Community Based Health Project
CBHP

Health Audit
Report
2014

"I am like this lamp, lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole world. That is Health for All"

- Arole and Arole, 1994

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EXECUTIVE SUMMARY

The project aims to assist in the establishment of a Community Based Health Project (CBHP) in the rural villages of Buldana district in Maharashtra Province, India. Most importantly, the aim is to re-evaluate the previous report produced in 2012, comparing results and the level of improvement of health within the project villages. CBHP is a partnership between local staff in Buldana and students from the University of Melbourne in Australia.

In January 2014, one CBHP Australia research volunteer conducted fieldwork in the four project villages of Buldana district to gather data on the health of the community. This was done with the assistance of three volunteers who also traveled to Buldana district as part of the Volunteer Immersion Program in January 2014. Qualitative and quantitative data were obtained from villages in Buldana district.

Data was collected through: Focus Group Discussions with villagers and health care workers, one-on-one interviews with community members, a randomised cluster survey of households, and general observations. The main research areas of interest were access to water, sanitation, nutrition, gender equality, education, and validate previous study. Data were obtained in four villages in Buldana district: Tanda, Manubai, Khadki and Mohegaon. CBHP already had a Village Health Worker (VHW) in each of these villages.

The focus group discussions and one-on-one interviews revealed numerous issues identified by the community. These were: the limited education and employment opportunities in the villages; the lack of access to clean water, quality nutrition, toilets and health services; gender inequality seen through early marriages and the dowry system; lack of reliable roads and public transport servicing most villages. The discussions also highlighted numerous barriers to the improvement of health and health care services in the villages, including government corruption, lack of education and traditional customs and beliefs.

Data collected from the randomised cluster survey of households showed that access to water sources varied considerably amongst the villages; some were supplied with piped water, others only had access to open wells. The majority (73-100%) of families surveyed went to the toilet in open air spaces. There were no risk of malnutrition in children under the age of five; however this was based on limited data. With regards to education, the illiteracy rate amongst 5-14 year olds ranged from 0-12%. Gender disparities were seen in three villages, where girls tended to receive less schooling than boys, especially for high school and college.

Broadly speaking, CBHP had achieved a great improvement in 2013, as many of the main health issues were well tackled and had been solved. The VHWs have been considerably valuable, and CBHP India and Australia had performed crucial work in achieving solutions for the issues identified. In saying this, the health of the Buldana community is a complex and multifaceted issue. Improving the health of the community will require addressing the lack of employment opportunities, improving basic infrastructure including roads, clean water access and toilets, and improving access to primary health care in order to meet the health needs of the community. Potential initiatives to ameliorate the issues identified in the villages are suggested.

INTRODUCTION

CBHP is a partnership between local staff in Buldana and students from Australia, particularly the University of Melbourne, but also students or graduates from Sydney, Queensland and more.

In January 2014, one CBHP Australia volunteer conducted fieldwork in the villages of Buldana district to gather data on the health of the community. This was done with the assistance of three volunteers who also traveled to Buldana district as part of the Volunteer Immersion Program (VIP 2014). Qualitative and quantitative data were obtained from villages in Buldana district.

The previous project had successfully identified a few key problems of the four villagers in Buldana, in line with various reasonable solutions. Some of them had been implemented, and others had not. Thus, it was strongly recommend that the next volunteer teams could focus more on those recommendations and try to implement them if they were to be still applicable. The purpose of this report is to serve as an evaluation of the previous initiatives implemented, and to critically analyse whether they are still worthwhile, or whether further actions should be taken in modifying them.

AIMS

The Health Audit trip to Buldana from 3 January 2014 to 7 February 2014 aimed to collect data on the general health status and health needs of the local rural community, including data on the social determinants of health. This was in order to:

- Monitor the effectiveness of CBHP in improving the health of the community
- Re-evaluate and update the previous report completed in 2012, through comparing results and identifying improvements

METHODS

Key Points:
• Qualitative and quantitative data was obtained from villages in Buldana district
• Data was collected via:

- Focus Group Discussions with villagers, community leaders and health care workers
- Individual interviews with community members
- Randomised household cluster survey
- General observations

The main research areas of interest were access to water, sanitation, nutrition, gender equality, education and validate previous report findings.

The Health Audit collected both qualitative and quantitative data from four villages in the Buldana district: Mohegaon, Khadki, Naiknagar (Tanda), Manubai. CBHP had a Village Health Worker (VHW) in each of the villages.

1) Qualitative data on the major health issues; knowledge, attitudes, practice; social determinants of health; health facilities in the community:

a) Focus Group Discussions (FGD) (led by the Health Audit team)
• Target Participants: Health Care Workers (HCW), women in the community and adolescent girls
• Recruitment: participants were recruited by the CBHP team from four villages that arecurrently serviced by CBHP Village Healthcare Workers (VHW), where the interviews were usually held in the VHW house
• Questions addressed the following themes:
(*see Appendix 1 for questions used)

• Facilitators: The focus groups were facilitated by the Health Audit team, with the assistance of Marathi interpreters. One Health Audit member facilitated discussion, whilst the other took notes and operated the voice recorder. The interpreters were pre-informed in the content of the FGDs, and in troubleshooting.

b) Individual Interviews with members of the community (Health Audit team)
Selected FGD participants were invited to participate in individual interviews with the Health Audit team. These interviews provided anecdotal data on the issues affecting the interviewee, their family and community.

c) Observations of village life (Health Audit team & Volunteer program)
The Health Audit (HA) team and volunteers were asked to record interesting observations made during field visits to villages, schools, etc. relating to the health of the community.

2) Quantitative data on health indicators; social determinants of health

a) Cluster Survey

Volunteers conducted a randomised cluster survey of households in each village visited, focusing on major issues identified by the Health Audit team: water & sanitation, malnutrition and education. Volunteers were instructed to, where possible, talk to the woman in charge of the household.

• *See appendix 2 for method, appendix 3 for specific questions and appendix 4 for survey template

RESULTS

FOCUS GROUP DISCUSSIONS AND INDIVIDUAL INTERVIEWS

Key issues raised by villagers, community leaders and local health workers:

- Lack of Employment and Income-Generating Opportunities:
  - Most of the villages still partake in farming only (both parents)
  - Some have their own farm
  - Completing further studies does not always help in gaining employment or more income
  - Government corruption that involves bribing, limits access for the poor
- Limited Education Opportunities:
  - Education for sanitation especially
  - Lack of access to schools, especially high school, due to distance, school fees (for private schools), material fees, and transport costs, significantly hinder access to education (past primary school).
  - Bus to government school in Buldana itself is very costly
- Clean Water Access Issues:
  - Unclean water causes diarrhea and other water-borne diseases
  - Not sufficient water in the summer due to draught, and lack of rainwater systems, however not a problem in the wet season
- Lack of Toilet Facilities:
  - Lack of water supply for toilet facilities
- Roads/ Transportation:
  - Government bus come 4 times a day, and it is sufficient enough for the villagers
- Lack of health services:
  - Lack of medicine supply (variety and quantity) – pain killers, diabetes medicine, worm tablets, multi-vitamin tablets

- Gender issues:
    - Negative societal perception of non-arranged marriages
    - Dowry system perceived to contribute to gender inequalities
        - Education for girls helps to improve the situation, as they are not expected to pay as much for a dowry if they can generate their own income.
        - 200,000 rupees for farmer (less dowry); 500,000 rupees for government worker (higher dowry). The higher the salary of the husband, the larger the expectation of the value of the dowry.
        - Sufficient education can make a difference for the dowry system (as girls have an increased chance of voicing their opinion and questioning the system
    - Girls didn't receive much schooling because of income and issues of safety, given that they must travel considerably long distances to reach Buldana town or education services.
- Domestic violence:
    - Violence does occur in Mohaegon village (particularly when men have access to alcohol)
- Government policy:
    - Financial benefits are available to families with two or less children, as a disincentive to have large families. This system can sometimes lead to a third child (female) being abandoned.
    - Government programs and auxiliary nurses often do not/ can not provide enough contraception pills and condoms to villages

Common Health Problems According to Villagers and Local Health Workers:

- Infectious:
    - Cough (Winter)
    - Fewer/ Flu (Winter)
    - Diarrhoea (Wet season)
    - Malaria (Mosquitoes)
    - Pneumonia

Less Common Health Problems and/ or village specific problems:

- Mental Health
    - Mental issues were ignored, as VHW is not specifically educated in this field.
- Infectious
    - Tuberculosis (TB) (Tanda/ Manubai)
- Asthma (Tanda/ Manubai)
- Eye problems

    - Issues with eye sight within the elderly population (Khadki & Tanda)
    - Cataracts (Moheagon)
- Dengue fewer (Khadki)
- Female issues: white vaginal discharge (Moheagon & Manubai)
- Smoking tobacco and alcohol consumption is common (Manubai)

Health problems that no longer exist in particular villages:

- Dengue fewer (Moheagon)
    - Villagers undertake spraying and burning procedures to reduce the prevalence of mosquitos
    - People aware of protection against from mosquitoes
- Breast feeding is common largely due to the encouragement from the VHW (Moheagon)
    - VHW will help out in giving birth (she brings them to the hospital)
- Abortion (Moheagon)
- Smoking and Alcohol (Moheagon)
- TB is no longer common in Tanda
- Alcohol is no longer a problem in Tanda
- Suicide of farmers is no longer a problem across all of the villages
- Female infanticide no longer exists in Tanda
- Malaria is no longer a problem in Manubai,
    - they now have access to clean water
    - community help to clean up the environment
    - Mosquito coils have been implemented

Health Attitudes/ Barriers to change

- People don't use the toilet in Tanda because there is not enough water supply, even though they have 30-40 toilets; People don't use the toilet built by the government in Khadki, because it is not convenient for them

- Common beliefs that private hospitals are better than government hospitals
    - A perception that government hospitals are not adequate, and that a family must save enough cash to be able to visit a private hospital, despite the quality of service in a private hospital not actually being superior. This was made evident in comparing the x-rays viewed from both institutions
    - People usually visit the VHW before visiting the hospital.

Existing Programs & Initiatives

- Government
    - Mid-day meal

        - High protein nutritious yellow rice provided to primary school children
    - Contraception pills
        - Supplied by the government once every fortnight
    - Financial support
        - Government subsidises 1000 rupees for girls who attend to high school (forms of encouragement), which has resulted in girls having their own bank accounts
        - 600 rupees per month given to the elderly (>65)

- Auxiliary Nurse Midwife (ANM)
    - Comes to village once/ twice a month
    - Educates school children on the health system
    - Educates pregnant women on the importance of breast-feeding
    - Adolescent girls program (only in Manubai)
        - Health issues education
        - Counseling
    - Supplies some nutritional food to children
        - Sweets, eggs, biscuits & protein powder
    - Women's groups (only in Khadki)
        - Discuss health, children, and breastfeeding
    - The provision of the following vaccines to all children and pregnant women:
        - Vaccine (BCG), Vitamin A oral solution, measles, tetanus, whooping cough, TB, polio oral solution, cholera, jaundice (yellow and white)

- Non-government organisations
    - Subsidy cataracts operation
        - Charitable trust near to Aurangabad provided free cataracts operation for Below Poverty Line (BPL) individuals, whereby patients only have to pay for the medicine
        - Most of the Manubai villagers know about this, 5 of them have made use of the service

- Village Health Workers
    - Visit 5-10 houses a day
        - Checks if anyone in the family is sick or pregnant
    - Health education: teaches about diet, sanitation and water boiling for sanitation
    - Accompanies pregnant women to the hospital if necessary, or otherwise attends to homebirths
    - Provides basic medicines (paracetamol, Oral Rehydration Solution, co-trimoxazole, mebendazole, Fe, fotale) and apply Betadine antiseptic, bandages

  - Treats TB with DOTS program, treats malaria with chloroquine
  - Tanda VHW specifically banned alcohol in the village
  - Tanda VHW saved baby girl from being killed/ abandoned by sending her to the orphanage in Buldana
  - Tanda VHW runs women groups: educates them about the importance of saving girls from being abandoned
    - (once a month/ once every two months)

Collapsed Programs & Initiatives

- Microfinance & self-help group in Manubai
  - There were 4 groups previously
  - Collapsed due to inefficiencies and financial mismanagement

Suggestions

- Adolescence girls program
  - Promoting health and other education
  - Sewing or computer class in the village itself
  - Possibly including widows

- Another VHW
  - Many of the VHW is comfortable with working alone, but hoping for another one to divide the tasks

- Education program
  - Health, sanitation, diet, waste water disposal

- Glasses and eye check
  - Aimed at providing for untouchable families
  - 10-15 people needed eye operations in Manubai

Special case

- A women attempted to commit suicide in Tanda by ingesting insect poison, and two years prior she attempted to burn herself

OBSERVATIONS OF VILLAGE LIFE MADE BY VOLUNTEERS

The feedback form mentioned in the previous form was not attached, therefore a new form was attached in this report.

From informal discussions with the volunteers during the trip, the issues identified were:

1. **Issue:** open drainage and stagnant water pools in all of the villages
   Proposed intervention in the past: working with watsan iNGOs
   New proposed intervention: educating environments cleaning by VHW

2. **Issue:** littering, the lack of proper rubbish disposal and the burning of rubbish
   Proposed interventions in the past: advocacy program about impact of rubbish on health; finding ways to dispose of rubbish; education on dangers of burning rubbish particularly plastics
   New proposed intervention: implementing the provision of rubbish bins and plastic bags for rubbish

3. **Issue:** Children are often unhygienic and dirty.
   Proposed interventions: sanitation project in school

4. **Issue:** Villagers often spit anywhere in the village, whether it be a public space or not (including women and children but mostly men).
   Proposed interventions: sanitation project in school, education by VHW

Cluster Survey

73 families were surveyed from Mohegaon, Tanda, Khadki and Manubai villages.
(*See appendix 5 for results tables for each village surveyed)

Family size
The average family size across four villages was 5.8 people
(lowest: Manubai 5.3, highest: Khadki 6.4)
The average number of children up to the age of 25 in each family surveyed was 2.4
(lowest: Manubai 2, highest: Khadki 2.7)

Water source
- Tanda: all families surveyed used the **open well** as their main water source. Median walking time to water source was 10 minutes (range: 10 minutes)

- Manubai: 60% families nominated a **tube well** as their main water source, 40% **dug well**. Median walking time to water source was less than a minute (range: <1 to 15 minutes)

- **Khadki:** 65% families nominated a **tube well** as their main water source, 20% **piped water**, and 15% **dug well**. Median walking time was 2.5 minutes (range: <1 to 10 minutes)

- Mohegaon: all families surveyed used the **piped water** as their main water source. Median walking time to the water source was 5 minutes (range: 2 to 8 minutes)

Water sources varied from summer to winter; in the summer tube wells often dried up so families needed to access an alternative water source (e.g. open well) which was usually further away from their homes. However, sometimes the open well water even dried up as well, resulting in Tanda having only limited access to water in summer. CBHP provided them water in summer 2013, and a water project was proposed.
(*See Water Project 2013 for more information)

Toilet facilities
Most families went to the toilet in open air spaces, i.e. field or bush (Tanda: 73%, Manubai: 63%, Khadki: 100%, Mohegaon: 100%). The rest of the families used a private toilet. A few families had access to a private toilet but preferred to go to the toilet outside due to lack of water available for flushing the toilet. No families used a public toilet, even though this was available in Mohegaon.

Malnutrition
None of the children under the age of five assessed were identified at being at risk of malnutrition. Children were assessed using weight-for-age (World Health Organization classification of 'normal weight for age' >-2SD, 'low weight for age' -3SD to -2SD and 'very low weight for age' <- 3SD). Available from: http://www.who.int/childgrowth/standards/weight_for_age/en/

Where possible, weight for age was measured, but often measuring scales were not available and some families declined measuring weight. The Medecins Sans Frontieres mid upper arm

circumference (MUAC) screening tool (>134mm 'normal', 125-128mm 'at risk of malnutrition', 109-124mm 'moderate malnutrition', <108mm 'severe malnutrition') will be used in this case. Available from http://malnutrition.msf.org.au/muac.html

Note: Tanda village health worker mentioned there were two malnourished children in the village, however the cluster survey was not able to find this.

Education

The aim of the data was to gather a record of the highest level of education obtained by young people aged 5-25. Due to a translation misunderstanding, however, the particular question was interpreted as whether or not the child attended school.

From the survey, 95% of the children in four of the villages went to school in their respective village. Families that could afford it would allow their children to further their education in the other private school near the village or the government school in Buldana.

- Manubai had the highest rates of education, 100% of children between 5-11 years old surveyed went to school in the village.

- Tanda had the second highest rates of education, 92% of children between 6-20 years old surveyed receive education.

- Mohegaon had the third highest rates of education, 90% of children between 6-12 years old surveyed went to school in the village.

- Khadki had the lowest rates of education, 88% of children between 6-14 years old surveyed went to school in the village.

Discussion

As mentioned, the purpose of this audit is to critically analyse the outcome of the CBHP effort throughout 2012-2013, by comparing results with the previous audit conducted in January 2012.

As with any research, there are numerous biases that may have affected the quality and accuracy of the data collected. The language and cultural difference between the villagers and the health audit team was a considerable barrier. Working with the Marathi translators was very helpful, however, it is unknown how much information was lost in translation. It was important to keep emphasising to the translators to repeat as much of what was said as possible, without personal interpretation or summary. Also, it had been advised not to ask any questions that would lead to villagers thinking the volunteers were there to provide them medication, food, and material or financial help. No commitment should be given, as CBHP does not want to disappoint the villagers by making promises that might not be achieved. The team always commenced by introducing themselves as students or volunteers.

The previous report made note of politically sensitive issues such as 'the value of female children' and the issue of 'giving dowries', stating that such issues would not be fully understood. As part of the Volunteer Immersion Program in 2014, the team conducted research on gender inequality, which lead to the Women's Empowerment Project (WEP). See *CBHP Women's Empowerment Project Report 2014*. In line with this, CBHP and the VHWs have implemented a range of gender-specific initiatives including: women's and adolescent girls groups which began in Khadki, Tanda and Manubai and was generally run by VHW or ANM, and the CBHP sewing program implemented in early 2013 (see the *Sewing Training Program 2013-2014 for* more information). Initiatives which are still in the early development stages are the computer training program, and also the hostel for adolescent girls and women wanting to pursue their education and vocational skills training. In general, there is an increase of gender equality awareness, and initiatives such as the ones mentioned will hopefully assist in bringing about positive change in relation to gender equality within Buldana.

The cluster survey was conducted using a smaller sample size as compared to the 2012 report (78 participants, as compared to 120), resulting in decreased validity and ability to generalise or extrapolate data. As for water sources, overall, villagers seem to have less access to piped water. However, according to the interview, more villagers were aware of the importance of the purification of water by boiling it or another method as taught by the VHW, for instance. In relation to toilet and sanitary facilities, villagers still prefer to defecate in open air spaces due to the lack of water in public and private toilets. More individual toilets had been built recently in Tanda and Manubai. Malnutrition, on the other hand, provided more positive results. With regards to the cluster survey, there was not a single malnutrition case found. Furthermore, in the interviews with the VHWs, it was mentioned that malnutrition had been significantly decreased as the government had started to provide nutritious food, along with the education and help from ANM and VHW. Education is still key in community health as it is a complex multi-faceted issue, affected by many social determinants of health. Secondary schooling was still limited as the accessibility was limited due to distance. Factors such as transportation, income, safety and lack of relevant opportunities after graduation, meant that many children, predominantly girls, were discouraged or not able to pursue further education. With the words of the VHWs in mind, a range of options were proposed by the research team, including: (i)

recycling books, uniforms, bags and stationary, (ii) rickshaw and bus services provide by CBHP, (iii) free hostel in Buldana, (iv) establishing secondary schools or colleges in the vicinity of the villages (iv) incentives for parents to allow further education for their children. With regards to recycling education materials, however, the syllabus changed every 2-3 years, and children usually wore their uniforms to a point at which they were not recyclable or mendable. The provision of government transport services was reported to be problematic as the services rarely operated on time or frequently enough. Furthermore, parents and girls felt it unsafe to travel by bus, especially due to the threat of being exposed to bullying. The proposal of a hostel service was implemented, for more information, (see *CBHP Women's Empowerment Project Report 2014*). To establish high schools or colleges in villages requires a considerable amount of funding, resources, land, professionals, and government support, and was therefore deemed unrealistic. As for the incentives plan for parents, it is again an issue of funding. More importantly, however, is the challenge of shifting deep-rooted societal norms, such as that the girl must stay at home to do house chores and look after the siblings. Despite research concluding that families are better off if they allow their daughters to be educated, it is much more complex than this. Overall, however, the VHW had been given great support in informal education as listed in the result section. They have been really helpful not just in improving basic health attitudes, but also in individual cleanness and sanitation, pregnancy and birth precautions, birth control, and more.

Many of the health issues listed previously, no longer exist due to the efforts of the VHW and ANM. The communities are able to witness the validity of the fact that prevention is better than cure. Given the health knowledge provided by the VHW, much good behaviour by the villagers can be observed. Conversely, there are still a variety of negative attitudes, superstitious beliefs, or behaviors of the villagers resulting in poor health conditions. Many of the VHWs report that it is sufficient to have just the one VHW; however having another one will be more beneficial in many cases. Also, hospitals are usually far away from the village, especially for Manubai. The low-cost medical clinic that was mentioned in the 2012 Health Audit had not been implemented due to lack of funding, professionals, a site, management, and government support.

The water, sanitation and hygiene (WASH) program was also carried out in one of the classrooms of Khadki school, teaching children the importance of purifying water, washing hands with soap and water, removing stagnant water, and covering the mouth when coughing. A lesson on basic germs was also covered. The previous CBHP India volunteers had created informative Marathi posters displaying positive healthy habits, and these were presented to the class. The lesson required a maximum of 35 children in a classroom, and that the students be in grade 6 or above. It was identified that the classroom size was too small for the interactive sanitation game to be carried out, so it was modified for the nature of the space. It is also difficult to conduct the activities outside of the classroom, as it would distract other classes. Language is an issue, as English is generally not spoken the villages, and they have their own village dialects which differ slightly from one another. Translators are essential for the activities and lessons to be carried out. It was suggested that CBHP India volunteers should be trained in order to carry out the program sufficiently, and CBHP Australia volunteers could be there to assist with the games and activities. The sanitation program was generally helpful, and children appeared to understand, as they were able to answer the questions from volunteers. Repetition enhances memory, thus it is important to ask questions in class in order to ensure children understand

the material. This should be carried out continuously in the school to ensure the best outcome. Collaboration with and active involvement of the teachers would also enhance the effectiveness of the delivery of the program.

In the data collection methods, particularly the discussions with the VHWs, the initiatives that had been previously implemented were not discussed in detail, nor were they addressed one by one in order to assess the effectiveness, or lack thereof, of each initiative. This was mainly due to not wanting to overwhelm the participants with too many questions during the discussions. It will be better in the future, however, if each of the previous programs could be evaluated in order to determine what was successful or unsuccessful, and therefore which particular schemes could be replicated elsewhere.

A few suggestions were proposed in terms of ways to broaden income sources for BPL families. The idea of training men and women in skills such as candle-making, handcraft making, and tailoring, for example, were constructive, as they could be sold to retail markets locally or within Australia, in order to contribute towards income-generation. This venture is something that can be looked into further. On the other hand, ideas such as investment or micro-finance could potentially be quite challenging due to the levels of corruption present in society. Corruption is identified as a very serious issue in India, which especially disadvantages the poorer population. The infrastructure of the villages was also another significant issue. As most of the roads are under-developed, public transport is not easily accessible in the village, and many of the beneficial programs for BPL families are not properly targeted or implemented.

In short, CBHP has achieved a significant improvement in 2013, as many of the main health issues were well tackled and have been solved. There were few suggestions from the villagers and VHW in the result section. CBHP will be implementing a computer-training program, a girls hostel in Buldana town, a rainwater harvesting system in Tanda, a buffalo raising enterprise for financial sustainability, and many more new initiatives this year. Nevertheless, greater manpower, funding, research, and effort will be required for future growth of the CBHP program.

APPENDICES

Appendix 1: Script and Questions for Focus Group Discussions

INTRODUCTION:
Welcome, and thank you all for contributing your time and efforts to be here today.
As you may know, the Community Based Health Project is underway, and we are constantly seeking more feedback in order to improve our services and projects. Today, we wish to learn from you, **what are the changes have been made**, **what the existing community's health issues are**, and **what could be done to improve the health of the people of Buldana**. These are the goals of our discussion today.
We invited you here because we know that each of you has valuable knowledge and experiences to share. We ask that you will be open and honest with us, for no one will be identified or reprimanded for what they say here. The better we can understand what the real issues are, the better we can bring good health to the community.
In order to ensure that everyone's thoughts are heard, we ask that only one person is speaking at a time. We ask that you speak for yourself, not what you think others believe, and that you respect the opinions of others, for different opinions will be heard today and we may not agree on everything.
In addition, we wish to record this discussion so that we have an accurate record of the information collected today.
Does anyone have any questions? Does everyone understand and agree with the goals of this discussion? Is everybody ok to proceed?

Focus Group Discussion - Health Care Workers

- What are your main day-to-day concerns as health workers?
- What do you think are the major health issues in the community?
- What are the other health issues in the community? (is it common?)
- What are the underlying causes of health problems in the community?
- What do you think of the health system here? Is it effective?
- What current/previous initiatives/programs make a positive contribution to the health of the community? (what works?)

(check the previous initiatives and programs mentioned in the health audit, ask them specifically instead of generally)

- What current/previous initiatives/programs are unhelpful?

(check the previous initiatives and programs mentioned in the health audit, ask them specifically instead of generally)

- One of the major difficulties is having adequate health staff in rural areas. How can this issue be addressed?
- How can the health of the community be improved?
- Are there any new program implement by the government or any other organization?

(check the previous initiatives and programs mentioned in the health audit, ask them specifically and see if they are still existing. If no, why?)

- What is the average amount of children in a family?
- Are there any women's groups within the village?
- Are there any single mothers or widows? Are they treated differently?
- Are you aware of any cases of domestic violence in the village?

Probing Q's:

- Could you tell us more about that?
- Could you give us an example?
- What do you mean by...?

Focus Group Discussion – Women and Adolescent Girls

- What are your main day-to-day concerns?
- What are your main concerns regarding your health and your family's health?
- What are your main concerns regarding the healthcare system?

OBJ

Health care/programs/diseases

- Who do people visit for healthcare? (hospitals, healthcare workers, local traditional healers)
- Do you have trouble accessing health care? Is it far away? Can they get necessary medicines?
- What are the common diseases and health problems in the community?
- What are the common causes of death in community?

Gender equality

- Do women face any specific health issues?
- How much schooling do girls usually receive?
- At what age do girls get married?
- Do women work? Is there a difference in the work men and women do?

Education

- What is your highest level of education?
- Do you think girls should go through same level education level as boys? Is it common for boys and girls to receive the same education level? If there's a difference, why?
- Would you like to study more? What is stopping you from doing so?
- Would you prefer to stay in Buldana to further your study?

Families/Reproductive Health ('family planning')

- Were you married? If so, at what age?
- What's the optimum age to get married?
- What do you feel about early marriage?
- How do you feel about arranged marriage and 'love' marriage? Which do you prefer?
- How do you feel about the dowry system?

• What beliefs are there regarding family size? What is the ideal number of children in a family? (activity with each participant given counters to vote on their ideal no. of children)
• Is breastfeeding common? When is breastfeeding stopped?
• How many years apart are children usually born?
• Who is present when you give birth? (Healthcare workers? Traditional healers?)
• Where do you give birth? (At home? At hospital?)
• Is it preferred to have a son/ daughter? Is having a daughter a burden for the family?

Malnutrition
• Is there usually enough food for the family? (Quantity of food) Do you go hungry?
• What foods do you eat? (Quality of food)

Water
• Do you have any problems accessing clean water?
• Where do you get your drinking water from?

Sanitation
• What do you believe is important when trying to maintain good hygiene?
• Do people go to the toilet near places where you get drinking water?
• Where do you bathe?

Women's rights
• Do you think women receive same rights as men? Do you think they should receive equal rights?
• To ask men: Do you think that women should have the same rights as you?

Focus Group Discussion – Community Leaders

Open Questions:
• Can you tell us about what different groups exist in the community? For example, different ethnicities, religions, classes/castes?
• What are your main day-to-day concerns as community leaders?
• What are your main concerns regarding health in the villages?
• What are your thoughts and concerns about the current healthcare system?
• Are there any new program implement by the government or any other organization?

Health /diseases
• What are the common diseases and health problems in the community?
• What are the common causes of death in the community?

Water
• Are there problems in the villages accessing clean water?

Sanitation

• Is hand-washing with soap a common practice? (before cooking and eating, after toilet)

Malnutrition

• Is malnutrition a problem?
• Do people get enough amount of food? Do people get a wide variety of food?

Employment

• How do people in your village earn money?
• Is unemployment common?

Families/Reproductive Health ('family planning')

• In your villages how many people live in the same house? (give a range: for example 3-10 people)
• Is the current population size too small, ideal, or too large?
• What are the cultural beliefs regarding family size?
• Do boys and girls learn about family planning & contraception at school? If so, what standard?

Gender equality

• Are there any single mothers? Are they treated differently?
• Do women work? What work do they do?
• How much schooling do girls usually receive?
• At what age do girls get married?
• Are there any abandoned girls in the village? If yes, what happens to them?

Extra Questions if there is time:

• What are your thoughts about contraception use? Is it easily available in this village? Does the government supply any forms of contraception?
• Is there any care is there from healthcare workers during the pregnancy? (eg Checking weight gain in pregnancy and blood pressure; micronutrient supplementation; breastfeeding education)
• Do families get visited by health workers? How often?
• Are there immunisations/vaccinations programs? What age? What vaccines?
• Is smoking common? Is smoking a problem?
• Is drinking alcohol common? Is it a problem?
• Are mosquitoes a problem? Malaria prevalence, use of mosquito nets, mosquito coils
• Are serious injuries (trauma) common? Eg: car/bus/bike accidents?
• How long does it take you to go to your main water source and take it back home?
• Who collects the water? (Children?)
• Are there specific places where people can go to the toilet when they are outside the house?
• What type of public toilet facilities are available?
-Flush toilet?
-Pour-flush toilet?
-Simple pit latrine -Ventilated improved latrine?

- Are mental health problems like depression common?
- Is there any stigma/discrimination against people who have depression?
- If someone is depressed is there anyone/anywhere they can go to for help?
- Who eats first? Children? Men? Women?
- Do women like to bear many children? Do men like to have many children?
- What happens if there are unwanted pregnancies?
- What age should girls get married?
- Do you think men and women should have equal rights and opportunities?
- Should girls be educated as much as boys? Why/why not?
- Should men and women use contraception?
- What types of contraception have you heard of?
- Do you think people engage in pre-marital or extra-marital sex?
- Should all people in the community be educated about safe sex? At what age?
- What are the barriers to using contraception?
- Whose responsibility is it to use contraception? Men or women?
- How can the access to contraception, for those who want to use it, be improved in the community?
- What are your sources of income (farming, manufacturing, services, etc.)
- Are income problems common in the community?
- Are there any domestic violence case?
- Are there any rape case?

CBHP
community based health project

Appendix 2: Cluster Survey Method

Spend ~10mins/cycle (ie steps 1-5)

1. Find the location within the village that is geographically in the centre of all the houses
2. Spin a pen to determine which direction you will head in
3. Draw a number (1-15) randomly out of an envelope
4. Walk in the direction the pen points and count the number of houses you pass on your left
5. Stop at the number drawn and survey the house
6. Repeat steps 1-5 alternating between left and right sides of the road (at step 4)

Note:

-Start by telling them you're not from the government and they're able to talk freely with you

-If the number drawn is greater than the number of houses, when you reach the end of the village, backtrack while continuing to count, until you reach the number drawn

-If the number drawn results in a house already surveyed, redraw another number

-Start at the centre of the houses, not the political/spiritual 'centre'

Appendix 3: Cluster Survey Questionnaire

Village name:

Household no. (e.g. 101 = village 1; household 1):

1. How many people live in this household?
    - Total (children = aged 25 or under)

2. For each person aged 5-25:
    - Age (years)
    - Gender
    - Highest level of education obtained (write grade e.g. 4th standard, if college write college)

3. For every child under the age of 5 present:
    - Age(months)
    - Gender
    - If scales available: measure the weight of the child to the nearest 100g(e.g.5.1kg)
    - If scales unavailable: measure their mid-upper arm circumference using the MSF armband, record the measurement (mm)

4. What is the main source of drinking water for your household?
    - Piped water
    - Tube well/ borehole (hand pump)
    - Dug well (open)
    - Rainwater tank

5. How long does it take to go there, get water and come back? (no. minutes)

6. Where do your family members usually go to the toilet?

- Private toilet in home
- Public toilet
- Field / bush

Appendix 4: Template for data collection used in the Cluster Survey

House ID	No. of people		5-25 years old			<5 years old			Water		Toilet
	Total	Children (≤25 yo)	Age (years)	Gender	Education	Age (months)	Gender	Weight (kg)	Source	Time (mins)	

Appendix 5: Feedback form for observations of villages

Name:

Village:

Observations:

1.

2.

3.

4.

5.

Please pass this form back to the primary researcher after visited to each of the villagers. Also, remind the primary researcher if a new form wasn't given for the next visit.