A Step-by-Step Guide to KEY Informant Monitoring

A Participatory and Community-Based Monitoring, Empowerment and Advocacy Tool
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To

Key Informant Monitoring

A Participatory and Community-Based Monitoring, Empowerment and Advocacy Tool

by

Kirstan Hawkins
Deepa Pokharal
Surbir Sthapit
Hom Nath Subedi

Kathmandu, September, 2004
Key Informant Monitoring (KIM) is more than a monitoring tool. It is a tool for empowerment, advocacy, and giving a voice to marginalised groups.

**Examples of issues brought before the VDC as a result of Key Informant Monitoring**

In one VDC a Dalit woman had gone to the primary health-care centre and the doctor asked for 8,000 rupees (an unofficial payment) to treat her. The woman did not have the money to pay for treatment and died two hours later.

Dalit women in another VDC reported that the MCHW would not enter their houses.

The issue was raised in another VDC that although there was a commitment for 33% representation of women, none of the committees and groups in the community had adequate representation of women.

In another VDC, Key Informants reported that women did not have access to land for agriculture even though there had been some NGO projects working on women’s right to land. The issue was investigated further by the NGO.

**Examples of actions taken by VDCs**

- Improvements to water supplies for health facilities
- Commitments to supply wood for infrastructure improvements
- VDC made accountable to ensure 33% representation of women
- Commitment to improve women's access to land
ACRONYMS

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ACRONYMS

CBOs  Community Based Organisation
DDC  District Development Committee
EOC  Emergency Obstetric Care
HPs  Health Post
KI  Key informant
KIM  Key informant Monitoring
MCHW  Maternal and Child Health Worker
NSMP  Nepal Safer Motherhood Programme
PEER  Participatory Ethnographic Evaluation and Research
PERs  Peer Researcher
PHCs  Primary Health Centre
SHPs  Sub-Health Post
TBAs  Traditional Birth Attendants
VDC  Village Development Committee
INTRODUCTION TO THE GUIDE

Key informant monitoring (KIM) is an innovative and participatory approach to programme monitoring and research. KIM is more than a monitoring tool; it is also a tool for advocacy, participatory planning and empowerment of marginalised groups.

KIM is an adaptation of the Participatory Ethnographic Evaluation and Research (PEER) method. KIM was adapted by the Nepal Safer Motherhood Programme (NSMP) to be used in the specific context of rural Nepal.

This document is a practical step-by-step guide to using KIM. The aim of the guide is to enable agencies and programmes to implement and adapt KIM to suit the specific needs and context of their programme.

The guide is divided into three sections:

Section 1: Participatory Ethnographic Evaluation and Research (PEER) and Key Informant Monitoring (KIM)

This section provides a brief explanation of:

- The principles of the PEER method
- How KIM was adapted and piloted
- Key features of key informant monitoring
- The difference between KIM/PEER and other research and monitoring methods
- How KIM can be used
- Examples of sectors to which KIM can be applied

Section 2: The KIM Process

This section provides a practical step-by-step guide to how to implement KIM and covers:

- Explanations of the steps in the KIM process
- A guide to training key informants
- How to carry out the data collection and data analysis
- How to use KIM for advocacy and participatory planning
- KIM as a process for empowering key informants and communities

Annex: Data Produced by NSMP

The annex provides a summary of data produced by NSMP. It includes:

- An example of a data analysis framework
- Summary of findings of monitoring data, and changes between rounds one and three
- Logframe showing rounds one, two and three of KIM for Baglung District
SECTION 1: PEER and KIM

What is the PEER method?

About PEER

Participatory Ethnographic Evaluation and Research (PEER) is a rapid, participatory and qualitative method, which can be used for programme appraisal, design, monitoring, evaluation and research.

PEER is more than a monitoring and research method. It enables agencies to engage in active dialogue with communities and gives a voice to poor and marginalised groups.

The PEER approach trains members of the target community to become programme researchers and evaluators. It is based on the anthropological method, and enables programmes to gain an in-depth understanding of the realities of the everyday lives of the poor and marginalised. Unlike traditional anthropological research, PEER can be carried out within a short-time frame (two to three months).

How has PEER been used?

PEER has been used in a variety of programme and social contexts including: in Zambia to understand young people’s sexual and reproductive health; in Myanmar and Cambodia to design a social marketing programme for STI and HIV prevention among sex-workers; in Cuba for HIV prevention among men who have sex with men; and in Brazil for monitoring a district wide health sector reform programme.

PEER has been used to gain an in-depth understanding of:

• How people make decisions, e.g. related to health seeking behaviour, livelihood strategies or household resources

• Who exercises power and how power relations are experienced by marginalised groups

• How people talk about and experience key issues in their daily lives

• How people identify their livelihood, health, social and emotional needs

• Who is excluded from resources and services and how they are excluded

• Whether the programme is meeting the needs of poor and vulnerable groups, and barriers to access experienced by different groups in the community

• Changes required in programme approaches to better meet the needs of marginalised groups.

¹ For more information on PEER see the following websites: www.options.co.uk and www.swansea.ac.uk/cds
Principles of PEER

The key principles of the PEER method are:

• The research is carried out by members of the target group. They are known as peer researchers (PER).
• PERs carry out conversational interviews with other people from their social network.
• The interviews are designed by the PERs during a short participatory training.
• All interviews are conducted in the third person. PERs ask interviewees to talk about “what other people like them” do or say. Interviewees are never asked to talk about themselves directly.
• All interviews are confidential and peer researchers do not note down the names of interviewees or other people in their social network.
• PERs conduct several interviews with the same interviewee on different themes.
• During data collection peer researchers receive regular supervision from facilitators.
• Facilitators interview the peer researchers and record the detailed data from the peer interviews.
• At the end of the data collection peer researchers conduct their own analysis of the main findings.
• Facilitators support peer researchers to present their findings and recommendations to the programme/agencies.
• A detailed analysis of data is also carried out by a social analyst.
• The entire process takes two to three months and produces quick, actionable data.

Why was NSMP interested in using PEER?

A key indicator in the Nepal Safer Motherhood Programme (NSMP) logframe is to monitor changes in the social context in which pregnancy and child-bearing take place. NSMP was therefore interested in adapting the PEER method to be used in small rural communities in Nepal.

Some of the main features of PEER which made it attractive to NSMP are:

• The tool recognises divisions in society and associated differences in perceptions of behaviours.
• Interviewers are drawn from the same social group as interviewees, so that they are talking to people with whom they have familiarity and a relationship of trust.
• The emphasis on respondents not talking about themselves means that the method allows sensitive issues to be discussed.
• The method can serve as a base for giving a voice to marginalised groups and as an advocacy tool.
Key Informant Monitoring

What is Key Informant Monitoring?

- Key Informant Monitoring (KIM) is an adaptation of the PEER method. As with PEER, KIM takes as its starting point the fact that the wider social (including religious, cultural, economic, political) environment is important in shaping behaviour.

- In the context of NSMP, KIM has been used to understand the social contexts which shape maternal health seeking behaviour and maternal health outcomes.

- The term key informant (KI) is used as the concept of peers and peer networks was found to have limited meaning in small communities of rural Nepal, where social and geographical mobility of women is limited.

- Communities in rural Nepal are highly stratified by ethnicity/caste, gender, kinship and age, which together limit public social interaction. In such a structure it is necessary to recognise and give emphasis to these social divisions in the selection of key informants.

- Key informants are therefore not selected from one homogenous group, but include women from different castes, ethnicity, social status, age and location.

- As with PEER, KIM is built on partnerships with local NGOs and other community based structures.
Important Features of KIM

**Strengths:**

- KIM is a low-cost method as it works with people at community level and does not require many materials
- Because local people carry out the interviews it is a rapid approach, as time is not needed to build relationships of trust
- The data has credibility for advocacy purposes as it reflects what is actually said by people in the communities
- Because interviews are carried out in private among peers, it enables in-depth research on sensitive issues which are not spoken about in public
- Through facilitating meetings with VDCs and DDCs the data can be used to advocate for change
- Action plans are made at VDC and DDC level based on the recommendations presented to them by key informants. VDCs and DDCs are made accountable to these action plans through the next round of KIM.
- KIM is a good tool to use in situations where there are power imbalances as it empowers more marginalised groups to voice their views, and information can be gathered in an informal way which does not intimidate respondents
- KIM can be used in a range of different sectors
- KIM can collect in-depth information over a short time period
- KIM provides important feedback on whether programme approaches are appropriate, and provides important information to allow inputs to be refined.
- KIM is easy to use in situations of conflict where mobility is difficult and outsiders are not able to work at VDC level. The tool reduces suspicion as community members carry out the interviews rather than outsiders. This has been a key strength in the context of Nepal.
- KIM involves participation of community members from the initial stage through to DDC presentation, allowing for ownership of information and findings.
Risks and Cautions:

• It is difficult to replicate KIM on a large scale. It is best used for in-depth analysis of sensitive issues and to gain an understanding of perceptions and processes of behaviour change.

• KIM can be misunderstood as a quantitative method. It does not produce data that can be easily quantified and does not replace survey methods. KIM is best used as complementary to surveys and can be used to ensure that survey questions are appropriate to context.

• KIM initiates processes which can challenge existing relations of power. It can therefore create situations of conflict, which need to be carefully managed and facilitated to ensure that the key informants are not made more vulnerable in the process.

• Key informants may become biased in their data reporting over time if they begin to identify strongly with the programme. It may therefore be advisable for monitoring purposes to train new groups of key informants for each monitoring phase.

• The effectiveness of the tool depends upon appropriate selection of key informants. It is essential that those responsible for KI selection have internalised the principles of the method and the KI selection criteria.

• The facilitation of advocacy meetings (e.g. with VDCs and DDCs) and dissemination of findings must be carried out by someone who has a good understanding of the KIM process, to ensure that there are no misunderstandings of the process and purposes of the tool.

How was KIM Piloted and Adapted by NSMP?

First Pilot Phase

During the first pilot phase the KIM tool was field-tested in three VDCs. The pilot was set up to test the validity of different ways of collecting the data.
VDC 1: The approach followed the principles of PEER, and data collectors were key informants drawn from different groups in the community.

VDC 2: The approach followed traditional in-depth interviewing techniques, and data collectors were NSMP facilitators and local NGO staff.

VDC 3: A mix of the two above approaches. Key informants interviewed people from their own social category and facilitators/NGOs interviewed members of social groups not represented by the KIs.

Lessons from Pilot 1

Lessons learned from the first pilot were used to design the second pilot.

The key lessons from pilot 1 were:

• Male and female KIs were selected, but it was found that male KIs dominated the process and only reflected positive aspects of male behaviour towards women.

• KIs were selected from key people in the community, such as community leaders and teachers, because VDCs assumed that KIs needed to be well educated. The pilot did not therefore reflect the views of marginalised and low status groups.

• The interview prompts were developed by a consultant and KIs practised the prompts during the training. KIs therefore found it difficult to internalise the interviews and give meaning to them.

• There was confusion over the difference between KIM and other survey methods. Interviews were conducted as if they were semi-structured questionnaires, which constrained open discussion.

• The data produced normative responses as KIs had understood that they should report “correct” answers rather than what was actually said in conversations.

• Data analysis focused on trying to quantify the data. This meant that the important qualitative findings relating to perceptions were lost.

Lessons from Pilot 2

Following feedback from pilot 1 the KIM tool was redesigned and piloted again in 2 new VDCs. The main differences between pilot 1 and pilot 2 were:

• Only female KIs were selected as the programme wanted to focus on women’s perceptions.

• Education and literacy levels were not used as criteria for KI selection.

• KIs were selected to represent different groups in the community (e.g. by age, caste, ethnicity, social status).

• The training of the KIs was participatory. During training emphasis was given to forming open “wh” questions, and to practising conversational interviews.

• Interview prompts were developed by the KIs during the training.

• KIs were not asked to write down the interview narratives, only to record key words and phrases after the interviews.
• Only female facilitators were used during the data collection/debriefing.
• Data analysis focused on analysing similarities and differences in perceptions rather than quantifying responses.

The approach used in the second pilot phase was then implemented for monitoring key indicators of the NSMP programme. The next section outlines the steps in the process of implementing KIM.

Implementation phase

The implementation phase of the KIM tool was carried out in 3 rounds over a period of two years, with a gap of 12 months between each round of data collection.

Round 1 consisted of initial selection and training of KIs and collection of baseline monitoring data.

During rounds 2 and 3, KIs were given a short refresher training. Data were collected to monitor changes from the previous round.

Each round of data collection was carried out over a 4 week period.

How is KIM different from other methods?

Focus Groups and PRA

The main differences between KIM and focus groups and PRA is that:
• Key informant interviews take place in the private sphere
• KIM collects private discourses/narratives of the social group
• KIM is less likely to produce normative responses
• As a result KIM is best used for exploring very sensitive issues

KIM can be used in conjunction with group discussions and PRA.

For example, NSMP facilitated group discussions during the debriefing phase in order to analyse the findings of different KIs. These discussions were similar to focus groups; however, they were not seeking to find consensus among the group, but similarities and differences in the interview narratives of the different KIs.

Knowledge Surveys

KIM is not a survey method, and is not used instead of surveys.

Surveys produce broad statistical data, for example on trends in behaviour and levels of knowledge among the community.

KIM is used to explore specific issues in-depth, among a small group of respondents.

KIM can be used in conjunction with surveys to help understand the factors leading to changes in behaviour (i.e. causality)
NSMP used KIM in conjunction with a knowledge survey. The knowledge survey examined changes in levels of knowledge among the target communities. KIM examined changes in perceptions of the target group on several key indicators.

KIM can also be used to design survey questionnaires in order to ensure that the appropriate questions are being asked.

**How can KIM be used?**

**KIM can be used:**

- As a tool for collecting baseline data and conducting situation analysis
- As a monitoring tool to assess changes in community perceptions against key indicators
- As an awareness raising tool to identify key issues of importance to communities and to different groups
- As a programme development tool to identify community members who can act as change agents and groups in the community who are not being reached
- As an advocacy and participatory planning tool, to ensure that planning is appropriate and based on community demand
- As an accountability tool, to monitor the extent to which plans have been implemented
- As a tool for strengthening the voice of marginalised groups
- As a tool for coordinating organisations in planning, implementing and monitoring programmes based on community demand
INTRODUCTION: The Steps in the KIM process

This section provides a detailed step-by-step guide of how to implement KIM, using the example of how NSMP has implemented KIM. However it is important to bear in mind that KIM can be used in different sectors to understand a wide range of issues.

The KIM process implemented by NSMP followed these basic steps:

- Selection and orientation of facilitators/trainers and of NGO focal persons
- Development of criteria for key informant (KI) selection
- Selection of KIs
- Training of KIs
- Supervision of KIs during data collection
- Debriefing of KIs and joint data analysis
- Presentation of findings and recommendation to VDCs and DDCs
- Development of joint action plans based on KI presentations to VDCs
- Monitoring of plans and changes in community perceptions (2nd and 3rd round monitoring)

SECTION 2: THE KIM PROCESS

STEP 1: Facilitators, social analysts and NGO focal persons

Facilitators

Skilled facilitators carry out the training of key informants. The facilitators conducting the training also conduct the debriefing and the data analysis.

The same facilitators are used throughout the KIM process, as it is important that facilitators build rapport and a relationship of trust with the KIs.

Facilitators MUST have an initial training/orientation in the principles of the KIM method. In the case of NSMP, the NGO HICODEF provided the orientation training to the NSMP facilitators.

Criteria for selection of facilitators
- Good interpersonal and communication skills
- Good listening skills
- Good analytical skills
- Able to document data
- Able to establish relationships of equity with KIs
- Same gender as the KIs
Social analysts

Facilitators may need to be supported by a social analyst to carry out the initial training of the KIs and the data analysis. The same social analyst should be used throughout the KIM process.

In the case of NSMP, the NGO HICODEF undertook the initial training of KIs jointly with NSMP facilitators. HICODEF has skilled sociologists who had been briefed in the principles of the PEER method. HICODEF were also involved in piloting and adapting the KIM tool. For the second and third round monitoring the NSMP facilitators carried out the refresher training of the KIs without the support of the social analysts.

Skills of social analyst
- Experience in qualitative research methods (e.g. sociology, anthropology)
- Good interpersonal and training skills
- Able to develop simple analytical framework
- Skills in synthesising qualitative data

Focal Persons

Focal persons may come from local NGOs, CBOs or government. They may be members of local groups or committees. Most importantly focal persons should be based in and have knowledge of the communities and VDCs in which KIM will take place.

Role of the focal persons
- Support VDCs to select appropriate KIs
- Act as a bridge between KIs and VDCs/ DDC
- Facilitate meetings between KIs and VDC
- Facilitate meetings with DDC.

STEP 2: Orientation of focal persons and VDCs

A vital role of the focal person is to assist the VDC in selecting the KIs. The effectiveness of KIM depends upon the selection of appropriate KIs. Facilitators provide a one-day orientation to focal persons on the KIM approach, to ensure that they understand the uses of KIM and the criteria for KI selection.
**The orientation workshop covers:**
- General principles of KIM
- Objectives and rationale of the research/monitoring
- Rapport building with focal persons
- Internalising the KIM approach
- Finalising KI selection criteria

Focal persons provide an orientation to the VDC on the principles of the KIM approach and criteria for KI selection.

**STEP 3: Selection of Focal Areas and Key Informants**

**Selection of focal areas**

It is important to select a small sample of VDCs' communities for in-depth monitoring, rather than a large unmanageable sample. NSMP selected two VDCs from each of six programme districts for implementing KIM.

**Number of KIs to be selected**

The number of KIs selected for training depends upon the needs and capacity of the programme.

NSMP selected six KIs per VDC. It is suggested that between six and twelve KIs per VDC is ideal, in order to ensure both representativeness of social groups and manageability of data.

**Basic criteria for KI selection**

1. They should be members of the community
2. They should be from the target group
3. They should not be from implementing partners
4. They should not be involved in implementing the programme
5. They should be motivated
6. They should be available to attend training and debriefing workshops
7. They should be available to carry out interviews over the data collection period

**Specific selection criteria**

Facilitators and focal persons identify more specific criteria during the orientation workshop.

The specific criteria identified depend upon the needs and context of the programme.
For example, NSMP was interested in finding out about differences according to caste, age, ethnicity and location of women in the community.

**NSMP criteria for KI selection**

- Basic literacy
- Women of reproductive age (15-49 years)
  - 15-20 years (unmarried - 1)
  - 21-30 years (married - 2)
  - 31-40 years (married - 2)
  - 41-49 years (mother-in-law - 2)
- Representing all castes and classes of the community
- Having no minor children
- Able to give time
- Sociable / practical
- Not reserved
- Who can ask questions and probe
- Positive learning attitude
- Interested in working for the community

**STEP 4: Training the Key Informants**

**KIM Ethics**

Facilitators should develop a set of ethics for conducting KIM, which they should discuss and agree with KIs during the training. These ethics guide the entire KIM process.

**NSMP developed the following set of ethics to guide the KIM process**

- Explain the objectives of the research and the value of the conversation to your respondent.
- Use the leisure time of your respondent.
- Select a private site for discussion.
- Do not ask personal questions. Only ask questions in the “third person”.
- Listen to the respondent carefully. Do not interrupt when she is in the middle of answering.
- Collect the information through discussion.
- Ask only what the people do. Do not try to give advice.
- Do not give your opinion to the respondent
- Do not correct their answers.
- Ask open questions to get in-depth information.
- Do not force information.
- Keep the atmosphere pleasant and friendly.
- Make more questions from the initial answer to get deeper information by following up with “wh” questions.
- Do not ask closed questions which require “yes” and “no” answers.
- Allow deep discussion, rather than writing in front of the respondent.
- If the respondent cannot give the information do not stick with the same question.
- Try to get it indirectly through other related questions.
- Encourage respondents when they give crucial information.
- Thank them for their time.
- Keep all the information confidential.
Planning the TRAINING

Length of training

The initial training of the KIs takes between four and six days.

For the second and third round of monitoring, refresher training of KIs takes between two and three days.

The training approach

**The training, at a glance, should:**

- Be as participatory and informal as possible
- Have a major focus on practice
- Make clear the objectives of the study
- Ensure that the KIs have internalised the KIM approach
- Focus on developing the prompts and questioning skills
- Practise using open questions (Where? When? How? Why?)
- Help KIs to select questions as entry points to conversations
- Help KIs recall interviews, rather than writing long notes
- Develop a code of ethics with the KIs
- Help KIs select respondents
- Discuss problems and find solutions
- Build the confidence of the KIs, especially the less literate/vocal

Identifying themes and sub-themes

Prior to the training, facilitators (with the programme) identify the major themes for monitoring. Facilitators break these themes down into sub-themes.

**The objectives of the KIM tool, as used by NSMP, were to monitor changes related to three key indicators:**

- Barriers to use of emergency obstetric care (EOC) services
- Quality of health care.
- Social status and mobility of women.

These indicators were the key themes for the interviews. The themes were then broken down into sub-themes.

This is an important step as the themes and sub-themes provide the framework for developing the interviews, and for debriefing and data analysis.

**Themes and Sub-Themes from NSMP**

**Theme 1: Barriers to EOC**

Sub-themes: identifying risks; transportation; economic/financial; roles of service providers
Theme 2: Quality of Care
Sub-themes: acceptability; affordability; availability; effectiveness

Theme 3: Social Status of Women
Sub-themes: decision-making role (at home and in community) influencing role (at home and in community) ability to express needs (at home and in community)

The Training Process

Step 1: Clarifying the objectives with KIs

In order to clarify the objectives of the study with the KIs, facilitators begin the training with a group discussion to draw out the key themes:

Group discussion

Facilitators ask KIs to discuss key questions related to the main themes.

For example, in the NSMP training KIs were asked to discuss:

What are problems that women have in their community?

What problems have they heard women talking about related to pregnancy and childbirth?

Facilitators draw out the key issues from the KIs’ discussion, and link them to the themes and sub-themes. The sub-themes help facilitators to narrow down and focus the discussion.

Step 2: Explaining questioning technique

The aim of this session is to help KIs to practise asking open and probing questions.

KIs may not be used to a questioning process and how to probe. For example in the NSMP programme the KIs were women from rural communities, and had not been used to questioning other people.

Questions should not be leading, and should not allow a yes/no answer.

Leading questions are those which suggest an answer in the question:

An example of a leading question is: Is it true that service providers treat women badly at the local health centre?
This question both suggests an answer, and encourages the interviewee to respond with a yes or no.

Open questions can be prompted through using “wh” questions.

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<thead>
<tr>
<th>“WH” Questions</th>
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<tbody>
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<td>What?</td>
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<td>When?</td>
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<td>Where?</td>
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<tr>
<td>How?</td>
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<tr>
<td>Why?</td>
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</tbody>
</table>

**Step 3 : Practising open questions**

Facilitators show KIs a picture:

Facilitators encourage KIs to ask “wh” questions about the picture.

- Where is the cart going?
- What is on the cart?
- Why are the men pushing the cart?
- Why is it only men who are pushing the cart? etc

The aim of the exercise is to familiarise KIs with how to form open questions and how to probe using “wh” questions to elicit more in-depth information.
**Step 4: Introduce the concept of third person interviewing**

This can be a difficult part of the training and needs some time and practice.

Using the third person is important because it allows respondents to talk about sensitive issues without talking directly about themselves. It also enables the interview to extend beyond the experience of one person to gain a reflection of wider community experiences.

However, it is often difficult to start interviews in the third person as we are not used to asking questions in this way.

Because KIs and respondents are from the same community, respondents may question why KIs are asking them to talk about “other people like them”. It is therefore important to find a comfortable way for KIs to begin the interview.

**Workshop exercise: Third person interviewing**

Facilitators explain the concept of third person interviewing. KIs are not going to ask respondents to talk about themselves, but about what “other people like them” do and say.

Facilitators role play asking open “wh” questions, using third person interviewing.

KIs divide into pairs and practise asking about “other people”, using different ways of framing the question e.g.

“what do other women like you” say or do?
“what do women you know” say or do?
“what do others in the community like you” say or do?

KIs decide on the way of asking the question with which they feel most comfortable.

**Step 5: Identify the content of the interviews**

Facilitators elicit key issues related to each of the themes and sub-themes, in order to identify the interview prompts.

Facilitators start with theme 1.

**E.g. Theme 1: Barriers to using Emergency Obstetric Care (EOC)**
Facilitators break participants into groups.

Each group is given one of the sub-themes.

**e.g. group 1: risks**
- group 2: transportation
- group 3: economic/financial
- group 4: roles of service providers

Each group is asked to identify a list of open questions related to their sub-theme.

Groups present the questions to the large group and facilitators write them on paper and put them on the wall.

### e.g. First interview (NSMP)

Women’s perception of barriers to accessing EOC services during pregnancy, delivery and until 45 days after delivery

**Areas to collect the information**

<table>
<thead>
<tr>
<th>Barriers to EOC</th>
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<tbody>
<tr>
<td>Risk</td>
</tr>
<tr>
<td>Financial</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Role of Service Providers</td>
</tr>
</tbody>
</table>

### Step 6: Developing the prompts

During step 5 KIs will have come up with a long list of questions for theme 1.

Facilitators now work with the KIs to reduce these questions to short “prompts”, which will help the KIs structure their conversational interviews. The prompts should be phrased in the KIs own words.

Some of the long questions can be grouped together under one short prompt using “wh” questions to help probe.
Example of prompts developed by KIs in the NSMP Programme

Interview 1: Barriers to Access to EOC

Tell me what do other women you know (women like you) say about:

What is the difference between normal women and pregnant women?
What kinds of illness (danger signs) have women been facing during pregnancy, delivery and until 45 days after delivery? Which illnesses are dangerous and why?

Where do women go for help if they have these illnesses? Who makes the decision to go to the service centres (health centres)? What kind of facilities do they provide. What do women say about how service providers behave?

What kind of transport do they use to carry pregnant women and women who have difficulties after delivery? What kinds of other transportation are available (to pregnant women and women who have difficulties after delivery)? Who arranges the money? And how?

Now repeat Steps 5 and 6 for theme 2

Second interview (NSMP) - Theme 2

Women’s perception of quality of care of service centres and health personnel during the pregnancy, delivery, until 45 days after delivery and for other sicknesses

Areas to collect the information

- Quality of Care
- Availability
- Effectiveness
- Acceptability
- Affordability

Interview Prompts

Interview 2: Quality of Care

Tell me what do other women you know (women like you) say about:

What kinds of illness do people face here? Where do they go if they have these illnesses? What kinds of services are available? Where do the different communities go? What do they say about the service? What do they say is good and what is not good? Why?
Where do they go if they have a complication during pregnancy, delivery, after delivery and during normal times? Why? Whose service do women prefer? What do they say about the cost of different services? Whose services are easily accessible to most of women? Why?

Now repeat Steps 5 and 6 for theme 3

Third interview

Women’s perception regarding social status of women in the community and their house

Areas to collect the information

Women’s Social Status and Mobility

Decision at family and community  Influence on decision  Ability to express their need

Interview prompts. Interview 3: Women’s social status and mobility

What do other women you know (women like you) say about:

What groups are there in the village? What kinds of work they are doing? Which work do most men prefer women to do in the community and which do they not like women to do? Who makes decisions about work in the community/social work when both men and women gather together? Can women express their social needs in the community (Probe which needs?, how?, why? and why not?)

Who makes the decisions about work at home? Which work can women make their own decisions about at home? Do families agree on these decisions? To whom can women express their desires? What kind of feelings can women share with their husbands? What are relations like between them? What kind of feelings can women share with their mother-in-law? What are relations like between them?

When developing the prompts KIs are asked to:

Use “wh” question Like who, when, where, what, Why and how to get core information.

A useful prompt is often to ask the interviewee if they can tell a story about someone they know who had a specific experience e.g. went to the health center: what happened
The Save the Children programme “Saving New Born Lives” has used the KIM tool to monitor the effectiveness of its birth preparedness package and the appropriateness of the five key messages of its behaviour change communication (BCC) programme. The following are examples of the prompts developed for theme (interview) 1.

**First interview**

Women’s perception regarding the birth preparedness package and the messages spread for care of women during pregnancy, delivery and post-partum and also for newborns

**Areas to collect the information**

| Access to information | Birth planning for normal delivery | Birth planning for EOC |

**Prompts: Interview 1**

What do other women you know (women like you) say about:

- What types of information women get during pregnancy, delivery and post-partum and also about newborn babies? Who gives the information/messages? Where do they get the information/messages? How? What do they think about the source (means) of the information? What do they think about the message? Which messages did they use and not use? Why and why not? How did they use the messages?
- What do they say is a normal delivery? What do they arrange for a normal delivery and newborn baby? How, why, when? Which sickness (danger signs) do the women perceive as life threatening during childbirth?
- What are the danger signs observed in the mother and children? What do they do in these conditions? What do they do in critical conditions at the time of childbirth? What do you say about birth preparedness programme? What is good/bad about it?

**Step 7: Practising the interviews**

**PRACTISE**  **PRACTISE**  **PRACTISE**

The rest of the training time is given to practising the interviews, and making any necessary adjustments to the prompts.
Facilitators start with interview 1:

- Facilitators role play the interview (using third person interviewing)
- KIs practice the interview in pairs
- KIs discuss any problems with the interview in the large group
- KIs practice in small groups
- KIs practice (role play) in the large group

This process is followed for each of the interviews in turn.

During the practice session facilitators give time to encourage and support those KIs who are having difficulties. In the NSMP example it was found that women with the lower literacy levels and lower caste women needed more support during the interview practice.

Step 8: Developing Ethics for the Monitoring/Research

KIs and facilitators discuss and agree on the ethics and standards for conducting the interviews.

Step 9: Selecting Respondents

KIs decide who they are going to interview. Facilitators ensure that appropriate respondents are selected for representativeness.

Depending upon the needs of the programme, the facilitators can work with KIs to agree some basic criteria for selecting respondents. For example, if the programme is interested in the perspective of low status/lower caste women then they ensure that KIs do not select higher status/high caste women as respondents.

Focal persons can also give support to KIs in selecting respondents.

Ideally KIs select between 3 and 6 respondents to conduct interviews over a one to two month data collection period.

STEP 5: Data Collection

KIs are asked to conduct the interviews with their selected respondents during their free time.

Ideally interviews are carried out in places and at times where they would normally meet, ensuring privacy to allow the conversation to take place freely.

Interviews are conducted as free flowing and relaxed conversations.

Interviewees are not asked to give the names of “other people” like them, and interviewees’ names are also kept confidential.

Respondents are interviewed on each of the themes.

Each interview is carried out on a different day (usually with the gap of a week between each interview). For example:
KIs take notes of key words and phrases to remind themselves of the content of the interview. Depending upon the situation, KIs can write short notes either during or after the interview. In the case of NSMP it was decided that it was better to write the notes after the interview so as not to disturb the flow of the conversation or make the respondent feel uneasy.

**STEP 6: Supervision and Debriefing**

Supervision and debriefing can take place in a number of different ways. Facilitators provide the supervision to the KIs, and it is advised that they meet with the KIs weekly during the supervision process.

**The weekly meetings with KIs can take place individually:**

**Supervision of peer researchers in Myanmar**

During peer research with sex-workers in Myanmar, supervision was conducted on a weekly basis with individual peer researchers. Supervisors interviewed the peer researchers on the interviews that had taken place the previous week and made detailed notes of these interviews. The supervisors’ data provided secondary data for the final analysis.

**Or they can be facilitated in a group**

**Debriefing of NSMP KIs**

NSMP held weekly debriefing sessions with all the KIs in a group. Each debriefing session covered one interview theme. For example during week 1, KIs carried out interview 1 with their respondents. Debriefing was held at the end of the week and the group discussed the main findings of interview 1. Facilitators noted down key areas of similarity and differences between the interviews. KIs discussed the interviews and agreed on the main findings and recommendations. The same process was followed for each of the interview themes. NSMP recommends that 2 days should be allocated to each debriefing session if it is conducted in a group.
There are advantages and disadvantages to both approaches:

**Advantages to individual supervision:**

Supervisors are able to collect detailed data from the KIs.
KIs may be more comfortable initially sharing interviews individually (especially non-literate KIs).
KIs interviews will not be influenced by seeking a group consensus.

**Advantages to group debriefing**

It may be more time effective, especially if KIs live long distances apart.
Data is processed during the debriefing and therefore may be more manageable.
KIs learn to listen to and respect differences among the group.
KIs develop the confidence to talk in a group and express differences of experience.

Group debriefing sessions require careful facilitation to ensure that less vocal or less confident KIs are supported to share their interviews, especially if their findings differ from the main group consensus.

**STEP 7: Data Analysis**

**Data analysis takes place on two levels:**

1. Analysis of data by KIs and facilitators for presentation to VDC/DDC (programme/agencies)
2. Synthesis of data by facilitators and social analysts to identify causal factors relating to behaviour change, as a basis for programme development.

Both stages of data analysis are equally important and require different skills.

**Analysis of data by KIs/ facilitators**

If KIs are supervised individually during the data collection process, they are all brought together at the end of the entire process for a one to two day workshop. The workshop is run by the facilitators. The aim of the workshop is for KIs to:

- Share their findings in a group
- Identify main areas of similarity and difference
- Identify recommendations to present to the programme/agencies

If KIs are supervised through weekly group debriefing, the level 1 data analysis takes place during the debriefing sessions.

It is recommended that prior to the debriefing/data analysis sessions the supervisors develop a data analysis framework. It is likely that supervisors will need the support of a social analyst to develop the framework. The framework should help facilitators to draw out key findings and to identify areas of similarity, difference between different groups in the community. An example of a data analysis framework is provided in the Annex.
Facilitators should note down key quotes from interviews to illustrate the issues raised in the analysis.

In the second and third round of monitoring, facilitators use this framework to note down the main changes that KIs have identified in their interviews, noting again areas of difference and similarity.

Documenting and synthesising the data

The second level of data analysis requires skills in documenting and synthesising data. The aim of this level of data analysis is to produce an analysis of processes of change and factors underlying behaviour, behaviour change, and similarities and differences between different groups in the community.

It is recommended that this stage of data analysis is undertaken by a social analyst. The social analyst should also be involved in the training of the KIs and in developing the data analysis framework to guide the supervision and debriefing sessions.

STEP 8: Presentation of findings and joint planning

Advocacy and joint planning

Following each round of data collection and analysis, the KIs’ recommendations and findings are presented to the programme/agencies.

In the case of NSMP, annual meetings were facilitated with the VDCs in which KIs presented their findings and recommendations.

The NGO focal person facilitates the meeting, with all the KIs participating.

The Presentation includes:
- Objectives of KIM
- Objectives of the interviews
- Summary of main findings
- Key recommendations

Following the presentation, the KIs, facilitators, and NGO focal persons sit with the VDC and representatives of other local institutions (e.g. mothers groups) to identify the problems and develop a committed joint action plan to address these problems.

The focus of the action plan is to identify concrete actions that can be taken by the VDC and other institutions to make improvements.

The second and third round of KIM is used to monitor the extent to which VDCs have implemented the action plans from the first round and to revise the plans according to the new KIM findings.
Examples of issues brought to the VDC

In one VDC a Dalit woman had gone to the primary health care centre and the doctor asked for 8,000 rupees (an unofficial payment) to treat her. The woman did not have the money to pay for treatment and died two hours later.

Dalit women in another VDC reported that the MCHW would not enter their houses. The issue was raised in a VDC that, although there was a commitment for 33% representation of women, none of the committees and groups in the community had adequate representation of women.

In another VDC, KIs reported that women did not have access to land for agriculture even though there had been some NGO projects working on women’s rights to land. The issue was investigated further by the NGO.

Examples of actions taken by VDCs as result of joint action planning with KIs:

- Improvements to water supplies for health facilities
- Commitments to supply wood for infrastructure improvements
- VDC made accountable to ensure 33% representation of women
- Commitment to improve women’s access to land

Following the VDC meeting, NSMP also holds a meeting with the DDC.

The meeting involves all stakeholders at DDC level (e.g. donors, NGOs, community groups).

The NGO focal person makes the presentation to the DDC (following the same structure of the presentation to the VDC). The focus of the DDC meeting is on issues that can be influenced at district level.

Following the presentation, the NGO focal person facilitates the discussion with stakeholders, and action plans are developed which outline commitments to address key issues raised by KIM.

Examples of actions taken by DDCs

- Donor commitment to support DDC to improve water supply to health facilities
- Support from the District Health Officer to carry out monitoring of Maternal and Child Health Workers, to ensure all women in the community are being treated equally.

Through joint participatory planning, the KIM process has facilitated concrete changes at both VDC and DDC level.

The most important part of this process is that recommendations being made to VDCs and DDCs are from the target group, and therefore have authenticity and validity.
Empowerment of KIs

KIM is not only a data collection tool. One of the most important aspects of KIM is that it has also facilitated a process of empowerment of key informants.

**Examples of empowerment of KIs**

Key informants have developed skills in questioning and analysis of conditions of women in the community.

During debriefing sessions women who have previously had little opportunity to speak (e.g. those who are illiterate, low-status, low-caste) have been encouraged to share the views and perspectives of other women like them, and have been listened to with respect.

Key informants have been able to express the concerns and perspectives of other women like them in front of the VDC.

Key informants have participated in joint action planning with the VDC and in monitoring implementation of the action plans.

In one VDC the Maoists had refused to allow anybody to move out of the community. One of the KIs who had attended training was able to put her case to the Maoists regarding the need for the monitoring and was permitted to continue.

**Application to other sectors**

The examples provided in this document have been specific to safe motherhood, as they are derived from NSMP’s experience. However KIM can be used across a range of sectors to explore many different issues.

**Kim is most effectively used to:**

- Explore sensitive issues
- Give a voice to marginalised groups

**In order to adapt Kim to other sectors the programme needs to:**

- Identify their objectives
- Identify the themes and sub-themes they want to find out about
- Identify KIs from the target group with which they are working
- Go through the steps of the KIM process as outlined in this guide.

**Key sectors/areas in which KIM could be applied include:**

- Gender and power relations
- Rights based approaches
- HIV/AIDS and risk behaviours
- Sustainable livelihoods
- Resource management (e.g. water management)
- Vulnerable groups (e.g. sex workers, street children, trafficking of women and children, men who have sex with men)
### Annex: DATA PRODUCED BY NSMP

**Example of a data analysis framework: Theme 1.**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Key Issues</th>
<th>Key Questions</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers to OEC</td>
<td>Risks</td>
<td>Perceptions of: differences between normal women and pregnant women; kinds of illnesses women face during pregnancy, delivery, and until 45 days afterwards; which illnesses are dangerous.</td>
<td>What are the main differences/similarities expressed in the KIs' interview narratives under each of the sub-themes? Who are the differences/similarities between (which social groups/which communities?)</td>
<td>Similarities/differences by caste, ethnicity, social status, age, location see annex 1 for example of data collected</td>
</tr>
<tr>
<td>Transport</td>
<td>Availability and accessibility of transport for pregnant women and women who have difficulties after delivery.</td>
<td>How are the differences/similarities expressed (give examples of quotes).</td>
<td>When/how do they occur/take place?</td>
<td></td>
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<tr>
<td>Financial</td>
<td>Access and control over to financial resources. Decision-making over how and when money is used.</td>
<td>What are the causal factors/why do they happen?</td>
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</tr>
<tr>
<td>Role of service providers</td>
<td>Health seeking behaviour: categorisation of illnesses; where women go for help if they have these illnesses; who makes the decisions related to seeking different health care providers; health facilities provided; women's perceptions of different providers' facilities.</td>
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</tbody>
</table>
Summary of Key Findings and changes seen in Round 1 and 3 Monitoring

<table>
<thead>
<tr>
<th>Areas</th>
<th>Round 1</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers to EOC services</td>
<td>• Even though women themselves knew about obstetric dangers signs, mothers-in-law and husbands who were not aware about danger signs created delay in decision making process.</td>
<td>• Almost all the people in the villages aware about danger signs and decision-making has become quicker.</td>
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<tr>
<td></td>
<td>• MCHW not very popular</td>
<td>• Much greater confidence in MCHW's services</td>
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<td></td>
<td>• MCHW not used for delivery and TBAs were mostly called for delivery</td>
<td>• Trend of calling MCHW for home delivery has increased and trend of calling traditional healers and TBAs has decreased.</td>
</tr>
<tr>
<td></td>
<td>• In case of emergency people take loans from rich people or from emergency funds.</td>
<td>• Traditional healers refer obstetric cases to MCHW.</td>
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<tr>
<td></td>
<td>• Poor women not part of the group funds</td>
<td>• Number of funds increased in the villages, but the money given out as a loan is not enough, hence utilisation of fund low</td>
</tr>
<tr>
<td></td>
<td>• Doko, dola, stretchers used for transportation in rural areas and then ambulance called up to the road head</td>
<td>• Even poor women are part of community group funds</td>
</tr>
<tr>
<td></td>
<td>• Men of higher caste do not carry women of lower caste</td>
<td>• More transportation schemes established than before, in some districts almost every ward has one doko.</td>
</tr>
<tr>
<td></td>
<td>• Jeep owners and other vehicle owners are not supportive in carrying a woman in labour to the health institutions.</td>
<td>• Bicycle ambulance very popular in Rupandehi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Though the transport owners and men have become supportive in carrying women to health institutions in emergency, poor families cannot afford to pay for ambulance and men from higher caste do not carry women of lower caste</td>
</tr>
</tbody>
</table>

The first round of data collection was in March 2002, the second in February/March 2003, with a third in February/March 2004. Data from the first round were used to further refine project design and to establish a baseline against which to monitor subsequent change.
### Quality of Care
- MCHW not very popular
- MCHW was not used because “she referred the cases anyway”
- Nurses and doctors in some hospital show discrimination between rich and poor
- Service providers not regular at the Sub-health posts and health posts
- CEOC preferred to BEOC as it provides blood transfusion and CS service
- MCHWs behaviour reported to be very positive. She counsels the women well and treats them well.
- Women appreciate the fact that the MCHW refers the cases to appropriate health institutions immediately if she cannot manage the case.
- The attitudes of the service providers reported to have improved and women have the feeling that they will not have to die if they go to the hospitals.
- Service providers have become more regular at the sub-health posts and health posts
- CEOC preferred to BEOC as it provides blood transfusion and CS service

### Status of Women
- Women do not talk about pregnancy related problems with their family members
- Most women cannot make decisions about going the health institutions for care
- Men hold decision-making positions in community groups.
- Dalits not participating in community groups.
- Mothers-in-law not supportive of daughters-in-law
- Most women talk about their pregnancy and related problems mostly with their husband and then with mothers-in-law
- Most women influence family members and community members to go for ANC check-ups and to the health institutions in case of complications.
- More women involved in decision-making positions in the groups.
- More dalit women are now members of community groups.
- Husbands and mothers-in-law have become very supportive
Summary of Findings of the third round of KIM

Barriers to EOC services

The third round of KIM revealed that the knowledge about obstetric danger signs, where to go to and preparations to make beforehand has improved over a period of two years. The third round of KIM revealed much greater confidence in MCHWs’ services than during the first and second round of KIM. The fact that MCHWs have the kit boxes has helped to increase their credibility. In some VDCs it was mentioned that after the MCHWs have gone for further training (ANM), women have started going back to TBAs for delivery. This indicates that the trust in MCHW has increased over a period of two years. Referral has increased at all levels: from traditional healers and TBAs to MCHWs; MCHWs to PHCs and hospitals; and from BEOC centres to CEOC. This has helped to increase early decision-making, thus reducing the first delay. There are more emergency funds in the wards than before, giving the communities a sense of financial security. The loans given out from the funds vary from 500 rupees to 2,000 rupees and some women do not take money from the emergency fund as it is not enough to cover all the expenses for an obstetric emergency. In hilly areas like Baglung and Parbat, dokos and one stretcher per ward are kept ready for transporting women to hospital in emergencies. In Terai districts like Nawalparasi and Rupandehi, bicycle ambulances have proved to be a very cost effective means of transportation.

Quality of care

MCHWs have become more popular in most places, because these women are from the community and are available any time in the villages. They are called for home deliveries and they have started visiting even Dalit people’s houses to conduct deliveries, which they did not do before. MCHWs treat patients nicely and counsel them well. Communities appreciate the fact that they refer complicated cases to the appropriate health institutions immediately. In some VDCs the link between TBAs, Janne Aaimayee (experienced women) the MCHW has improved. In some districts, women also like the PHCs because the service providers behave more politely towards them than before. Baglung hospital is mentioned as being very popular because the service providers are caring and nice and there is a provision for free maternity service for the poor. Physical infrastructure at the sub health posts has improved, with curtained spaces and beds for ANC checkups. People prefer hospitals with CEOC to those with only BEOC, because they are aware that hospitals with BEOC cannot provide caesarean section services and must refer such cases to CEOC centres. Hence they prefer going to the CEOC immediately. In terms of affordability of services, government hospitals are perceived to be much cheaper and MCHWs are also perceived to be affordable because they do not charge a fixed amount for conducting deliveries.

Status of Women

Most women talk about their pregnancies mainly with their husbands and mothers-in-law. However for abortion related matters women talk mostly with their friends. Women can make decisions at family level to go for ANC, call the MCHW for delivery and can influence other people in the community to take pregnant women family members for ANC, to call the MCHW for delivery and to take women with obstetric complications to the health institutions. More women than before are holding important positions in different groups, e.g.: chairperson, vice-chairperson or treasurer. This has enabled them to have stronger voices in decision-making. Men have become more supportive of their pregnant wives and take care of them by doing heavy work themselves, taking care of the children and by taking them for ANC.
Source of Information

In the third round of KIM, the women mentioned that the changes seen over a period of two years are due to different activities going on at the VDCs and due to mass media used for BCC activities. The pregnant women and their mothers-in-law gatherings, “Aama” radio programme, key chains of the Birth Preparedness Package, plastic bags with SM messages and posters were some of the things mentioned by women as source of information. Most of the people in the communities where KIM was conducted are aware about the obstetric danger signs. The knowledge-based survey conducted by NSMP in 12 months period also supports this finding. The results of knowledge survey done with mothers-and-law and husbands in 2001 and 2002 shows an increase in levels of knowledge about obstetric danger signs, places to go in case of emergency and preparations to make beforehand increased by more than 50% on average. Regarding the source of information, the knowledge survey also shows that there is an increase in radio and print materials being mentioned by the respondents as major sources of information.

Through the establishment of safe motherhood networks in two VDCs of Baglung, women have been conducting awareness-raising activities on safe motherhood. Efforts to establish more community emergency funds continue. VDCs have supported sub health posts in improving their physical infrastructure, and are discussing the behaviours of health service providers as a way of increasing awareness of this important aspect of obstetric care.

Differences in findings between Districts

Even though the findings were more or less the same across all six districts, there were some specific things mentioned for individual districts.

- Baglung District Hospital is perceived to be very popular in terms of service availability as well as for the attitudes of service providers.

- PHCs in Parbat and Baglung are specifically mentioned as being liked by women for service availability whereas in other districts, PHCs were not mentioned as being preferred service sites.

- In other districts, even poor and marginalised women can influence decision-making to some extent at home and in groups, but in Baji and Chaudhari communities, women cannot influence decision-making.

- In hilly districts like Baglung and Parbat, a doko is kept ready as emergency transport and jeeps are not popular because they are full most of the time.

- In terai districts like Nawalparasi and Rupandehi, the bicycle ambulance has become very popular and people like it because it is cheap and easy to maintain.

- In Baglung and Parbat, women have started going back to the TBAs for delivery, because the MCHWs have gone for training.

- Parbat hospital was appreciated for having a good and quick referral system. They telephone Baglung or Gandaki hospital before sending the woman there.

- Women who can afford to go a private hospital prefer going to AMDA hospital in Rupandehi because it provides services especially for women and children.
Log frame Showing results of first, second and third round of KIM
Baglung (Bihun & Damek VDCs)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>1. Women perceive that the trend of seeking care from the traditional healers has decreased and the number of women who seek care from MCHWs for pregnancy and delivery-related cases has increased. Women seek delivery care from local healers and experienced women. The local PHC is also acceptable.</td>
<td>There is more belief in the value of MCHWs' services, and calls for them have increased in the last 12 months, but many women still prefer to deliver at home. The local PHC is also popular, because the service providers behave nicely and refer complicated cases to the hospital immediately. Women still do call traditional healers when in labour, but the traditional healers now refer emergency cases to the hospital immediately. The community prefers Baglung hospital where 24 hours service and blood and surgery is available. Women felt that the husbands forced them to have sexual intercourse during pregnancy or right after delivery, which they thought was dangerous as it caused heavy bleeding. Traditional healers are still called for long labour, but they refer the cases to the health institutions or MCHW, which helps to reduce delay in decision-making.</td>
<td>Women perceive that the trend of calling MCHWs for home deliveries has increased more than last year. MCHW is perceived to be experienced and helpful. She goes to conduct deliveries any time she is called, does not ask for specific amount of money and if the family cannot afford to pay right away, she agrees to take the money later on. Kushmisera PHC is also popular, because there is separate room for maternity services, and refer complicated cases to the hospital immediately. The community likes Baglung hospital where 24 hours service and poor people are treated free of cost.</td>
</tr>
<tr>
<td>Physical Barriers</td>
<td>Roads and Transport</td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td>1. Women perceive that communities have started local transportation schemes and people know about them.</td>
<td>Due to the distance to health facilities women seek care with local healers.</td>
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</tr>
<tr>
<td>2. Women perceive that drivers of Jeeps and buses are supportive in carrying poor women to hospitals in emergency.</td>
<td>Transport is not kept ready, as this is auspicious, so referral is delayed while a doko or dola to carry the woman is constructed.</td>
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<tr>
<td>3. Women perceive that men have become more supportive in carrying a woman in emergency to a health institution.</td>
<td>The poor road conditions deter care seeking at night.</td>
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<tr>
<td>4. VDCs initiate improvements to roads and bridges</td>
<td>Vehicles travelling on rough motorable roads are not used due to fear of prolapse.</td>
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</tbody>
</table>

ANC check ups have increased among almost all the cases.

Obstetric danger signs and know what kinds of services are available at SHP level. But old people and some poor people who have no time to go to the orientations and other awareness raising activities conducted in the VDCs are not aware about danger signs.

Due to the increased level of knowledge about danger signs quick referral has also contributed to this.

<table>
<thead>
<tr>
<th>Roads and transport</th>
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</thead>
<tbody>
<tr>
<td>There are now transportation schemes in every ward. A doko is kept ready in every ward, and the community sees great value in this as women can be carried in a doko to the hospital immediately if needed and the same doko can be reused for other people. A stretcher is also available in the sub health post. Women in one VDC said that the jeeps are usually full and drivers do not take sick people even if they see them on the way.</td>
</tr>
<tr>
<td>Due to bad road conditions people find it easier to carry women in a doko than in a jeep. Men have become more supportive in carrying women to hospital in emergency cases, but men from higher castes do not carry the women of lower castes. They only help them by</td>
</tr>
</tbody>
</table>

VDCs are not aware about danger signs.
<p>| | |</p>
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</thead>
<tbody>
<tr>
<td>5. Women perceive that more emergency funds have been established, especially in poor communities (e.g., in Baji and Chaudhary communities).</td>
<td>Women perceive that more emergency funds have been established, especially in poor communities (e.g., in Baji and Chaudhary communities). When a high-caste woman is referred, low-caste men are asked to help carry her. When a low-caste woman is referred, the high-caste men try to find others to help carry her. Providing money or logistical support. Since the MCHWs are available in the community, women prefer calling them for delivery.</td>
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<td>6. Women perceive that people are utilising the emergency fund for EOC.</td>
<td>Women perceive that people are utilising the emergency fund for EOC.</td>
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**Finances**

Women perceive that since there are emergency funds in every ward, money can be available immediately if any woman has obstetric complications. They feel that women will not have to die due to lack of money. Women perceive that the emergency funds have been used only for a few cases of obstetric complications, but since the fund is there, it has given the people a sense of security that money can be available whenever needed. Funds have been used for other illnesses also and for spending on food for the postpartum mother. Poor women who are not members of the emergency fund groups are given subsidized loans or grants. But if the woman’s husband drinks or plays cards, the groups do not give loans easily. Poor and unemployed women do not seek care at the hospital.

Due to the security situation it is difficult to take anyone to the health institution during night-time. The groups charge minimum amount of money for using dokos and stretchers so that people would return them after using it and they could use the money for maintenance of the stretchers. The money is added into the emergency fund.

**Finances**

Women perceive that since there are emergency funds in every ward for which 3000-3500 rupees are kept in reserve for obstetric complications. In case of obstetric complications, up to 500-2000 rupees is given as a loan. The loan is given without any interest for a month and then 1.5% interest rate is charged after that. The emergency fund has also been given to non-members with the condition that they return it within 15 days. Some groups have used some amount of money for income generation activities. Women perceive that money can be available immediately if any woman has obstetric complications. They feel that women will not have to die due to lack of money. But rich people have not used the emergency fund and some other people have not used it because the money given from the fund is not enough to cover the expenses for obstetric complications.
<table>
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<tr>
<th>Quality of Care</th>
<th>1. Women perceive that the physical facilities in the SHP have improved (curtains, beds, separate rooms)</th>
<th>2. Women perceive that health service providers have started to become more regular in the SHPs/HPs/PHCs and hospitals</th>
<th>3. Women perceive that Health Workers have started behaving more politely to the patients</th>
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<td>Women do not use village health facilities due to the lack of physical facilities (bed, curtain, etc.), equipment and medicines, non-availability of health staff during working hours, high charges and lack of experience and discriminatory behaviour of health staff.</td>
<td>Health staff are believed to discriminate in favour of their friends. When a stranger's baby dies, it is believed that the health staff have given medicine to cause this.</td>
<td>Women perceive that health service providers have started to become more regular in the sub health post and health posts. MCHWs' and AHWs' behaviour was appreciated by the people because they are available in the community all the time and come immediately even when called</td>
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<td></td>
<td>Women perceive that the physical facilities in the sub health posts have improved. There is a separate examination room, bed, and curtains More women than before go for ANC checkups, but rather than delivering at the sub health posts, women prefer calling MCHWs for home delivery. Faith in MCHWs' services has increased. Women perceive that Parbat hospital and Baglung hospital provide good quality services. Baglung hospital is more popular because it provides 24-hour services including surgery and blood, has the necessary equipment, and the medicine is cheap because of Sajha drug store. The services in Kushmisera PHC were found to be expensive. Most women believe that if a woman can be taken to Baglung hospital she can be saved.</td>
<td>The credibility in MCHWs service has improved and women feel that she has the kit box with all the necessary medicines, which gives them confidence in her service. Kushmisera PHC was particularly mentioned for having a separate room and necessary equipments and availability of service providers. Baglung hospital was very much popular for providing 24-hour services, separate maternity wards, availability of blood transfusion and C-section in all the health institutions, SHPs, PHC and hospitals service providers were perceived to be available more than in the past. MCHW was liked by all because she did not discriminate between rich and poor and in different castes. She is available any time and is nice and polite to all. MCHW counsels the women well and refers the complicated cases to appropriate place. The AHW was also perceived to be nice and kind and responsive. Baglung hospital was very popular for having nice, kind and caring health care staff.</td>
<td>Women perceive that physical infrastructure of the SHPs has improved and there is a separate room for ANC, there are beds and curtains. More women than before call the MCHW for delivery. Though some women still call the TBAs and Janne Aaimayee (experienced old women) for delivery, they call the MCHW if they feel that they cannot manage the delivery case. The links between TBAs or experienced women with the MCHW seems to have improved.</td>
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</table>
service providers who did not discriminate between castes and rich and poor. Women feel that they will not have to die if they go to Baglung hospital. In terms of affordability, Baglung was much preferred than anywhere else because people feel that services are given free of cost to poor people. The availability of Sajha drug store at Baglung hospital has enabled people to buy medicines immediately at a good price compared to other medical stores. The MCHW was also perceived to be affordable. Kushma hospital was also mentioned as having a good referral system because they telephoned Baglung or Pokhara hospital to refer the case if it could not be managed there. Referral has improved at all levels, i.e., traditional healers/ TBAs to MCHW, MCHW to the PHC or Baglung hospital, Kushma hospital to Baglung or Pokhara and Baglung to Pokhara.

Women still do seek care from traditional healers and janmaaimayee (local woman who assists women during delivery) for long labour, but they now give some spiritual healing water and refer the case to hospital immediately. Referral has improved significantly, and communities appreciate that the MCHW refers complicated cases to appropriate health institutions if she cannot handle them. Women perceive that health staff have improved their behaviour towards the patients compared to how they used to behave. The MCHW was well liked because she counselled the women well, did not discriminate between rich and poor or according to castes. The service providers in Kushma PHC, Parbat hospital, and Baglung were also liked for behaving politely and for explaining things nicely. The traditional healers and TBAs were also said to be very nice.
Social Context

1. Women perceive that women have started talking about pregnancy-related problems with husbands and mothers-in-law.

2. Women perceive that husbands and mothers-in-law support pregnant women to seek care during pregnancy, delivery, and after delivery.

3. Women perceive that daughters-in-law are listened to in the decision-making process.

4. Women perceive that more women are involved in decision-making in group meetings.

Women do not speak of their obstetric problems. Those who do, wait until they cannot tolerate them or are at ‘last stage’. Women believe that cleaning floors, brushing, cleaning clothes, cutting trees, and lifting heavy weights is dangerous to them, but only in Magar communities do other family members help them. In Brahmin, Chhetri, and Dalit communities they do not.

Though women do not want to have intercourse immediately before or after delivery, believing this to be very dangerous, they are forced to by their husbands who threaten them, talk about them with their male friends, refuse to care for the children, and quarrel with them.

Women know symptoms of danger in pregnancy but cannot go for care, as the parents-in-law and husband do not consider these dangerous. Women know about the boksi (witch) and cost, deliveries are often unattended.

Men believe that women are only able to work and bear children.

Almost all the women talk about pregnancy-related matters with husbands. Some women talk to their mothers-in-law too. Women have started sharing in group meetings, things that they learn in training programmes.

Women can make decisions at family level regarding household chores, farming, children’s education etc. But major decisions like selling and buying properties is still made by men.

However, Magar women can make decisions to buy jewellery for themselves or anything they want. Even in major decisions are made jointly. Most women can decide themselves to go for ANC checkups, to call MCHW for delivery and to join the groups and attend training programmes. Husbands are supportive in the decisions and help their pregnant wives by listening to their problems, doing heavy work, looking after the children and taking them for ANC. But in some poor families, pregnant and newly delivered women do all the work themselves.

Women can influence communities in establishing emergency funds and transport, decide on how to operate them, can conduct awareness raising activities on safe motherhood and influence families to take a woman with obstetric complications to the health institutions.
Women are only involved in community decision-making forums as a formality; they are ignored in practice and only men make decisions. Women are considered unable to make decisions even with regard to buying simple goods, undertaking transactions, seeking treatment, etc.

Where women have tried to influence decisions they have been teased, accused of damaging the household's prestige, bitched about, beaten, etc.

Women's groups are encouraged by men to use their money to build temples or roads. Men oversee the process but do not provide labor. When women's groups do not have money they are ignored.

decision-making, but daughters-in-law who do whatever they like or spend money on their own are not listened to.

If women manage the household expenses, the community does not give loans easily because they do not own fixed assets like land. However, women perceive that women manage the house more efficiently and can repay loans on time. Women are involved in different groups in the community (e.g., mothers groups, school management, forestry, etc.). They make decisions regarding the operation of emergency funds.

Women can make decisions in groups consisting only of women, but women do not make decisions in groups including both sexes. Even if men ask their opinion, women agree to whatever the men decide. Men do not like women making decisions about buildings, roads, etc. Women make only household-level decisions. Men make major decisions like buying and selling land. Women's decisions to establish emergency funds or take a woman with complications to the health institution, are respected by the community.

Women perceive that women would manage the household expenses more efficiently than men and are likely to save money and repay any loans taken by the family on time. However, most families have men as household-heads. More women are involved in different groups and some hold the chairperson, vice-chairperson or the treasurer's position. This has helped in women's voices being listened to in decision-making process. Women have formed a safe motherhood network in the village and conduct many awareness-raising activities in safe motherhood. In women's group women find it easier to voice their opinion, but in groups with men and women, except for educated women, most of them find it difficult to voice their opinions.

In some families even if the mother-in-law and the daughters-in-law are not in talking terms, the mother-in-law take good care of them when they have delivered a baby.

Pregnancy is thought to be a special condition by most of the husbands and they support their wives. But some husbands still force their wives to have sex against the wives will.
Nepal Safer Motherhood Project
Teku, Kathmandu, Ph: 977-1-4262110, 4248991
Web: www.nsmp.org

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