



Guidelines for Developing Home-Based Reminder Materials

Helping Families
Save Sick Children



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Guidelines for Developing Home-Based Reminder Materials

Helping Families Save Sick Children

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September 2004

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The children in the cover photos are healthy children.

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PREFACE

These guidelines reflect the experiences and lessons learned from a global project that developed communication materials to improve the health of young children. Project HOPE undertook the “Mothers Reminder Material” (MRM) initiative with the CHANGE and BASICS II projects to enhance the performance of existing child survival programs in nine countries (Dominican Republic, Ecuador, Ghana, Guatemala, Malawi, Mozambique, Nicaragua, Peru and Uzbekistan). The aim of this project was to develop materials to help mothers and other caregivers know when they need to seek immediate medical care for a sick child.

The guidelines present practical, easy-to-use methods for creating effective materials and take you step-by-step through the processes needed to plan, research, design, test, produce, distribute and evaluate reminder materials. The appendices contain resources and templates for everything from organizing a workshop, hiring consultants and testing materials, to soliciting production bids from printers, to guidelines for acquainting families with the use of the material.*

The primary audience for these guidelines is Private Voluntary Organization (PVO) country staff working in child survival programs in developing countries. Although it is hoped that the document may be useful to a much wider audience, where it addresses “you,” the authors have PVO staff in mind.

Clearly, this is not the first set of guidelines on developing effective health education materials.¹ However, this document is distinct in that it focuses specifically on developing home-based reminder materials and is aimed at PVO country staff.

The basic organization is as follows: After the introductory discussions, the steps in the MRM development process are described in chronological order. Each section briefly explains the step’s purpose and recommended procedures. Tools, resources and summaries of actual field experience are found in boxes throughout the text as well as in appendices. Also included are comments from the field gathered in 2003 by Project HOPE.

It should be noted that although these guidelines are based on experiences in nine countries, they most heavily reflect the activities and results in Nicaragua, Malawi, and Ghana, the countries with which the primary authors worked most closely. The authors apologize for possibly omitting equally innovative and interesting ideas and lessons from the other country experiences.

* This document uses a “MRM” or a “material” interchangeably to refer to a “Mothers Reminder Material.”

¹ For example, see:

- HealthCom Project. HealthCom Communication Toolbox. Washington, D.C.: Academy for Educational Development, 1995.
- O’Sullivan, G.A., J.A. Yonker, W. Morgan, and A.P. Merritt. A Field Guide to Designing a Health Communication Strategy. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, March 2003. Can be downloaded at <http://www.jhuccp.org/pubs/fg/index.shtml>
- U.S. Department of Health & Human Services, Public Health Service, National Institutes of Health, National Cancer Institute. Making Health Communication Programs Work. Bethesda, MD, September 2002. Can be downloaded at <http://cancer.gov/pinkbook>
- Younger, E., S. Wittet, C. Hooks, and H. Lasher. Immunization and Child Health Materials Development Guide. Seattle: Bill and Melinda Gates Children’s Vaccine Program/PATH, 2001. Can be downloaded at http://www.childredivaccine.org/html/ip_clinical.htm

ACRONYMS

ARI	Acute Respiratory Infections
CHW	Community Health Worker (<i>brigadista</i> in Nicaragua)
C-IMCI	Community-Based Integrated Management of Childhood Illness
CS	Child Survival
IMCI	Integrated Management of Childhood Illness
MOH	Ministry of Health
MRM	Mothers Reminder Material
NGO	Non-governmental Organization
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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Appropriate Care-Seeking for Child Health

Every year almost 11 million children in developing countries die before reaching their fifth birthday, many during the first year of life.

Seven in ten of these deaths are due to acute respiratory infections, diarrheal disease, malaria, measles and malnutrition. In addition to substantial mortality, these conditions account for three out of four sick children seeking care in health facilities.¹

To respond to this situation, in 1995 WHO and UNICEF launched the Integrated Management of Childhood Illness (IMCI) strategy.² IMCI encourages mothers and other caregivers to use simple signs to detect cases needing immediate medical treatment. When a sick child is brought to health providers, they should not only treat the immediate cause of the visit but should also examine the child and ask questions to assess if the child presents other conditions that require treatment. Providers should also take advantage of a sick child's visit to counsel the caretaker on appropriate nutritional practices and ensure that the child's immunizations are current.

After completing a process of adapting national IMCI guidelines, many countries have undertaken significant efforts to train facility-based health providers in IMCI protocols and to strengthen support systems (such as drugs, supervision, health information systems and referral).

Studies in several countries, however, have shown that merely having well-trained providers available in facilities to treat sick children who show up will not have a significant impact on overall child

mortality. In many countries, the majority of children die without ever reaching the public health system.

Of those children who are taken to a public health facility, many arrive too late with severe conditions that cannot be successfully treated. A child mortality survey conducted in Bolivia³ found that only 18 percent of caretakers of children who died sought care from a Western-style medical provider. Over 70 percent of this group sought medical care for the first time on the day the child died, and over 40 percent of all caretakers in the study did not realize that their child was gravely ill until the child died.

Ministries of Health and NGOs/PVOs have responded to the low utilization of health services by introducing a community component of IMCI (Community-Based IMCI or C-IMCI). Although C-IMCI activities are designed to address specific concerns in specific contexts, many approaches follow the C-IMCI framework developed by BASICS II and the CORE Group.⁴ This framework promotes a multisectoral approach for improving child health and nutrition. It includes three elements:

- Improving partnerships between health facilities and communities,
- Providing appropriate care within the community, and
- Promoting key family practices.

C-IMCI assumes that even with facility and community-based child health programs in place, families play the key role in promoting the health of their children and in determining when to seek

care outside the home. To carry out timely and appropriate care-seeking for child illness, families must:

- Recognize when a child's condition requires medical care from a trained provider,
- Be willing to take the child for medical care as soon as possible,
- Be able to overcome obstacles to take the child for care, and
- Have enough confidence in the care to be willing to incur the costs and make the effort.

Bringing a sick child to a trained health provider may be difficult, time-consuming and costly, especially for rural families. Many families prefer to try home care first, using either traditional or Western treatments. If care is sought outside the home, caretakers often first choose to consult community-based providers (such as drug sellers and traditional healers). A number of factors may deter caretakers from seeking care at a health facility, including having previously had a negative experience (poor treatment by health center staff), perceived poor quality care (including lack of drugs) and high cost (in time and resources).

The Bolivian study and other studies indicate that many caretakers do not recognize medically-defined danger signs, or if they do, they do not realize their severity and the importance of immediately taking the child to a trained provider. There are several reasons for this:

- Parents may classify symptoms in ways quite different from the ways doctors do and thus have their own concepts of what signs indicate danger. Traditional beliefs in many parts of the world attribute certain symptoms and illnesses to evil eye, shame and other non-medical causes. Even if caregivers consider a condition serious, they may not consider bringing the child for modern medical treatment as the most appropriate response.

- It is extremely difficult to judge degree of severity—to decide how much diarrhea is dangerous, how hot a child needs to be, or how long a child is hot before a fever is critical.
- Caretakers may recognize a condition as worrisome but not sense the need to act urgently.
- Finally, there may be cultural beliefs such as fatalism or fear of going to a modern practitioner because of the shame of a family member dying in a hospital.

These issues led to the idea of developing some kind of take-home material, which can help mothers and other family members figure out what to do when their child becomes sick.

¹ World Health Organization, IMCI Information Package: Management of childhood illness in developing countries: Rationale for an integrated strategy, 1999.

² World Health Organization. Bulletin of the World Health Organization, 1995, 73 (6): 735-740.

³ Aguilar, A. M., R. Alvarado, D. Cordero, P. Kelly, A. Zamora, and R. Salgado. 1997. Mortality Survey in Bolivia: Investigating and Identifying the Causes of Death for Children Under 5. Arlington, Va.: BASICS.

⁴ Reaching Communities for Child Health and Nutrition: A Proposed Implementation Framework for Household and Community IMCI (HH/C IMCI). Arlington, VA: BASICS II, 2001.

The Mothers Reminder Material (MRM) Initiative

THE CHALLENGE

To motivate mothers and other caregivers to recognize and act on warning signs that a sick child needs immediate medical care.

Project HOPE health staff noted that despite repeated health education, projects in many countries have had limited success in getting mothers and families to recognize and act on important signs that their ill children needed to be taken as quickly as possible to a health care provider. To address this challenge, Project HOPE submitted a proposal to the Glaxo-Wellcome Trust in the United Kingdom to develop a “mothers reminder card” to help mothers and families recognize the most common, significant danger signs. In 2000, Project HOPE received a grant from Glaxo that supported the development of reminder cards in nine countries: the Dominican Republic, Ecuador, Ghana, Guatemala, Malawi, Mozambique, Nicaragua, Peru and Uzbekistan.

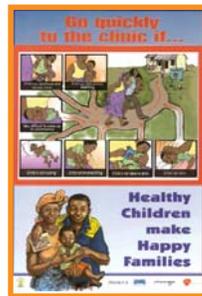
The MRM Initiative

In June 2000, Project HOPE contacted USAID’s BASICS II Project (USAID’s child survival “flagship” project) and CHANGE (USAID’s project specializing in behavior change in health and nutrition) to assess their interest in collaborating on the initiative. The three groups agreed to collaborate along the following lines:

- The material would not necessarily be a “card,” so the term mothers reminder material or MRM was adopted.
- In each country the material would not necessarily have the same basic design.



Dominican Republic



Ghana



Guatemala

WHAT YOU NEED

- ◆ Funding
- ◆ Budget and work plans
- ◆ Staff time, experience, and motivation
- ◆ Expertise on care-seeking for child health, materials development, and formative research
- ◆ These guidelines and/or other, similar guides/manuals

RESULTS

- ◆ Unique material developed, produced, distributed and used
- ◆ Greater understanding and awareness (in your organization and among partners) of the barriers to improved care-seeking for child-health emergencies
- ◆ Enhanced staff skills in many useful program areas
- ◆ Improved knowledge among families of important danger signs and motivation to act quickly

TIME

Approximately 6 months, if the process goes smoothly

- Both the content and form would be determined on the basis of an assessment of mothers and families and health workers perceptions and preferences.
- A major product of this activity would be these detailed guidelines.

The partners also agreed that the MRM alone was insufficient to achieve appropriate care-seeking for ill children. To achieve significant changes in appropriate service utilization, a program would need to support the material with additional activities that address barriers to appropriate emergency care-seeking beyond lack of knowledge of danger signs.

A major interest of BASICS was to ensure that the messages in the materials were consistent with each country's IMCI messages. CHANGE wanted to assess how well mothers' concepts of danger and illness severity could be understood and incorporated into the materials.

Most country activities followed the order of the steps listed below. These activities were managed by Project HOPE in eight countries and by BASICS in Ghana.

Nicaragua was the first country to develop an MRM in late 2000. A draft version of these guidelines was produced in March 2001, based mostly on the Nicaragua experience, and was distributed to the other participating Project HOPE and BASICS country offices. This draft version was the basis of the curriculum for the Malawi/Ghana MRM workshop held in April 2001 in Malawi (see *Appendix B*). By late 2003, all of the nine countries had produced and distributed MRMs. Copies of the materials are included in *Appendix A*.

Result

The MRM initiative was successful in many ways:

- Distinct, locally appropriate materials were produced and given to families in all nine countries.
- Local staff of Project HOPE, BASICS and other partners in the nine countries improved their understanding of an effective behavior-change communication process and gained skills in formative research, materials design and pretesting, monitoring and other areas.

The MRM Development Process

- ◆ Coordinate with stakeholders, including the Ministry of Health (MOH)
- ◆ Review existing information/identify information gaps
- ◆ Plan, carry out and analyze new field research (individual and group interviews), as necessary (new research was not done in Ghana)
- ◆ Use existing information plus research findings to design draft materials
- ◆ Plan, carry out and analyze in-depth pretesting
- ◆ Revise one or more materials, then plan, carry out and analyze final pretesting, as necessary
- ◆ Finalize the design
- ◆ Produce the materials
- ◆ Train distributors
- ◆ Distribute materials and give an orientation to families
- ◆ Monitor the use and effectiveness of the MRM, make needed adjustments
- ◆ Evaluate the use and effectiveness of the MRM; use findings to guide future actions—expansion of coverage or development of new MRM

- Partner organizations and country staff also gained a fuller appreciation of the complexity of achieving a major impact on appropriate care-seeking for child health. It is not merely a matter of mothers and families recognizing danger signs but that other barriers—the traditional practice and ease of first providing care at home and/or getting help in the community, monetary costs, access to services and service quality and availability—must also be addressed.
- There are indications that the initiative will be modified or expanded in some countries. Project HOPE in Nicaragua intends to develop and use a reminder material for mothers-to-be. Numerous other PVOs in Ecuador, Peru and the Dominican Republic are using MRMs or plan to.
- Based on feedback from country staff and an evaluation in Nicaragua (page 41), it appears that the MRMs are meeting their first objective of helping mothers and families know when they should seek modern medical care for their sick children.

Lessons Learned

- The initiative showed that it is possible to incorporate families concepts and vocabularies into materials but these concepts and terms are not always accepted by national-level public health officials.
- Family-group interviews in Nicaragua (a mother, father, and grandmother together) worked well and could be utilized to answer other research questions about family decision-making.
- Drawings alone did not communicate the danger signs well to mothers who cannot read. It was also very difficult to convey degrees of gravity of an illness, even using a few words. For example, how does one express when a fever is too high or has been around too long,

or diarrhea has become too frequent or voluminous, or fast breathing has become too fast?

- To address such problems, the country teams quickly realized the importance of health workers or volunteers carefully explaining the material to each family when it received its copy. In Guatemala, health volunteers review information on each month's MRM calendar page during monthly home visits.

Another response to the communication challenges was the idea of developing “talking” materials that would use a computer chip and solar, mechanical or some other power source. Such materials might provide more information, be more effective in motivating action and would be listened to frequently because of their novelty. Such materials would allow mothers to actually hear the sounds of breathing that is too fast, a child wheezing, etc. Although the partners consider this a promising idea, it was decided that the MRM initiative lacked the time and funds to develop it. Even if an effective “talking” material were developed, of course, programs and communities would have to face other barriers to timely and appropriate care.

Field staff made the following suggestions on how to improve this or similar initiatives:

- Develop a peer approach, mother to mother, where the health staff would facilitate and identify and bring the successful families together to help others learn to take care of their children. (Nicaragua)
- Make big posters with all the danger signs and post them in health facilities. (Malawi)
- Make materials on safe motherhood, reproductive health, breastfeeding for the communities. (Uzbekistan)

- Incentives for staff. Make a small quantity of materials for health workers focused on quality of care. Sell material to other PVOs to reach higher distribution. Also use complementary communication channels and reinforce the capacity of health workers. (Peru)

These guidelines are the final product of the MRM initiative. It is hoped that they will be useful to Project HOPE as well as many other organizations working to improve child health.



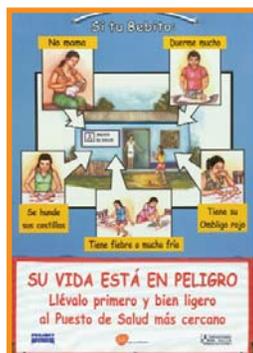
Mozambique



Malawi



Nicaragua



Peru

FIELD NOTES

General comments about the value, importance and rigor of the MRM Initiative from Project HOPE staff working on the initiative included:

- ◆ Developing the MRM was very important, given it is a material needed to complement the IMCI strategy. It will assure the diffusion of this knowledge at the family level. (*Ecuador*)
- ◆ Very [important], since the study revealed that mothers don't know much about danger signs, so [the MRM] gave us the opportunity to teach them and they can be reminded by the calendar. (*Guatemala*)
- ◆ Contributed to the identification of the real problems and their causes for the high percentage of neonatal deaths. Was very important; often materials are developed without taking into account the target group. (*Peru*)
- ◆ One of very few negative comments was that "Our staff was overwhelmed with the process, that is, the pretest and distribution, which was very time-consuming, given that they had some other activities to do."



Uzbekistan

Steps in Developing Home-Based Reminder Materials (MRM)

Step 1 Organize the Process and Involve Partners

Step 2 Plan and Conduct Formative Research

Step 3 Analyze, Summarize and Use the Findings

Step 4 Design the MRM

Step 5 Pretest the MRM

Step 6 Finalize and Produce the MRM

Step 7 Distribute and Provide Orientation on the MRM

Step 8 Monitor and Evaluate the MRM

1 Organize the Process and Involve Partners

THE CHALLENGE

To achieve the good will and support of other organizations working in child health.

Involvement of partners from the beginning is important for several reasons:

- Without the participation and approval of the MOH, the material is unlikely to be widely used.
- Other organizations have valuable experience and resources that can support MRM development, production, dissemination and monitoring/evaluation.
- The more aware and involved other organizations are, the more likely they will consider using or adapting the MRM for their programs, thus expanding its impact.

Coordination should be done through initial contacts, a stakeholders meeting, and then occasional communication and meetings. The objectives of the stakeholders meeting are to achieve consensus on the content of MRM, and to obtain assistance in identifying existing information, carrying out formative research and pretesting, production and distribution.

Meet with Key Partners

You should meet with each of the principal organizations and projects working in child health (such as the MOH, WHO, USAID, other bilateral donors, UNICEF, PVOs/NGOs and large health projects) to:

- Inform them of the plans to develop an MRM. Explain the intention to develop and use a material that supports the essential IMCI objective of increasing appropriate health services utilization for severe child illness.

KEY ACTIONS

- ◆ Identify partners and discuss proposed activity
- ◆ Invite partners to stakeholders meeting
- ◆ Arrange meeting logistics
- ◆ Prepare agenda, materials and draft work plan
- ◆ Hold meeting
- ◆ Revise work plan and disseminate minutes

RESULTS

- ◆ Technical agreement on content of MRM
- ◆ Promise of practical assistance in identifying existing information, carrying out formative research and pretesting, production and distribution
- ◆ Draft work plan with timing and responsibilities
- ◆ Reduced risk of opposition/discord among organizations working in child health
- ◆ Meeting minutes prepared and disseminated

TIME

Meetings with individual partners and the stakeholders meeting should be held as soon as the preparatory steps can be completed. It should take no more than two weeks to plan and hold these meetings.

- Assure them that the MRM messages will be consistent with existing guidelines and materials. To do this, a small technical group should be established to review the MRM before pretesting and again before production of the final material.
- Ask them to share any educational materials and/or research reports on child survival, especially on danger signs and/or care-seeking practices and barriers.
- Inquire whether they want to participate in: (1) the technical group that decides on the content of the material; (2) conducting formative research and/or pretesting; (3) using the MRM in their project areas (you need to decide who will pay for the production of copies for partners and costs associated with training the health staff or volunteers who will distribute the MRM and explain it to families). Partners may prefer to wait until a draft MRM is designed before deciding.

Hold a Stakeholders Meeting

Once individual meetings have been held with the key partners, organize a larger stakeholders meeting to inform a wider group of interested organizations, solicit their support and hear their ideas on the format and content of the MRM.

Before the stakeholders meeting:

- Complete the review of existing information and decide if any field research is needed.
- Identify, contract and orient a research director—either a staff member, if one has qualitative research experience, or a consultant.
- Make tentative decisions about the general type of material, research objectives, geographical areas where the research will take place and the location and scope for the distribution.

You may prefer to introduce the MRM on a small scale and then expand distribution once it has been evaluated or you may choose to use the MRM on a larger scale from the outset.

- Prepare a draft schedule of activities for developing, using and monitoring the MRM at the implementation sites.

At the stakeholders meeting, you should:

- Explain the objectives of this initiative.
- Inform participants about the purpose and plans for the MRM development.
- Begin to build consensus on the key concepts that should be included in the MRM. A menu of topics can be found in *Appendix C*.
- Ask participants to share any educational materials and research they have on child survival (CS), especially danger signs.
- Inquire if they might want to participate in: (1) conducting formative research and pretesting; and (2) using the MRM in their program areas.

Experience with stakeholders meetings in the first few countries suggests that you should:

- Schedule the meeting when there are no competing events
- Plan on a half-day meeting
- Reserve a comfortable location such as a hotel
- List and then invite key contact people and potential partner organizations—governmental, private sector and NGO
- Limit participation to key partners and potential collaborators, for a total of 20 to 30 people
- Re-confirm people's participation a day or two before the meeting

Agenda for the Nicaragua Stakeholders Meeting

Introductory presentations: 60 minutes

Welcome

- ♦ Introduction of partners and attending organizations and what they are doing in child health
- ♦ Description of the global MRM initiative
- ♦ The plan for developing an MRM:
 - The current plan for developing the MRM (main partners, location and scope of initial distribution, who will orient families)
 - Schedule of main activities

Coffee/tea break

Small group work: 90 minutes

Each group should meet for 30 to 40 minutes, followed by a 15-minute presentation and discussion for each group.

- ♦ *Group 1*—review proposed content for newborns; what should be cut or changed?
- ♦ *Group 2*—review proposed content for older babies and young children: what should be cut and/or changed?
- ♦ *Group 3*—review country experiences in developing and using materials for mothers and families—best formats, delivery channels, designs, messages, etc.

Discussion and closing: 20-30 minutes

- ♦ Invite comments and questions
- ♦ Invite groups to participate in the research and/or production and use of the MRM
- ♦ Get agreement on members of the technical review committee, if the partners support such a group.

In addition to a national-level meeting, the HOPE/Malawi team also organized and held additional stakeholders meetings in each of the two districts where the MRM would be used.

Maintain Contact with Stakeholders

You should prepare and distribute a summary of the stakeholders meeting. Every month or two, you should visit, call, or send an e-mail, fax or letter to update partners.

Partners may want to review the material at various stages of production (before pretesting and before production).

Once the MRM has been developed and is ready to use, you may invite partners to participate in a “launch event.” In some countries the appropriate time for such an event will be several months after the MRM has been pilot-tested in a small number of communities. In countries that skip this pilot phase, the launch should take place just before the material is ready for use in the field. The launch event might include community health fairs or similar activities, or it might be limited to a meeting of one-to-three hours for representatives of participating organizations, communities, community volunteers, health facilities and the press. The launch may include preparation and dissemination of material for the press and community. Any activities, especially at the community level, should describe the MRM and the importance of appropriate care-seeking.

STEP 1

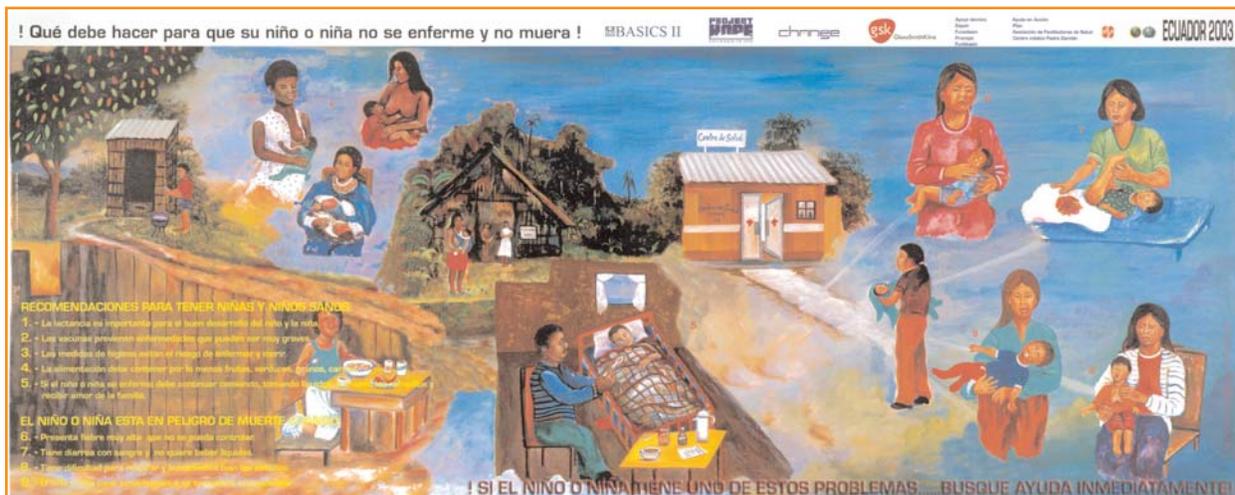
Results

Project HOPE in Ecuador formed an inter-agency committee to work on the MRM, so that 14 organizations (the MOH and NGOs) have been able to distribute and use the material nationwide. Project HOPE was invited to present the MRM experience at the regional IMCI meeting in Quito in June 2003. Project HOPE offices in the Dominican Republic and Peru also collaborated with multiple PVOs on this effort.

FIELD NOTES

Stakeholders

- ◆ We needed to negotiate with MOH on which danger signs to include and about local terminology. *(Nicaragua)*
- ◆ Interested PVOs met, formed a technical committee, identified and prioritized research needs, and designed the research plan. *(Ecuador)*
- ◆ At the beginning we involved the MOH, but we should have more actively involved other PVOs from the beginning and throughout the process, mainly at the local level. *(Nicaragua)*
- ◆ The MOH was not heavily involved, not like we would have liked. They participated little due to their other commitments.



Mothers Reminder Material from Ecuador

2 Plan and Conduct Formative Research

THE CHALLENGE

To gather relevant information that enables the design of a material that will be optimally effective with users, by accommodating their concepts and preferences.

Despite overwhelming evidence to the contrary, planners often assume they “know their target audiences”—what information or services they need, what their perceptions are and what they will like. Getting input from typical members of participant groups (in the case of the MRM, with mothers, other family members, community leaders and volunteers and health staff) is the best way to guard against using false assumptions and to provide appropriate and understandable information.

Formative research means gathering information for the purpose of preparing better plans. It is a process through which you and your partner organizations invite opinions and other ideas from relevant groups of people so that you may develop the most appropriate, clear and motivating content in the most acceptable, attractive and usable format. This phase starts with a review of existing information followed by in-depth individual and group interviews with representative members of participant groups.

Review Existing Information

Before beginning new information-gathering, review all available documentation and conduct a few in-depth interviews with specialists on the questions of interest. The purpose is to take advantage of what others have already learned in order to avoid unnecessary new research. Specific information is needed on:

- Mothers’ and other key family members’ perceptions of common childhood-illness symptoms and illnesses—what signs mothers consider signals of severity, how they interpret and classify these and what care they give or seek.

KEY ACTIONS

- ◆ Collect and summarize existing information
- ◆ Plan additional information gathering
- ◆ Develop budget for information gathering
- ◆ Hire a research coordinator and team
- ◆ Prepare research plan
- ◆ Adapt question guides
- ◆ Make logistical arrangements
- ◆ Train the team, including pretesting the instruments
- ◆ Carry out field work

RESULTS

- ◆ Key information to guide content and format of MRM and support activities
- ◆ Enhanced skills of staff
- ◆ Input from participant group on MRM

TIME

5-8 weeks

- Mothers' and other key family members' awareness and evaluation of IMCI danger signs.
- Approaches and results of previous attempts to integrate mothers' traditional beliefs with Western medical concepts.
- Patterns of use of various providers and, in particular, barriers to timely utilization of MOH or other modern services.
- Project experiences with educational materials, particularly home-based materials—any lessons learned regarding use, format, literacy levels, ability to interpret drawings, etc.
- The design and effectiveness of existing educational and training materials on danger signs, care-seeking, and home management and prevention of child illness (results of pretesting, monitoring and evaluation).

In most MRM countries, useful insights and ideas emerged from the review of existing information. If the existing information answers the main research questions for the relevant geographical area, new formative research is not required.

Summary of Existing Information in Nicaragua

Information on care-seeking

A study carried out in 2000 on danger sign recognition and care-seeking for maternal and neonatal health found that fewer than a third of mothers were significantly concerned with such danger signs as anemia, pre-eclampsia and hemorrhage during pregnancy; obstructed labor and hemorrhage during childbirth; anemia during the postpartum period; and difficult breathing among newborns. The study identified difficult access to health services and poor treatment by providers as important barriers to appropriate care-seeking.

Project HOPE's March 2000 baseline survey in Jinotega Department provided many indications of the need to focus on danger signs. For example, only 20% of mothers knew that rapid breathing and chest indrawing were danger signs for severe acute respiratory infection (ARI). In the three study districts, 25%, 50% and 70% of mothers who recognized danger signs for diarrheal disease said they would go to a health facility if they noticed one of these signs. Thirty to 40% of mothers recognized danger signs during pregnancy and postpartum. No surveyed mothers in two districts and 30% in the other district recognized danger signs during childbirth.

A 1999 study of perceptions of quality of childbirth care in Chontales Department found a strong preference for traditional birth attendants (TBAs). Mothers perceive them as providing personalized, kind, patient and traditional care as opposed to the often unfriendly, expensive, embarrassing, impersonal care in health facilities.

Existing information in Nicaragua indicated some knowledge of danger signs as well as significant access and quality of care barriers to care-seeking.

Educational materials

Project HOPE staff collected educational materials on danger signs and care-seeking. Only one, a calendar from Project Concern, was explicitly designed for mothers to use in their homes. The staff photocopied the illustrations of danger signs from the materials and then grouped all the illustrations together by danger sign (for example, rapid breathing). These were used to generate ideas for illustrating particular danger signs.

“No one had any studies or materials on danger signs.

This justified the need to develop this material.”

(Project HOPE/Guatemala)

At the Malawi-based workshop to prepare Malawi and Ghana staff for the MRM process, participants systematically analyzed how much was already known on key research questions. This analysis is found in *Appendix D*. Based on this analysis, project staff in Ghana decided to forego new formative research but then conduct enhanced pretesting of the draft MRMs (by asking about danger sign concepts before showing the materials) to ensure that they had not missed key information from the users. The Malawi workshop agenda is found in *Appendix B*.

Carry Out New Formative Research

Most likely there will be some gaps in the existing documentation. In this case, it is recommended that the principal in-country partners plan and conduct new field research.

To coordinate new research, you should first identify an experienced researcher, from within the organization or a research consultant. A sample job description used in Nicaragua can be found in *Appendix E*. The research teams should comprise staff from your organization and other interested partners. Ideally, the members should have previous experience in using qualitative methods. The teams will likely include four to eight interviewers and note-takers who will need to spend approximately two to four weeks in training, fieldwork and analysis.

STEP

2

Basic Skills Needed for Qualitative Researchers

- ◆ Respect for and willingness to listen to participant groups and learn from them
- ◆ Ability to establish a relationship with community members
- ◆ Natural inclination to ask questions
- ◆ Fluency in the local language and familiarity with the local culture
- ◆ Some technical knowledge of the topic
- ◆ Ability to synthesize what is important and relevant

Prepare a Research Plan and Adapt Question Guides

Most of the research designs used in the nine MRM countries were similar to the one first used in Nicaragua. The focus of the study was on concepts, perceptions, expressions and practices related to danger signs for child illness and their relation to immediate care-seeking. The groups consulted were mothers of young children, their husbands and grandmothers and community health workers.

In Nicaragua, the research methods used were:

- Small group discussions with mothers, fathers and grandmothers of children under two (26 discussions);
- In-depth interviews with mothers at a health facility about current illness episodes of their young children (16 facility interviews);
- In-depth interviews with community health volunteers and TBAs (12 interviews); and
- In-depth interviews with mothers at home concerning the availability and use of educational materials at home (20 interviews).

(English translations of the research guides used in Nicaragua are found in *Appendices F1-F4*.)

When choosing communities for your sample, select four to ten communities that are representative of the entire program area. The sample should encompass an appropriate number of rural and urban communities as well as areas with various degrees of access to a health center or hospital. Study communities should not have an unusual number of special projects operating in the area.

Within the selected communities, criteria for choosing participants should be governed by the decision of what age range of children the MRM will cover. You might want to include a separate quota for mothers of infants under two months to be certain that they are included in the sample. In Nicaragua, group-discussion participants had to have a child less than two years of age, be available and willing to participate and have no other family member participating in research. Mothers in health facilities had to have a child

less than two years of age who had just completed a medical consultation in the facility for an illness covered by IMCI.

Train Interviewers and Organize Field Work

In the MRM countries, the local HOPE offices planned travel, transportation, the schedule for covering the various study communities and arranged for vehicles, drivers and supplies (research guides, pens, tape recorders and tapes, refreshments for participants).

Depending on the interviewers' experience, two or three days of training may be needed for them to review the research objectives and the findings from the existing information, to learn recruitment procedures, research methods and instruments and the schedule. During the training, team members should have an opportunity to practice note-taking and leading group discussions with actual mothers of young children (rather than just role-playing among themselves).

In situations where team members lack research experience, training should last up to five days and cover basic qualitative skills, including:

- creating an atmosphere in which participants feel their opinions will not be judged
- not asking leading questions
- not reacting positively or negatively to participants' responses
- clarifying answers
- rephrasing participants' responses

FIELD NOTES

Research Approach

HOPE/Peru staff used a different research method. They conducted 13 case histories of infants who had died in their first month of life (this project focused on neonatal health). Researchers interviewed the mothers and other household members, neighbors and friends, formal and informal health personnel and local leaders to form a portrait of how the infant's health deteriorated, how people felt and what they did and why. These in-depth case histories yielded interesting information on community perceptions and practices, the strong impact of traditional medicine, the role of traditional healers and birth attendants, danger signs, access to information, care at health facilities and the influence of family members.

- polling group participants
- contrasting opinions within a group
- asking probing questions to understand more clearly and understand why
- encouraging all members of a group to participate and none to dominate

The guides for the group discussions should be constructed to facilitate use of such skills.

Tape-recording the group discussions is optional, particularly if the note-takers are experienced. Recordings can, however, serve as a back-up in case the research notes are incomplete or unclear. In the field, participants should always be asked to agree to be taped before the recorder is used. If discussions or interviews are to be recorded, researchers should practice this during their training.

Carry Out Field Work

The first step in the selected communities is to meet with community leaders to explain the purpose and methods of the research and to request their approval for carrying out interviewing in the community. Recruitment procedures may vary according to the nature of your organization's existing community programs. In Nicaragua, recruitment was assisted by the local HOPE staff working with the community health workers (*brigadistas*) and TBAs. They organized community meetings to recruit and inform people about the need for certain types of participants for group discussions. While random house-to-house recruitment would have been preferred, the method used was the most practical given the time constraints.

Group Discussions

Each group discussion needs a facilitator and a note-taker. At the beginning, the facilitator should

explain the purposes and themes of the discussion, as well as the purpose of the tape-recorder and should ask the group's permission to use it. After all of the participants have introduced themselves and told the group about their children, the facilitator can lead a discussion on the following topics:

- Illnesses of greatest concern in children under five (the facilitator may want to ask specific questions about newborns)
- Types/classifications of illnesses
- Signs and symptoms of each illness
- Care-seeking patterns for each illness
- Reactions to the IMCI (doctor-defined) danger signs
- Attitudes towards children's illnesses (fatalism, etc.)
- Roles of fathers and grandmothers in care-seeking

In Nicaragua, the research team decided that it was too time-consuming to cover all 16 IMCI danger signs in each discussion, so each discussion covered only four or five of the IMCI signs. This required a higher total sample size, so that enough people discussed each sign.

Interviews on Current Illness Episodes

You may also interview mothers with sick children at a hospital or health center. The focus of these interviews is on learning what the mothers noticed, thought, felt, and did during the current illness episode. The main topics to be covered are:

- Recognition of the illness
- Recognition of danger signs (severity)
- The decision to seek help outside of the home
- The action of taking the child to the health facility

Interviews

Interviews with community-based workers and volunteers can be conducted covering the following topics:

- Their role in promoting community health: their educational activities, use of educational materials, counseling mothers, their perceptions of why mothers seek their help and why they refer children to health facilities
- Their opinion on danger signs: their knowledge of danger signs in newborns and other children under five years, their perceptions of mothers' knowledge of danger signs, perceptions of the obstacles to appropriate care-seeking practices
- Their opinions on the MRM: what materials they consider most appropriate for mothers, their own preferences for materials

Home interviews on educational materials

The topics to be covered are:

- Presence of educational and decorative materials
- Location of the materials
- Content of the materials
- Where obtained
- Reasons why mothers look at it/use it
- Aspects of the material that they most like or dislike
- Opinions and preferences regarding educational materials

FIELD NOTES

Formative Research

- ◆ The research was somewhat complicated, above all the coordination with the local PVOs, transportation and then the analysis of information...It was very useful that the study confirmed previous beliefs about the theme. *(Ecuador)*
- ◆ It was not easy to speak about danger signs in the communities, since people were not familiar with these terms. We needed extra time in order to obtain the desired results. Most mothers did not know danger signs and didn't seek health services immediately because they need permission from their spouse or mother-in-law... *(Peru)*

3 Analyze, Summarize and Use the Findings

THE CHALLENGE

To pull out key information from research and use these findings to improve the design and effectiveness of the MRM.

During analysis, the research team sorts and discusses the information they have learned from all the respondents, looking for similarities and differences among participant groups (mothers and fathers, mothers of older children and newborns, rural and urban mothers) and extracting the key findings regarding the main research questions. The final step is deciding what the implications of the key findings are for the program, or in this case, for designing, using and supporting the MRM.

Analysis can be one of the most difficult tasks in qualitative research. However, it does not have to be so daunting if the entire research team is clear about the main research questions, if investigators take good notes and are able to highlight the information of key interest and if the amount of information is manageable (the number of interviews and discussions is not too large).

Analyze Findings

After conducting each group discussion or interview, the researchers should either highlight or summarize the findings—ideally the same day, while the information is fresh. They can do this with a highlighting marker in the notes or in the margin of the page. An alternative is to develop a one-page summary format for each interview or discussion. The researchers can write key summary information and quotes onto these sheets for use during analysis sessions. The sheets can easily be shuffled, so that, for example, the team can look at responses of all fathers to a question or the response from rural sites and compare and contrast the responses.

KEY ACTIONS

- ♦ Analyze research findings
- ♦ Summarize key findings
- ♦ Discuss implications for MRM and support activities
- ♦ Prepare report on conclusions and recommendations
- ♦ Get additional input from mothers to help develop concepts (optional)

RESULTS

- ♦ A final research report that provides effective guidance on the content and format for an effective MRM
- ♦ Enhanced skills among staff for analyzing and assessing the implications of the findings of new research

TIME

No more than a week for analysis and a week for report writing

Ideally, all of the field researchers should participate in the analysis sessions, which may take a few days. The group needs to examine findings for each major research question by: (1) respondent group (mothers of infants under two months old, mothers of infants 3 to 23 months old), and (2) location (rural or urban, rural with good access and rural with difficult access). They also need to examine questions by what was learned via the different research methods to see if different methods provide the same or somewhat different findings. Although group discussions and interviews in health facilities cover the same topics, the discussions do so in a more general way, whereas the individual interviews cover a specific, current episode of illness. Both the household and community health worker interviews should yield information on caretakers' preferences for the design of the material. A short summary of highlights of formative research findings from the MRM countries can be found in *Appendix G*.

The next step is for the research coordinator to summarize the findings and their implications in a clearly written, short report. The research report should describe the background, purposes and methodology of the research. The report should be organized by the key research questions and what the team learned about each question. This is more useful than separately summarizing the research and findings by method used. Not counting the appendices, the research report should not be longer than 30 pages (shorter is preferable). It does not have to cover everything that everyone said—only the things that people said about the key research questions. The research coordinator must decide what is important and be able to pull out important summary statements. While part of the analysis is to look at frequency of responses, the generalizations should go beyond this. The

analysts also need to combine responses from different questions creatively and read between the lines (or words). The research report should provide effective guidance on the content and format for an effective MRM.

Plan and Conduct Concept Testing (optional)

Following the analysis of the formative research, a useful step is to take the project team's ideas about the concepts, vocabulary and drawings back to the field to get mothers' reactions and ideas. In Nicaragua, HOPE staff, the research consultant, a communication consultant and an artist went to the field for a few days to do this. The artist listened to the mothers' ideas about the best ways to show various concepts and modified drawings following the mothers' suggestions. Participants were not recruited using any particular method; typical mothers simply met in a few project communities.

Research Report Outline

Nicaragua

- Background
- Research Objectives
- Methodology
- Analysis of Findings
 - Objective 1: Barriers to Timely Care-Seeking
 - Objective 2: Mothers' Danger Signs
 - Objective 3: Mothers' Reactions to Doctors' Danger Signs
 - Objective 4: Popular Expressions for Danger Signs
 - Objective 5: Mothers' Preferences for the MRM and its Use
- Conclusions
- Recommendations for the MRM

4 Design the MRM

THE CHALLENGE

To design an MRM that communicates key information well, is attractive, useful and does not cost too much.

After reviewing the formative research results, you are now ready to develop the MRM content and design. This step can be complicated and take some time. It is important that all key stakeholders agree on the approach before the design is undertaken.

This section provides some hints on how to design effective communication materials for low-literate audiences and how to use a creative brief, a useful tool to “show” the artist—as well as the partners—what the proposed material should look or sound like, what it should communicate and how.

Print Materials for Low-Literate Populations

Preparing materials for low-literate people requires extra care. People without a formal education have difficulty interpreting images—particularly if they are not familiar with the visual cues used. For example, everyday codes of the visually literate urban resident, such as a stop sign or traffic light, may have absolutely no meaning to a rural person who has never seen traffic signs.

FIELD NOTES

It is not easy to get consensus on the danger signs to include. It is also difficult to decide which popular terms should be grouped together. How to depict the drawings is something that takes time and much effort. It is hard to express a health message in few words or with drawings. (*Project HOPE/Nicaragua*)

KEY ACTIONS

- ♦ Prepare one or more creative briefs
- ♦ Hire an artist
- ♦ Prepare two or more prototype materials
- ♦ Take materials through a technical review

RESULTS

- ♦ Approved creative brief for each prototype (or one, specifying different prototypes within it)
- ♦ Approved prototypes to pretest, produced in sufficient quantities to be pretested (at least one for each interviewer)

TIME

Design and first revision of prototypes should take no more than a month. Further revisions, based on partner comments, could add another month.

Literacy rates are often low in rural settings. Designing materials that convey messages effectively without words is challenging. Developing materials for low-literate, rural populations requires stricter adherence to basic design principles than developing materials that communicate through text as well as images.

Since carrying out a new health behavior in a rural area often means breaking away from an established tradition, individual community members need to be assured that they are not being asked to act alone but rather as part of a group. Print materials can effectively provide a model of how others (neighbors and friends) have already adopted a new health action.

A poster is often the first idea that design teams consider when they think of communication materials for a health intervention. Because they rely on words, posters are not effective for rural, low-literate groups unless they are used to support oral communication and discussion.

Interactive materials encourage exchange between members of the target audience and the material and the health worker (or facilitator). A good action-oriented tool illustrates and clarifies the message.

Qualities of Effective Communication Materials

1. Establish a personality.

Effective communication messages give the material a vivid, appealing personality that helps it stand out from the crowd.

2. Position the material.

Effective communication must make clear how the material fits into the audience's life. It lets the audience focus quickly on whatever specific benefit is being offered.

3. Feature the most compelling benefit.

Effective communication materials address real needs. Messages are specific and single-minded.

4. Break the pattern.

Effective communication materials excite the ear and the eye with a look and sound of their own.

5. Generate trust.

Members of an audience will not try out a behavior they hear about from someone they

do not trust. Effective communication materials, therefore, must not only speak truthfully, they must ring true in every way. Trust is generated by tone, presentation, serious images, credibility and a solid foundation.

6. Appeal to both the heart and the head.

No decision to try something new is made entirely in the mind. Trials are decided partly in the heart. Effective communication materials and messages must invest the message with real emotional value consistent with the product's personality.

7. Material responds to communication strategy.

Be sure to check that whatever is produced maintains focus, is directed to your target audience, deals with the defined health problem and addresses the feasible behaviors.

Source: *HealthCom Communication Tool Box, 1995*

Formats considered in various MRM countries included:

- a baby book
- a monthly calendar
- a folder for the child health card
- a thick poster with a pouch to hold the health card
- a printed cloth that women would use for dresses or skirts or hang on the wall as decoration
- a thick poster with two side flaps that fold in (provided more room for messages)
- a thick poster with a wheel that reveals different specific messages as it is turned
- a talking reminder material (a few mock-ups were pretested in Nicaragua, but due to long lead time and high cost, this idea was put on hold)

Attractive elements that were used in some of the MRM materials included a clock, a mirror, a calendar and a place to put a photo of their child.

There is an important interplay between the design of the material and the number of messages. For example, a baby book or a monthly calendar (Guatemala) can contain a number of messages on danger signs and care-seeking, home care and prevention. However, a poster or printed cloth should accommodate only a few key messages on danger signs and care-seeking.

Major Design Decisions

You need to make seven major design decisions:

1. **Format**—what shape, form, material, size the MRM should be.
2. **What danger signs to include**—what words and language to use to describe them.

FIELD NOTES

Designing Materials

In Nicaragua the formative research showed that the MRM should contain few words and use the caretakers' expressions. Rather than "danger signs," it would simply refer to the need for immediate action if your child had any of the conditions listed or illustrated on the material.

It was agreed that the material needed to illustrate and emphasize the urgency of immediate care-seeking and the designers were encouraged to find a popular saying that would support this concept. It would also use relatively few illustrations or photos since space was limited and it was not felt that every danger sign had to be illustrated given that most people could not correctly interpret illustrations of danger signs unless they could read.

It became obvious from both the formative research and concept testing in Nicaragua how important it was for the material to be thoroughly explained to families when they received their copy. It also seemed like a good idea to encourage parents who cannot read to ask friends and relatives (including children) to read the text to them occasionally.

In Nicaragua, it was decided to produce a material that hangs on the wall, partly to keep it out of reach of children and partly so it might be easily noticed.

The Nicaragua project team agreed that the material should be distinct, appealing, memorable and should contain elements that would make people want to look at it daily, to make it more interactive. Four ideas for such "attractive" elements were considered.

3. **The care-seeking message related to the danger signs**—what to do if your child has one of these signs and how quickly to do it.
4. **The overall message to be used**—this is the overarching message of the material. It can be the care-seeking message or it could have more of a focus on the result of appropriate care-seeking, such as “a healthy family is a happy family.”
5. **Additional attractive elements**—what should be included to make the MRM more useful, looked at more frequently and more interactive.
6. **Partner logos**—it is important to include logos of all the key partners. However, for overall usability of the material, they should be kept as small as possible, preferably at the bottom of the material.
7. **Layout**—this should specify how all of the elements work together. For example, should the overall message be at the top and the calendar at the bottom? Should the health center be in the middle with all the danger signs around it?

FIELD NOTES

Material Design

- ◆ After the formative research, we tabulated and analyzed the results and held a workshop to define materials with NGOs. The people in the materials represented different cultural groups in the country. The material showed the practices described by the mom with visual details. Efforts were made to combine many messages in a visual manner. *(Ecuador)*
- ◆ After the pretest, the artist, technical staff members and MOH and population representatives discussed how the material should be designed as well as its format and contents. Producers also gave their technical input. *(Malawi)*
- ◆ Most interviewees, as well as local health staff and the inter-institutional IEC group, suggested a calendar for danger signs for under 2 year olds that could focus on relevant danger signs in each season, so we decided on a calendar with multiple pages. *(Guatemala)*
- ◆ Formative research identified preferences and needs on the content and form of the material. We decided on a large poster to be hung in the house. Also, since a safe place to keep health documents was needed, we added the pouch on the bottom part of the material. *(Peru)*
- ◆ We started with experience from other countries and had a meeting with various NGOs and institutions to discuss working together. From this meeting came the idea of a clock to make the material more attractive and useful. Moms said that a clock could be useful in their house and could be related to the idea of “not losing time, not waiting too long to seek care.”
- ◆ This design process took a while—it was hard to integrate the 16 IMCI practices in a material. It was very intense work and took a long time to prepare the graphic messages and words as simply and clearly as possible. It would have been much easier and faster if we had only focused on the danger signs. Eventually we decided to eliminate the preventive messages and focus only on the danger signs. *(Dominican Republic)*

It's a good idea to develop two to three different prototypes to pretest with mothers in order to get an idea which might be most effective. There are two ways to do this:

- Two or three different formats that contain the same design elements/layout.
- Same format, with different design elements/layout.

If you want to test both different formats and different layouts, you should develop four prototypes—two with the same format, but different layouts and two with a different format and different layouts.

Once you have an idea about the elements for each prototype, the next steps are to:

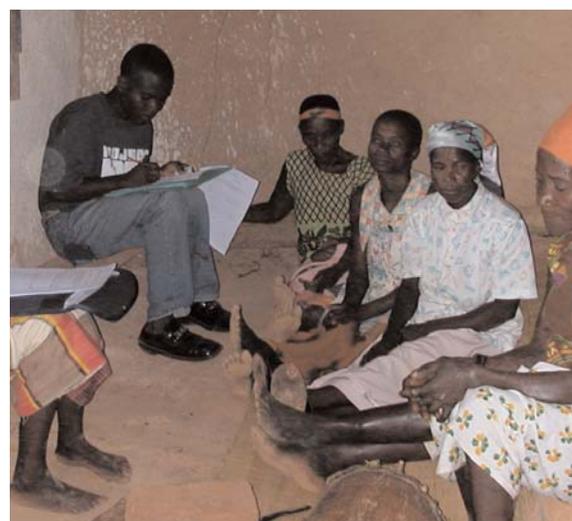
- Describe them in a creative brief
- Get approval of key stakeholders
- Hire a designer to develop the draft of two or three prototype materials

Prepare a Creative Brief

A creative brief can serve as a useful bridge between the formative research for the MRM and the design of the material. This is a short, clear statement about the upcoming material based on previously known information and new research findings: who the audience is and what their concerns are, what the MRM's objectives are, how it is expected to achieve these, what it should look like, what it should say and how it should be used. All key partners should be given an opportunity to comment on the creative brief and then agree to the final version. The brief helps assure that all relevant individuals and partner organizations are "on the same page" before beginning the process of developing the material.

The creative brief should be prepared jointly by the research director and research team and the key people preparing the content and format of the material. You need to identify a person experienced in material design from within your own organization or one of the partner organizations. If no one is available, you should hire a consultant to design one or more versions of the MRM and work with you to manage the production. Once it is finalized, the creative brief will show the artist who is designing the material what they need to do.

Once you have a creative brief, you can start developing the material. For a list of basic principles for designing print materials, see *Appendix H*.



Staff from Project HOPE/Mozambique getting feedback from mothers

Elements of a Creative Brief

- ♦ **Background**
What is the background of this activity? Why are you doing it?
- ♦ **Target Audiences**
Whom do you want to reach with your communication? Be specific. Do you need to reach both mothers and fathers? What are their important socio-economic, cultural, educational, life-style and psychological characteristics? Others?
- ♦ **Objectives**
What do you want your target audience to do after they hear, watch or experience this communication?
- ♦ **Obstacles**
What beliefs, cultural practices and misinformation stand between your audience and the desired objectives?
- ♦ **Key Benefit**
Select a benefit that the audience will experience if your audience does what you would like it to do. (In the case of the MRM, the benefit from the organization's viewpoint is that children who might otherwise die will be saved by their parents' timely actions. However, this may not be the benefit that the communication should use to motivate parents to action. That should be gleaned from the parents themselves via the formative research.)
- ♦ **Support Statements/Reasons Why**
These are the reasons why the key benefit outweighs the obstacles and reasons why what the MRM is promoting is beneficial.
- ♦ **Tone**
What feeling should the communication have? Should it be authoritative, light or emotional? Are you appealing to parents to avoid the guilt of not acting in time; to become well-informed so that they can take needed actions; to carry out their responsibilities as "good parents"; to do their job so the health personnel can do theirs?
- ♦ **Format**
What should the MRM look like (based on audience preferences, requirements for communicating the agreed-upon information, feasibility of production and cost, sustainability)? Should it be a print or audio material? Should it have many words or few? Should it use photos or drawings and in what style? Where will families keep, store or hang it? What design elements will make it so attractive that people will want to look at or listen to it frequently?
- ♦ **Creative Considerations**
Is there anything else the creative people should know? What language or languages? What type of people should be represented in photos or drawings?

5 Pretest the MRM

THE CHALLENGE

To learn how to improve the MRM by getting feedback and suggestions from users.

Before finalizing the MRM, you need to find out what works and what doesn't. Pretesting refers to learning or discovering the reaction of your target audience to one or more draft materials (prototypes) prior to producing and distributing the materials. Pretesting helps identify strengths and weaknesses of a material and can help make it more effective. It can also provide information to help you decide which MRM prototypes are more likely to be preferred and used by mothers.

Good pretesting is essential for developing effective communication materials because it:

- Refines the message and increases the odds of developing a successful material
- Ensures that the audience understands the message
- Reveals potential problems (acceptability of expressions, images, etc.) before the material is produced
- Involves local people in the program development process
- May increase the understanding of the importance of the activity with those involved in the pretesting.

Too often, programs either do not pretest or do a "quick and dirty" pretest that gives little useful feedback. Reasons given for not pretesting include: lack of time or money; the false confidence of technical people who feel that they "know their audiences"; and the false confidence of creative people about their design. Don't accept these excuses!

Pretesting can save time and money and lower the risk that the materials will offend or give misunderstood advice to the target

KEY ACTIONS

- ◆ Hire a pretesting coordinator and team
- ◆ Outline a pretesting plan and budget
- ◆ Adapt question guides
- ◆ Plan and make logistical arrangements
- ◆ Train the team
- ◆ Carry out fieldwork
- ◆ Prepare a report on findings and recommendations for finalizing the MRM

RESULTS

- ◆ Research report, including recommendations for: format, danger signs, images, text and layout
- ◆ Decision on format
- ◆ Directions for designer to make revisions to MRM
- ◆ Enhanced skills among staff for planning, conducting and analyzing pretesting research
- ◆ Participant group input into the MRM

TIME

Once the pretest is designed and the lead researcher is hired (1-2 weeks), it should take about 3-4 weeks to train the interviewers, conduct the fieldwork and complete the analysis

audience. It cannot guarantee success, but it can help reduce some of the uncertainty and risk of producing materials that may be misunderstood or misinterpreted. The more changes needed to be made to the material based on the pretesting results, the more successful the pretesting process.

Pretesting provides information on the following five aspects of a material:

1. Comprehension

Do people understand what the material is trying to say? Is the message as clear as it needs to be in order to be understood? Which illustrations and vocabulary were understood and which weren't? How well does each image depict its relevant text? Which prototype is most clearly understood?

2. Acceptability/Believability

Is there anything in the message that is offensive? Is there anything that people perceive to be false and unrealistic? Is there any element that might irritate the audience? Which prototype is the most acceptable and believable and why?

3. Personal Relevance

Does the target audience perceive that this material is talking to them or to "others"?

4. Attraction

Is the message interesting enough to attract and hold the attention of the target group? Do people like it? What elements do they like and dislike? Which prototype attracts the most attention and is best liked?

5. Persuasion

Does the message convince the target audience to do the suggested action? Which prototype might best convince them?

If done carefully, pretesting should tell planners not only how well target groups "like" a proposed communication material and feel that it is culturally appropriate but also how well the material communicates the messages and the likelihood that the communication will stimulate the desired actions.

First identify an experienced qualitative researcher, with good skills in analyzing research—possibly the same person who coordinated the formative research. See *Appendix E* for a sample job description and qualifications for the lead research consultant for pretesting.

The research teams should include staff from your organization and other interested partners. Most of the team members should have previous experience doing qualitative research interviewing. The decision on the number of interviewers depends on the sample size per site and number of sites. If, for example, there are two teams and six sites with six families and two community health workers per site, you'd probably need two interviewers per team. This way each team could finish one site per day and fieldwork would take a total of two days. This would require two vehicles.

Prepare a Research Plan

Participants in the Pretest

The main requirement for selecting respondents for pretesting the MRM is that they are members

of the target audience. For example, if the target audience is households with at least one child under five years of age, make sure that each household you include has at least one child under five years of age. Rather than just limiting the interviews to mothers, Nicaragua also included fathers and grandmothers in the pretest discussions. Because all of these people will be using the MRM in the home and may be involved in the care-seeking decision-making process, consider including them in the research.

Since the MRM could be used as an educational aid by community health workers or volunteers, and, in some cases, facility-level health workers, it is important to pretest the prototypes with some members of these groups as well.

Method

There are different ways to conduct materials pretesting. Many programs pretest by conducting focus groups or by asking individual people (often several hundred) a limited number of questions about a material (a material may take many forms—for example, a radio or TV spot, a poster, a play or song) and analyzing the results quantitatively. These approaches are appropriate for certain types of materials (focus groups are often more efficient if you need to play a radio or TV material). While quantitative pretesting with a small number of questions is effective for determining how well your material is understood, it is less helpful for indicating exactly what details need to be changed.

For an MRM with a relatively large amount of information, a more qualitative in-depth individual interview approach is recommended: more open-ended questions asked to fewer members of the target audiences.

If the MRM is to be used as a counseling aid, it should be pretested first as a static piece and then used for counseling. Both the counselors and persons counseled should be asked about their reactions to the material and to the experience of counseling or being counseled with it.

The following describes a relatively simple, low-cost research method.

The interviewer:

- Goes to places where people similar to the target audience live or congregate
- Screens potential respondents to make sure they meet the criteria for the target audience
- Shows one prototype:
 - ◆ asks overall appeal questions
 - ◆ asks questions about the care-seeking image (central image, such as parents going to the health center)
 - ◆ asks questions about each text piece for the care-seeking image (reads it if the respondent doesn't read)
 - ◆ asks how well the image interprets the text
 - ◆ asks questions about the generic message image (such as a healthy family), if there is one
 - ◆ asks questions about the text for the generic message image (reads it if the respondent doesn't read)
 - ◆ asks how well the image interprets the text
 - ◆ asks questions about the danger sign images, one at a time
 - ◆ asks questions about each text piece for each danger sign image (immediately after seeing that image—reads it if the respondent doesn't read)
 - ◆ asks how well the image illustrates the text

- ◆ gets feedback on the additional elements (such as a mirror, calendar, or clock), such as how often people would be likely to use them
- ◆ gets feedback on the format—size, shape, material—and overall layout
- Asks for any suggestions for improvements
- Shows second prototype and asks comparative questions between the two as well as reasons. The answers to these questions can be very helpful in deciding which format to continue with. To reduce order bias, it's important to rotate the order in which the prototypes are shown: in the first interview, the interviewer would show MRM A first, and the second interview would start with MRM B. Sample pretest questionnaires for family members can be found in *Appendix I*.

Interviewing health workers should follow the same basic approach. For community health workers, the same questions could be asked. For facility-based health workers however, the pretest questions should be modified and much shorter. Sample pretest questionnaires for facility-based health workers can be found in *Appendices 12 and 13*.

Sample Size and Selection

The more diverse the communities in the program area are, the more communities you need to include. However, in general, we recommend keeping the sample size limited. If you ask detailed questions, you can learn a lot from feedback on an image from as few as 20 to 30 people. For example, if you want to know what parents of children under two months think as well as those with children from two months to five years, you will have to interview parents with children in both age groups. Because of the

number of images to review and the amount of time it takes to ask the questions, sometimes it is better to have each person look at all the images and text and only half of the danger signs. You would need to interview twice as many people, since only half would look at any given danger sign.

For health workers or community health workers, the sample can be even smaller. Results from interviewing 10 to 15 of either group would provide useful complementary information to that of the parents and family members.

You will also need to decide how you will select your sample. How many interviews will you do at each of how many different sites? It is recommended that you go to at least one to two sites in each district (if this is a national program, at least one to two sites in three diverse districts). Ideally, you should do pretesting in the home. This will give you an opportunity to include other family members in the discussion and get a good idea where the respondents might place the material. If your timing or budget does not allow household visits, you could pretest at a central location like a health facility or a market place. In either case, you will need to develop screening criteria as well as take steps that favor a random sample. For example, interview every fifth house or third mother leaving a well child clinic.

Train Interviewers, Organize and Carry Out Fieldwork

Prior to going to the field, the lead researcher should spend one to two days to train the interview team on how to use the question guides and how to select the participants. If possible, practice with actual respondents should be conducted during the training to provide

interviewers a real experience. The lead researcher can also provide feedback to the interviewers.

If possible, the designer should observe some of the pretest interviews to understand how people talk about elements that work and do not work. Whether or not this happens, it is important for the designer to understand that the objective of the pretest is not to criticize design elements but to make sure that the material communicates most effectively to the community.

It is important to inform and get the approval of all appropriate authorities regarding the pretesting research—before the research begins.

Analyze, Summarize and Use Findings

Following pretesting, the information should be analyzed to provide guidance on what revisions are needed to make the MRM more acceptable, attractive, understandable, persuasive or personally relevant to the target audience. However, deciding what detailed changes to make to the MRM—on the basis of feedback from pretesting—is not always straightforward.

For example:

- People in many places find it unpleasant to see sick, unhappy children or old people, yet these might be essential aspects of the messages.
- People from different ethnic groups or even villages may want people dressed just the way they dress. This is not feasible, but clothing in the illustrations needs to be acceptable to everyone even if it is not exactly what people wear.
- Pretesting should help confirm or change previous decisions on how many regional versions of materials to make with different languages and illustrations. Programs can rarely

FIELD NOTES

Pretesting Approaches

The pretest sample in Nicaragua included 18 mothers (plus the father and grandmother, if available), 18 health workers, and 12 CHWs/TBAs in six communities in two health districts (two in each were rural and one peri-urban). They were asked about two prototypes. At the end of each interview, the respondent was asked briefly about the second design and which design he or she preferred. The messages and illustrations on each design were very similar.

In Peru, the MRM was pretested using focus groups of seven to ten mothers from 15 different communities.

In Malawi, the MRM prototypes were pretested by seven mothers with children under two months, 21 mothers with children aged 2-59 months, seven Health Surveillance Assistants and seven facility health workers.

In Ghana, the MRM prototypes were pretested with 50 caretakers, mostly mothers with children under five years and 15 health workers.

manage more than three versions. Produce the minimum number, as long as the images and words are acceptable and understandable to audiences.

- Respondents in pretests commonly want to see the life represented that they aspire to, not the life that most actually lead. They may prefer to see nicer furniture, sanitary systems, household appliances and utensils than they actually have. Again, some compromise is likely to be needed, perhaps leaning towards people's desired, rather than actual lifestyle.
- Pretests need to be certain to get feedback on any drawings of different parts of people's

bodies to be certain they are understood and not offensive. The scale of drawings or photos on the same page or material also need to be carefully tested for comprehension.

- In many places, audiences do not like aspects of drawings that make them more realistic, such as shadows or wrinkles. The creative and program people must work together to reach reasonable compromises between preferences and realism, creativity and clear communication.
- When analyzing findings, it's important to separate out results by different target groups. For example, if you are interviewing both families of newborns and families of older children, you should analyze results separately. It is important to keep the health worker opinions separate from the household opinions.

Base decisions on what to change on information from the households rather than from health workers if they differ. For example, health workers sometimes think that it does not matter if the mothers do not understand an image or text—since the health worker will explain it. However, families are the primary target audience so if they do not understand something, it would be more effective to try to make it easier for them to understand.

If significant changes are made to the material following the pretest, the revised material should be taken back to the field (in different sites) for a quick “re-pretest” to confirm that the changes are well understood and accepted.

Applying Findings from the Pretest

Pretest finding	Change required in the MRM
Some people do not understand certain words	Change vocabulary to use words they understand and use daily
Some people are offended by a word or phrase	Change vocabulary to use an inoffensive word or phrase
Some people are confused by an image	Try to make the drawing clearer
Some people feel that the MRM is meant for other people and not for them	Review your choice of vocabulary and depictions of the people to make them more appropriate.
Some people don't like the way one of the people looks in the images	Revise the drawing
Some people do not understand what the MRM is asking them to do	Make the vocabulary simpler and clearer. Make sure the urgency message is clear

6 Finalize and Produce the MRM

THE CHALLENGE

To secure final approvals, translate feedback from pretesting and produce an effective product.

Now you are ready to finalize and produce the MRM. You should work closely with the design consultant to make sure the changes (based on the pretest results) are made in the material. Before producing, you should ensure that all necessary approvals have been secured.

In order to select the producer, you will need to get bids from several different production houses. It's important to work closely with the selected producer to ensure the quality of the material. Most of these activities covered only several districts of the country. If higher quantities were produced, unit costs would have been lower.

Develop Specifications and Select a Printer

It is advisable to have someone familiar with materials production, possibly someone from the MOH or another project, to assist in writing specifications and getting bids for the production of the MRM. Solicit production bids from two to four companies that have produced similar materials. The request for bids should be in writing, should ask for samples of similar products and client references and should contain as detailed a list of specifications as possible. See *Appendix J* for an example of a request for a bid.

Specifications need to be developed to include in a written request for bids.

- If the MRM is printed, select an appropriate stock (weight, thickness) and quality of paper. Slightly glossy paper is better than non-glossy for showing photos, but too glossy paper is hard to look at in bright light. Also, if something heavy is to be attached to the material, make sure that the paper is heavy enough to support it.

KEY ACTIONS

- ◆ Identify potential companies to produce the MRM
- ◆ Determine your production budget
- ◆ Prepare a request for proposal to produce the MRM
- ◆ Select a company and sign a contract
- ◆ Coordinate with the company during the production process

RESULTS

- ◆ MRM produced
- ◆ Experience managing the production process

TIME

Revisions to material (based on pretest results), including approvals should take no more than a month. Production could add another month.

- Specify paper size. Using standard size paper can save money.
- Describe other physical characteristics of the material (degree of plastification, colors and other elements such as a calendar or mirror to be included).
- Determine the quantity of each material to be produced. Produce as many copies as you anticipate needing in the next year plus an extra 50 to 100 copies. Base the estimate on actual planned use; for example, numbers of health workers who will be using it, health centers displaying it, mothers receiving copies or institutions requesting samples. The extra 50 to 100 copies are needed to respond to requests for samples of the material from within your organization and also from donors, evaluators, trainers and representatives of other institutions.
- Printing more copies costs less per copy than printing fewer copies, although savings become minimal after reaching a certain number. You may need to make a compromise on the attributes of your MRM in order to be able to afford producing sufficient copies.

When you receive the bids and are making a decision on which producer to use, besides considering price and promised delivery date, always review materials that each company has produced and check with recent clients about quality, timeliness and staying within the budget.

Once a producer has been selected, an agreement (contract) should be prepared and include:

- A precise description of the physical characteristics of the material (size, paper weight, degree of plastification, colors, other elements)
- Number of copies to produce

- Price for the work
- Payment terms
- Production schedule and completion date
- Price for corrections that are not the fault of the firm
- Any special work that the firm will provide

Supervise Production

Supervising production can be demanding. The following guidelines will help keep the process under control.

1. Ensure that the final version is correct before giving it to the printer.
2. Meet with the person handling the job and “walk” through every aspect of the material—page by page, illustration by illustration.
3. Explain that these materials have already been pretested and approved and the printer’s responsibility is to produce the materials and not change or adapt them.
4. Review the blueline and check that pages are in the proper order and the text, illustrations and photographs are clear.
5. Arrange to observe the press run and check that the colors are correct and the paper is the quality agreed upon.

A production checklist that can be used to facilitate the production process is located in *Appendix K*.

7 Distribute and Provide Orientation on the MRM

THE CHALLENGE

To ensure that the MRMs reach appropriate families and are explained to them.

Once the MRMs are produced, they need to get out to the families. It is important to make sure they are distributed to the appropriate families in an organized way and by people who will explain the messages to them. A training and distribution plan should be developed as well as written guidelines for the distributors to orient families on how to use the materials.

Plan Distribution

With key partners, the MRM manager needs to make decisions about:

- Which districts, communities and health facilities will get MRMs (See *Appendix L* for a sample distribution plan.)
- What families should receive copies: families with children under two or five years of age or pregnant women
- Who will distribute them
- How and when to train the distributors to distribute and keep records
- The schedule for distribution

Health workers or volunteers who will provide orientation to families on the MRM should receive copies during their training and then take copies back to their communities or facility. They should leave the training with a clear idea of how and when they will distribute and explain the MRM to families. A one to three page guide with illustrations should be developed for health staff or volunteers to use in explaining the MRM to families. Training should include role-playing about orienting families on the MRM. The guide can be used as a

KEY ACTIONS

- ◆ Prepare a distribution plan including resources required
- ◆ Plan training component for people distributing the MRM
- ◆ Adapt orientation guidelines
- ◆ Adapt forms for monitoring distribution of the MRM
- ◆ Train the distributors
- ◆ Manage and supervise the distribution and orientation

RESULTS

- ◆ MRMs distributed and records of everyone who received MRM
- ◆ Enhanced skills in counseling and orientation for distributors

TIME

Planning for distribution, training, developing the materials and the actual training should take two to four weeks. Distribution timing depends on what distribution method is being used and how many distributors there are.

reminder during the orientation to make sure the distributor covers all the key points. (See *Appendix M* for an example of an MRM orientation guide.)

Each distributor should receive enough copies of the MRM for all families with a child under two (or under five, depending on the project) plus a certain number of extra copies (perhaps 10 percent extra to give to families with a new baby or families that move into the community). Before the training, each distributor should find out how many families meet the criteria in their communities. If there are not enough copies for all families with children of the priority ages, families with younger children should be the priority.

After dividing up copies for each distributor, the remaining copies should be stored at the project or MOH office at the district or project level.

Ideally, distributors will be community-based workers who normally visit homes as part of their work. During these visits, they can deliver the MRM and explain and discuss it with the mother and, if possible, with other family members. Being able to include other family members is a main benefit of home distribution.

In Peru, MRMs are distributed during community meetings. If there is not a cadre of community-based workers that can distribute the MRM house-to-house or through community meetings, the material should be distributed (and orientation given) at health facilities. Mothers might be given the material during prenatal, well-baby, growth-promotion sessions (Ghana is using this approach), or during sick child visits.

Regardless of where and how the materials are distributed, the project should develop a method for distributors to record which families receive a

“We didn’t prepare a formal presentation to orient mothers, but realized that just giving out the materials was not enough and decided it was necessary to think of some guidelines.”

(Project HOPE/Peru)

copy of the MRM and when. This might be a community map or a listing of families. In the future it will be important to know which families received MRMs for monitoring of MRM use. See an example of a distribution recording form in *Appendix N*.

Suggested Steps for Distributing an MRM to a Family

- ◆ Explain the purpose of this material and how it is intended to be used.
- ◆ Go over the entire material, illustrations and text, with the family, either reading the text or having a family member do so.
- ◆ Ask questions to confirm that the family understands everything in the material.
- ◆ Ask if the family has any questions.
- ◆ Discuss where the family will put the material and when and how often they will consult it.
- ◆ Discuss what the family would do in case of a child illness emergency: what health facility would they go to, how they would get there, who would decide, where they would get any needed money; and
- ◆ If possible, look at the child's health card and immunization record and discuss any needed actions by the family.

Train Distributors

Ideally, it will be possible to take advantage of some already-planned occasion, meeting or training to orient the distributors on how to hand out and explain the MRM as well as record who received them. A minimum of a half day is needed for this training but a full day is preferable.

The following general training content is suggested, but country programs should feel free to modify it:

- Explain the background and purpose of the MRM.
- Briefly review the country's IMCI plans and status. Invite questions and discussion.

FIELD NOTES

Distribution and Orientation of MRM Materials

- ◆ **Ecuador:** The MRM was distributed to families who came to educational meetings at one of the NGOs. Each recipient completed a form with their name, the number of children under five, address, name of the caretaker and number of hours of "education" they received.
- ◆ **Nicaragua:** Health staff distributed some MRMs during home visits or during visits to the health center. Community health workers also distributed materials to the communities. This took two months. The distribution guidelines facilitated the process, but not all the distributors used the guide—some gave the guide to friends or family to do the job.
- ◆ **Malawi:** The MRM was distributed at health facilities during under-five clinics and door-to-door in estate compounds and villages. Distribution was time consuming and because it was the rainy season and roads were bad, it was hard to do door-to-door distribution. There were individual and group discussions of materials at health centers.
- ◆ **Uzbekistan:** The materials were distributed through SVP—primary health care centers staffed with general practitioners and midlevel providers—with the assistance of nurses and through maternity houses. Nurses and midwives gave health talks to mothers of children under five.
- ◆ **Guatemala:** Local health workers, who visit 20 families per month, gave out the MRM and explained the material. Every month they visit families and review the messages on the next month's page. They have instructions and a short message list to follow.
- ◆ **Peru:** Distribution was through support groups for breastfeeding, in meetings, education sessions and communal meetings. In more distant areas, MOH mobile brigades distributed materials. Beforehand, there was a directive signed by the regional director to explain the purpose and mode of distribution.
- ◆ **Dominican Republic:** Distribution was done by collaborating organizations in their communities.

STEP 7

- Explain the importance of appropriate care-seeking to improving child health. Ask participants to brainstorm about barriers to appropriate care-seeking.
- Explain how the MRM is intended to address two of the barriers: not knowing when urgent care is needed and not being motivated to seek care immediately without delay.
- Briefly describe the formative research and pretesting, the major findings and how these contributed to the design for the material. Focus on the fact that the material attempts to meld the families' concepts and vocabulary with those of the health system.
- Explain other elements of the material, such as a mirror or calendar, to make the material more useful and something people will look at regularly.
- Describe what is expected of the distributors during home visits.
- Explain how each action is best done.
- Distribute, read and review the distribution guidelines.
- Practice all of these tasks in role plays using copies of the MRM.
- Review record-keeping material and instructions.
- Discuss other tasks related to MRM: storage, possible participation in monitoring, etc.
- Invite questions and discussion.

FIELD NOTES

Training for Distributors

In order to achieve better acceptability and management of the material, we trained 34 technical staff from the 14 different partner organizations responsible for distribution and orienting the community on how to use the MRM. (Ecuador)



Staff from Project HOPE/Peru explaining MRM to mothers



Staff from Project HOPE/Mozambique listening to fathers

8 Monitor and Evaluate the MRM

THE CHALLENGE

To systematically assess families' use of the material and then use findings to enhance the MRMs' effectiveness.

As a complement to careful planning, program activities should be assessed, adjusted and improved as needed. Monitoring means getting feedback on program activities (in this case, distribution and use of MRMs) and then using that information to make adjustments to improve the program. Monitoring may be ongoing or done periodically through special studies. Evaluation usually occurs well after the program has begun or as it is ending. It usually employs quantitative methods.

Monitor

Approximately three months after the distributors have delivered the MRMs to families and oriented them on their use, a monitoring study should be carried out in three to six representative communities. On the basis of the study, partner organizations should decide if any changes are needed in the material or in the way it is used. The monitoring study may cover such questions as the following.

With families:

- Was the MRM distributed as planned? Do families still have their copies?
- Is the MRM kept in the intended locations in homes where it was distributed?
- What is the condition of the material?
- How often do people use or consult it? Why do they use or consult it?
- How well do people understand the information?

KEY ACTIONS

- ◆ Prepare a monitoring plan and question guides
- ◆ Monitor the MRM and its impact
- ◆ Make adjustments based on monitoring findings
- ◆ Prepare an evaluation plan and question guides
- ◆ Carry out the evaluation
- ◆ Use the findings to improve the current MRM activities and their expansion or modification

RESULTS

- ◆ A report that provides the basis for decisions to modify the material or the way it is being used or supported
- ◆ Enhanced staff skills for planning, conducting, analyzing and using the findings

TIME

For monitoring, two weeks for planning and preparation, no more than a week in the field, no more than two weeks for analysis and report-writing. Planning and preparation for the first evaluation study may take longer than two weeks but will be shorter if the survey is repeated. Fieldwork may take two weeks and data entry and analysis are likely to take several weeks.

STEP 8

- How often have families actually used it for guidance on a child health problem? Was it consulted every time a young child was sick, and if not, why not?
- How satisfied are families with the advice? How useful was it?
- How many parents took a child with a danger sign to a health facility? If not, why not? What happened (transport, availability of care/medicine, satisfaction with care)?
- What people outside of the family have they shared the MRM with or talked to about it?
- Do they have any suggestions for improvement?

With distributors:

- How easy or difficult was the distribution of the MRMs and orientation of families and why?
- How easy or difficult was it to store MRMs and why?
- How easy or difficult was it to keep records on the distribution and why?
- What do they think the MRM's impact has been? Have more people come for advice on danger signs? Have people asked them to explain the MRM messages?
- Do they have any suggestions for improvement?

With facility-based health workers:

- What differences have they noticed in utilization of their services for child illness?
- How many caretakers say the MRM influenced their care-seeking decision?
- Are more mothers bringing their child for appropriate reasons (danger signs)?
- Are more mothers bringing their child before it is too late to help?

- Have they made any changes in services to make them more acceptable (more medicines, better patient flow, improved information to caretakers)?

The monitoring findings should be used to revise the design and content of the MRM, as well as the manner in which it is distributed, explained, used or reinforced. If additional copies of the MRM are to be produced, other organizations that may be interested in using the material should be invited to a discussion of the proposed changes. Responsibilities for funding, distribution and training on the revised MRM should be clarified. Partners should also understand the recommendation that the MRM be used only in communities that have reasonable access to health services of an acceptable quality.

Monitoring Results in Nicaragua

One to three months after distribution, Project HOPE interviewed 76 mothers in two of the three health districts where the MRM (with a mirror, calendar and place for the child's photo) had been distributed.

- ◆ Almost all mothers had hung the material on a wall.
- ◆ Almost all understood its basic purpose and the need for urgent care-seeking in response to danger signs.
- ◆ Many looked at the calendar and mirror regularly.
- ◆ Few mothers had placed a photo of their child in the space intended for this.
- ◆ Some materials had already started to deteriorate, particularly the attachment of the calendar and mirror.
- ◆ The great majority whose child had been sick stated that they had consulted the material and almost all claimed to have gone quickly to a health facility.

Evaluate

Special funding allowed some MRM countries to evaluate the material. Where possible, evaluation of an MRM should be integrated into broader program evaluations, because formal evaluation requires a larger and more carefully selected sample and is more expensive. Ideally, an implementing organization may take advantage of another evaluation to add a small number of questions that address changes in knowledge, attitudes, perceptions and actions related to use of the MRM.

The MRM, or the larger program it is part of, should be evaluated six months or more after the materials have been distributed. This time frame is important to assess the longer-term impact of the material after the initial curiosity and interest among families has had time to settle. The wait also allows a better assessment of the material's physical durability and allows time for families, communities and health services to address transportation, quality of service and other issues that may inhibit improved care-seeking for child health emergencies.

Basic evaluation designs include:

- Baseline and evaluation surveys with or without “control” families or communities
- An evaluation survey without a baseline with or without “control” families or communities
- Qualitative evaluation via focus group discussions or in-depth interviews

Interviewing families who did not receive an MRM in the MRM-distribution communities would indicate whether the MRM messages spread within communities. Interviewing families in neighboring communities would indicate whether MRM messages spread beyond the communities where the materials were distributed.

Interviewing families in similar but distant communities would allow the program to compare families unaffected by the MRM with families who received copies and orientation.

Evaluations should include interviews with the staff of health facilities on patterns of service utilization. Are more children being brought in earlier and for appropriate danger signs? If health facilities are willing, health workers may ask caretakers who bring in sick children a few questions to try to assess the impact of the MRM in their care-seeking decision.

Which evaluation design a particular program selects depends on available time, budget and expertise, as well as the evaluation objectives and if the MRM is integrated into a larger program.

Nicaragua

Because Nicaragua was the first MRM country, Project HOPE headquarters encouraged the program to plan and conduct a focused evaluation to learn lessons that might be useful both in-country and in the other MRM countries.

The Nicaragua evaluation, conducted six months after the MRMs had been distributed, consisted of interviews with 49 mothers in health facilities, 100 mothers who had received MRMs, 96 mothers (the control group) who had not received MRMs (in similar but different communities), 14 community health workers (distributors) and 14 facility-based health workers.

The study yielded many interesting findings, including:

- Virtually all of the MRMs had been distributed to appropriate families.
- Mothers with MRMs recognized more danger signs than mothers without MRMs.

- There was no significant difference in timing of care-seeking between the two groups of mothers.
- Care-seeking was not as immediate as hoped due to parents waiting for the child to improve, lack of money, distance of the health facility and other known barriers.
- Mothers found it difficult to assess the gravity of signs.
- Community health volunteers' association with the MRM gave them increased credibility.
- In a small number of cases, materials had started to deteriorate or mothers did not display them.
- Illiterate mothers were less likely to consult and clearly understand the material.
- Signs of pneumonia were much more likely to motivate care-seeking than signs of diarrhea or dehydration because many mothers felt they could handle diarrhea at home with extra fluids.

See *Appendix O* for more information on the methodology used in the Nicaragua evaluation.

Peru

Project HOPE/Peru evaluated its MRM as part of a larger child survival project evaluation in rural communities of the isolated jungle region where it works. The evaluation was conducted using qualitative and quantitative methods with mothers, community volunteers and health staff and in communities that did and did not receive the material. As in Nicaragua, the evaluation's basic finding was that the MRM was making a positive contribution towards timely danger sign recognition but that many barriers remained to appropriate care-seeking.

Some specific findings were:

- The material was making a good contribution to danger sign recognition but other barriers to

improve care-seeking for child emergencies remained.

- Other important factors inhibiting more timely care-seeking are strong folk beliefs in the area and significant problems in access to and quality of services including provider communication with clients.
- The MRM is reinforcing information on danger signs given in health talks in communities and health facilities.
- Distribution, particularly through the health system, was not complete several months after it had begun and some mothers were not well oriented on the material.
- Mothers suggested a stronger material that would not warp and that had larger drawings.

General Findings

Feedback from country staff and available information from monitoring and evaluation studies indicate that:

- The process used to develop MRMs was a feasible and effective one.
- The MRM is a useful tool but not a magic bullet. Programs need to take additional complementary actions before they can expect a measurable impact on child survival itself. Therefore, the MRM should be included as part of a larger strategy for improving the health of young children.

Appendices

- A. Mother Reminder Materials—Samples From Nine Countries
- B. MRM Workshop Agenda
- C. Menu of Topics for Mothers Reminder Materials
- D. Research Gaps in Existing Data
- E. Job Description and Qualifications for the Research Consultant
- F. Research Instruments from Nicaragua
- G. Research Findings
- H. Basic Principles for Designing Print Materials
- I. Pretesting Guides
- J. Sample Request for Bid
- K. Production Checklist
- L. Distribution Plan for the MRM
- M. Guidelines for Explaining the Reminder Material to Families
- N. Register for Distribution of the MRM
- O. Methodology Used in the Nicaragua MRM Evaluation

MRM Materials

Dominican Republic

This reminder material has a built-in clock to encourage families to look at it frequently. The clock was suggested by mothers. The clock links up with the advice that mothers should not “lose time” in taking their child to the health center if they notice any of these danger signs.

Programa de Materiales Recordatorios

RECORDATORIO PARA LAS MADRES

ALERTA... Cuando su niño(a) presente cualquiera de estas señales de peligro llévelo URGENTEMENTE al Centro de Salud

Fiebre alta
Ataque o convulsiones

No puede mamar bien
Respira con dificultad o forzado
Está aletado y decaído

Centro de Salud

Hace pupú con sangre
Tiene diarrea abundante

Vomita todo
No quiere comer

DOMINICAN REPUBLIC

Sto. Dgo. Mayo - 2003

INSTITUCIONES PARTICIPANTES

- SESPAS • OPS / OMS • Clínica Orden de Malta
- Cruz Roja Dominicana • Tu Mujer • IDDI • Servicio Social de Iglesias
- Asoc. Mujeres en Acción "Madre Cándida"

Ecuador

This reminder material encourages families to seek help immediately if they recognize any of these danger signs. In addition, the material offers advice on how to keep children healthy. Drawings of typical families were used to make the material more attractive to families. The detailed messages are all together in the lower left corner.

! Qué debe hacer para que su niño o niña no se enferme y no muera !

RECOMENDACIONES PARA TENER NIÑAS Y NIÑOS SANOS

1. - La lactancia es importante para el buen desarrollo del niño y la niña.
2. - Las vacunas previenen enfermedades que pueden ser muy graves.
3. - Las medidas de higiene evitan el riesgo de enfermarse y morir.
4. - La alimentación debe cubrirse por lo menos frutas, verduras, granos, carnes.
5. - Si el niño o niña se enferma, debe consultarse con el médico, farmacéutico o recibir el apoyo de la familia.

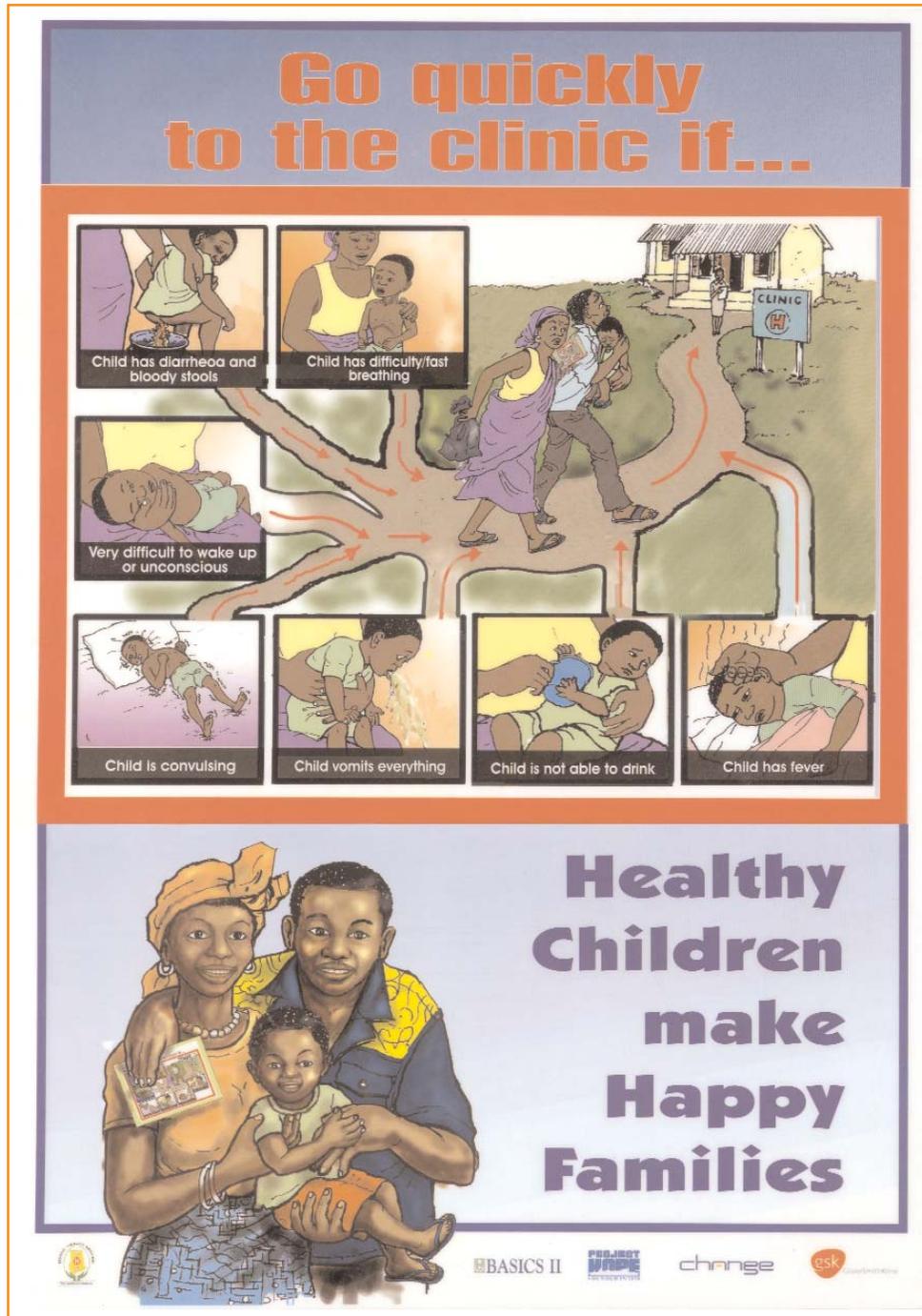
EL NIÑO O NIÑA ESTÁ EN PELIGRO DE MUERTE SI:

6. - Presencia de sangre muy alta que no se pueda controlar.
7. - Tiene diarrea con sangre y no quiere beber líquidos.
8. - Tiene dificultad para respirar y el pecho se abulta por encima.
9. - Tiene convulsiones o se desmaya.

! SI EL NIÑO O NIÑA TIENE UNO DE ESTOS PROBLEMAS.....BUSQUE AYUDA INMEDIATAMENTE!

Ghana

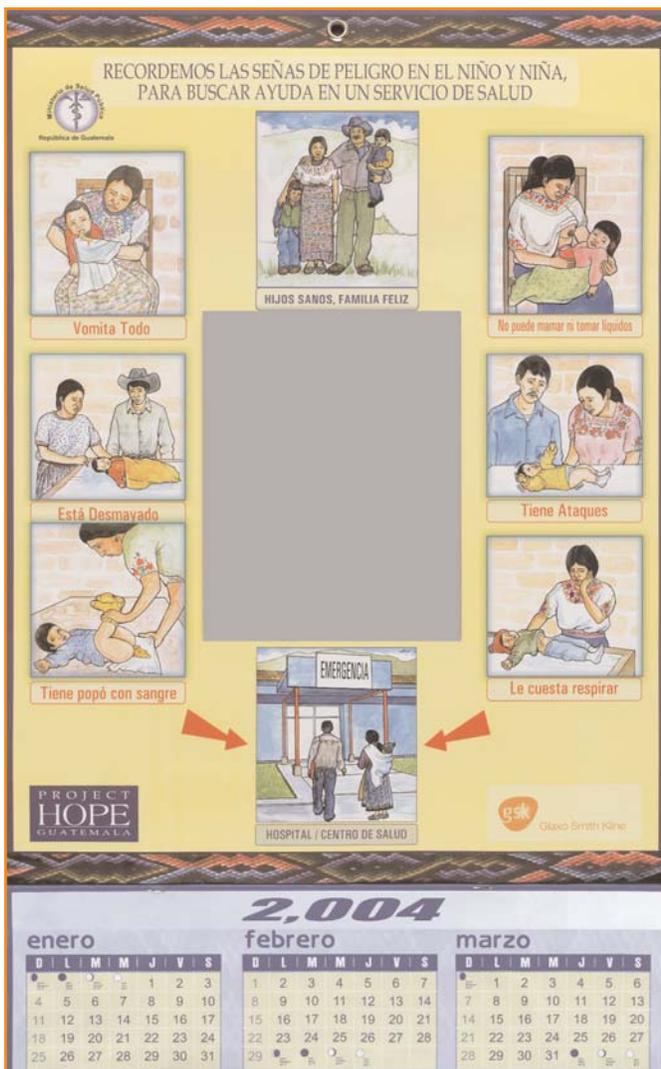
This reminder material has a pouch where families can keep child health and immunization cards. A slogan “Go quickly to the clinic if...” is displayed prominently to motivate families to visit the clinic if their child has one of the danger signs. A positive outcome is displayed by the picture and message about the happy family.



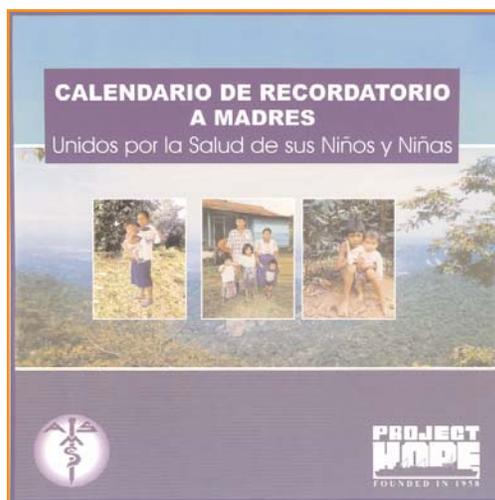
Pouch →

Guatemala

This material highlights several danger signs and encourages families to visit the health center when a child has any of the danger signs. If the child is taken to the health center, the family should remain healthy and happy, like the family at the top of the material. A mirror and a calendar encourage families to look at the material often.



This calendar, also from Project HOPE in Guatemala, reminds mothers how to keep their children healthy. The calendar also provides space for detailed information on danger signs. Each month focuses on a specific health problem often prevalent during the particular month.



Malawi

This is another example where a mirror and calendar are used to increase the use and visibility of the reminder material. Multiple years are included in tear-off pages so the calendar can be used for several years.

KALENDALA YA 2002-2005

✧ Kutsekula Chimbudzi Chamagazi
 ✧ Kuchepa kwa madzi mthupi
 ✧ Kutentha thupi
 ✧ Kusanza zonse
 ✧ Kukomoka
 ✧ Kukanika kumwa
 ✧ Kukana kuyamwa
 ✧ Kufooka kwambiri
 ✧ Kutsokomola, kupuma mofulumira ndi kulowa m'chifuwa

Tiplite ndi ana ku Chipatala mwamsanga tikaona zizindikiro zoopsazi

CALENDAR 2002							CALENDAR 2002						
November							December						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2	1	2	3	4	5	6	7
3	4	5	6	7	8	9	8	9	10	11	12	13	14
10	11	12	13	14	15	16	15	16	17	18	19	20	21
17	18	19	20	21	22	23	22	23	24	25	26	27	28
24	25	26	27	28	29	30	29	30	31				

esk GlaxoSmithKline
 PROJECT PRIDE
 BASICS II
 change

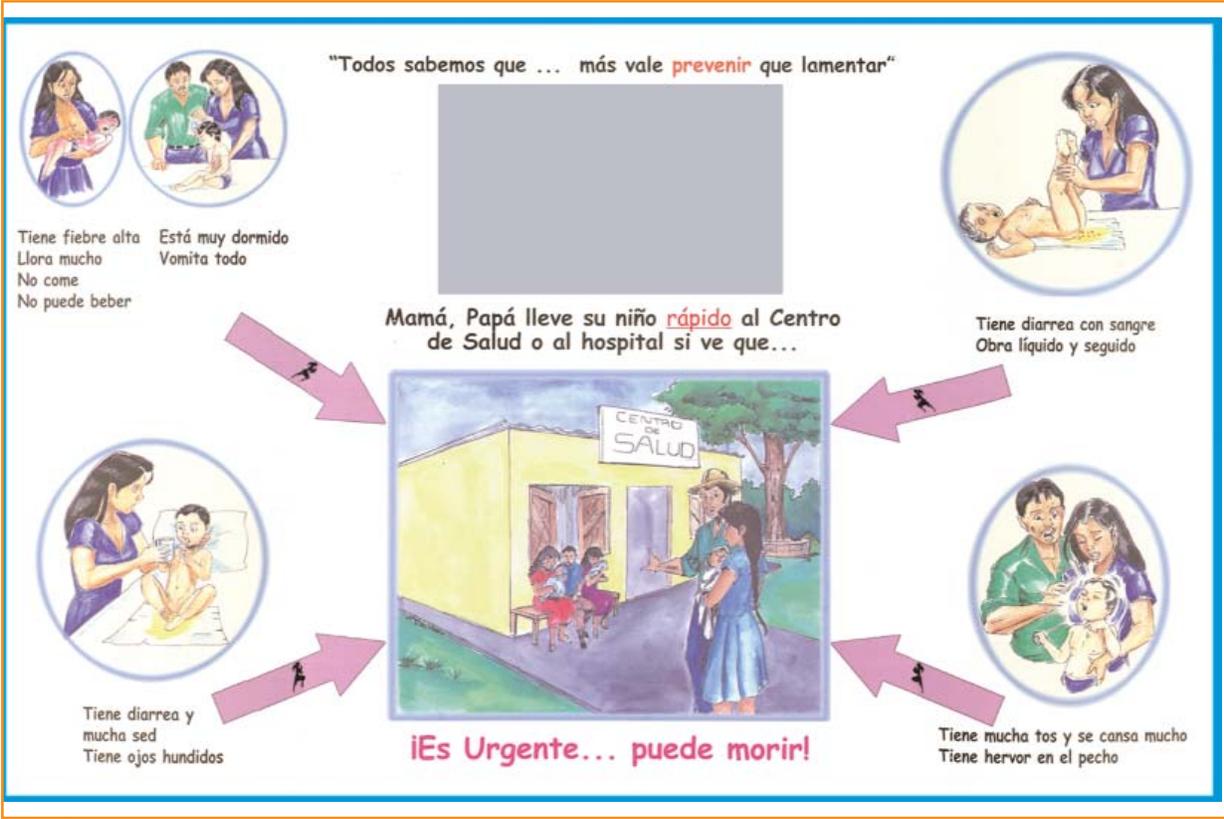
Mozambique

This reminder tool is a large booklet for community health volunteers to use with mothers. The booklet is appropriate for the local context, since few mothers can read.



Nicaragua

This was the first mothers reminder tool developed. The idea of using a mirror and a multi-year calendar was introduced and later replicated in many countries. A unique feature of this reminder material is the image of the baby in the top left. This space is left blank so families can put a picture of their own child there.



Peru

This reminder material also has a pocket where families can keep their child health and vaccination cards. This poster concentrates on neonatal health, the focus of the project in Peru.



Uzbekistan

This material is for families to hang in their homes and shows the danger signs to encourage them to visit the health clinic.



This poster designed for use in health facilities shows good practices for keeping children healthy.



MRM Workshop Agenda

Malawi, April 2001 (for Malawian and Ghanaian participants)

Workshop Objectives

1. To learn about the importance of care-seeking within the context of IMCI, and how the MRM can assist in prompting disease recognition, severity, and care-seeking.
2. Plan a national level stakeholder meeting to garner consensus and avoid duplication of efforts.
3. Develop research plan and adapt questionnaires for additional research needs for each country.
4. Develop plan for materials development, pretesting, and production for the MRM in each country.
5. Discuss strategies for dissemination of material, related training, monitoring, and evaluation.

Materials needed

Overhead projector, overhead paper, writing pens, power point apparatus, large flip chart paper, markers, notebooks, pens, photocopy machine

DAY 1 Total=7 hours, not including lunch and breaks

Topics	Methods	Estimated time
Workshop Opening	Presentation, questions and discussion	10 minutes
Welcome Objectives/agenda	Prepare teams/revise guidelines	10 minutes
Plans and logistics		10 minutes
Ice-breaker/Introductions	Participatory ice-breaker	20 minutes
Child survival programs in Malawi and Ghana; IMCI plans and status in the 2 countries	Presentation from Malawi;	20 minutes
	Questions and discussion	10 minutes
	Presentation from Ghana;	20 minutes
	Questions and discussion	10 minutes
Achilles' heel of IMCI? Challenge of appropriate care-seeking for childhood illness	Presentation of study findings	30 minutes
	Synopsis of information from Nicaragua research on reasons for delayed or no care-seeking	10 minutes
	Discussion of available information from Malawi and Ghana regarding care-seeking patterns;	10 minutes
	Questions and discussion	10 minutes
The global MRM initiative	Introduction to MRM Initiative; status	10 minutes
	Questions and discussion	15 minutes

Topics	Methods	Estimated time
Overview of MRM development process	Review of major steps in MRM development and draft MRM guidelines	15 minutes
	Questions and discussion	10 minutes
Key MRM concepts	Presentation and discussion	30 minutes
Coordination with stakeholders	Brief presentation on objectives, organization	10 minutes
	Questions/discussion	20 minutes
Stakeholders' meetings	Break into country groups to discuss stakeholders meetings	10 minutes
	Malawi to finalize plans, handouts, etc.	30 minutes
	Ghana to make basic plans: who, when, where, how organized	20 minutes
	Meet in plenary to report out and discuss	10 minutes
Review of existing information	Presentation of main research questions	10 minutes
	Presentation of findings before Nicaragua research	10 minutes
	Questions and discussion	10 minutes
Key research questions for Malawi and Ghana	Joint discussions of extent to which known information answers the questions for each country	40 minutes

DAY 2 Total = 5 hours, 45 minutes, not including lunch and breaks

Feedback on Day	Collect comments, feedback, suggestions on workshop	10 minutes
New formative research needed	Presentation of research plans and basic findings from Nicaragua on danger signs and materials	30 minutes
	Questions and discussion of how research should vary from this model in Malawi and Ghana	30 minutes
Plan new formative research—approach	Break into country groups to plan: research team, methods, sample size & characteristics, study communities, method of informing communities, recruiting, schedule and logistics, plans for training team, analysis and reporting	90 minutes
Plan new formative research—approach	Country presentations	20 minutes
	Questions and discussion	10 minutes
	Country presentations	20 minutes
	Questions and discussion	10 minutes
Plan new formative research— instruments	Break into country groups to draft question guides [adapt Nicaragua guides]	120 minutes
Feedback on guidelines	Discussion/notation of needed changes to guidelines	5 minutes

DAY 3 Total = 6 hours, 30 minutes, not including lunch and breaks

Topics	Methods	Estimated time
Feedback on Day 2	Collect comments, feedback, suggestions on workshop	10 minutes
Plan new formative research	Exchange and read other team's guides	30 minutes
	Give feedback and suggestions, decide on revisions	50 minutes
Review of existing country materials (educational, manuals) on child health danger signs	Country presentation	20 minutes
	Questions and discussion	20 minutes
	Country presentation	20 minutes
	Questions and discussion	20 minutes
Considerations for design of MRM	Each country group asked to interpret materials in local languages from other country	20 minutes
	Discussion of cost, literacy levels, concepts, vocabulary, durability, attractiveness, visibility, memorability, identification, drawings vs. photos, healthy children vs. sick children, information vs. motivation, etc.	20 minutes
	Brainstorming on alternative materials; discussion of special challenge in designing materials for illiterates	20 minutes
Creative Brief	Presentation of creative brief	10 minutes
	Discussion	5 minutes
Plan the design process	Discussion on in-house and external resources likely to be needed in each country	20 minutes
Pretesting	Presentation on principles, methods used in Nicaragua	20 minutes
	Questions and discussion	10 minutes
Pretesting planning	Selection of one existing material from each country to pretest; break into country groups to plan pretesting of that material: teams, recruitment, sample, guides (adapt Nicaragua approach/protocol)	90 minutes
Feedback on Guidelines	Discussion/notation of needed changes to guidelines	5 minutes

DAY 4 Total = 6 hours, 30 minutes not including lunch and breaks

Topics	Methods	Estimated time
Feedback on Day 3	Collect comments, feedback, suggestions on workshop	15 minutes
Pretesting	Presentation of pretest plans	15 minutes
	Each country team role-plays two pretest interviews	60 minutes
	Questions and discussion, including the art of interpreting pretest results	15 minutes
Materials production	Brief presentation of considerations (cost, quantity, size) discussion of how likely to be done in each country	30 minutes
Orientation of health workers and volunteers	Joint discussion of how this is best done in Malawi and Ghana	40 minutes
Monitoring and evaluation	Joint discussion of how M&E likely to be done in Malawi and Ghana	40 minutes
MRM guidelines	Discussion of MRM guidelines, where they should be changed and how	30 minutes
Develop country schedules	Break into country groups to review and revise country schedule, based on times and resources available, etc.	40 minutes
	Present schedules to plenary	15 + 15 minutes
	Discuss	15 minutes
Finalize plans for Stakeholders Meeting	Determine specific roles/responsibilities for the stakeholders meeting	30 minutes
Feedback on workshop, clarifications of next steps	Discussion, including scheduling any desired follow-up meetings	30 minutes

Menu of Topics for Mothers Reminder Materials

Neonatal: (birth up to 2 months)

Immediate Newborn Care

- Immediate breastfeeding/colostrum
- Breastfeeding on-demand
- Exclusive breastfeeding
- Keep infant warm

Prevention of Infection/Home Management

- Keep cord clean/covered/dry
- Return for well-child and well-mother visits
- Follow provider care instructions
- Immunization—BCG/OPV1/Hep B (depending on country protocols)
- Hygiene at home: hand washing
- Continue breastfeeding
- Good breastfeeding technique
- Use of bed nets/mosquito nets (where applicable)

Reasons to Seek Care

- Convulsions
- Fever—unusually warm/cold skin (cool feet)
- Fast or difficult or unusual breathing
- Not feeding or breastfeeding (feeds less frequently than every 3 or 4 hours)
- Umbilical redness and/or pus discharge and/or foul smell
- Diarrhea
- Unconscious/lethargic/less than normal movement
- Has difficulty sucking
- Excessive limp or stiff body
- Skin infections—boils, raw, red skin and pus
- Vomits more than three times a day
- Excessive, ongoing crying

Children: 2 months up to 5 years

Prevention

- Immunization coverage
- Exclusive breastfeeding on-demand up to 4 to 6 months
- Appropriate complementary/solid feeding by (4 to) 6 months (frequency, food density, variety, amounts)
- Participate in well-child visits
- Vitamin A supplementation, where in effect, every 6 months
- Iron supplementation (if available)
- Basic hygiene practices—hand washing, safely dispose of feces
- Use of bed nets/mosquito nets (where applicable)
- Use clean water for cooking, drinking
- Increase feeding/breastfeeding during and after disease episodes (smaller/more frequent)
- Follow provider care instructions; use up all medication, even after child seems better

Home Management

- Increase liquids during disease episodes
- ORT during diarrhea/dehydration
- Use local remedies to soothe cough/sore throats
- If condition worsens, seek care

Reasons to Seek Care

- Not able to drink or breastfeed/feed
- Vomits everything
- Convulsions
- Fast or difficult breathing
- Diarrhea (14+ days, blood in stool)
- Restless/irritable/crying/fussy
- Dehydration/sunken eyes/local signs of dehydration (e.g., extreme thirst, drying out, no urination)
- High fever/extended fever for more than 3 days; hot body
- Lethargic or unconscious, very tired, listless, sleepy
- Stops playing/lacks energy/other unusual behavior
- Stiff neck with fever
- Rash + fever + cold symptoms (depends on country's measles policy; some may not want contagious children brought to health services; may spread disease).
- Not growing; has stopped growing or very low weight (where growth monitored)
- Cold extremities (arms or legs)

Research Gaps in Existing Data

How existing information answers principal research questions, and what are data gaps in Malawi and Ghana

Question	Kasungu, Malawi	Mulanje, Malawi	Ghana
What are mothers attitudes regarding management of common and potentially serious illnesses? What factors lead to delays in care-seeking?	<ul style="list-style-type: none"> Some information Attitudes— recognition of seriousness, illness vs. normal, home management of common illnesses 	<ul style="list-style-type: none"> Some information Attitudes— recognition of seriousness, illness vs. normal, home management of common illnesses 	<ul style="list-style-type: none"> A lot overall, but may vary in certain BASICS districts to almost nothing
What are mother's and families' perceptions of danger signs that should stimulate immediate care-seeking? What local phrases and expressions do they use to describe them?	<ul style="list-style-type: none"> Some information Phrases/expressions (villages vs. tea estates) 	<ul style="list-style-type: none"> Some information Phrases/expressions 	<ul style="list-style-type: none"> A lot No gaps
How much do mothers understand and believe in medically defined danger signs?	<ul style="list-style-type: none"> Almost nothing 	<ul style="list-style-type: none"> Some information Understanding and beliefs (why) 	<ul style="list-style-type: none"> Some information Understanding OK but no information on beliefs
What words and phrases for danger signs do mothers understand and will best motivate them to appropriate careseeking?	<ul style="list-style-type: none"> Some information How to motivate mothers 	<ul style="list-style-type: none"> Almost nothing 	<ul style="list-style-type: none"> Some information How to motivate mothers
What is the best type of educational material to serve as the MRM as well as the best distribution mechanism?	<ul style="list-style-type: none"> Some information Good ideas on type of material and distribution, but need preferences of mother 	<ul style="list-style-type: none"> Almost nothing Need preferred material and distribution 	<ul style="list-style-type: none"> Almost nothing Need preferred material and distribution

Job Description and Qualifications for the Research Consultant (Nicaragua)

Phase 1: Formative Research

Estimated time: 25-30 days

1. Identify, review, and analyze existing information to assess what is known about mothers' concepts of danger signs, care-seeking patterns and reasons for them, home-care practices, key preventive practices, and lessons on the best formats and ways of using take-home materials.
2. Supplement the review of documents by scheduling and carrying out key informant interviews with anthropologists, public health experts, and other health researchers.
3. Help design a small qualitative study on the questions of interest, using small group discussions, in-depth interviews in communities and health facilities, home interviews concerning educational materials, and possibly other qualitative and/or participatory methods.
4. Adapt the suggested research methods and question guides as appropriate to the key research questions and capabilities of the team members.
5. Help plan the training of the research teams.
6. Train the research teams, and, with them, pretest the instruments and revise them as necessary.
7. Work with the coordinating organization to plan logistical support for field-work.
8. Conduct some of the interviews, and supervise the research teams in the field.
9. Organize and oversee the preliminary analysis of findings with other members of the research teams. Work with selected members of the research teams and project staff to finalize the findings and their implications for the design of the MRM and supportive activities.
10. Write a report on the formative research.

Phase 2: Design and manage pretesting of the MRM

Estimated time: 20 days

1. Help design and plan pretesting of alternative formats, messages, and design elements for MRMs.
2. Adapt the suggested research methods and question guides as appropriate.
3. Help plan the training of the research teams.
4. Train the research teams, and, with them, pretest the instruments.
5. Work with the coordinating organization to plan logistical support for field-work.
6. Conduct some of the interviews, and supervise the research teams in the field.
7. Organize and oversee the preliminary analysis of findings with other members of the research teams. Work with selected members of the research teams and project staff to finalize the findings and their implications for the design of the MRM and actions to support its effective use in the field.
8. Write a report on the pretesting.

Requirements

- University degree in social sciences, anthropology, sociology or related fields.
- Proven experience in the design, conduct, and analysis of qualitative research involving poor rural mothers, particularly with regard to child health.
- Proven experience in training and supervising field research teams.
- Ability to speak one or more local languages in which interviews will be conducted is highly desirable.

Research Instruments (Nicaragua)

F1: Discussion Guide for Group Discussions with Mothers, Fathers, and Grandmothers of Children under 2 years old (to be slightly modified for each group)

Concept	Basic Questions	Probing (Follow-up) Questions
Introduction	<p>Explain the purpose of the discussion, that there are no “correct” answers, the time it will last, that we would like to record the discussion only so the researchers can listen to clarify something in their notes, and that refreshments will be served.</p> <p>Ask each participant to describe her/his family, particularly the youngest child.</p>	
Symptoms and diseases of most concern from the mothers’ viewpoint	<p>What are the most serious health problems that affect children in this community?</p> <p>Are there other important health problems that affect children? [repeat as many times as necessary to generate a list]</p> <p>[Write/draw a list of the problems. Once the list is complete, explore each problem with the group.]</p>	<p>For each problem, please tell me what you think about the causes, how serious it is, and who it affects most</p> <p>In your opinion, what is the best treatment [for each problem]?</p> <p>Tell me if your child has suffered [from each problem] recently. If so:</p> <ul style="list-style-type: none"> ■ What happened? ■ What did you do? ■ Who decided to seek outside care ■ Why did you decide to seek care? <p>The last time your child had [the problem] what did you notice?</p>
Mothers’ own (classifications)	<p>How do you know if your child has [say each problem mentioned previously]?</p> <p>What signs or symptoms do you see?</p>	<p>How did you decide that it was [the problem]?</p> <p>How can you distinguish [the problem] from other illnesses or health problems?</p>

Concept	Basic Questions	Probing (Follow-up) Questions
Mothers' (emic) signs and symptoms	<p>If your child under 2 is sick, what things do you notice that make you think that you need to take the child right away for medical care?</p> <p>[Write/draw a list of these signs.]</p>	<p>Anything else?</p> <p>For each sign/symptom:</p> <ul style="list-style-type: none"> ■ What exactly do you note/see in the child? ■ When does this symptom become dangerous? ■ What illness or problem usually causes this sign/symptom? ■ What other symptoms would you probably see at the same time? <p>[Ask the participants to score these symptoms by how serious they are.]</p>
Care-seeking based on mothers' signs and symptoms	<p>For each sign or symptom, where or from whom would you seek care or help? First, second, third...</p>	<p>If not mentioned, ask about when they:</p> <ul style="list-style-type: none"> ■ Take the child to a traditional healer, herbalist, traditional midwife, or other traditional provider ■ Take the child to a doctor or nurse ■ Call a provider to make a home visit ■ Go to a pharmacy, market or store to buy medicine ■ Treat the child at home and wait to see what happens
IMCI danger signs	<p>Now, I'm going to mention and ask some questions about some signs and symptoms that doctors think are important.</p> <p>[For each sign, first use the IMCI terminology, then explain the concept and ask what words the participants use to describe it.]</p> <p>Note: Discuss as many signs as reasonable in each discussion. Start the next discussion where you left off in the list of signs.</p>	<p>For each sign or symptom that I mention, please tell me if your child has this symptom, how worried are you about it?</p> <p>In your opinion, what are the possible causes of this symptom?</p> <p>Do you believe that this problem is more of a problem in newborns or in children more than 2 months old?</p> <p>Do you think that if you see this symptom you should take your child for care outside of your home?</p> <p>[If yes] where? Is it important to take the child immediately, or can you wait to see if the child starts to get better? If you wait, for how long?</p>

Concept	Basic Questions	Probing (Follow-up) Questions
		<p>[If no] what would you do then?</p> <p>Of all the signs that have been mentioned, which do you consider the most dangerous, and why?</p> <p>Has your child had this sign?</p> <p>[If yes] what did you do and why? What happened?</p> <p>What is the best type of medical care for this symptom? Why?</p> <p>What signs do parents usually take their children to a health facility for care?</p> <p>Why do some parents not do this?</p> <p>What obstacles do they commonly have to overcome to do this? What others?</p> <p>If not mentioned, ask about: cost, time/other responsibilities and activities, the need for permission and/or money from the father, difficult travel, lack of friendly treatment at the facility, lack of respect there for cultural traditions, limited service hours or lack of medicine, lack of confidence in the services.</p>
<p>Traditions of remaining in the home for the first 40 days</p>	<p>Please tell me about the special period for mothers and newborns in the period right after birth.</p>	<p>How long after the birth do mothers normally try to stay at home?</p> <p>How long after the birth does the child normally stay in the home?</p> <p>Are there some circumstances during this period when it's okay for the mother and child to leave the home? What are they?</p> <p>What happens if the newborn (less than a month old) becomes sick?</p> <p>Is it likely that the family would take it outside of the home for care?</p>

Concept	Basic Questions	Probing (Follow-up) Questions
		<p>When do you know that it's necessary to take a newborn outside the home for care?</p> <p>Who is the person most likely to take the newborn outside of the home for care?</p> <p>Is it likely that you would take the baby somewhere in your community or outside to a hospital or health center?</p>
Attitudes towards children being sick	<p>When a child is sick, do you wait to see if he or she will get better or do you start treating the child as soon as you see a problem?</p>	<p>Do you think that illnesses can get better on their own, or do they have a tendency to get worse if you don't do anything? Give examples, please.</p> <p>For serious illnesses of children, do you think that the parents can prevent the child from dying by their actions, or is what happens God's will or the destiny of the child?</p>
<p>[Questions only for fathers and grandmothers]</p> <p>Their role in caring for the child, routinely and when the child is sick</p>	<p>Please tell me about your normal role in caring for the child.</p> <p>What is your role when the child is sick?</p> <p>Also, tell us about how you participate in the decision to seek medical care outside of the home if your child is sick.</p>	<p>Do you take the child to a health center or hospital?</p> <p>Do you go with the mother and child to the health center or hospital?</p> <p>Do you help with the expenses of getting treatment for the child's illness, in giving or in borrowing the money you need?</p>

F2: Question Guide for Interviews at Health Facilities

This guide will need to be formatted and adapted for local use.

Date: _____ Interviewer: _____ Community: _____

Municipality/District: _____

Note: Interview mothers more than 18 years old with a sick baby or young child.

Introduction

Project HOPE, in collaboration with the Ministry of Health, is trying to learn about illnesses that affect young children around here so we can improve health programs. We would like to ask you a few questions if you are willing. Thank you.

What is your name?

How are you related to the child?

What is the child's name?

How old is [child's name]?

Actions at Home

1. How long has [name] been sick?
2. When you were home, what was the first thing that you noticed that made you think [name] was sick?
3. Who was the first person in the family who noticed that [name] was sick?
4. What did you think [name] had at first?
5. Did you give anything or do anything at home for [name]? What did you give or do?
6. Who decided to give or do this for [name]?
7. Why did you decide to do this?
8. What happened then? Did [name] improve or get worse?
9. What other things did you notice about [name's] condition besides what you told me about first?
10. Before coming here, did you consult with anyone or seek help for [name's] illness? Who and what happened?

11. How many days after [name] was first ill did you do this? Why?

12. Of everything you noticed about [name] what worried you the most? Why?

13. Of everything you noticed about [name] what didn't worry you? Why?

Decision to Seek Care at a Health Facility

14. Why did you bring [name] to the hospital [or health center]?

15. How many days after [name] was first ill, did you decide to bring him/her to the hospital [or health center]?

16. Why did you wait this many days before deciding?

17. Who decided that [name] should be brought here?

18. Who brought [name] here?

19. Was it easy or difficult to arrive here? Why?

20. Now that you are here, how does [name] seem to be doing?

21. What disease did they say the child has?

Thank you very much for your help.

F3: Question Guide for Interviews with Community Health Workers

This guide will need to be formatted and adapted for local use.

Date: _____ Interviewer: _____ Community: _____

Municipality/District: _____

Introduction

Project HOPE, in collaboration with the Ministry of Health, is trying to learn about illnesses that affect young children around here so we can improve health programs. We would like to ask you a few questions if you are willing. Thank you.

Type of CHW: Community health volunteer TBA CHV/TBA

Role of CHW in community health promotion

1. Do you do any educational activities with mothers and families in this community? [If yes] could you tell me what you do?
2. Do you use any type of materials to help you teach mother and families about health topics? [If yes] what type of material do you use? Can you show it to me? How do you use it?
3. What activities do you do related to newborn care?
4. What activities or advice do you give to mothers about how to care for babies older than 2 months?
5. Do people in the community come to you for advice when their children are sick? [If yes] what type of advice do you usually give? Can you give me some examples?
6. How often do people ask if they should take their child to a health facility?
7. In what situations do you advise the family to take a newborn to a health facility?
8. In what situations do you advise the family to take a baby over 2 months old to a health facility?

Opinions about Danger Signs

9. Can you tell me some dangerous signs and symptoms of illness for a baby under 2 months old?
10. Can you tell me some dangerous signs and symptoms for a newborn who has diarrhea?
11. Can you tell me some dangerous signs and symptoms for a newborn who has a respiratory problem?
12. Can you tell me some dangerous signs and symptoms for a child more than 2 months old?
13. Can you tell me some dangerous signs and symptoms for a child more than 2 months old who has diarrhea?
14. Can you tell me some dangerous signs and symptoms for a child more than 2 months old who has a respiratory problem?
15. Do you think that mothers and families know the danger signs for a newborn and for children over 2 months old that you have mentioned? Which do they think are important or dangerous? Which do they recognize but do not consider dangerous?

Signs the mothers and families recognize and consider important or dangerous

Signs the mothers and families recognize but do not consider important or dangerous

16. Although a mother recognizes a danger sign in a child, are there obstacles that cause delays in bringing the child for care at a health facility? What are the reasons for delay? Which reason do you consider most important?

Obstacles/reasons why mothers delay in bringing a sick child to a health facility

Opinions on Health Materials

We would like to design a material to help mothers and families remember the dangerous signs and symptoms in a sick child and to urge them to immediately take such a child to a health facility. This material will be given out by health workers in facilities and communities.

17. We would like you to first tell us, based on your experience, what type of material do you think is the most appropriate to give to mothers and families?

18. Now I am going to show you some educational materials. I would like your opinion on these materials, and I'd like you to tell me which you prefer and why, always remembering that they will be given to mothers and families of young children.

Type of Material	Preference (1,2,3...)	Why do you prefer this material?

Thank you very much for your help.

F4: Question Guide for Interviews with Mothers at Home

This guide will need to be formatted and adapted for local use.

Date: _____ Interviewer: _____ Community: _____

Municipality/District: _____ Person Interviewed: _____

Introduction

Project HOPE, in collaboration with the Ministry of Health, is making home visits, because we would like to design some health education materials to help families. For that reason, I would like to ask you a few questions about these materials. Please, can you show me any material that you have here at home that has information or messages about health? (Ask permission to look in each room.)

Material Shown

Material	Materials found in home	Topic(s) included	Where is the material kept? (Note if attached somewhere)	How long have you had this material?	Where did you get it? Who gave it to you?
Poster	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Pamphlet	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Calendar	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Sticker	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Child health card	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Material	When was the last time you read or looked at it?	Why did you read or look at it?	Can you explain a little about what the material says?	a. What do you like about the material—size, color, figures, type of material, utility, size of printing? b. Is there anything you do not like?
Poster			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	
Pamphlet			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	
Calendar			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	
Sticker			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	
Child health card			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	
Other (specify)			<input type="checkbox"/> Explained everything <input type="checkbox"/> Explained some <input type="checkbox"/> Couldn't explain	

Do you know any song, poem, or saying that helps you remember information about health?
 [If yes] can you tell it to me so I can copy it?

We would like to design a material that has health information. What would you like this material to be like?

Type of Material	Characteristics

We would like to design a reminder material to give to mothers and families. The idea is that the material will help you remember danger signs when children are sick and also other important information about child health. We would like the health workers in health facilities and in communities to explain the material when they give it to you. Your opinion will help us a lot to design a good material.

Type of Material	Preference (1,2,3...)	Why do you prefer this material?

Thank you very much for your help.

Research Findings

This appendix summarizes major formative research findings from Nicaragua and compares them with findings in other MRM countries. The Nicaragua findings are bulleted.

- Mothers, fathers, and grandmothers understood and shared most of the doctors' concepts of danger signs, although they referred to them in their own popular vocabulary and expressions. Respondents did not consider a few of the 15 doctors' danger signs to be reasons for concern (dry mouth, not gaining weight, bites and marks on the skin, and unusual thirst). Although a few traditional concepts, such as "empacho," did not correspond to medical concepts, in general there was substantial overlap.

This was not true in all countries. In Africa, there was more disagreement between mothers' and doctors' evaluation, classification, and interpretation of symptoms. Depending on the cause they attributed to symptoms, African mothers tended to classify symptoms as either appropriate or not appropriate for modern health care. Signs related to convulsions, lethargy and refusal to drink were not well known by many mothers in MRM countries. In a few countries, such as Peru and Mozambique, mothers strongly supported traditional explanations and treatments. For example, many of the Peruvian respondents interpreted the babies' health problems as punishment for some major or minor transgression by the mother or father.

- Mothers and families tended to delay care-seeking after they had noted a danger sign, mostly because they wanted to try home

remedies first and wait to see what God willed for their child; the expenses involved; difficulties of travel; limited service hours of facilities; concern that the facility would be out of needed medicines, so that the family itself would have to purchase them; and in some cases, because of less-than-respectful treatment by providers.

These barriers to timely, appropriate care-seeking were very similar in all of the countries. An additional barrier noted in Peru (and likely present in some of the other countries) was the cultural and even linguistic gap between providers and mothers, which contributes to a lack of respect shown to mothers. Research in some countries also found a need for the husbands' or mothers-in-law permission to seek care in a health facility.

- Families in Nicaragua had few print materials. Five of 20 had posters, and 13 had child health cards, but people did not consider these to be "educational." When shown various materials, families' preferences were for a brochure, poster, calendar, or flipchart, the formats with which they were most familiar.

Few if any educational materials were found in homes in the MRM countries.

In addition to revealing important local expressions and vocabulary for illness, the Nicaragua research showed that the main problem was that caretakers tended to delay taking the child because they did not realize the severity of their child's illness. They first

tried home treatment and sought help within the community. Additional barriers to appropriate care-seeking were identified, many related to families' desire to avoid unnecessary cost and to less-than-full confidence in the facilities and the way they would be treated. In many countries, the father has the major role in deciding when to seek outside care, but several other persons may also have a say.

- In Nicaragua, when the researchers showed mothers, fathers and grandmothers existing health education materials, it became evident that many of them could not easily read the text. People who could not read the text could not interpret the drawings or photos correctly. These findings, along with the absence of print materials in people's homes, were of concern.

The partner organizations considered the possibility of developing a "talking material" that used a computer chip. Mock-ups of three such materials, using components available from Radio Shack, were actually tested in the field in December 2000, and in general were very well received. However, these materials could not be developed within the current budget and schedule. Therefore, while the partners hope to investigate audio alternatives, they decided that they should continue to develop the best possible print materials under the MRM initiative.

Basic Principles for Designing Print Materials

Design/Layout

- 1.* Present only one message per illustration, especially on posters, counseling cards, and handouts.
2. Limit the number of concepts and pages on materials.
- 3.* Make the materials interactive whenever possible.
- 4.* Leave plenty of white space. Balance text, illustrations, and white space.
- 5.* Arrange messages in the sequence that is most logical to the audience.
- 6.* Use illustrations to help explain the text. In some materials, especially for non-literate viewers, illustrations carry most the weight.

Illustrations

- 7.* Use appropriate styles: photographs without unnecessary detail; complete drawings of figures when possible; and, line drawings. There is no need for elaborate decoration or excess in shadows.
- 8.* Use simple illustrations. Unnecessary detail can distract the viewer from the central message.
9. Use familiar images that represent objects and situations where audience can relate.
- 10.* Use realistic illustrations. Often symbols are too abstract.
- 11.* Illustrate objects in scale (especially correct anatomical proportions using a projected slide to facilitate accuracy) and in context whenever possible.

Note: The principles marked with an (*) are particularly important when producing print material for non-literate rural audiences.

Source: *HealthCom Communication Toolbox*, 1995

12. If symbols are used, pretest them with members of your audience.
13. Use appropriate colors. In most cultures, colors have special meaning. For example, red is associated with alertness, danger, and life support. Color is best for posters, although full-color separation is not needed (screens will do fine). Be careful with color registration for clear printing.

Text

14. Use a positive approach. Negative approaches are very limited in impact, tend to turn off the target audience, and will not sustain an impact over time.
15. Use the same language and vocabulary as your audience, as found in formative research. Limit the number of languages (for example, Spanish and two local languages) in the same material.
16. Repeat the basic message at least twice in each page of messages.
17. Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14 point font for text, 18 point for subtitles, and 24 point, for titles.
18. Use upper and lower case letters. Text presented only in upper case letters is more difficult to read.

Supervision

19. Without careful supervision, it is very easy to receive materials with wrong colors, incorrect alignment, or careless print jobs. It is best to have an experienced member of your team providing close supervision of the production process.

Pretesting Guides

I1: Nicaragua Pretesting Guide for the Reminder Material for Mothers (Fathers and Grandmothers)

Date of the Interview: _____ Community: _____

Name of Researcher: _____

Introduction

Project HOPE, BASICS, and the Ministry of Health are designing a reminder material for families in this part of the country to help them care for the health of their young children. We have prepared a draft of one material, but before we print and distribute it to the families, we want to talk with some people like you to see if the material is ready or if we need to make some changes to make it better. Could you answer some questions to help us learn this?

Look at the material. Can you read the words?

Check the type of person and if they can read the material.

Type of Person	Check who is participating	Check if they can read
Mother		
Father		
Grandmother		
CHW		
TBA		

Initial Reaction

1. Please tell me your initial reaction to the material.
2. In your opinion, what can this material be used for? What is its purpose?
3. Is there any aspect of the material that right away you like a lot or that bothers you?

Text and Drawing

If the respondent can read, ask him/her to read the first sentence out loud. If no one can read, you read it.

4. In your opinion, what does this sentence mean?
5. Are one or more words difficult to understand? [If yes] tell me which, please.
6. Can you suggest how we can say the same idea in words that people will understand better?
7. Do you think the idea of the message is good, so so, or bad?
8. Who is this message for? Is it for people like you?

Pneumonia

9. Please look at this drawing (respiratory illness). What do you see in this drawing?
10. What do you think the drawing is showing? Anything else?
11. Have you seen children like the child in the drawing?
12. Looking at the drawing, what problem does the child seem to have?
13. Do you think the idea that this drawing wants to show is clear? Do you have any suggestion for making the idea clearer?
14. Do you like the drawing? Why?
15. Does anything in the drawing bother you? (If yes) what? Why?
16. Do you have a suggestion for making the drawing more pleasant?

If the respondent can read, read the sentence out loud. "Signs of pneumonia..." If no one can read it, you read it.

17. In your opinion, what does this sentence mean?
18. Can you suggest how we can say the same idea in words that people will understand better?
19. In your opinion, if your child had any of these illnesses, would that be a reason to take your child to a health facility?
20. In your opinion, what does "fast breathing" mean?

21. In your opinion, what does "difficult breathing" mean?
22. In your opinion, what does "make a sound like a cat" mean?
23. Can you suggest how we might say "fast breathing," "difficult breathing," or "makes a sound like a cat" in words that people will understand better?
24. Do you agree that "fast breathing," "difficult breathing," and "makes a sound like a cat" are the most important signs of pneumonia, bronchitis, or asthma?
25. Are there other signs that we should include?
26. Have you seen any of these signs in your child or in a child of friends or relatives? Which? Any other?

Diarrhea

[The guide follows the same type of questions (9-26) about the signs of diarrhea.]

Dehydration

[The guide follows the same type of questions (9-26) about the signs of dehydration.]

Other Signs of Serious Illness

[The guide follows the same type of questions (9-26) about the signs of serious illness.]

Beautiful Child

[This section of the material invites parents to attach a photo or other memento of their youngest child.]

27. What do you believe is the idea of this part of the material? Tell me how you understand it.

28. What should the family do with this space?
29. What would you put here?
30. What is your opinion of this section of the reminder material?

Mirror

31. What do you think of the mirror?
32. Do you already have a mirror in your home? Do you have one on the wall?
33. How much do you think that you would use a mirror on the reminder material?

Calendar

34. What do you think of the calendar?
35. Do you already have a calendar in your home?
36. How much do you believe you would use the calendar on the reminder material?

The Material in General

We are almost done. I just want to ask a few final questions about the material in general.

37. Are the ideas in the material new for you or are they things you already knew? Which ideas or danger signs are new for you?
38. What is your general opinion about the material?
39. Do you believe the material would be helpful to families?
 - a. How do you think families around here would use the material?

- b. Do you like the material? How would you use it if you had a copy?

40. What do you think about the size of the material? Do you have any suggestions for changing it?
41. What do you think about the colors in the material? Do you have any suggestions for changing them?
42. If you had one of these materials, where would you put it (in what room and where in the room)?
43. Do you have any additional suggestions for the material?

Thank you very much for your help.

I2: Ghana Pretesting Guide for the Mothers Reminder Material

Pre-Testing of Mothers Reminder Materials GHS-MOH, Ghana BASICS II

Interviewer's Name: _____

District: _____ Village: _____

Date of Interview: _____

Introduction

Good morning/afternoon my name is _____. I am working for the Ghana Health Service & BASICS II. We are designing a reminder material for families in Ghana to help them take better care of children. Before the material is complete, we need to ensure that it will be acceptable and would convey the intended message. Your responses would therefore assist us to improve upon the material. Do I have your permission to go on? Thank you.

Section A

(Only ask this section of caretakers, not health workers. Record in mother's own words)

How old is your youngest child? _____
if child is 5 years or older, discontinue

Can I ask you what level of school you have completed? _____

Before I show you the material I would like to ask you some questions on illnesses that affect children in this community.

1. What illnesses usually affect children under five years in this community?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
 - f. _____
 - g. _____
 - h. _____
2. Which of these do you think are most serious and can cause death in children?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____
 - f. _____
 - g. _____
 - h. _____

2a. What about these illnesses makes you think these are the most serious?

3. What signs or symptoms are most serious for children and would lead you to seek medical care immediately?

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____
- g. _____
- h. _____

3a. **If fever is mentioned at question 3, ask:** How do you decide when a child's fever requires you to seek medical treatment?

3b. **If diarrhea is mentioned at question 3, ask:** How do you decide when a child's diarrhea requires you to seek medical treatment?

3c. **If lethargic/unconscious/lack of playing is mentioned at question 3, ask:** How do you decide when a child's lethargy/lack of playing requires you to seek medical treatment?

Section B

Please check (✓) the type of material and version.

Material: Folder Poster
Version: A B

(Ask this section of caretakers and health workers)

I'm now going to show some materials to you and ask a few questions about them. In this discussion there are no right or wrong answers to the questions. All that I want is your candid opinion about these materials so feel free to talk.

Please look at this material for a moment.

Initial Reaction

- Please tell me your initial reaction to the material.

- In your opinion, what can this material be used for? What do you think is its purpose?

- Is there any aspect of the material that you like? Which aspect and why?

3a. Is there any aspect of the material that you dislike? Which aspect and why?

Text and Drawing (Happy Family)

- Please look at this drawing. What do you see in this drawing?

- What do you think the drawing is showing? What else? (probe)

- Have you seen children/families like the ones in the drawing? Yes No
- If **yes**, are they like most children/families around here? Yes No
- If **no** at question 6 or 6a, please explain how they are different from most families around here.

- Do you like the drawing? Why?

- Does anything in the drawing bother you? (If yes) what? Why?

- Who can read the words?

Check (✓) against the type of person and if they can read the material.

Type of Person	Check who is participating	Age of person	Can he/she read? (Yes/No)	Age of child
Mother				
Father				
Grandmother				
Community Health Nurse				
Other health worker				

If any of the respondents can read, ask him/her to read the first sentence out loud. If no one can read, you read it.

10. In your opinion, what does this sentence mean?

11. Are one or more words difficult to understand? [If yes] tell me which, please.

12. Can you suggest how we can say the same idea in words that people will understand better?

13. Do you think the idea of the message is...

a. Very good c. Not good
b. Good f. Not good at all

14. Why do you think this message is _____ ?

15. Who is this message for? Is it for people like you?

16. How well do you think the drawing illustrates the message?

a. Very well c. Not well
b. Somewhat well f. Not at all

17. What suggestions do you have to make the picture more clearly reflect the message?

Text and Drawing (Care-seeking picture)

18. Please look at this drawing. What do you see in this drawing?

19. What do you think the drawing is showing? What else? (probe)

20. Have you seen families like the ones in the drawing? Yes No

21. **If yes**, are they like most children/families around here? Yes No

22. **If no at either of previous two questions**, please explain how they are different from most families around here.

23. Do you like the drawing? Why?

24. Does anything in the drawing bother you? (If yes) what? Why?

If the respondent can read, ask him/her to read the first sentence out loud. If no one can read, you read it.

25. In your opinion, what does this sentence mean?

26. Are one or more words difficult to understand? [If yes] tell me which, please.

27. Can you suggest how we can say the same idea in words that people will understand better?

28. Do you think the idea of the message is...

a. Very good c. Not good
b. Good f. Not good at all

29. Why do you think this message is _____ ?

30. Who is this message for? Is it for people like you?

31. How well do you think the drawing illustrates the message?
 a. Very well c. Not well
 b. Somewhat well f. Not at all
32. What suggestions do you have to make the picture more clearly reflect the message?
-

[Questions 18-32 are repeated for the other drawings and captions.]

Folder to hold Child Health Records Booklet

33. What do you believe is the idea behind the development of this material (Show the folder)? How should it be used?
-

The material in general

We are almost done. I just want to ask a few final questions about the material in general.

34. Are the ideas in the material new to you or are they things you already know? Which ideas or danger signs are new to you?
-
35. What is your general opinion about the material?
-
36. Do you believe the material would be helpful to families?
-
- a. How do you think families around here would use the material?
- b. Do you like the material? How would you use it if you had a copy?
37. If you had one of these materials, where would you put it (in what room and where in the room)?
-

38. How often do you think you would refer to this material? Why?
-

39. What do you think about the size of the material? Do you have any suggestions to improve upon it?
-

40. What do you think about the colors in the material? Do you have any suggestions to improve upon it?
-

41. Do you have any additional suggestions for the material?
-

(Show the other type of material)

This is the other version of the material. Please look it over for a moment.

42. What do you believe is the idea behind the development of this second material? How should it be used?
-
43. Which one of the two do you think you'd be more likely to use/look at more often? Why?
-
44. Which one do you think would be more likely to remind you to take your child to the health center if s/he had one of the symptoms on the material? Why?
-
45. Which one would you prefer to have in your home? Why?
-

[Questions on drawings and captions are repeated.]

Thank you very much for your time and patience!

13: Nicaragua Pretesting Guide for the Reminder Material for Health Staff (Doctors, Nurses, Sanitary Inspectors, and Auxiliary Nurses)

Date of the interview: _____ Name of the health facility: _____

Location: _____

Name of the interviewer: _____

Person interviewed (check): Auxiliary nurse Sanitary inspector Nurse Doctor

Introduction

Project HOPE, BASICS, and the Ministry of Health are designing a reminder material for families in this part of the country to help them care for the health of their young children. We have prepared a draft of one material, but before we print and distribute it to the families, we want to talk with some mothers, fathers, grandmothers, and health personnel to see if the material is ready or if we need to make some changes to make it better. Could you answer some question to help us learn this?

Text and Drawings

Please read the first sentence.

1. What do you think about the first sentence (MAMA! PAPA!...)?
 - a. Do you think that families can understand what it means?
[If not] why not?
 - b. Do you have any suggestions for changing the language?

Please read the text and look at the drawing on signs of respiratory illnesses.

2. Do you agree that these are the most important signs?
3. Do you have any suggestions for eliminating, adding, or changing any sign?
4. Do you have any suggestion for changing the language?
5. Do you think that the drawing communicates the idea of a child with

respiratory illness? Do you have any suggestion for improving the drawing?

Please read the text and look at the drawing on signs of serious diarrhea.

6. Do you agree that these are the most important signs?
7. Do you have any suggestions for eliminating, adding, or changing any sign?
8. Do you have any suggestion for changing the language?
9. Do you think that the drawing communicates the idea of a child with serious diarrhea? Do you have any suggestion for improving the drawing?

Please read the text and look at the drawing on signs of dehydration.

10. Do you agree that these are the most important signs?
11. Do you have any suggestions for eliminating, adding, or changing any sign?

12. Do you have any suggestion for changing the language?
13. Do you think that the drawing communicates the idea of a child with dehydration? Do you have any suggestion for improving the drawing?

Please read the text and look at the drawing on signs of serious illness.

14. Do you agree that these are the most important signs?
15. Do you have any suggestions for eliminating, adding, or changing any sign?
16. Do you have any suggestion for changing the language?
17. Do you think that the drawing communicates the idea of a child with serious illness? Do you have any suggestion for improving the drawing?
18. Do you have any comments or suggestions on the part of the material where the family puts a photo or memento of the child?
19. Do you think that looking at the mirror would be a motivation for families to put the material on a wall and use it? Do you have comments or suggestions about the mirror?
20. Do you think that looking at the calendar would be a motivation for families to put the material on a wall and use it? Do you have comments or suggestions about the calendar?

The Material in General

21. What is your general opinion about the material?
22. Do you believe the material can help families know when they should bring their sick children to a health facility?
23. Do you believe that people really will use it when their children are sick?
24. What do you think about the size of the material? Do you have any suggestions?
25. What do you think about the colors on the material? Do you have any suggestions?
26. Do you have any additional suggestion about the material?
27. Do you have any questions for me about how the reminder material will be used?

Thank you very much!

Sample Request for Bid

Part A: Cover page

Issuance Date: Thursday, August 7, 2003: 12:00 noon

Closing Date: Monday, August 19, 2003

Closing Time: 12:00 noon

Subject: Request for Quotations for Printing of Materials

Ladies/Gentlemen:

[ORGANIZATION NAME] is soliciting quotations from qualified organizations to provide printing of materials, as described in Part E.

Please submit your most competitive offer in accordance with the attached instructions, with all required certifications, and in compliance with the commodity schedule. Any subcontract issued as a result of this Request for Quotations (RFQ) will be subject to all instructions, certifications, terms and conditions, and specifications included in this RFQ.

This RFQ in no way obligates [ORGANIZATION] to award a contract nor does it commit [ORGANIZATION] to pay any cost incurred in the preparation and submission of an offer. Any questions concerning this RFQ may be directed to [NAME OF PERSON WHO CAN ANSWER] in writing by e-mail at [EMAIL ADDRESS] or fax [FAX NUMBER] no later than Thursday, August 14, 2003.

We thank you for your interest in this solicitation and look forward to receiving your offer.

Sincerely,

[NAME]

[CONTACT INFORMATION]

Part B: Instructions

1. Preparation of Offers

- 1.1 Offerors are expected to examine the specifications and all instructions contained in this RFQ. Failure to do so will be at the Bidder's risk.
- 1.2 Offers must be firm for [30] days following the Bid Closing Date. Proposals offering less than 30 days will be considered non responsive and will be rejected.

2. Contents of Offers

- 2.1 Offerors shall provide the unit price for each item in the Bid Schedule. For each line item the quantity given shall be multiplied by the unit price, and the results provided. In case of any discrepancy between a unit price and the total price, the unit price will be taken as correct and the total price adjusted accordingly. It will be assumed that no offer has been made for any line item for which a unit price or total price is not shown.

3. Signature and Submission of Offer

The Offer must be signed by a person duly authorized to do so. A bid submitted by a corporation must bear their seal.

The Offeror's proposal must be delivered, not later than 12:00 noon Monday, August 19, 2003 to the [ORGANIZATION AND ADDRESS]. Faxed and electronic proposals will not be accepted.

4. Late Offers

Offerors will be held responsible for ensuring that their proposals are received in accordance with the instructions stated herein. A late offer will not be considered even if it became late as a result of circumstances beyond the Offeror's control; it will only be considered if the sole cause was attributable to the Buyer, or any of its employees.

5. Bid Evaluation and Contract Award

- 5.1 Awards will be made to the lowest responsive and responsible firm whose offer is most advantageous to the Buyer, after a thorough evaluation of all bids, considering the following evaluation factors:
 - (a) Total Offered Price;
 - (b) Conformance with the Technical Specifications stated in Part E;
 - (c) Conformance with the Terms and Conditions;
 - (d) Proposed Delivery Period (early delivery preferred);
 - (e) Past Performance of Supplier;

A "responsive" offer is one which complies with all of the terms and conditions of the RFQ without material modifications. A material modification is one which affects the price, quantity, quality, delivery or installation date of equipment or materials, or which limits in any way responsibilities, duties or liabilities of the Bidder or any rights of [ORGANIZATION], as any of the foregoing have been specified or defined in the RFQ.

A "responsible" Offeror is one who has the technical expertise, management capability, workload capacity, and financial resources to perform the work.

[ORGANIZATION] will reject all offers that are not responsive. [ORGANIZATION] reserves the right to reject a bid, if the bidding firm is not fully qualified to provide the goods and services as specified in the contract or who has demonstrated prior difficulties in providing goods and services in a responsive fashion.

- 5.2 [ORGANIZATION] reserves the right to delete any item or group of items.
- 5.3 [ORGANIZATION] is under no obligation to award a contract

5.4 [ORGANIZATION] reserves the right to increase or decrease the quantity of an item duly awarded in accordance with the RFQ by 20% (twenty percent) plus any fraction necessary to equal a whole number of the quantity bid, at the unit price offered. This option shall be exercised, if at all, at the time an award is made.

6. Specifications

Please see detailed specifications in Part E.

7. Non Compliance with Specifications

In the event that the item offered does not fully comply with these specifications, the Offeror shall state definitively wherein the proposed unit does not comply, referring to the applicable paragraph of these specifications. When no statement to the contrary is received, the successful Bidder shall be considered as having met all of the provisions of the specifications under that paragraph and shall be bound to any claims made by the Buyer.

[Add other relevant instructions.]

Part C: Bid Schedule

Item No	Item Description (See technical specifications in Part E)	Quantity to print	Unit price	Total price
1.	Printing and Lamination of Mothers Reminder Material	10,000.00		
	Total price			

Part D: Conditions of Contract

[Add relevant conditions of contract]

Part E: Technical Specifications

Item No	Mother Reminder Materials	Quantity to print
1.	Specifications for Section Mothers Reminder Material—Poster or Wall Chart Paper: Vanguard 180gms or higher Paper size: 14" X 23" Full color both sides 17" X 13" Double side lamination with 100 micro film	10,000.00

Part F: Subcontract Clauses

[Add relevant subcontract clauses]

Production Checklist

We have:

- ___ 1. Ensured that the final versions **are correct** before giving them to the producers.
- ___ 2. Met with the person(s) handling the job and walked through with him or her every aspect of the material, page by page, illustration by illustration.
- ___ 3. Clearly explained that these materials have **already been pretested and approved** by the audience involved and that their responsibility is to produce the materials, not change or adapt them.
- ___ 4. Prepared an agreement that indicates the following:
 - ___ Precise description of the physical characteristics of the material (size, paper weight, degree of plastification, colors, other elements)
 - ___ Number of copies to produce
 - ___ Price for the work
 - ___ Payment terms
 - ___ Production schedule and completion date
 - ___ Price for corrections that are not the fault of the firm
 - ___ Any special work that the firm will provide
- ___ 5. Asked to see their final version (camera-ready copy) **before** they begin production/copying.
- ___ 6. Seen the final version (camera-ready copy).
- ___ 7. Arranged to be at the printers for the initial run to check that (1) colors are correct, (2) pages are in the proper order, (3) fonts/type set is as agreed upon, (4) text and illustrations/photographs are clear, and (5) paper is the quality and color agreed upon.
- ___ 8. Been to the printers and confirmed everything listed in #7 during the initial run.

Source: *HealthCom Communication Tool Box (slightly adapted)*

Distribution Plan for the MRM

Area/District	Community	Number of appropriate families	Mode of distribution 1) house-to-house 2) at health facilities 3) at growth promotion or vaccination sessions	Person responsible (and title)

The number of appropriate families is based on the list of all those with children under 5 years of age.

Guidelines for Explaining the Reminder Material to Families

Nicaragua

Introduction

The Ministry of Health, Project HOPE, BASICS, and other organizations have prepared a material to help Nicaraguan families protect their children's health. It is a "reminder material" that helps families remember: (1) what are the danger signs for sick children; and, (2) the critical importance of promptly bringing a child with one of these danger signs to the closest health center or hospital.

You, the community volunteer or traditional midwife, play a very important role in protecting your community's health. The reminder material is a tool that can help with this. You can help by:

- Giving the reminder material to all families in your community with one or more children under 2 years of age.
- Explaining carefully to mothers—and if possible to the father and grandmother—what all of the words and drawings mean and how to use the material.
- Answering all questions that people in your community have regarding child illnesses and the importance of seeking care immediately when they notice a danger sign.

This guide is to help you carry out these tasks.

Questions and Answers

- **Who should receive the reminder material?**
All families in your community with one or more children under 2 years of age.

- **How should you record which families have received a copy of the material?**
You should complete the form with the name of the mother, the date you gave her a copy, and the number of children less than 2 years old. Keep the form to show staff from the health center or hospital.
- **Can you give the reminder to the family without giving an orientation?**
You should not do this. It is better to return another day when the mother—and if possible the father and grandmother—are available to participate in the orientation. It is very important to explain the material to all families, especially to those who do not know how to read.
- **How long should the orientation take?**
It should take at least 15 minutes.
- **If a family has more than one child under 2, can they receive more than one copy of the material.**
No, in order for the most families to get the benefits of the material, no family should receive more than one copy.
- **What should you do when a family has a new baby?**
If you still have a copy to give, you should give them a material and the orientation about it.

■ **What should you do if you can't answer a question from the families?**

First see if another health volunteer or traditional birth attendant can help. If not, you or the family can get the answer at the health center or hospital.

■ **When should you give the material and orient the families?**

There is no exact answer to this. You should carry out your tasks when it is convenient for you and when you expect the mother and possibly other family members to be at home.

The Steps to Orient Each Family about the Material

1. Greet the mother (and other family members), explain the purpose of the visit, and give them the material.

The purpose of the visit is to give and explain the material that is intended to help the family protect and maintain their young children's health. The material was designed with the help of mothers and families, and for that reason it uses common words and popular expressions. The material reminds families of serious conditions that their child may have and encourages them to take quick action if they notice any of these danger signs.

You can also mention that the material has features for the enjoyment and practical use of the family (such as a calendar, a mirror, and a place to put a photo of their child or children).

2. Explain the text and drawings on the material.

Ask a family member to read all of the words. If no one can do this, you should do it. Explain how the material emphasizes the importance of acting fast, without delay, if they notice any of the danger signs. Note the messages that express this idea: "It is

better to prevent than to be sorry later." "It is urgent...[your child] can die." You can explain that delay can result in bad sickness or even death, but quick treatment can save the child and allow him or her to become healthy again.

Check that the mother understands each danger sign. Note that the signs are grouped by signs of dehydration, signs of serious diarrhea, and signs of serious respiratory infection.

Invite the mother/family to ask questions.

3. Explain the other elements of the materials (e.g., calendar, mirror, and place to put the photo and information on the child).

The calendar: Show how it is organized, that the order of the months is: upper left, lower left, upper right, lower right. Note that at the end of every 4 months, the family should tear off the top two sheets in order to see the sheets with the next 4 months. Note that it shows the phases of the moon and holidays. Suggest that the family use the calendar to write down important events such as birthdays and anniversaries, dates of the mother's menstruation, and medical appointments, including the dates when the baby should be vaccinated.

The mirror: You can suggest that besides using it for combing hair, putting on makeup, and looking at your face, once in a while the mother should lift up the baby so s/he can see how he or she is growing big and healthy.

Healthy baby: Explain that if you have a photo of the youngest child (or children), you can tape or glue it over the photo of the other baby. If the family wants, help them to write down the name and birth date.

Invite the mother/family to ask questions.

4. Discuss where the family will place the material and when and how they should consult it.

The family should place the material on a wall, at an appropriate height for the mother to use the mirror, in a place where it will be seen often.

They can look at the calendar, mirror, and photo whenever they want.

They should consult the information on danger signs and the importance of immediate action whenever the child is sick.

5. Discuss what the family would do in case their child is very sick:

- to what health facility would they take the child,
- who would go with the child,
- how would they travel there,
- who would participate in the decision, and
- how would they obtain (or save) the money.

Discuss each question, the possible answers, and which answer seems the best for this family. If the family cannot answer one or more questions well, you can suggest that they discuss it, and discuss again (or if you visit regularly, and that later you will return to talk about it again).

6. Examine the child health card and discuss the actions that family should take.

Note if the child (or children) has all of its immunizations up to date. Motivate the family to go for any needed care or carry out preventive actions they are not doing. Help the family to understand the card better.

7. In summary, ask the mother/family to explain the overall purpose of the material, confirm where they plan to put it, and how they plan to use it.

Register for Distribution of MRM

Community: _____

Nearest Health Center: _____

Name of Distributor: _____

Mothers

Mother's name/address	Number of children under 2 years	Date of MRM distribution	Place where MRM will be put

Mothers-to-be

Name/address	Months pregnant	Date of MRM distribution	Place where MRM will be put

Methodology Used in the Nicaragua MRM Evaluation

(Excerpts from the evaluation report)

This evaluation was carried out in the Municipalities of Jinotega (Jinotega Department), Matagalpa (Matagalpa), and San Pedro de Lóvago and Acoyapa (Chontales).

Sampling

The study universe consisted of all mothers who received the MRM and health staff, community health volunteers, and midwives in each of the municipalities; as well as all of the mothers with children from 4 to 28 months old who brought their children for care at a health facility on the day of the study and mothers who did not receive an MRM.

Below is a description of the sample for each population group:

Population Groups	Sample (for each of three provinces)
Parents of children 4-28 months old	Any who brought a sick child to the health facility on the day of the study
Health staff	4
Mothers who received an MRM	30
Mother who did not receive an MRM	30
Community health volunteers and midwives	4

A total of 49 parents with children 4 to 28 months old were interviewed at health

facilities, 100 mothers who received an MRM, 96 mothers who did not receive an MRM, 14 health staff, and 14 community volunteers or midwives.

Instruments

This primarily quantitative evaluation utilized the following instruments:

Questionnaire 1 was directed to mothers and fathers of children 4 to 28 months old, who brought their sick children to a health facility on the day of the survey. They were asked about:

- General information (8 questions)
- History of the current illness (7 questions): what signs of concern the family noted, who and when; what the parents did; whom they consulted; if they consulted an MRM; what triggered the decision to bring the child to a health facility; factors that influenced the parents; the parents' satisfaction with the care-seeking decision.
- The presence of an MRM in the home; use of the MRM; parents opinion on the MRM

Questionnaire 2 was directed to mothers at home who received an MRM (20 questions) and **Questionnaire 3** was directed to mothers at home who did not receive an MRM (14 questions). These instruments covered almost precisely the same topics:

- General information
- Child illnesses in the past three months: for any illness, what signs of concern the family noted; what the parents did; if they asked for advice and from whom; how much time passed between noting a danger sign and taking the child to a health facility; what

made the parents decide to act; the parents' satisfaction with the care-seeking decision

- Knowledge of danger signs: what are the danger signs, what they should do and not do; parents' beliefs concerning urgency of action, an appropriate time to wait before acting
- People from whom they ask advice about illness
- The presence of an MRM in the home; where it is kept; if they attached a photo of their baby on the material; if they consult the MRM for health advice; how often they look at the calendar; how often they look at the mirror; if they discussed the MRM information with anyone; their suggestions on improving the MRM and making the information clearer; the physical condition of the MRM

Questionnaire 4 was directed to health volunteers, midwives, and community committee members (9 questions). It covered:

- General information
- Involvement in child health: if they have noticed any impact of the MRM on whether and how soon families bring sick child to a health facility
- The MRM: the number of people who have asked them about information on the MRM; if since the MRM distribution, the respondent has followed up with families on the MRM; their opinion on the usefulness of the MRM and why; what aspects they believe families like the most.
- Comments: any problems in the distribution of the MRM, orientation of families, recording the copies distributed; suggestions on how to improve the material.

Questionnaire 5 was directed to health staff and contained several questions on:

- General information
- Trends in child health consultations in the last three months: if they have noticed any change in utilization, reasons for consultations or delays in seeking consultations

- The MRM: their opinion on families consulting the MRM—how many, how often; how familiar they are with the MRM; how useful the MRM is and why.
- Comments: any suggestions for improving the material; analyze information in clinic registers.

Information Collection

Before information collection, the field team met to review and revise the instruments and to standardize their use. At the same time, instructions on completing all instruments were prepared.

One day was devoted to pretesting the instruments in a community outside of the sample. Information was collected in the field during five days in April 2002.

Data Analysis

For analysis, five databases were designed in Epi Info 6.04, one for each questionnaire. The information collected in three provinces was entered in the Project HOPE office in Chontales and then forwarded to the research consultant for manipulation and analysis. The analysis focused on the knowledge and practices of respondents in relation to their use of an MRM.

The results were presented in frequency tables and percentages of variables already defined, as well as in graphs.

This evaluation report contains, first, the results of each question guide. The second section compares the results in areas where this was possible, e.g., in general information on the child, morbidity in the last three months, and actions taken by the mother during illness, as obtained from questionnaires 1, 2, and 3; knowledge on danger signs, based on the responses to questionnaires 2 and 3; and the usefulness of the MRM and suggestions obtained from answers to questionnaires 2, 4 and 5.