begin to see patterns and connections both within and between the themes.[72] You may be interested in summarizing the information pertaining to one theme or capturing the similarities or differences in people's responses. Develop a list of key points or important findings you discovered as a result of categorizing and sorting your data. As you go through the data, try and answer the following questions:

g) What new things did you learn?
h) What does all this mean?
i) What are the key ideas being expressed within the theme?
j) What are the similarities and differences in the way people responded
k) How many times did a particular topic or issue come up?
l) What is really important? What will those who use the results of the evaluation be most interested in knowing?

[72] For example you could compare breastfeeding patterns by area, nutritional status, illness status, and child care patterns, or cultural patterns. If you were interpreting by cultural patterns you should pay attention to beliefs or terms that are mentioned frequently and explain common practices. Many cultures have a set of beliefs related to the child's ability to chew, swallow, and digest foods, and these beliefs affect the timing, type, and dilution of foods that are offered. From a programming standpoint, the purpose of collecting this information is to discover whether these beliefs affect people's willingness to change feeding behaviors (AED/ LINKAGES p. 41). If you were interpreting the data by population you could determine if the responses from influential people are consistent with what mothers say, and the extent to which these people influence mothers and others in the household and community (AED/LINKAGES p.41).

When analyzing focus group data consider whether certain topics keep being said, whether certain topics evoke stronger emotion, whether the participants share more personal information about certain topics more than others or if two or more themes occur together consistently (whenever you find one, you find the other) and make note of these things. Notes can be put on the summary tabulation sheet. See Table 20 for an example. Take note of the following:

Extensiveness and frequency: Some topics are discussed more by participants (extensiveness) and also some comments are made more often (frequency) than others. These topics could be more important or of special interest to participants. Also, consider what was not said or received limited attention. Did you expect but not hear certain comments?

Intensity: Occasionally participants talk about a topic with a special intensity or depth of feeling. Sometimes the participants will use words that signify intensity or tell you directly about their strength of feeling. Intensity may be difficult to spot with transcripts alone because intensity is also communicated by the voice, tone, speed, and emphasis on certain words. Individuals will differ on how they display strength of feeling and for some it will be a speed or excitement in the voice whereas others will speak slowly and deliberately.

Specific information (Specificity): Responses that are specific and based on personal experiences should be given more weight than responses that are vague and impersonal. To what degree can the participant provide details when asked a follow up probe?

Relationships: Two or more themes occur together consistently in the data. For example new mothers consistently list mother-in-law as a trusted source of information about how to feed infants and young children. Such connections are important to look for because they can help explain why something occurs.

Context: Participant responses were triggered by a stimulus--a question asked by the facilitator or a comment from another participant. Examine the context by finding the triggering stimulus and then interpret the comment in light of that environment. The response is interpreted in light of the preceding discussion and also by the tone and intensity of the oral comment.

Internal consistency: Participants in focus groups change and sometimes even reverse their positions after interaction with others. When there is a shift in opinion, try and trace the flow of the conversation to determine clues that might explain the change.

Finding big ideas: One of the traps of analysis is not seeing the big ideas. Step back from the discussions by allowing an extra day for big ideas to percolate. For example, after finishing the analysis, you might set the report aside for a brief period and then jot down the three or four of the most important findings. You might also ask the focus group facilitator to review the process and verify the big ideas.

Step 5: Report findings

9. Create a summary of what you found. An easy way to summarize the results is to create a summary tabulation table like the one in Table 19. Summary tables can present responses to a question, topic, time period or event or by different groups. Use quotes taken from the data to illustrate the themes if possible. Be sure to keep track of the source of the information of the quotes (individual, site and date).

Time estimate for preparing and analyzing six to eight focus groups

Focus group preparation 4 days
Conducting focus groups 3-4 days (2 groups/day)
Note expansion and preliminary coding 2 hours per FGD (same day as the FGDs)
Coding, organization, and interpretation 6 days
Report writing 3 days

Source: Making Sense of Focus Group Findings: A Systematic Participatory Analysis Approach. (2003). de Negri, B. & Thomas, E. Washington, DC: Academy for Educational Development, p. 28.

Table 19. Example summary tabulation table analyzed by question

Question	Themes and codes	Quotes	Notes
What makes a quality mother-to-mother support group?	relevance (RE); participation (Part); good (GO) facilitator (FAC); content (CO); respect (RES); timing (TM)	*"A good facilitator is necessary. She must be knowledgeable and respect us." 23/05/ 2013; Mother, age 23, Community A* *"The group needs to focus on topics that are relevant to us." 24/05/2013; Mother, Age 18, Community B*	When mother participants talked about 'good' facilitators they shared a lot of detailed information on how the facilitator behaves.
What is the benefit of mother-to-mother support groups?	Benefits to self: knowledge (KNOW); self-efficacy (SE); skills (SK); social capital (SC); comfort (COM); no benefit (NB) Benefits to facilitator (BFAC) Benefits to family (BEF) Benefits to community (BCOMM)	*"Previously, before the support group, I would give my children warm water after delivery. Now I don't because of what I learned in the mother-to-mother support group in our community. Now I give breast milk and only breast milk until the child is six months old. After the child exceeds six months, I introduce complementary foods. I learned how to prepare the right complementary food from the group." 30/05/2013; Mother, Age 19, Community C* *"There is no benefit for me." 04/05/2013; Mother, Age 28, Community C*	The theme that mother-to-mother support groups are of no benefit was raised a lot by (mother) participants.
What would you change about the mother-to-mother support group	timing (TM); location (LOC) incentives (IN); topics (TOP); facilitator (FAC); teaching style (TS)	*"It would be better if the group could meet in the early afternoon when it is too hot to work in the fields and before our husbands come home." 19/05/2013; Mother, Age 28, Community A* *"Currently we meet in the courtyard of the group's leader but she lives far away from the rest of us. I would like it if we could meet closer to town." 020/05/2013; Mother, Age 28, Community B*	Mother participants very concerned about the distance and the amount of time they spend traveling to get to the mother-to- mother support groups.

ANALYZING, USING AND REPORTING FORMATIVE RESEARCH

Step 1. Interpret the findings from individual sessions. Detailed instructions on how to analyze data for each specific research activity are provided at the end of each module. More general instructions are provided below.

"Before beginning to interpret your information, it is a good idea to review your summaries of the codes, topics, and focus groups. You may decide to group the information from different groups together if the findings are very similar. It is also helpful to listen to the tapes again if you have time.

Identifying Variables That Can Influence Interpretation

When interpreting the information, it is very important to pay attention to variables that could influence your interpretation. For example:

Participant dynamics. How did the participants relate to each other? Was there any tension or conflict between them, either open or hidden? Did some of the participants dominate the discussion? Did some participants seem afraid to express their opinions in front of others due to age differences or class differences? If yes, then it is important to reread the results to see if the participants' responses might have reflected conflict or fear of offending the others. In your conclusions, you may want to give some details about the context of the group's dynamics. This will help the reader to better understand your conclusions.

Tone of voice. A statement can be interpreted many different ways depending on the tone of voice that was used. For this reason, it is helpful to listen to your tapes again, paying attention to the participants' tone of voice. The following phrase, for example, can be interpreted four different ways:

- The nurse was HELPFUL!!! [Speaker is enthusiastic.]
- The nurse was HELPFUL??? [Speaker is doubtful.]
- The nurse WAS helpful. [The nurse is not helpful now.]
- The NURSE was helpful. [In contrast to someone else, the nurse was helpful.]

[Identify tone of voice in interview / FGD transcripts in brackets]

What was NOT said. Look for what was not said. What did you expect to hear, but did not? Why do you think the participants did not mention this?

Pay special attention to silences. Silence following a question may have a significant meaning depending on the culture. In some cultures, it may indicate disagreement, while in others, it may be a sign of respect.

In trying to interpret silence, evaluate why certain aspects of an issue have not been mentioned.

What prompted the response: When interpreting your information, look at what provoked the response:

- Was it an open-ended question? If yes, then the response should be given more weight.
- Was it a closed ended question? If yes, then the response should be given less weight.

- Was it a leading question? (Did it encourage the participant to answer a certain way?) Iyes, then the response should be given less weight.
- Was it a response to another participant's comment? If yes, then the response should be given more weight.
- Was a participant responding to pressure from the group? If yes, then the response should be given less weight.

Other variables: There are a number of other [v]ariables that could significantly influence your interpretation, including:

- The frequency of the response, without taking into account who said it: More frequent responses should be given more weight.
- The number of people who gave a response: Responses given by many participants should be given more weight than those given by only a few participants.
- The basis of the response: Responses that are based on personal experience should be given more weight than hypothetical responses.
- The emotion, sincerity, and spontaneity of the response: Responses that are emotional, spontaneous, or sincere have more weight than those that are not.
- The specificity of the response: A specific response, giving details, should be given more weight than a vague response.

The focus group context is important to consider because it affects the comfort level of participants and, consequently, how they respond to questions. If participants did not feel at ease, they might not have been as open, truthful, or relaxed as they would have been in a different context. Contextual factors can be difficult to analyze using only transcripts or notes, however. Before interpreting your results, it is a good idea to discuss the following questions as a team:

Also consider the context

Research activity setting and time: Was the setting comfortable and the time convenient for the participants? Were the participants in a hurry to finish for any reason? If the setting was uncomfortable, the time was inconvenient, or the participants were in a hurry, then they might not have given in-depth responses to the questions or they might have given answers that they thought would satisfy the moderator (so that the discussion would be shorter).

Facilitator and note taker: How do you think the respondents reacted to the moderator? Were they comfortable with the moderator? Do you think that with a different moderator, the discussion would have taken another direction? The moderator always has an effect on the participants' responses, whether or not he or she intends to. Participants answer questions differently depending on how comfortable they feel with the moderator and how skillfully the discussion is guided. This is something to keep in mind when trying to figure out what your results mean."[73]

Step 2. Triangulate all qualitative findings with quantitative data

After all the research is completed, there will be a wealth of results, ranging from summaries and transcripts of group discussions and various summary tables. During this step all the results that were analyzed and summarized initially will be synthesized and interpreted as a complete set.

Begin to think about what was learned from the entire research process. Interpreting the data means deciding what the respondents were really saying, the strength of their feelings and beliefs, and the reality of their intentions. The purpose of the interpretation is to help develop recommendations with a focus on program actions and priorities.

[73] de Negri, B. & Thomas, E. (2003). Making Sense of Focus Group Findings: A Systematic Participatory Analysis Approach. Washington, DC: Academy for Educational Development, pp. 59 -61.

Comparing the results of different methods is called *triangulation*, and it is one way to check the validity of your conclusions. Triangulation can be achieved by comparing your results with results from your qualitative research and previous qualitative and quantitative studies to see if your findings support or conflict with them.

When interpreting and triangulating the data it is useful to use different charts, graphics, and examples[74] such as quotes to clarify and summarize and show patterns and trends. Charts, graphics, and examples help those who were not involved in the research to see the results and understand the implications. For instance, using Table 20 [75] you can list optimal maternal and child nutrition practices and contrast them with what is known about actual practices in a given country/setting and with suggestions for feasible new or improved practices. Table 20 also summarizes what is known about the motivations for current or recommended changes in behaviors as well as what appear to be the barriers to these 'new' practices. Keep in mind that the reasons *why* people behave or believe as they do are as important as the practices themselves.

Table 20. Summary of key behaviors

Optimal practice	Current behavior	Motivation/Rationale for current behavior	Barriers to practicing optimal behavior	Recommendations for feasible/ better practices	Motivations and barriers for recommended behaviors

Step 3. Integrate all the information collected and analyzed during phases 1 and 2 into one document. Share and discuss the document.

Prepare a summary report that provides results key recommendations and priorities for behavior change needed by planners.

Be sure to draw conclusions on the key issues:

- The ways in which current practices are contributing to maternal and child malnutrition and food insecurity
- The improvements that families indicated they can and will make
- The factors that motivate or enable improvements
- The constraints to adopting the new practices
- The sources of information and resources for maternal and child nutrition and food security

A general template for a summary report is provided in Appendix 12. The summary report is intended for program planners and in some cases, policy-makers. Keep the audience in mind at all times. Focus on the essential points and leave out details that do not relate directly to planning.

[74] For a more comprehensive summary of different types of charts, graphics and examples that can be used to summarize data and show patterns and trends see *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*, Section 8.

[75] This table adapted from table in*The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011). This resource can be downloaded free of charge at: www.iycn.org

Step 4. Apply research results to develop the social and behavior change communication and activity strategy using the results of the formative research.

Unfortunately, the description of this step is beyond the scope of this guide. Nevertheless, there are many helpful, free guides that can assist you with developing a SBC strategy.

- O'Sullivan, G.A., Yonkler, J.A., Morgan, W., and Merritt, A.P. *A Field Guide to Designing a Health Communication Strategy*, Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 2003.

- Chen, P.F. *Planning Behaviour Change Communication (BCC) Interventions: A Practical Handbook,* 2006.

- Cabañero-Verzosa, C. Strategic communication for development projects: A toolkit for task team leaders. Washington, D.C., International Bank for Reconstruction and Development/ World Bank, 2003.

- National Cancer Institute (NCI). Making Health Communication Programs Work. A Planner's Guide. Bethesda,Maryland, U.S. Department of Health and Human Services, National Institutes of Health, NCI, 2001.

- *CModules: A Learning Package for Social and Behavior Change Communication (SBCC).* Washington, DC: C-Change/FHI 360, 2012

For more guides check out the resource finder on the Health Compass website at: http://www.thehealthcompass.org/healthcompass?page=2&decision_tree=sbcc_tools&f[0]=im_field_putting_the_steps_to_wo%3A738&f[1]=bundle%3Asbcc_capacity_strengthening_tool&f[2]=bundle%3Asbcc_capacity_strengthening_tool

REFERENCE MATERIALS

This toolkit is comprised of materials adapted or taken directly from handouts, facilitator materials, and training guidelines from the following twelve sources:

1. *Analyzing Qualitative Data.* Ellen Taylor-Powell and Marcus Renner (2003). University of Wisconsin-Extension, Cooperative Extension, Madison, Wisconsin. This resource can be downloaded free of charge at: http://learningstore.uwex.edu/pdf/G3658-12.pdf
2. *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development. This resource can be downloaded free of charge at: http://www.globalhealthcommunication.org/tools/58/
3. *Formative Research: Skills and Practice for Infant and Young Child Feeding and Maternal Nutrition* by AED/ LINKAGES India. (2003). This publication can be downloaded free of charge from http://www.linkagesproject.org/media/publications/Training Modules/Formative_Research_Module_2-23-04.pdf
4. *How to Conduct a Food Security Assessment.* (2006, 2ND Ed.). International Federation of Red Cross and Red Crescent Societies, Geneva. This publication can be downloaded from www.ifrc.org
5. *Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health & Social Analysis Action*. (2007). Barton, T., Rubardt, M., Reilly, J. Cooperative for Assistance and Relief Everywhere, Inc. (CARE). This publication can be downloaded from www.care.org/reprohealth
6. *Methodological Guide: Participatory Appraisal of Nutrition and Household Food Security Situations and Planning of Interventions from a Livelihoods Perspective.* (2003). Karel Callens, K., & Bernd S., FAO. This resources can be downloaded free of charge at: http://www.fao.org/docrep/006/ad694e/ad694e00.htm
7. *Qualitative Research Methods: A Data Collector's Field Guide*. (2005). Natasha Mack, Cynthia Woodsong, Kathleen M. MacQueen, Greg Guest, & Emily Namey. Research Triangle Park, NC: Family Health International. This publication can be ordered from publications@fhi.org
8. *Qualitative Methods in Public Health: A Field Guide for Applied Research* (2004).Priscilla R. Ulin, Elizabeth T. Robinson, Elizabeth E. Tolley. John Wiley & Sons.
9. *The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices.* USAID's Infant and Young Child Nutrition Project. (2011). This resource can be downloaded free of charge at: www.iycn.org
10. *Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS*. (2006). International HIV/AIDS Alliance. This publication can be downloaded from www.aidsalliance.org
11. *Training in Qualitative Research Methods: Building the Capacity of PVO, NGO, and MOH Partners;* and *Qualitative Research Methods: A Data Collector's Field Guide.* Adapted by: The CORE Group Social and Behavior Change (SBC) Working Group This publication can be downloaded at: http://www.coregroup.org/storage/documents/Workingpapers/qrm_complete.pdf

Appendix 1: Key Issues Related to Maternal and Infant and Young Child Nutrition[76]

Topic	Related Key Issues
Exclusive Breastfeeding	• Delayed initiation of breastfeeding • Beliefs that colosturm is not good for the newborn • Need of ritual feeds, cleansing • Giving prelacteal feeds in place of colostrums • Feeding water, milk, or other liquids, usually by bottle (for instance, water may be given in hot / dry seasons because women fear child is thirsty or will dehydrate without water) • Premature introduction of complementary foods because the mother feels her milk is not enough to nourish the baby • Image of breastfeeding • Issues with breastfeeding in public • Social support • Perceived ease/difficulty of breastfeeding • Perception of insufficient milk related to breast size, diet, and confidence • Cultural expectations of women • Rituals for introducing foods • Lack of time/ employment constraints
Complementary Feeding	• Dilute or watery foods with low nutrient density • Delay in introducing complementary foods • Low frequency of feeding • Inadequate amounts consumed per meal (small servings, lack of supervision, lack of appetite) • Lack of variety (lack of protein and/or micronutrients) • Child's refusal or lack of interest in eating • Lack of persistence or coaxing of a child with poor appetite (however, forced feeding is practiced in some countries) • Food availability • Perceived amount child needs • Perceived ease/ difficulty of preparing food for child • Desire for an independent child • Food taboos for children • Perceived indicators that child's hunger is satisfied • Normal family meal pattern • Socialization of child to accept amount given and not ask for more • Willingness to be patient and persistent
Feeding child when ill	• Belief that breast milk can cause or worsen an illness • If and why some foods perceived to worsen or cause illness • Degree of concern about lack of appetite and weight loss • Perception of child appetite
Maternal Diet	• Perceived needs of pregnant and lactating mother • Food taboos and reasons for taboos • Beliefs about relationship of diet to quantity and quality of breast milk • Feelings of stress • Increased food and nutrition needs • Traditional rules for food distribution within the family • Fear that gaining too much weight during pregnancy will lead to hard delivery
Maternal Health	• Perception of health services • Perceptions of decreased workload/ increased need for rest for pregnant women • Perception of anemia • Child spacing

[76] While this table is comprehensive it is not complete. Table adapted from *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*. Kate Dickin, Marcia Griffiths &Ellen Piwoz (1997). Academy for Educational Development

Supplementation	• Understanding of why supplements are necessary • Perceived benefits / consequences of supplementation • Desire to follow traditional practices
Food Security	• Availability- sufficient food for all people at all times • Accessibility- physical and economic access to food for all at all times • Adequacy- access to food that is nutritious and safe, and produced in environmentally sustainable ways • Acceptability- access to culturally acceptable food, which is produced and obtained in ways that do not compromise people's dignity, self-respect, or human rights • Agency- the policies and processes that enable the achievement of food security
Water, Sanitation and Hygiene (WASH)	• Hand washing practices • Knowledge of relationship between contaminated food or water and illness • Perception of time and resources needed for hygienic behavior • Access to soap and water • Household sources of water for homestead gardens • Environmental enteropathy • Poor sanitation, lack of latrines • Animals in the homestead • No water treatment
Gender	• Roles • Responsibilities • Access to resources • Autonomy • Constraints and opportunities (e.g., female mobility) • Decision making (e.g. what, when, how much to feed infants and when to initiate BF and when to introduce supplemental foods / liquids)
Age	Age of the mother can cause substantial shifts in her status, autonomy and roles within a household and her relationship with the grandmother[77]

[77] Amy Webb Girard

Appendix 2: Key Domains for Formative Research on Maternal and Child Nutrition

Please note: The following set of key domains and questions are meant to be comprehensive but are by no means complete. Many of these are measured in Barrier Analysis - the "domains" are also determinants of behavior.

Key domain	Brief definition or comment	Use to answer this research question.
Perception of nutritional status and perceived severity	Perception that malnutrition is a problem and not just "the way people are." Feelings concerning the seriousness of malnutrition among pregnant and lactating women and their young children (including evaluations of both medical and clinical consequences and possible social consequences).	Is malnutrition a familiar notion to the community? What does the community perceive as malnutrition? How important is it? How are there many thin children or adults are there in the community? How do people describe and explain this? What do they do about it?
Perceived personal (or group) risk	It's not unusual for people to be aware of a risk for people in general, but not strongly believe that they themselves are at risk.	What are peoples' perceptions around what makes a person susceptible to malnutrition
Perceived control	The perception that the situation is not fixed by God or destiny, that one/one's group may legitimately address it.	What are peoples' perceptions of how much control they have over things such as crops, illness, etc.?
Self-esteem	An individual's sense of his or her value or worth or the extent to which a person values, approves of, appreciates, prizes, or likes him or herself (Blascovich & Tomaka, 1991). Self-esteem has been related both to socioeconomic status and to various aspects of health and health-related behavior, as has a related construct, self-efficacy.	Do women value themselves? Get an understanding of whether women think they should be given special treatment (i.e., decreased workload, more food, help with household chores) when they are pregnant or lactating?

Key domain	Brief definition or comment	Use to answer
Self-efficacy	Perception that the person themselves can successfully execute the behavior required to produce the desired outcomes (Bandura, 1977).	Get a sense of whether women are confident that they can keep themselves and their children well nourished and healthy?
Collective efficacy	Confidence that if a group acts together, they can affect change (Bandura, 1986). It involves the belief or perception that an *effective collective* action is possible to address a social or public health problem. There are three different dimensions:	Get a sense of peoples' • Perceived efficacy to take action as a group • Perceived capability of other community members • Perceived efficacy to solve
Social capital	Refers to connections within and between social networks.	Measures three aspects of structural social capital (membership in groups, involvement in citizens activities, and social support from the community), as well as cognitive social capital (trust, social harmony, perceived fairness, and sense of belonging).
Social cohesion	Social cohesion consists of the forces that act on members of a group or community to remain in, and actively contribute to the group. In cohesive groups, members want to be part of the group. They generally like one another and get along well, and are loyal and united in the pursuit of group goals. Social cohesion is an important antecedent and consequence of successful collective action. Social cohesion mediates group formation, maintenance, and productivity.	**Sense of belonging**- *Is the extent to which individual members feel as if they are an important part of the group or community.* **Feelings of morale -** *Refer to the extent to which members of a group or community are happy and proud of being a member. I am happy to be part of this community.* Are the people in the community willing to share responsibility for making the community a better place to live why or why not? **Social trust -** *Is the general confidence that one has in the integrity, ability and good character of other people? Trust is sometimes thought of as the glue that holds a group or community together and makes cooperative action possible.* Can other people community) be trusted why or why not? **Social reciprocity -** *Refers to mutual interchange of favors, privileges and benefits in a relationship. For example, if someone helps another build their well or bring in their crop, the person who receives the favor is expected and actually returns the favor at a later date*. Do neighbors help each other out? How do mothers help one another out? **Network cohesion:** A social network consists of all of the dyads or pairs of individuals (or groups) within a community that are linked by some form of social relationship (kinship, friendship, economic tie, etc.), while a communication network consists of all of the dyads or pairs of individuals (or groups) within a community that are linked by information exchange. Who talks to who? What do they discuss?

Key domain	Brief definition or comment	Use to answer
Beliefs and attitudes	Frame of reference, which may affect both perception of problem and perception and nature of acceptable solutions.	Possibly examine the meaning of negotiation in relation to the balance in power in the partner relationship and the ability of women to participate in decisions affecting their health.
Perceived social norm	Behavioral expectations and cues within a society or group regarding current and possible new practices.	What are women expected to be like in this community? What are men expected to do for their families? What happens if people don't do what is expected of them in this community?
Participation in household decision-making	A dimension of women's empowerment.	Explore power relations between men and women; help measure women's ability to influence key decisions that affect her life/ her negotiating power about key decisions that affect her life. Also explore mothers ability to negotiate with grandmother in decisions around maternal and child nutrition and health behaviors (especially true for first time mothers).
Women's control over assets	A dimension of women's empowerment.	Explore whether women have control over material assets that might help her exercise control over her own life and/or increase her role and status in the family or community
Perceived feasibility/ acceptability	Explore whether people think they can do a behavior and whether that behavior is acceptable by others.	Gain a better understanding of the perceived feasibility/ acceptability of possible new practices such as: *Put your newborn to the breast immediately after birth *Give colostrum (yellow breastmilk) *Give only breastmilk to the baby for the first six months * Produce enough breastmilk * Produce good quality breastmilk *Properly position the baby on the breast *Continue breastfeeding until baby is six months of age * Continue breastfeeding child until the age of 2 years *Start giving baby food in addition to breastmilk at 6 months *Know what types of foods to feed young children in addition to breastmilk *Able to feed young child (e.g., frequency, amount, density) so that they are healthy and strong *Eat an additional meal when pregnant or lactating *Take the supplements that pregnant and lactating women should take *Request help when needed *Wash hands with soap (or ash) during the critical times *Wash your child's hands with soap (or ash) before they eat *Space the birth of your children (delay getting pregnant)

Key domain	Brief definition or comment	Use to answer
Participation	This dimension measures the range of participation to include the traditionally disenfranchised members of the larger community (e.g., women, lower class, ethnic groups, age, occupation, as related to IYCF & maternal nutrition), as well as the diversity of activities which members get involved, ranging from planning, selection of leaders, decision on services and modes of delivery, resource mobilization and management, to evaluation of program outcomes.	Explore the dimensions of participation: • Access to participation • Extent and level of participation How many committees/ community organizations/ community groups are there that deal with maternal and child health? How do these committees/ community organizations/ community groups encourage people in the community to actively participate? How are traditionally excluded or more disadvantaged members included in community meetings or invited to get involved in community activities?
Access to health service providers, medical services, and health products		What kind of services are there? Who is able to access health services? Where do people prefer to go to get health services? What is the perception of the quality of the services? What do people like or dislike about these services? What are ways these services could be improved?
Social support	Positive endorsements and/ or practical support of family, friends, community leaders	How do fathers support the mothers of their children when they are pregnant or lactating? How do older, more experience mothers help younger mothers? Who in the community offers mothers the best support and information on raising your children? How do community leaders support women in being good mothers? How do grandmothers support mothers?

Key domain	Brief definition or comment	Use to answer
Flow of information	Frequency of use of local media and other information mechanisms by community members to learn about (and/or to provide information about and support) the program/issue.	Where do you normally hear nutrition and health information? How do they prefer to get health information? What are popular forms of mass media TV, radio, newspapers, mobile phones, Internet, etc.? Do influential people (chief, teacher, religious leader, business owners) in the community ever discuss these issues?
Local food systems and recent changes		How do households obtain their food? What do they produce? What do they purchase? Other sources? Has this situation changed in the last years? How? Why? How are these charges perceived? Why?
Food habits, preferences and related beliefs		-How many meals do the different household members eat a day? In which season? What do they eat? Any snacks in between? Do children eat differently? How? What age groups (e.g. infants, school age children)? -Has this changed lately? Why? How are changes perceived? Why? Why not? Coping mechanisms: How do eating patterns change in times of scarcity? How is food obtained in such cases? If the household had more resources, what foods would they like to eat more or more often? Why? What foods are considered especially good or to be avoided in certain circumstances? Which foods? When?
Activities of household members related to food and	(e.g. food collection, food production, food processing, purchasing, preparation)	What are these activities? Who performs them: men? women? children? How much time does it take them a day? Does this vary? When? Why? (season? other factors?)

nutrition		
Production for household consumption		What foods are produced by the household? How many months do staples last? During which months do they eat the other foods? Has this changed in the last ten years? How? How are these changes perceived? Why? What are the problems encountered? What are the periods of food scarcity? For which foods? What efforts do people make to overcome these? What level of control do women have over food produced by the household (kitchen garden or larger farming activities? Do women have a say in whether food grown on the homestead are retained by the household for home consumption or whether they are sold and how that income is used? Which foods do women have control over (i.e., morning and evening milk or evening milk only; small livestock or eggs; maize or sweet potatoes?

Appendix 3: Example Consent and Debriefing Scripts

***Please note that the food market analysis has a separate consent form.**

Consent script (read aloud)

Hello and thank you for agreeing to meet with us today. My name is_____and this is _____. We are working with CARE on maternal and child nutrition project. The purpose of this session is to gather your perceptions on maternal and child nutrition in your community. Your responses will help us to understand the reality of maternal and your child nutrition in (NAME OF COMMUNITY) and to help other families. There are no right or wrong answers to any of the activities or questions- this is not a test. We would like to know about what you do normally and ask your opinions. The session will take about one hour. _____(note taker's name) will be writing down some things we talk about so we can remember them later. Also, we would like to use a tape recorder. Does anyone object? We are the only ones who will you're your name and your child's name and we will not use names in any reports we write. You have the right to refuse to participate without penalty. You have the right to leave at anytime and the right to not answer questions you do not wish to. Do you understand what I said? Do you have any questions?

(Allow interviewee to ask questions and respond as needed. Once questions are answered begin the interview).

Debriefing script (read aloud)

We have completed the session. We want to thank you for spending time with us and participating. You have helped us understand the reality of maternal and child nutrition in _____. This will help us design interventions that are specifically tailored to families in _____. Do you have any additional questions? (After any questions have been asked and answered) Thank you again for your time and responses. If you would like any further information about the [name of project] please contact _____, at_____.

Appendix 4: Blank Designing for Behavior Change (DBC) Framework[78]

Behavior[A]	Priority Group or Influencing Groups[B]	Determinants[C]	Bridges to Activities[D]	Activities[E]
To promote this Behavior…	…among this audience… (circle one) Priority Group: Influencing Groups:	…we will research these Determinants… *These can only be determined by conducting research studies.	…and promote these Bridges to Activities (priority benefits and priority barriers)…	…by implementing these Activities.
Indicator:				Indicators:

A. What is the specific, feasible and effective **Behavior** to promote?

B. Who are the **Priority Groups** and **Influencing Groups**? (Describe in six ways.)

C. What are the most important **Determinants affecting this Behavior with this group**? (The Determinants are: perceived self-efficacy/skills, perceived social norms, perceived positive consequences, perceived negative consequences, access, cues for action/reminders, perceived susceptibility, perceived severity, perceived divine will, policy, and culture.)

D. Which **Bridges to Activities** need to be promoted?

E. Which **Activities** will be implemented to address the Bridge to Activities

[4] The DBC Framework is adapted from AED's BEHAVE Framework.

[78] For more information on the DBC framework see the *Designing for Behavior Change Curriculum (*2008) that was developed by the CORE Group, Social and Behavior Change Working Group. Copies of this curriculum can be downloaded free of charge from http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

Appendix 5: Consent Script for a Local Food Assessment

Please read the following script to business owners BEFORE collecting any data.

Hello, my name is _____. I am working with CARE on a maternal and child nutrition program. Part of the ongoing research for this program is to conduct a local food assessment to understand the food security situation in this region. This survey will help us understand what foods are regularly available to the local population and help us design interventions that are specifically tailored for the women and children here.

All of the information collected today will be confidential. Your name, the name of your business, and the prices we collect will not be published and will only be used for research purposes by CARE. We do not intend to disrupt the flow of business and aim to stay out of the way of your customers. We may like to meet with the you (the owner/ manager) for about five minutes following our data collection for follow up questions.

We would also like take pictures specifically of the food you sell. No photographs will be taken that will identify your business, staff, or customers.

Appendix 6: Local Food Assessment Sheet

Fill out this survey in the market/ markets of the community you are working in order to collect information about what foods are currently available and their respective prices. The survey is composed of a spreadsheet with eight food groups.

Date: _____ Time of the day (HH:MM) _____

Data collector name: _____

District: _____ Village/Town/City: _____

Type of business (circle one): shop super market stall

Food group	List of food items found
1. Fruits	Record only fresh fruits, NO dry, frozen, canned, etc.
2. Vegetables	Record only fresh vegetables, NO dry, frozen, canned, etc.
3. Bread, cereal, grain	Record all bread, grain and cereal products
4. Dairy Products	Record all fresh milk, cheese, yoghurt

5. Meat, fish, poultry, game, seafood products	Record all fresh meats, fish, poultry, game seafood products
6. Milk substitutes	Record all skim milk, non-fat milk, evaporated, sweetened condensed, flavored (chocolate milk and other flavors) breast milk substitutes (milk for infants), powdered milk, soy milk
7. Snacks	Record the snack foods
8. Other	Record any other products that do not fit any of the other categories

Additional notes:

Appendix 7: Example Food Cards for Card Sort

Maize

23

Appendix 8: Blank Card Sort Data Collection Form

Note taker name: _____

Community name: _____

Category of Card Sort	Card numbers

Appendix 9: Example Key Informant Interview Guides[79]

Objectives:

1. To understand the strategy and operation of each agency or community group, specifically each group's:
    a) Priorities
    b) Promotion activities
    c) Staffing
    d) Support and supervision structure
    e) Community reach
2. To gather information on how agencies and groups communicate and work together.

Participants
District Agriculture Director
District or sub-district health director
Agriculture Extension Worker or NGO agriculture extension field staff
Frontline Health Professional
Community Health Volunteer
Community Leader

Please note that there is a consent script which needs to be read to each informant before the interview. This consent script can be found in Appendix 3. Each informant that is interviewed needs to verbally agree to participate before the interview starts.

District Agriculture Director
Note the sex of the respondent

(This will vary widely depending on whether the project will have a food security platform or the food security/dietary diversity activities. Select the following topics accordingly.)

(Open the discussion with introductions, connecting yourself with CARE and the CARE platform program. Gauge whether or not he/she seems familiar with CARE.)

1. How long have you been in this district? How long in this position?

2. What are the current priorities in agriculture? (cash crops and value chains, vs. improving productivity of staple crops and existing livestock to improve livelihoods?)

3. Do you promote kitchen gardens or vegetables for consumption?

4. Do you promote improved care of local poultry? Do you support the use Newcastle vaccines for chickens? Do you conduct vaccination campaigns? Are vaccines readily available? Where?

5. Do you also promote raising goats, lambs or other small animals for milch/milk or meat?

[79] All key participant interview guides developed by Judiann McNulty

6. Are you running modern, safe and effective food storage programmes/trainings for farmer families and commercial interests? (If yes…) What has been the response? Do women participate?

7. What is the staffing structure at the Ministry of Agriculture down to the community level? Are these positions fully staffed? How common is turn-over? Who trains the staff and/or volunteers who work directly with farmers? Is there an in-service training plan? What are recent topics discussed? What's the supervision system like? Does it work well? What would help improve it?

8. What approaches are used to educate farmers? (Farmer field schools, demonstration plots, farmer's clubs?) How often are extension workers expected to go to the villages? How often are extension workers able to visit? What would affect their ability to travel to the villages?

9. What role do women play in agriculture? (His/her perspective.) How does the agriculture extension system interact with women? Are there any women staff or volunteers? Are there any NGO or other services provided in the district directed predominantly at women farmer/groups? Can CARE get contact addresses for these?

10. What is the relationship between agriculture and the nutrition of women and children?

Agriculture Extension Worker or NGO agriculture extension field staff
Note the sex of the respondent

(Open the discussion with introductions, connecting yourself with CARE and the CARE platform program. Gauge whether or not he/she seems familiar with CARE.)

1. Who interacts directly with the farmers? Are there women farmer groups/clubs/collectives? Who interacts directly with the women farmers? How often? What are your current approaches used to educate farmers? (Farmer field schools, demonstration plots, farmer's clubs?) How often do extension workers go to the villages? What would affect their ability to visit the villages?

2. What role do women play in agriculture? (His/her perspective.) How does agriculture extension system interact with them? Are there any women staff or volunteers? Is there an agency/NGO or group with objectives to work with women farmers in your area? If so what group and what work do they do?

3. Do you do any promotion of kitchen gardens or vegetables for consumption? Do you promote improved care of local poultry? Do you support the use Newcastle vaccines for chickens? Do you conduct vaccination campaigns? Are vaccines readily available? Where?

4. Do you also promote raising goats, lambs or other small animals for milch/milk or meat?

5. Are you running modern, safe and effective food storage programmes/trainings for farmer families and commercial interests? (If yes…) What has been the response? Do women participate?

6. Would you be interested in learning about the nutrient value of different crops, fruits, etc.? Do you think it could be useful in your work? How?

District or sub-district health director
Note the sex of the respondent

(Open the discussion with introductions, connecting yourself with CARE and the CARE platform program. Gauge whether or not he/she seems familiar with CARE.)

1. How long have you been in this district? How long in this position?

2. What is the coverage area? (If they have a map posted, refer to it. Verify the number and location of health facilities.)

3. What are the principal health issues in the coverage area? In general? For adult women? What about for children under two?

4. What are the priority efforts in the coverage area? Current status? (i.e. Rollback Malaria, VTC, etc.)

5. Is additional funding allocated from the central government for these initiatives? Are there funds for extra staff?

6. How are these priorities established? (Directives from MOH, or local plans, etc.)

7. (Probe: If he/she has mentioned a principal health issue that is not addressed by the priority efforts mentioned, ask…) How would you go about adding XXXXX as a priority effort?

8. What are some of the main challenges of delivering health services in this area?

9. (If staffing is not mentioned, probe to ask…) Is there high staff turn-over? Do some positions remain unfilled for long periods of time? Why don't staff stay?

10. What kind of supervision do staff receive? (Probe for frequency, feedback mechanism, type of support provided through supervision, etc.)

11. Is there a regular plan for in-service training? How often? What are recent topics discussed in trainings?

12. What information/statistics do staff report to the district? (Ask to see the forms.) Is this done by hand or computer? How often? Who oversees data input for transmitting up to the next level? Are there any concerns about the timeliness or accuracy of the reports? How does the district/sub-district use this information or is it simply sent onwards? Is any of the information on trends shared with local government? For what purpose? (Try to ascertain whether there are plans or interest in using mobile technology to facilitate reporting. If possible, meet with the HMIS person to discuss further.)

13. (If nutrition has not come up as a topic before now, ask…) Are there issues of poor nutrition among children under two and pregnant or lactating women? (If yes, ask…) Do they have data about prevalence? (Might be only weight for age or weight for height of sick children, or anemia among women or children seeking care.) What from your perspective are the causes of each of these? What does the health department/health service do to prevent any of these forms of poor nutrition?

Frontline Health Professional
Note the sex of the respondent

(Open the discussion with introductions, connecting yourself with CARE and the CARE platform program. Gauge whether or not he/she seems familiar with CARE.)

1. How long have you worked in this post? Where were you before here? Where did you receive training?

2. (If this is a clinic/health center serving various communities, then ask…) How often do you go to each community? What is the purpose of these visits? How do you travel there?

3. (For people to come to the health center, ask..) How do people who come to the health center travel? How long does it take them?

4. What are the main health problems of women in this location? What are the main health problems of children under two years? (Probe for his/her perspective on causes.)

5. Where do most women deliver? Who attends the deliveries? Where do they receive prenatal care? Do these services cover the needs of the population? (Probe on coverage) After a delivery, when is the first time they are seen by a health worker?

6. Are there cases of poor nutrition among children under two? Among women? What types? How prevalent is malnutrition? What are the causes?

7. Is there a growth monitoring program? How often do growth monitoring sessions occur? Who conducts this program? What percentage of mothers come for growth monitoring? Do you know how to use a MUAC tape? (ask for demonstration) (If not, ask…) How do you identify cases of SAM? (may need to see the height board) Do you seek cases of SAM or wait for children to come? How do you and other health workers treat SAM? (If she says they use Plumpy Nut/RUTF, ask…) Where does the supply come from? Is there any currently in stock? Has this method of treatment been successful?

8. (Observe any nutrition-related posters on the walls, apparent age, quality and sponsor. Ask…) Do you have any materials for nutrition talks or counseling? (Review them rapidly for quality and accuracy). Where did they come from?

9. (Ask…) If a mother of a one-month old child says she doesn't have enough breast milk, what advice would you give her?

10. When did you last have any in-service training related to nutrition? What specific topics were covered? Who gave this training? What more would you like to learn about breastfeeding, complementary feeding, or maternal nutrition?

11. (Observe any hygiene-related posters on the walls, apparent age, quality and sponsor. Ask…) Do you have any materials for hygiene talks or counseling? (Review them rapidly for quality and accuracy). Where did they come from? In your opinion, what is the most difficult part of improving hygiene and sanitation behaviors? Why? What has been effective? Why?

12. Who supervises you? How often do you see this supervisor? What happens when the supervisor visits?

Community Health Volunteer

1. How long has he/she been working as a community health volunteer? Who gave her/him the initial training? What topics? How often does he/she get more training?

2. What are his/her main roles and responsibilities as a CHV? Which one requires the most time? Which one does he/she like best? How much time per week does he/she spend as CHV?

3. Is he/she responsible for a certain number of households, a sector of the community, a specific target age group, or the whole community?

4. How often does he/she have contact with the staff at the health center/clinic? What happens during these contacts? Does anyone from the staff ever accompany him/her during her work in the community (e.g. while making home visits).

5. What are the main health problems for women in the community? For children under two?

6. What are the principal causes of these problems?

7. If malnutrition has not been mentioned, ask whether there are malnourished children in the community. How does he/she identify them? What are the causes of the malnutrition?

8. Has the CHV ever received training in weighing, measuring, MUAC, plotting on growth cards?

9. Has the CHV ever received training on key messages in nutrition? In how to counsel mothers?

10. Are the mothers receptive to the messages? Do they change their practices when advised to do so? If not, why not?

11. Ask: If a mother of a one-month old child says she doesn't have enough breast milk, what advice would you give her?

12. What supplies and materials does the CHV have to work with? Condition? Check the materials rapidly for source, date, accuracy.

13. What motivates the CHV to take on or continue this work?

14. What more would he/she like to learn?

Community Leaders

Before conducting the interview with local leaders, it would be advisable to learn as much as possible from local CARE staff or local NGO staff about local leaders' roles, structure, function, formal relationship with higher levels of government, etc. With this understanding, you can then select the relevant questions below.

1. If elected, how long have they been in this role? If not elected, how did they come to have this role?

2. What are the main roles and responsibilities as community leaders? (from their own perspective)

3. How are you linked with the district/department government? Do you give input into their plans? Do they assign funds to this community for you to decide how to spend?

4. Do you make an annual plan for the community? Who is involved in this planning process? (gender) What were your priorities in the most recent annual plan?

5. What are the most positive aspects of this community? (resources, accomplishments, social cohesion, etc.)

6. What are the main challenges the community faces?

7. Have you presented any of these problems or challenges to higher government for support? Was this appeal successful or not? Why or why not?

8. Are there any malnourished children in the community? What do you think causes malnutrition?

9. What government service providers come regularly to the community? What do they do when they come? Does the population take advantage of these services? Why or why not? Do you know of other government services that should come but do not? Have you ever followed up with that agency to see why they don't come?

Appendix 10: Example Focus Group Discussion Guides[80]

Objective: To identify the key factors and people that influence maternal and child nutrition and health

Focus groups will be conducted with groups of 3-12 participants. The following groups will be asked to participate.

- Community leaders
- Health clinic staff
- Mothers of children under two years
- Fathers of children under two years (the same questions are used for the mothers and fathers)

In each of the focus group discussion guides there are several research areas. Under each research area there are questions and probes that represent important data to capture. Once the participants have responded fully to the lead question, use the necessary probes to fill in the remaining information.

[80] The focus group discussion guides in this appendix were adapted from a guide developed Dr. Amiee Webb Girard, Assistant Professor, Rollins School of Public Health, Emory University and Checklist 2 in *Guidelines for Participatory Nutrition Projects, Chapter 2: Participatory appraisal of community food and nutrition*, FAO, Agriculture and Consumer Protection Department. This document is a available for download at: http://www.fao.org/docrep/V1490E/v1490e02.htm

FGD Guide for COMMUNITY LEADERS and HEALTH CLINIC STAFF

Read the consent brief in Appendix 3.

Research area 1: Introductory questions about the community

1. Can you tell me a bit about this community?
    Probe: leadership, boundaries, cultures, livelihoods, health systems and facilities
    Probe: organization – specifically how information, norms may be disseminated in the community, how health care is provided to women in the community

2. What are your roles and responsibilities in the community?
    Probe: Decision making in regard to information dissemination, programs in the community etc; resolving disputes between / within families, etc.

Research area 2: Diseases, causes, and cures

3. What are the prevailing diseases in the community?
    Probe: How would you rank these in terms of severity (which are the most critical problems and needs to be addressed most immediately)?
    Probe: Who suffers from them?
    Probe: When do people suffer from them most?
    Probe: What causes them?

4. How do people deal with disease?
    Probe: What support is available? What activities or programs exist in your community to address these health issues?
    Probe: For each activity or program probe who is involved in these activities and how are they delivered?
    Probe: What diseases an traditional healer help with? Community health workers? Clinic staff? Etc.

Research area 3: Health problems facing women and girls

5. What do you believe are the health problems facing women in this community?
    Probe: general health problems; nutrition and food issues; access to care; family planning; mortality; morbidity, gender based violence; depression; anemia; etc.
    Probe: How would you rank these in terms of severity?
    Probe: What are the problems for non-pregnant women, pregnant women and breastfeeding women?
    Probe: Why is this so?
    Probe: How can these problems be addressed?

6. What activities or programs exist in your community to address these problems?
    Probe: Who is involved in these activities and how are they delivered?
    Probe: What else do you think should be done to address these problems? How do you think these ideas could be implemented?

I would now like to talk about adolescent girls in your community…

7. What do you believe are the health problems facing adolescent girls in this community?
   Probe: early marriage / pregnancy; female cutting; health problems; malnutrition / anemia and food issues; access to care; family planning; gender based violence
   Probe: how would you rank these in terms of severity? Why?

8. What activities or projects are in your community to address these problems?
   Probe: Who is involved in these activities and how are they delivered?
   Probe: What else do you think should be done to address these problems? How do you think these ideas could be implemented?

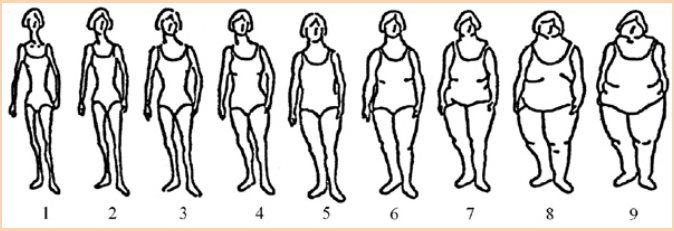
Research area 4: Perceptions of nutritional status

9. Is malnutrition a familiar notion to the community?
   Probe: What does the community perceive as malnutrition?
   Probe: How important is it?

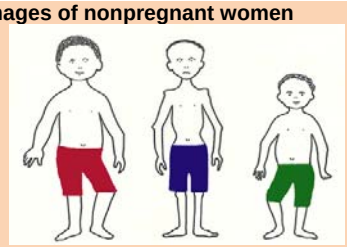
10. How are there many thin children or adults in the community?
   Probe: How do people describe and explain this?
   Probe: What do they do about it?

OPTIONAL EXERCISE: Card sorting activity on the perspectives regarding nutrition and body image of women in general and during pregnancy and children under five.You will need to create a set of cards with images of nonpregnant women, pregnant women and children under five that are a mixture of underweight, overweight and optimal weight.

Have the participant(s) look at the cards and pick out which ones best represent their answer to the following questions.



Example images of nonpregnant women



Example images of normal weight, underweight and stunted children

Have the participant(s) look at the cards and pick out which ones best represent their answer to the following questions.

1. Which women would you categorize as healthy?
2. Which women would you categorize as not healthy?

Observe where they put their cutpoints in terms of women's size in relation to health. Then ask:

3. Which one of these women would you trust to give you advice about how to feed your child?
4. Which one of these women takes the best care of her children?
5. Which one of these women do you think is able to exclusively breastfeed their child?
6. Which child would you categorize as healthy?
7. Which child would you categorize as not healthy?

Research area 5: Changing nutrition and food access, availability and coping mechanisms

11. What seasons of the year are people usually more malnourished/ better nourished? Why?
    Probe: What are the reasons for food unavailability?
    Probe: Who is most affected? How does it affect maternal and child nutrition?

Research area 6: Nutrition Services for women and children

I would now like to talk about other opportunities for community members to receive nutrition-related information or services.

12. What improvements have been made in regards maternal and child nutrition in the last 5 years in this community?
    Probe: Ask about organizations, government agencies or community based groups that are working on maternal and child nutrition
    Probe: How have these groups contributed to maternal and child nutrition?
    Probe on the status of the following and whether there been progress on any of these in the community:
    - Access to fortified foods and / or iodized salt
    - Access to micronutrient powders such as Sprinkles or micronutrient spreads or pastes (such as PlumpyNut) for women, children
    - Access to iron folic acid tablets for women and girls before and during pregnancy / postpartum vitamin A capsules for women
    - School feeding programs
    - Food baskets / food security initiatives
    - Family Planning access / availability
    - Construction of new facilities, provision of new health services including water and sanitation

Research area 7: Other services for women and children

13. What other improvements have been seen in this community over the past 5 years for women and girls?
    Probe: livelihoods initiatives, microfinance, literacy campaigns, school enrollment campaigns, agriculture training for women / girls, etc.

14. In this community, when/ where do women come together or meet regularly (without men)?
    Probe: When / where do men come together or meet regularly (without women)?
    Probe: When /Where do men and women come together / meet regularly together?
    Probe: How often do the different groups meet and what is being done at these gatherings?

15. Do any of these gatherings provide information or discussion on nutrition and / or health issues?
    Probe: Which of these would be appropriate as a place to provide nutrition and health messages or activities?
    Probe: How could these be used to improve health and nutrition of women and girls in the community?

16. Are there special events, occasions or festivals that occur periodically in the community (1-4 times a year) that bring people together?
    Probe: When do these occur?
    Probe: For what reason?
    Probe: Who attends? Who does not attend? Why not?
    Probe: Where do these occur?

FGD Questions for health clinic staff only

I would now like to talk about the services provided by this community health facility…

17. Which health services provided by this center are most used by the community?
    Probe: Which services are not used as often in this community?
    Probe: Why are these not used? - Distance, cost, acceptability, knowledge of service, permissions, etc.

18. Are there health services which you think are needed in the community but are not currently provided in this center?
    Probe: Can you please describe these?
    Probe: Why are they not currently provided?

I would now like to hear about your experiences providing care for pregnant women in this community

19. To what extent do women in this community come for antenatal care?
    Probe: When during pregnancy do women first come for antenatal care?
    Probe: How many women in the community come for antenatal care at least once (exact number not necessary can probe for some, most, about half)?
    Probe: How many come for care more than once during their pregnancy?
    Probe: What reasons do women give for not coming for antenatal care? - cost, distance, distrust, lack of awareness, lack of permission, transport, etc.

20. If I were coming to antenatal care for the first time, what types of services should I receive? Can you take me through the process step by step?

21. What types of services should I receive at follow-up visits?
    Probe: Preventive treatment for malaria, bednets, treatment for helminthes, iron / folic acid tablets, education and counseling. Probe specifically about iron / folate, malaria preventive treatment, helminthes
    Probe: Is the clinic always able to provide these services?
    Probe: Are there enough supplies, equipment personnel?
    Probe: Are there services that should be provided but the clinic is unable to? What services and why are these not provided?

22. If I were to receive antenatal care at this clinic what type of advice would I hear about nutrition and diet during pregnancy?
    Probe: How are women counseled on IFA tablets? Without leading the respondent too much, probe on whether the following are discussed with women – advantages; side-effects; how to reduce side-effects; how to take the tablets (with tea, milk or water); when to take tablets (i.e. before bed, after a meal, etc.); how to avoid forgetting to take the tablets
    Probe: What type of information would I receive about how much to eat during pregnancy? Probe about meal size, meal frequency, snacks

Probe: What type of information would I receive about what types of foods to eat or avoid during pregnancy?
Probe: What type of information would I receive about weight gain during pregnancy?
Probe: What type of information would I receive about fortified foods?
Probe: What type of information would I receive about early initiation and exclusive breastfeeding?

23. Of these recommendations / advice you've mentioned, which are typically not followed by women in this community?
Probe: IFA tablets, increasing intakes / meal size, gaining weight, eating recommended foods, etc

Follow up question:
For each recommendation not followed, why are these not followed / What reasons do women give for not following these recommendations?
Probe: conflicting messages in the community; access to foods in the community or household; cultural beliefs about eating down and whether women are afraid of having big babies; side effects of drugs / iron-folic acid tabs; distribution of food in the household; influence by others in the family or community, no autonomy or decision making power).

It will likely come out in the two previous questions but if not, ask their opinion about IFA- Do you think IFA is useful; necessary; available; accessible; acceptable for women in the community? Why do you think women do or do not use IFA?

24. If I were to come to this clinic for antenatal care and I was malnourished what type of support would I receive?

Last questions…

25. Is there anybody else in the community that women receive care during pregnancy?

26. Where else in the community do women receive information about how to eat when they are pregnant? What are they told?

27. What things prevent health workers like you from being able to provide the best possible care to pregnant women?
Probe: How can these problems be overcome?

Research area 1: Introductory questions about the community

1. Can you tell me a bit about this community?
    Probe: leadership, roles for women, cultures, livelihoods, health systems and facilities
    Probe: organization – specifically how information, norms may be disseminated in the community, how health care is provided to women in the community.

Research area 2: Diseases, causes and cures

2. What are the prevailing diseases in the community?
    Probe: How would you rank these in terms of severity (which are the most critical problems and needs to be addressed most immediately)?
    Probe: Who suffers from them?
    Probe: When do people suffer from them most?
    Probe: What causes them?

3. How do people deal with disease?
    Probe: What support is available?
    Probe: How do traditional healers help? How about community health workers? How about clinic staff?
    Probe: What activities or programs exist in your community to address these health issues?
    Probe: For each activity or program probe who is involved in these activities and how are they delivered.

Research area 3: Health problems facing women

4. What do you believe are the health problems facing women specifically in this community?
    Probe: general health problems; nutrition and food issues; access to care; family planning; mortality; morbidity; gender based violence; depression
    Probe: What are the problems for non-pregnant women, pregnant women, breastfeeding women?
    Probe: Why is this so?
    Probe: How can these problems be addressed?

5. What activities or programs exist in your community to address these problems?
    Probe: Who is involved in these activities and how are they delivered?
    Probe: What else do you think should be done to address these problems?

Research area 4: Health problems facing children under two

6. What do you believe are the health problems facing children, especially children under two specifically in this community?
    Probe: Anemia; diarrhea; malaria, respiratory infections; malnutrition
    Probe: Why is this so?
    Probe: How can these problems be addressed?

7. What activities or programs exist in your community to address these problems?
    Probe: Who is involved in these activities and how are they delivered?
    Probe: What else do you think should be done to address these problems?

8. Are children in this community at-risk from malnutrition (e.g., stunting, wasting, underweight) why or why not?

Research area 5: Changing nutrition and food access, availability and coping mechanisms

9. What types of food are produced by households in this community?

10. What foods are stored?
    Probe: How?

11. How many months do staples last?

12. What seasons of the year are people usually more malnourished/ better nourished? Why?
    Probe: What are the reasons for food unavailability?
    Probe: Who is most affected?
    Probe: How does it affect maternal and child nutrition?

13. How do eating patterns change in times of scarcity?
    Probe: How is food obtained in such cases?
    Probe: What do families do to overcome food scarcity?

Research area 6: Food preparation and usage

14. Who is responsible for the different tasks of providing for the daily meals in the household? (Men, women, children)
    Probe: Who collects the food?
    Probe: Who provides the money to buy food?
    Probe: Who purchases the food? Who decides what food to purchase?
    Probe: Who prepares the food?
    Probe: Who should be responsible to perform the different tasks?
    Probe: Why do you think that is? Why are the household responsibilities divided like that?

15. What determines the amounts and types of food that different individuals in the household get?
    Probe: Who (father, mother, children) gets the most and the least?
    Probe: What are the reasons why food is distributed this way?
    Probe: What happens to the leftovers?

16. We have heard in our discussions with others that women are not allowed to eat _____(mention some food that women are discouraged or not allowed to eat). What foods are discouraged for women (either in general or during pregnancy / lactation in this community?
    Probe: Why are these discouraged?
    Probe: Are there other foods that women are discouraged or not allowed to eat?
    Probe: Are there foods that pregnant / lactating women should eat?

Research area: Caring capacity

17. Who looks after small children and infants?

18. Who feeds them? How often?

19. Are any special foods prepared for children under two?
    Probe: How is it prepared?
    Probe: At what age do children start eating it?
    Probe: How often is it feed to children under two?

Appendix 11: Non-directive "questions" for use in Focus Groups and Other Participatory Activities

[Notice how few are actually questions]

1. Give me a [picture, description] of…
2. I'd like you all to [discuss, decide, tell me what happens when…]…
3. Tell me what goes…
4. Describe what it's like to …
5. Tell me about …
6. Tell me more about that…
7. Somebody sum this all up …
8. Give me an example. Explain to me …
9. Let me pose a problem …
10. I'm wondering what would you do if…
11. What I'd like to hear about is how you are dealing with …
12. Ask each other to find out …
13. I don't think I'm getting it all. Here's what I've got so far, tell me what I am missing or not getting correctly …
14. So, it sounds like you're saying …
15. That's helpful. Now let's hear some different thoughts …
16. How might someone do that?
17. I'd like you to word it as an "I wish" or a "How to."
18. How important is that concern?
19. So, the message you want me to get from that story is …[Do not fill in with your guess. Let your voice trail off and bite your tongue.]
20. I can't seem to read the groups' reaction to that. Help me out.
21. Let's hear a different perspective on this.
22. Say more.
23. Keep talking.
24. Don't stop.
25. Just say anything that comes to mind.
26. That got quite a rise out of everyone. What is everyone reacting to?
27. Can someone turn that [wish, dream, request] into a reality?
28. Does anyone know how to do it?
29. Let's see, we haven't heard from …
30. Before we move on, let's hear any burning thoughts that you have to get out.
31. Let's turn this complaint into a problem …
32. How can we solve it?
33. [I see in your face ... I hear in your voice] something important, but I don't know what it is …
34. You seem to have a lot of excitement and energy around that. Talk to me from the excitement.
35. What's bothering you?
36. Who can build on this last idea?
37. What am I not asking?
38. How come the energy level of the group just went down?
39. Think about a situation in which you ——-. Tell me about

Please note: Silence can mean various things: lack of understanding of a question or of the process, confusion, thinking or reflecting, or needing time to translate ideas and language.

Appendix 12: Example Qualitative Research Summary Report Template[81]

Executive summary (outlined first and written last; (3-4 pages)

- Brief summary of the contents of the report (this may be all that some people read)
- Key recommendations and priorities for programs to improve child feeding

Brief summary of research methodology (1-2 pages)

- Purpose of the research and how the selected methods achieve that goal
- Basic steps of the research methods

Description of population covered by the research (2-3 pages)

- Background description of aspects such as geography, demography, ethnicity, degree of urbanization, literacy, occupations, and income
- Types of people who participated in the study, such as mothers of children under three years old, fathers, and health workers
- Lifestyle context: general outlook on life, maternal and child caring roles, hopes for children, use of health care services, livelihoods

Description of current nutrition and health situation and child feeding practices (5 -7 pages)

- Nutrition and health status of the children in the study
- Food security status
- Summary of the practices related to maternal and child nutrition
- Comparison with previous studies
- Interpretation of the findings, emphasizing factors that need to be addressed in the program

Specific description of possible practice changes, motivations, and constraints (5- 7 pages)

- Description of maternal and child nutrition practices, by age group, that are most possible to improve, how, and why

Suggestions for a program strategy (3B5 pages)

- Key constraints that prevent mothers, families, and communities from following optimal practices. Include all factors: hygiene, child care, health information, lack of resources, seasonal availability of foods, etc.

Suggestions for a communication strategy (3-5 pages)

- Key constraints that prevent mothers or families from following optimal practices including
    - Knowledge and attitudes and how they might be overcome
    - Key phrases and ways to motivate improvements in practices
    - Images of persons regarded as trusted sources of information on child feeding
    - Access to various communication channels: interpersonal and mass media

Final recommendations for program design (2-3 pages)

Priority practice recommendations, messages and approaches that are suggested by the research results.

[81] This template adapted from *Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*, p. 8.10 -8.11.