**Activity 4 Analysis**

***Qualitative Research Methods Workshop***

**INSTRUCTIONS**

* Work in your group
* Read through 3 transcripts and discuss and identify a priori themes and 2 to 3 other themes/sub-themes. Use highlighters, parentheses. List on flip chart (60 minutes)
* Discuss themes/get consensus for one theme/sub-theme – create codes and definition (45 minutes)
* Apply codes to text (15 minutes)
* Report to group and discussion (60 minutes)

**TRANSCRIPT 01**

Q: So it sounds like the CSI is being adapted in several ways. It sort of depends on what the individual program might need, what the program is trying to accomplish, and what the staff there feel is appropriate. Is that right?

A: Yes. I think the CSI advanced our knowledge and understanding of child-centered social service delivery and what it meant to focus on improvement over time and begin to quantify that in some way. Its use of a scale was brilliant in my opinion, that zero to three, that was the greatest advancement. And its breakdown according to the six service areas. I think the limitations right from the get go, as I said, it did not take a systems approach. It looked at child measures only, not at family improvement, family measures, what the parent/caregiver learned about parenting, about economic strengthening, about health and hygiene and all of that, which presumably then would get carried over to family practice. It was only one child at a time so we always believed that the whole is greater than the parts and there wasn’t a sense of whole. So the lack of household piece I think is one big detriment. It is extremely subjective despite its efforts to be objective.

Q: Okay. So, anyway, I’m interested in you talking about being completely subjective, which of course—

A: Well, not completely, but heavily. More subjective. I didn’t say completely. I said more subjective than people thought it was going to be.

Q: Okay. I’ve heard that a lot.

A: On the positive side, I don’t believe we would have made the progress we did in the standards if we didn’t learn to think like the CSI made us think. I really think, I mean I said that before, but I really think it fed the way we think about the standards.

Q: And that’s really with the six domains in the service delivery areas that you were explaining.

A: Yeah. Different countries have standards that cover different areas and don’t necessarily break down with 6+1. And the one in Ethiopia, for example, has a whole extra domain on coordination, which is very systems-oriented. But it really got us to think. I think it would have been much more difficult for all of us to think in terms of standards if we didn’t have a clue of how they break down in terms of measurements, right, because the whole idea is to get standards that are measurable. So it really fed that process, which has been a significant advance. I mean also with some detriments and downsides but a significant advance in the field. So I really don’t want to denigrate the CSI at all.

Q: Okay.

A: Now let me say the third deficit. I think that the biggest thing that worries me as I move into [a new position] is that to the extent that we expect caregivers, volunteers, to fill out the CSI as part of a case management process, we have to understand that a high percentage of them are low literate or illiterate. And even the way it was put together it’s just still too complicated. And what I liked about the Project Hope adaptation is although they’re even more subjective, they did smiley faces. A super smiley face, a smiley face, a sort of flat face and then a sad face. So you get the question, which comes to you in pictorial forms, so you’re taught the question and presumably remember the question triggered by the picture, and let’s say one of the questions has to be very specific [like] eats two meals or more a day. You’ve got two little meals there and then it’s super happy, happy, blah or unhappy. Or I go yeah, [makes noises] kind of thing. And I’m not sure—I mean I think that’s even more subjective but at least it’s accessible to low literate people.

Q: So do you think it’s just—I want to go ahead and make sure. So the three challenges you really talked about are the family focused aspect, the subjectivity, and then expecting the level of caregivers out there to use it.

A: Well, I just want to add one other problem to it. I think we have to understand it within cultural context. I mean I really don’t know much about country XX. This may be true everywhere—family caregivers, parents always try to make their situation out to be as terrible as it possibly can be because they think that way they’re going to get more support. There is a natural inclination, and I have heard that, to say it’s terrible and we have nothing to eat and we’re starving. And that may be true and it may not be true. But people who are poor, who see somebody coming in with a pencil and a paper who has access to services, is going to try to get as much as they can and wouldn’t you do the same thing? So whenever there is the opportunity to say, “Oh, we’re suffering”. So you can just imagine that’s going to muck up the CSI left, right and center, isn’t it?

Q: Yeah. Interesting.

A: So I think we have to understand it in terms of cultural morays and approaches to need and hunger and illness and suffering. I also think we have to understand it in terms of the different values that are placed on the different domains.

Q: So what sort of improvements can be made to the CSI? How do you incorporate those sorts of things into the CSI in a different way?

A: I’m struggling with that myself. I mean I think, as I said, it’s a wonderful tool and it helps us understand the complexity of children’s needs. It unpacks the issue of OVC care. And so I think it has tremendous value in sensitization and training at all levels. I think we have to continue to adapt it for limited usage. If it’s going to be used other than a case management tool, because it’s terribly time consuming also, I’d like to see it used on a sampling basis. I don’t think we make enough use of sampling. So I think on a sampling level I think you can actually use it then for data collection, not to measure things over time, but to get some indication across a large number of children and a large number of programs. It can’t easily be used for outcome. Like everything it’s much easier to use for inputs and maybe a few outputs, but certainly not outcome. I think it still does have some possibilities but it’s got to be a whole lot simpler, a whole lot simpler, especially for volunteers. But it’s very difficult to reduce.

Q: And I was wondering if you could comment—I know you’ve worked with many different countries and they’re all doing different kinds of things. So do you have any sort of overarching thoughts about approaches to CSI training and different models that are used?

A: Well, it’s a long training and people have to do it in the field and it has to be observed in the field. So I mean you have to actually watch. The few times that I’ve led CSI training or worked to develop curricula, which other people then led, it always had a fieldwork piece to it. So you had to sort of explain the domains and explain quality standards. It all was tied together. And then actually teach the tool and then go out and do the tool. So it’s not you can’t do it in less than a week.

Q: Yeah.

A: Which is expensive and time consuming.

Q: Have you had any experience with step down trainings, so where there’s a tier T and then it keeps sort of stepping down to different levels?

A: Yeah. It’s called cascade training because it waters down.

Q: Can you elaborate on that?

A: Well, it’s inevitable. You train people who aren’t trainers. The TOT person is supposed to be a good trainer because that’s that person’s job. But the next level aren’t trainers. And they get about half of what you teach them and then they teach them and it’s about half. So if this is not crystal clear self-explanatory, it’s fraught from the beginning. But that’s true of everything that we do. I mean you really, in so much of what we train, you really need to hope to get a few core principles across, and a few extra things, but not all the details, the cascade approach is very difficult.

Q: Yeah. And it’s being used on such a large level in a lot of the countries. You just hear of thousands of people.

A: Because we can’t think of any other way. We were asked to think of other ways in the project and you say maybe this one could be done by radio and maybe this one could be a self-teach manual. Yeah. But they don’t read. So maybe this one could be some tapes. Yeah. But there’s no electricity. There’s almost no way around it. You tell me. I wonder about the reliability and the validity of the data that they’re getting.

**TRANSCRIPT 02**

Q: So in what ways has the CSI been helpful to your program?

F: Again, this is feedback from the field, that I think that what they’ve appreciated, the social workers, is that it gives them a tool that that they can work through all of the different areas [inaudible 25:04] the child’s well-being and perhaps previously, there wasn’t the same structure and the same discipline to make them think and consider each of those areas, and they may just have judged the situation a bit more on what was obvious and what was there. So, it makes them think through and check that they’ve considered all those different elements.

What else did they say? Yeah, I think that’s the main thing. Just look at it in a more holistic way.

Q: Where there any challenges to using the CSI that any of the social workers raised or that you’ve experienced?

F: No. They didn’t seem to. From my side, when I collected an initial sample of the data after we were using it just for a short time, I felt that the two countries were using it differently. I was surprised that the country XX assessments all came up much more positive. The average was much more positive than country YY. So...

Q: Can you talk about that a little more? I’m not sure I followed that. I think I had a little feedback, too.

F: Okay. I asked for a sample of I think 20 or 30 children and when I looked at the average, if I averaged the scores across all the domains, country XX came out much higher than country YY, which I think thought was a challenge because country XX is actually a poorer, less resource-rich country than country YY, and I think the living standards in country XX are lower, so I would have expected them to come out having lower scores.

But talking to our social workers in country YY, they were talking about how they judge it according to the community that they’re in and they say – they have to think – because they’re going to so many different communities, every time they have to think, “Okay, what’s the norm for this area?” And maybe it’s somewhere they haven’t visited before, so they’re always trying to judge it based on the norm for the area.

So for me, from a monitoring perspective, that’s a challenge because I can’t – I will find it hard to compare country with a country.

Q: Mm-hmm.

F: Because the comparisons are all local. Does that make sense?

Q: It does make sense. But it sounds like that that’s what’s working for the social workers, though, is by following the norm in a given community, that that helps them do their work and...

F: Yeah. And I think that has to be the way that they do it because it’s important for that child to fit back into that local situation. We’re always – we prepare children all together in one place, but they’re all going back to completely different setups and we want to have a certain standard, but we have to recognize that it’s going to be different in different communities when we’ve got kids from right across a country. And it’s quite varied.

Q: How do you think the CSI could be improved to better meet the program’s needs?

F: One thing that one of our social works brought up was that he felt that there should be a spiritual element to it...

Q: Interesting.

F: We’re a Christian organization, but we work with children of all faith, or no faith. But we felt that it would be good to have some sort of spiritual life element to it, that that part was missing. Religion is quite a key part of everyday life, so that was an assessment that came from there but I have no idea really how that would work in practice. [Laughs]

Q: Okay. Do you think that there be a specific domain around it or...

F: Yeah.

Q: ...was it just sort of left pretty general?

F: It was quite general, but I think he was implying that he wanted a domain – a spiritual domain. He was talking about how – of how he said it’s important for children’s resilience in coping with what they’re going through, is having that spiritual side as part of their coping mechanism. I guess it’s, in some ways, it’s in there in the psychosocial domain. Someone from country YY said that in their OVC guidelines, the psychosocial element very much includes a spiritual bit, but there’s no specific spiritual mention in that domain within the CSI as it stands at the moment.

Q: Okay. All right. I’m going to go onto the next section, which talks a bit about training. I can skip I think the first question, because you already told me that it’s the social workers who administer the CSI and that they do provide direct services to children.

F: Mm-hmm.

Q: Have all of those people who you just mentioned, the 12 in countries YY and XX, have they all been trained to use the CSI?

F: Only one staff member has attended a formal training. Our main social worker in country YY attended the regional training last year, I think. But we have kind of done internal, informal trainings ourselves based on the resources that we’ve got and the experience that the [inaudible 32:16] had during that training.

Q: Is that a training that you lead or that some of your staff lead?

F: I have led one and then our staff has done it themselves within their social work teams.

Q: Okay. And does it have a set agenda with it? Or does it vary depending on the group?

F: I think it’s -- the one that I’ve just done in country YY, I had a program and it was based on my resources from a training that happened a while back. And I based what I did on the format, but that was like a four-day training and I have [inaudible], it was quite condensed. And in terms of what the social work staff have done, I think that they have just kind of – it has been quite informal, more kind of discussing how they would do it, looking at the manual that they’ve got, and rather than it being an actual kind of workshop setting.

Q: So overall, how adequate would you say the CSI training as been?

F: I think we need more training and we would love to get a chance for more of us to go to external training and have a chance to interact with others. When I was at the regional training I should have mentioned that. I visited to organizations who were using it and that is informing how we’re using the CSI as well. So, I guess that – it was incredibly useful. It’s not an official training, I suppose, but I visited [another organization] and they’ve used it on a very, very large scale and that was really interesting to see how they were using their data from a monitoring – I did it from a monitoring perspective – how they were using large quantities of CSI data to develop their programs. And then I visited an organization that is smaller than ours and how they were doing it. That was a really useful learning experience to see practically how other people are doing it and what they were – the challenges that they had faced and how they were kind of changing things and moving forward with it.

**TRANSCRIPT 03**

Q: So in what ways has the CSI been helpful to your program?

A: Well, it helped us to really kind of, like when the, what’s it called in English, the different domains and the sub domains, those were very helpful for us to focus on what it is that makes children vulnerable and so it was a really good way for us to hone in on okay this is what we need to focus on first. The other stuff is important and we need to look at the other stuff but this is the priority. This is your priority. So that was one thing that it helped us with. The other thing is it helped us to get a numerical value of how vulnerable is the child because initially we had so many referrals and we weren’t able to get to them all at the same time and so we really had to kind of figure out how to determine who was a biggest priority without really knowing a lot about them and so we made our referral tool a little bit different and we added some of the same domains there as initial questions to determine if kids were actually in an extreme situation of vulnerability and they needed us to be admitted right away or if they were a little bit more stable and they could wait a month or so to be admitted. So it helped us to kind of look at things from a priority standpoint.

I think it’s good to explain who you’re getting the information from. I think what I like about the other thing that’s been helpful about the tool is it really gave the child, it empowered the child to actually answer some of their own questions and perspectives and I think that that’s something that we might not have taken into consideration had we not used the CSI tool. The other thing is that I don’t know that we would have focused on the events that affect children and like past events how they could be affecting the current situation. I think the social workers are really good at that piece but I don’t know necessarily that the case managers would have been able to look at those areas and so that’s been helpful. I like the tool that you can ask about what services that they have received because one of the things that’s important for our funder is to not duplicate services and so that’s been a piece that we’ve had to really focus on as well so that families aren’t getting educational scholarships from three organizations which is really a challenge to try and manage that for many reasons but I think that the tool helps us to at least keep that in our mind. You know? We’re constantly asking those questions and constantly thinking. As I’m talking with you, it’s quite possible that using this tool on a visit by visit basis would actually make it more valuable.

Q: Can you describe some of the challenges you’ve experienced using the CSI?

A: Yeah. The CSI from what I understand was initially developed for use in Africa and so if you look at the tools, even the pictures are more African related pictures. We are not African so it may be hard for the social workers to relate to the pictures. One of the other things that I’ve found challenging is that as a person who has been educated we have a tendency to infer a lot of information in using the tool but if you’re somebody who maybe is not at a level of education or training and doesn’t understand the intricacies of each domain, I think that you’re probably not going to use the tool as accurately. For example, how do you interpret a score of four?

Scoring a four in the food and nutrition domain might be beans and rice three times a day, eating three meals, seven days a week kind of thing but from my point of view a four as a professional nutrition-wise would be eating enough protein and vegetables and fruit and all of those things that go into a proper diet. It’s difficult when you have different people evaluating what is a four because for me a four would be the best and ideal nutrition available to kids but in my country. I guess then no child who is considered vulnerable would have a four. So for me it was difficult to train on what is a four when like what is a standard for kids. What would you consider a standard for kids? Should they receive three meals a day? Should they also receive three meals a day plus two snacks? How much protein should they receive a day? What about vitamins and fruits and vegetables and how much milk should they be drinking and like what is the standard and then from there I think then you can determine okay well obviously then there’s no kid in this country that we’re seeing that have a four. Even our case managers that are evaluating kids don’t eat three meals a day or they themselves don’t eat meat every day or a protein source every day or maybe their only protein source is beans. So how do they evaluate a four? So for me as a professional, it’s really difficult to know what a four is.

Q: So how do you deal with that with your staff? Do you have discussions about what is a four?

A: Yes. In every discussion we have, you’ll have a different point of view. I think that this is an area where we’ve not done a sufficient job in training our staff or even understanding it ourselves and why I would say that the validity of the tool is in question in our use because of that factor. We have defined four – the best nutrition for a child – a child who is fully getting the full nutrition that their body needs and that’s their human right to have. Well then we all agreed that there was no child that we cared for that would get a four but yet I still see fours because they go back to what is the standard so in their mind a four is, well if they’re eating beans and rice everyday then that’s fine and that’s probably a four.

Q: Are there any other challenges besides the validity issue and subjectivity of it?

A: There is the issue of the pictures. Have some that are Latin American. Also our staff says it takes a really long time to do on every child and so the length of the tool or the amount of information that they’re trying to gather to make a decision as to what level each child is that’s an issue. The other issue is when it comes to getting valid information. For example, we get some information from the families. We get some information from observation and then we get some information from speaking directly with the kids. They often differ. Well what information then is valid? Also culturally people don’t want to put themselves in a bad light so they to say what they think the person wants to hear so it’s not always honest.

Q: So you’ve talked a bit about sort of how you learned about the CSI. Did you directly train your case managers to use the CSI?

A: Yeah.

Q: How did that go?

A: Well that’s what I mean. I think I might be the crux of the problem. I trained myself by reading all the information that you guys have provided out there or they have provided out there and so I trained myself by reading and then I trained the staff by what I had read and then we had a volunteer come down and she read through all of the information as well and then she made some adjustments for us. Well she first went out with our staff and evaluated how they were doing and she had lots of observations and then she came back and then we made an adjustment to the tool which was adding the pictorial along with the questions and then she trained the staff again and then she went out and they did follow up post visits and they were doing better.

Q: So do they ever get refresher training or do they come to you for guidance on how to make care decisions based on scores?

A: Yeah. That was the second training that the staff had had and that was just last year so they’ve not had any refresher training since then. No. Yeah they can ask questions if they need to.

Q: And what would you say is the primary focus of the training?

A: On how to score the kids.