

## 2005 Country “x” MICS Journalists Workshop (3 hours)

Time	Task	Contents
Opening session  25 minutes	Welcome and Introductions Overview of the day  <i>Name of facilitator</i> (preferably a high-level Government official)	<ul style="list-style-type: none"> <li>• Welcome</li> <li>• Overview of the day</li> <li>• Description of folder contents</li> <li>• Introductions—each participant introduces himself, his/her employer, tells how long s/he has worked as a journalist</li> </ul>
Session One  20 minutes	What is the “Country “x” MICS <i>Name of facilitator</i>	Overview of the MICS in Country “x”
Session Two  20 minutes	Childhood mortality (or first key theme to be addressed) <i>Name of facilitator</i>	<ul style="list-style-type: none"> <li>• Infant mortality</li> <li>• Under-five mortality</li> </ul>
Session Three  35 minutes	Child Health and Development (or second most important theme) <i>Name of facilitator</i>	<ul style="list-style-type: none"> <li>• Total fertility rate</li> <li>• Immunization</li> <li>• Nutrition</li> <li>• Breastfeeding</li> <li>• Malaria prevention</li> </ul>
Session Four  35 minutes	Maternal Health (or third most important theme) <i>Name of facilitator</i>	<ul style="list-style-type: none"> <li>• Use of family planning methods</li> <li>• Antenatal care</li> <li>• Assistance and place of delivery</li> </ul>
Session Five  20 minutes	HIV/AIDS (or fourth most important theme) <i>Name of facilitator</i>	<ul style="list-style-type: none"> <li>• HIV Quiz</li> <li>• Awareness</li> <li>• Testing</li> <li>• Mother-to-child transmission</li> <li>• Condom use</li> <li>• Abstinence</li> </ul>
Session Six  25 minutes	Using the data Wrap-up and Questions <i>Name of facilitator</i>	

### Materials needed

- Computer and projector
- Flip chart and markers
- Index cards
- Copies of the agenda
- Copies of a MICS Journalists’ Guide (if available; if not, use Guide to MICS)
- Copies of other materials already produced, if any
- Camera (don’t forget to get journalists’ approval for further use of their photo)



## **Workshop Objectives**

At the end of the workshop, participants will be able to:

- Explain what the MICS is and how it is conducted
- List the kind of information it provides
- Define commonly used terms
- Explain a selected number of key results
- List at least three ways journalists will use MICS data in their future work

## **Opening Session: Welcome and Introductions**

Up to 25 minutes

Presentation of facilitators from the MICS implementing agency, government institutions, women's groups, National AIDS Commission, UNICEF, as well as from other UN agencies and NGOs who may be attending as specialists/resource persons to answer questions during the workshop.

Each participant introduces himself, his/her employer, tells how long s/he has worked as a journalist and describes level of knowledge about the MICS in the country.

## **Talking points**

- Welcome everyone
- Thank participants for coming
- Introduce facilitators
- Explain the objectives of the workshop
- Stress that the workshop is designed to be interactive. We will not be lecturing
- Remind journalists of the importance of accurate reporting
- Go through handouts
  - Agenda
  - Journalists' Guide and/or Guide to MICS
- Ask each participant to introduce him/herself and tell group about their work
- Ask for any questions and concerns



## **Session One: What is the Country “x” MICS?**

20 minutes

### **Learning Objectives**

By the end of the session, participants will be able to:

- Briefly explain the 2005 Country “x” MICS and its purpose
- List the main topics the survey covers
- Explain what a nationally representative sample is

### **Key message**

The MICS is a valuable tool for journalists as well as public health specialists; it provides key information on such issues as: childhood mortality, child health and development, maternal health, and HIV/AIDS. It is readily accessible, free, and used worldwide.

### **Talking Points**

The 2005 Country “x” MICS is a very detailed household survey that collects information about childhood mortality, maternal and child health, nutritional practices, HIV/AIDS and much more.

- In Country “x”, “number of” households from all parts of the country were surveyed between February and May 2005.
- “Number of” women (aged 15 to 49) were interviewed.
- Information was collected on “number of” children under age 5.
- Three questionnaires were used: a Household Questionnaire, a Women’s Questionnaire and a Questionnaire for Children Under Age 5
- The survey was conducted by the “Name of the Implementing Agency” with technical assistance from UNICEF. Most of the funds for the local costs were provided by “name of the funding agencies” through “name of the institution”.
- Funds were also provided by “names of other agencies/institutions”.
- MICS data is available in print and on the Internet. It is free to anyone who wants it.

### **What topics are covered in a MICS? What is a nationally representative sample?**

Discussion/exercise with journalists to list all topics they think are covered in the survey. Brainstorming of ideas on what constitutes a nationally representative sample.

*Ask participants to come up with list and write down on flip chart. Do this for several minutes so participants can see how much MICS covers.*

MICS surveys cover a range of topics including

- education
- orphanhood and vulnerability of children
- use of insecticide-treated mosquito nets
- maternal and child health
- nutrition
- reproductive health



- sexual behavior and knowledge of HIV/AIDS/sexually transmitted infections (STIs)
- malaria
- children's rights and
- use of health services

*Details: discuss further only if asked by participants*

It is worth mentioning the following:

**How is the data collected?**

- The data was collected by “number of” mobile interviewing teams each consisting of one supervisor, one field editor, four to five female interviewers, and one male interviewer.
- The interviewers receive comprehensive training on the ethics of interviewing and on the technical content of the surveys. They also conducted several practice interviews.
- Interviews were conducted in “names of local languages”.
- Staff were trained to measure level of iodine in the salt and to take height and weight (anthropometric) measurements of both mothers and children.

## Session Two: Childhood Mortality

20 minutes

### Learning Objectives

By the end of the session, participants will be able to:

- Define in simple terms what childhood mortality is and how it is calculated.
- Explain differences between infant and under-five mortality rates.
- Put into context the level of mortality among children in the country.
- Compare, if possible, the level of mortality in the country to that observed in other countries in the region and in the rest of the world.
- Explain how mortality has changed over time (in the last 10-15 years).
- Describe the most plausible causes of mortality among children.

### Key Message

- (*Actual proportion*) of children do not live to see their fifth birthday.
- Under-5 mortality has slightly increased since last MICS in the country.
- Mortality levels in Country “x” are generally higher than those observed in neighboring countries.

### Talking Points

- MICS uses a reliable method to estimate childhood mortality levels by asking a few simple questions about the number of live births a woman has ever had and the number of those children who have died.
- Infant and under-5 mortality rates are basic indicators of a country’s socioeconomic situation and quality of life.
- Reducing infant and under-5 mortality is one of the overarching goals of the Millennium Development Goals.
- For every 1,000 babies born, (*actual number*) die before their first birthday (infant mortality).
- For every 1,000 children born, more than 200 (*depends on data*) will die by their fifth birthday.
- Discuss possible reasons why Country “x” has higher childhood mortality levels than most of its neighbors.
- Identify possible reasons for upward under-5 mortality trends.
- Present some key maternal and child health interventions the Government may introduce to improve child survival.

## Session Three: Child Health and Development

35 minutes

### Learning Objectives

By the end of session, participants will be able to:

- Define the total fertility rate and know it is (*actual number*) children per woman.
- Know that child nutrition and health are still serious problems in Country “x”.
- Understand that there has been no improvement in overall children’s health status since 19??
- Show that the percentage of children receiving all vaccines has decreased from (*actual percentage*) in 19?? to only (*actual percentage*) in 2005.
- Understand the health benefits of breastfeeding, particularly of exclusive breastfeeding.
- Identify the key interventions families can use to prevent malaria.

### Key Message

There is a strong relationship between the education level of the mother and the health status of her children. More educated and more economically advantaged women: 1) have smaller families and 2) are more likely to seek good medical care for themselves and their babies. Children whose mothers have no education are less likely to be fully immunized and more likely to be malnourished and more likely to die in infancy and childhood.

In order to be fully immunized, children should receive the whole series of recommended vaccines at the proper age. Children should be exclusively breastfed until they reach 6 months as mother’s milk is the best nutrient infants can get, especially when they receive the first milk (within one hour of birth), or colostrum, which protects babies from infections before their immune system is mature. Exclusive breastfeeding is on the rise. Use of insecticide-treated bednets for children under-5 is a simple intervention that can dramatically lower malaria.

### Talking Points

#### *Fertility*

Definition of the term “TFR”: what is the total fertility rate?

Women in Country “x” still have very large families. The number of children born per woman is higher than in most other countries in the region. Women have on average (*actual number*) children but they only want to have (*actual number*).

- Over 1 in 3 (*actual proportion*) young women age 15-19 have already begun childbearing.
- The TFR differs greatly by residence: it is almost twice as high for rural women than for urban women.

### *Immunization*

- Only (*actual percentage*) of children 12-23 months received all the recommended vaccinations.
- 4% received no vaccinations at all.
- Vaccination rates vary according to a number of factors. Rates are higher for:
  - First births
  - Children living in urban areas
  - Children born to women who live in the (*name of*) region
  - Children born to women who have attended secondary or higher education

### *Nutrition*

- There has been no improvement in child nutrition since 19??.
- (*Actual percentage*) of kids under five are stunted, meaning that they are too short for their age, a sign that they may have suffered from poor nutrition over an extended period.
- (*Actual percentage*) of children are wasted; in other words, they are too thin (or weigh too little for their height) which is usually a sign of acute or recent nutritional deficit, a factor of high-risk mortality.
- (*Actual percentage*) are underweight, or they weigh too little for their age, which could be caused by either stunting or wasting.

### *Breastfeeding*

- Exclusive breastfeeding is recommended for the first six months of life, since breast milk contains all the nutrients that a baby needs.
- Antibodies in breast milk provide immunity to disease.
- Only about half (*actual proportion*) of babies are exclusively breastfed for the first six months of life.
- This is a dramatic increase from 19?? when only (*actual percentage*) of babies were exclusively breastfed for the first six months of life.

### *Malaria prevention* (in areas at risk of malaria and in malaria-endemic countries)

Children are especially at high risk of contracting malaria. Malaria is most often fatal in young children. The major preventive method—use of insecticide-treated mosquito nets—is very low (*actual percentage*), but represents a dramatic recent increase thanks to the government's new program to distribute bed nets in the most malaria at-risk regions of the country.

- Malaria is a major public health problem in Country “x”. The use of mosquito nets is the primary intervention recommended to reduce malaria transmission.
- It is estimated that (*actual percentage*) of hospital visits in Country “x” are related to malaria.
- Only 20% of children sleep under mosquito nets.

## Session Four: Maternal Health

35 minutes

### Learning Objectives

By the end of the session, participants will be able to:

- Identify the two most important family planning methods women use.
- Define antenatal care and assistance at delivery and know that maternal health services should continue to be improved.
- Explain how pregnant women can be protected from malaria.

### Key Message

Use of family planning is high compared to that of other countries in the region, but there is still an unmet need for family planning (*only for countries in which the unmet need module is used*).

More educated and more economically advantaged women are more likely to use contraception, and to seek good medical care for themselves and their babies. Whereas (*actual percentage*) of women receive some professional assistance during their pregnancy, only (*actual percentage*) give birth with the assistance of a trained provider.

Pregnant women are most likely to get malaria. Malaria complicates pregnancy. It is recommended, as a preventive measure, that pregnant women take at least 2 doses of intermittent antimalarial treatment during pregnancy, such as SP/Fansidar, but MICS data show that very few women follow the recommendation.

### Talking Points

#### Family Planning

- Despite the fact that almost all married women surveyed knew of at least one contraceptive method, only (*actual percentage*) of them are actually using one; (*actual proportion*) are using a modern method. This is higher than most African countries where a MICS has been conducted.
- Contraceptive use is:
  - Slightly higher in urban than in rural areas.
  - Higher in the (*name of*) region and lowest in (*name of region*).b
  - Higher in women with more education.
  - (*Actual percentage*) in women with no formal education vs. (*actual percentage*) in women with at least some secondary education.
  - Lower in young or old women compared to those aged 25-44.
- The most common method of contraception is injectables (??%), followed by female sterilization (??%), and the pill (?%).
- (*Actual percentage*) of women are not having their family planning needs met (*only for countries in which the unmet need module is used*).... that is to say that they

would either like to wait at least 2 years before having another child or that they don't want to have anymore children, but they are not using a method of family planning.

### *Antenatal Care*

- Antenatal care is the care a woman receives while she is pregnant. Many dangers can be avoided if a woman goes to a health centre or to a skilled birth attendant when she first suspects she is pregnant. She should then have at least four check-ups throughout each pregnancy.
- A skilled birth attendant (such as a doctor, nurse, midwife or auxiliary midwife) will help ensure a safer pregnancy and healthy baby.
- About (*actual percentage*) of women who gave birth in the past 2 years received antenatal care from a skilled birth attendant at least once during their pregnancy.

### *Care during childbirth*

- A much lower proportion of women are receiving assistance by a trained provider during childbirth (compared to those receiving antenatal care).
- Still a high proportion of women deliver their baby at home, most of them without the assistance of a trained provider, putting them and their babies at risk in the case of an emergency.
- (*Actual percentage*) of women who die in Country “x”, die due to maternity-related causes (*only for countries in which the maternal mortality module is used*).

*Maternal mortality* (only for countries in which the maternal mortality module is used)

- The maternal mortality rate is estimated at (*actual number*) deaths per 100,000 live births.
- MICS uses the “sisterhood method”, which relies on questions posed to all adults in a household about the survival of their sisters. This produces a maternal mortality rate estimate centered on 10 to 12 years before the survey.

### *Malaria prevention*

- Malaria is more dangerous during pregnancy, especially during the first pregnancy. It can cause severe anaemia ('thin blood'), miscarriage, premature birth or stillbirth. Babies born to mothers who have had malaria during pregnancy will probably be underweight and therefore more vulnerable to infection or death during their first year.
- (*Actual percentage*) of women received at least 2 doses of intermittent antimalarial treatment (SP/Fansidar) during pregnancy. Most of them were treated during routine antenatal clinic visits.

## Session Five: HIV/AIDS

20 minutes

### Learning Objectives

At the end of this session, participants will be able to:

- Identify three important ways to avoid HIV infection.
- Discuss differences in awareness and knowledge of HIV/AIDS and its prevention among women.
- Understand how HIV can be transmitted from mother to child.
- List three ways they can use this data in their work.

### Key Message

Awareness of HIV is high but knowledge is incomplete. More people need to be tested. Overall, discriminatory attitudes and practices are still very common.

### Quiz

Ask participants to estimate the HIV prevalence in Country “x”; identify individuals most at risk in the society, and why; and the best ways men and women can protect themselves from contracting HIV. In high-prevalence countries, talk about the social and economic ramifications of high levels of HIV.

### Talking Points

#### *HIV/AIDS Awareness*

- Almost all women have heard of AIDS but a good proportion still has misconceptions. Very few women have a good understanding about AIDS transmission. (*Actual proportion*) of women do not believe a teacher with the AIDS virus should be allowed to continue teaching and (*actual proportion*) would not buy fresh vegetables from a vendor who has the AIDS virus.

#### *Testing for HIV*

- (*Actual proportion*) of women reported that they had been tested for HIV and received the results. In most cases, women themselves asked to be tested.

#### *Mother-to-child transmission*

- (*Actual proportion*) of women know that the AIDS virus can be transmitted during pregnancy, at childbirth, or by breastfeeding.

#### *Condom Use*

- Condom use is one of the most important ways to avoid HIV/AIDS, especially in high-risk encounters. Only women who were sexually active in the year before the survey were asked questions about condom use.
- Overall, (*actual proportion*) of women reported using a condom the last time they had sex.
- Condom use is highest when women have sex with nonmarital, noncohabitating partners.

### *Abstinence*

- Only (actual proportion) of women choose to abstain from sex as a way to protect themselves from contracting HIV.

## **Session Six: Using the Data and Wrap-up**

25 minutes

### **Learning Objectives**

At the end of this session, participants will be able to:

- List at least three ways to use MICS data
- Describe how to bring MICS data to life for their audiences
- Develop at least three stories that feature or use MICS data

### **Key Message**

There are many ways to use MICS data; it can be used to support many of the stories you report everyday on health, the economy, and politics.

### **Talking Points**

- You can report on the data itself—interesting findings and trends, for example, or use the data to support other stories. You can compare regions of the country to each other, compare urban vs. rural respondents or girls to boys.
- Human interest stories are always popular. Remember that behind these numbers are real children going, or who would like to go, to school; whose parents, or themselves, live with HIV/AIDS; who get regularly sick with malaria, etc; and of real women who may be pregnant and living so far from a health center that they rarely receive antenatal care; of others who can not afford, or do not know about, family planning methods; others who suffer from domestic violence, etc.
- You can illustrate the issues, surprising findings, and trends revealed by the survey with stories that feature individuals and families.
- You can use survey data to educate your audience about malnutrition in rural areas, nationwide school attendance, family planning, use of maternal and child health services in a few targeted provinces, and HIV/AIDS prevention.
- You can use MICS data to support many of the stories you report everyday on health, the economy, and politics.
- Often the data influence policymakers' decisions to implement new policies or develop new programs.
- Oftentimes these decisions are controversial—and newsworthy.

*Story ideas may include:*

- The appointment of new people to health-related positions in government, the private sector or NGOs.
- The availability (or the lack) of new services, including child health services or HIV/AIDS counseling and treatment.
- The announcement of new policies concerning reproductive health, education, child labor, etc.



- The launch of a massive national-based bednet distribution.
- A discussion on the health and education budget allocations over the last five years.
- The beginning of a program to systematically register all births.
- The decision to honor a former health minister who had launched a number of projects that benefited the population (*perfect scenario to assess the current situation*).
- A discussion of new trends in family planning use, girls' education, infant health, etc.
- New ideas discussed in the society for improving the health status of a local area or of the entire country.
- A comparison of Country "x" with other countries in the region on many of the major health indicators.