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Child health in the community

"Community IMCI"

BRIEFING PACKAGE FOR FACILITATORS

CORE unicef

WORLD HEALTH ORGANIZATION

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Contents

Abbreviations

AFRO	WHO Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
AIN	Atención Integral a la Niñez
ARI	acute respiratory infections
BASICS II	Basic Support for Institutionalizing Child Survival
BCC	behaviour change communication
CBMIS	Community-based Management Information System
CBO	community-based organization
CBA	community-based activities
CCD	community capacity development
CORE	Child Survival Collaborations and Resources
CORPS	Community resource persons
C-IMCI	Community Integrated Management of Childhood Illness
CRC	Convention on the Rights of the Child
DHT	district health team
EPI	Expanded Programme on Immunization
HIV	human immunodeficiency virus
ITN	insecticide-treated bednet
IAWG	Interagency Working Group
IEC	information/education/communication
NGO	nongovernmental organization
IMCI	Integrated Management of Childhood Illness
KAP	knowledge, attitude and practice
MOH	ministry of health
ORS	oral rehydration salts
PLA	Participatory Learning and Action
PMTCT	prevention of mother-to-child transmission
PRA	Participatory Rural Appraisal
PVO	private voluntary organization
TIPs	Trials of Improved Practices
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VIPP	visualization in participatory programmes
VPD	vaccine-preventable diseases
WPRO	WHO Regional Office for the Western Pacific

Introduction

Integrated Management of Childhood Illness (IMCI)

Children under five years of age bear a disproportionate share of the global burden of disease. While major gains have been made in reducing childhood mortality during previous decades, stagnation or even reversals of trends have been observed recently in many countries. Most of the nearly 11 million child deaths each year are concentrated in the world's poorest countries in sub-Saharan Africa and South Asia. Diarrhoea, pneumonia, and neonatal conditions are the most prevalent causes of childhood mortality worldwide, with malaria and HIV infections contributing in many areas. Malnutrition is associated with 54% of all child deaths, and measles remains a major cause of death.

In response to this challenge, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) developed Integrated Management of Childhood Illness (IMCI).

IMCI is a broad strategy designed to reduce childhood mortality, morbidity and disability in developing countries, and to contribute to improved growth and development of children under five years of age. It encompasses improving: case management skills of health providers, the health system, and family and community practices.

The IMCI strategy sets priorities to address the problems that have the greatest impact on child survival, growth and development. Such problems include:

- malnutrition;
- micronutrient deficiency;
- HIV/AIDS, which is an underlying cause of mortality in up to 30% of cases;
- acute respiratory infections, which cause over 2 million child deaths per year;
- diarrhoea, which causes 1.2 million child deaths per year;
- vaccine-preventable diseases such as measles;
- malaria, which accounts for more than 600 000 child deaths per year.

IMCI includes interventions to promote growth and development, to prevent illness and to respond to it appropriately when it does occur. These interventions may take place in the health facility or in the home. Table 1 gives some examples.

These interventions are supported by the three components of the strategy:

- **Component 1**: Improving case management skills of health providers through training, using locally adapted guidelines.
- **Component 2**: Improving the health system by strengthening district health planning and management, making available essential drugs and supplies required for effective case management, providing quality support and supervision at health facilities, improving referral and health information systems and organizing work efficiently at the health facility.

Table 1. Types of interventions included in the IMCI strategy

	TYPES OF INTERVENTION	
SETTING	PREVENTION OF ILLNESS AN PROMOTION OF GROWTH AND DEVELOPMENT	RESPONSE TO ILLNESS
Home and community	Community/home-based feeding programmes; peer counselling	Early recognition and home management
	Use of insecticide-treated bednets (ITNs)	Appropriate care-seeking
		Adherence to treatment recommendations
Health facilities	Vaccination	Case management of diarrhoea, malnutrition, ARI, measles, malaria and other serious infections
	Counselling on breastfeeding and appropriate complementary feeding	Counselling on breastfeeding and appropriate complementary feeding
	Micronutrient supplementation	Micronutrient supplementation
		Antihelminthic treatment

- **Component 3**: Improving family and community practices by promoting those practices with the greatest potential for improving child survival, growth and development (henceforth referred to as "community IMCI" or "C-IMCI").

Links between the three components of the IMCI strategy

The three components of the IMCI strategy are linked and support each other when implemented simultaneously. For example, components 1 and 2 support component 3 when health providers trained in IMCI counsel mothers on home care / management of sick children. In turn, when mothers seek treatment outside the home and receive quality care at the health facility, demand and utilization of services increases. This demand can be met by having components 1 and 2 in place. In addition, community demand may facilitate outreach by facility-based health providers who can also supervise community health workers to provide quality care and reinforce health messages.

Improving family and community practices

Success in reducing childhood mortality requires more than the availability of adequate health services with well-trained personnel. As families have the major responsibility for caring for their children, success requires a partnership between health providers and families, with support from their communities.

Health providers need to ensure that families can provide adequate home care to support the healthy growth and development of their children. Families also need to be able to respond appropriately when their children are sick, seeking appropriate and timely assistance and giving recommended treatments.

IMCI and Child Rights

The right to survival and development is one of the four basic principles of the Convention on the Rights of the Child (CRC). Human rights principles underlie C-IMCI. The application of human rights principles to IMCI implies that the strategy

addresses not only the manifestations of the problem but also the underlying root causes. C-IMCI engages families and communities in discussions about child health and assists them to assess, analyse and take action on the problems affecting them and their children. It also promotes the participation of parents, other primary caregivers and communities to sustain new practices that support the changes they have chosen to pursue in child health. Community involvement and capacity development are central to the implementation of C-IMCI.

Briefing Package for "community IMCI" (C-IMCI)

Community-based activities are ongoing in many communities in most countries. This Briefing Package proposes a process for bringing principal partners together for planning and implementation at the national, intermediary, district and community levels. This process will: enable development of coherent strategic and operational plans at various levels; facilitate the sharing of experiences, resources and expertise among projects and geographical areas; and help ensure consistency. The process is best carried out with the assistance of a facilitator.

The Briefing Package is comprised of the following three documents:

Reference Document

The *Reference Document* contains guidelines for: gathering and analysing information about ongoing community activities at the national, intermediary, district and community levels; developing national strategic plans and operational plans at the national, intermediary, district and community levels; and implementing C-IMCI at the community level (with best practices from selected countries as examples).

Training Guide

The *Training Guide* is based on the *Reference Document*, and contains guidelines for training facilitators in planning for implementation of C-IMCI.

Case studies

Case studies supplement and enrich the training of facilitators.

The present material, the *Reference Document*, contains the following sections:

Introduction

The introduction serves as a short orientation on IMCI, provides a rationale for the development of the strategy, and describes the linkage between the three components of IMCI. In addition, it explains the rationale for the development of the Briefing Package and describes its potential users.

Chapter 1. Understanding C-IMCI

This chapter describes C-IMCI in detail, listing the key family and community practices with the greatest potential to reduce child mortality and improve child survival, growth and development. It also provides insight into principles guiding C-IMCI implementation, and offers examples of best practices in C-IMCI implementation from some countries.

Chapter 2. Planning for implementation of C-IMCI at National Level

This chapter describes steps in planning C-IMCI using the results of situation analyses in the country. It also provides detailed steps on how a national strategic plan may be developed and adopted.

Chapter 3. Planning for implementation of C-IMCI at Intermediary Level
This chapter briefly highlights the steps that are needed to work at the intermediary level in a country, region, province or state.

Chapter 4. Planning for implementation of C-IMCI at District Level
This chapter highlights the key points for district-level planning, and outlines and describes the steps. The chapter also includes information on scaling-up, sustainability, partnership and resource mobilization.

Chapter 5. Planning for implementation of C-IMCI at Community Level
This chapter outlines the general principles of C-IMCI and offers detailed guidelines on the planning steps. Country examples of C-IMCI implementation provide the user with a variety of methods that best suit particular country/community situations and needs.

Annexes
This section contains additional tools for planning. Each chapter refers the user to appropriate annexes.

How to use the Briefing Package

The Briefing Package emphasizes a *bottom-up approach complemented by a top-down approach* for C-IMCI planning. This is critical to successful implementation, because adoption of key practices at the national level should reflect community situations and needs. Community action plans are also supported by a policy environment that encourages implementation, sustainability and scaling-up.

The design of the Briefing Package is flexible so that facilitators can begin planning and implementation at any level, depending on available information and current community-based activities. Many countries, regions, districts and communities already implement some community-based IMCI activities. These activities need to be acknowledged and used as a base for expansion. This Briefing Package guides facilitators to determine where to begin, building from existing activities using structures already in place.

Even if community-based activities are already in place when the facilitator begins, planning should be done at the national level. This will ensure that policies and strategies support activities in regions, districts and communities. Data collected from communities and districts will define how the practices are structured for the country's national strategic plan and provide insight for lower-level planning. If the facilitator is asked to work only at the district level, these same advantages follow.

If C-IMCI activities are under way at the community level when the facilitator begins, the facilitator could help nongovernmental organizations (NGOs) and other partners initiate or strengthen interventions. The data and experience obtained from such implementation should be used to guide policies and strategies at the national level.

Users of the Briefing Package

Users of this Briefing Package (facilitators of the process) may include:

- People who have experience or are currently involved in implementing community-based child health programmes. They may be able to use the *Reference Document* as a stand-alone guide to assist them in understanding C-IMCI and applying the approaches to planning for implementation at the community level.

- People who have planning and management experience in implementing programmes at national, intermediary and district levels. Those people who may not have field experience in implementing community-based child health programmes, but who are involved in coordinating such programmes at national, intermediary and district levels, are likely to require training or orientation.

Specific responsibilities of the facilitator

The Briefing Package provides the facilitator with maximum flexibility to tailor his or her efforts to each situation and to respond to real needs. It will support the facilitator's work at the national, intermediary, district and/or community levels to facilitate development of a C-IMCI implementation strategic plan.

At each level, the facilitator's responsibilities will be as follows:

- Facilitate the establishment and orientation of a working group responsible for the community component of the IMCI strategic plan.
- Assist the group to carry out a situation analysis.
- Assist the group to run partner/stakeholder workshops and dissemination sessions
- Assist the group to design a C-IMCI strategic plan.
- Assist the group to design a C-IMCI operational plan, including monitoring and evaluation.
- Ensure, through follow-up, that the country/district is implementing the operational plan.

CHAPTER 1

Understanding C-IMCI

Evidence has shown that up to 80% of deaths of children under five years of age may occur at home with little or no contact with health providers. Community IMCI (C-IMCI) seeks to strengthen the linkage between health services and communities, to improve selected family and community practices and to support and strengthen community-based activities. Sixteen practices have been identified by UNICEF and WHO to be of key importance in providing good home care for the child in order to ensure survival, reduce morbidity, and promote healthy growth and development.

Key Family Practices (see Annex A)

The key family practices are grouped into four areas:

Promotion of growth and development

- Breastfeed babies exclusively for six months;
- From six months, give children good quality complementary foods while continuing to breastfeed for two years or longer;
- Ensure that children receive enough micronutrients – such as vitamin A, iron, and zinc – in their diet or through supplements;
- Promote mental and social development by responding to a child's needs for care and by playing, talking and providing a stimulating environment.

Disease prevention

- Dispose of all faeces safely, wash hands after defecation, before preparing meals and before feeding children;
- Protect children in malaria endemic areas, by ensuring that they sleep under insecticide-treated bednets;
- Provide appropriate care for HIV/AIDS affected people, especially orphans, and take action to prevent further HIV infections

Appropriate care at home

- Continue to feed and offer more fluids, including breast milk to children when they are sick;
- Give sick children appropriate home treatment for infections;
- Protect children from injury and accident and provide treatment when necessary;
- Prevent child abuse and neglect, and take action when it does occur;
- Involve fathers in the care of their children and in the reproductive health of the family.

Care-seeking outside the home

- Recognize when sick children need treatment outside the home and seek care from appropriate providers;
- Take children to complete a full course of immunization before their first birthday;
- Follow the health provider's advice on treatment, follow-up and referral;
- Ensure that every pregnant woman has adequate antenatal care, and seeks care at the time of delivery and afterwards.

Evidence for the key family practices

A recent publication presents the evidence for 12 of the key family practices (Hill Z, Kirkwood B & Edmond K. *Family and community practices that promote child survival, growth and development: A review of the evidence*. Geneva, World Health Organization, 2004 (ISBN 92 4 159150 1)). Some examples are given below.

Breastfeeding can reduce diarrhoeal mortality by 24–27 % among infants aged 0–5 months. Breastfed infants under two months of age are six times less likely to die of infectious diseases than non-breastfed infants. Breast milk provides all the nutrients needed for most infants up to six months of age. The infant digests it more easily than substitutes, and it provides anti-bacterial and anti-viral agents that protect the infant against disease.

Vaccine-preventable diseases account for approximately 10% of the global burden of diseases in children under five years of age and correspond to nearly 3 million child deaths per year. Measles account for most vaccine preventable deaths. A review of 12 studies found that measles immunisation was associated with reductions in total mortality that ranged from 30–86%. Additionally, providing vitamin A supplements as part of measles case management can reduce the case fatality rate by more than 50%.

Child malnutrition remains a common problem in the developing world. Estimates suggest that more than one third of young children are stunted (UNICEF 1998) and that malnutrition is a direct or indirect cause of over 50% of all childhood deaths. There is a strong association between complementary feeding and reduced mortality in children aged 6–11 months. Improved feeding practices to prevent or treat malnutrition could save 800 000 lives per year.

Children require increased food and fluids during illness to prevent malnutrition and dehydration and to speed up recovery. Feeding a nutritious diet to children with diarrhoea increases net energy and nutrient absorption without affecting stool output.

An estimated 90% of child diarrhoea is the result of poor sanitation, lack of access to clean water supplies and inadequate personal hygiene. Handwashing alone is associated with a 35% reduction in diarrhoea incidence. Observational studies in the Philippines and Sri Lanka found a 64% and 54% increase in diarrhoea in families with inadequate faeces disposal.

Malaria accounts for 25% of childhood mortality in Africa and is a growing problem. Use of insecticide-treated bednets (ITNs) is associated with a 17% reduction in child mortality, as compared to populations with no or untreated bednets. Most of the benefits of ITNs appear to be due to the insecticide treatment rather than the physical presence of the net. In Kenya, a 45% reduction in the frequency of severe malaria episodes was observed following introduction of ITNs.

Treating illness at home is a common practice. It is important, therefore, to ensure that these behaviours and actions are appropriate. Appropriate home treatment involves early recognition of the illness, prompt use of relevant pharmaceuticals and avoidance of ineffective and harmful treatments. Not all infections need to be treated by health professionals. Uncomplicated diarrhoea, for example, can be managed successfully at home by continuing to feed the child, offering more fluids and administering oral rehydration therapy (ORT) correctly. Interventions to improve home treatment of malaria could reduce child deaths by up to 40%.

Caregivers should be aware of signs indicating the need for seeking care outside the home. Studies examining factors that contribute to child deaths have found poor care-seeking implicated in up to 80% of deaths. Increasing and encouraging timely health facility use has a great potential for reducing mortality. To ensure that sick children recover quickly and completely, caregivers must adhere to the advice given by the health provider. Improving compliance to dosage and consumption of drugs is also important for reducing build up of resistance to medications.

Growth retardation is evident in 39% of children under five years of age in developing countries, and this is a marker for developmental risk. There is an extensive theoretical basis for the benefits of psychological stimulation on early childhood development. The growth and development of a child depends not only on the care, food and resources provided by a caregiver, but also on the psychosocial stimulation the child receives from the caregiver early in life. A child with well-developed psychosocial skills, who is able to engage the caregiver, may then be more effective in demanding and obtaining food.

General principles of C-IMCI

The important principles that underlie C-IMCI are as follows:

- C-IMCI is implemented at district and community levels, but should be linked to a national strategic plan that will provide policy direction and an enabling environment. Links should be established between community and district-level planning and implementation and between district, regional and national levels.
- C-IMCI should identify and build on existing programmes and community structures rather than create new ones.
- Participatory approaches to planning and implementing activities should be utilized to ensure ownership and sustainability.
- Successful implementation of C-IMCI requires effective partnerships at all levels. Clear definitions of roles and responsibilities of all stakeholders are essential.
- C-IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity and for promoting child growth and development.
- Implementation of C-IMCI requires the other two IMCI components to be in place, providing support to families and communities. In some situations, however, where the other two components are not in place, it may still be appropriate to implement C-IMCI interventions. In such cases, efforts should be made to ensure that the other two components are introduced.
- Phased introduction of promotion of key family practices is acceptable. Families and communities must not be overwhelmed by the introduction of too much at once, but a good C-IMCI plan should include the eventual phasing in of all the appropriate practices.

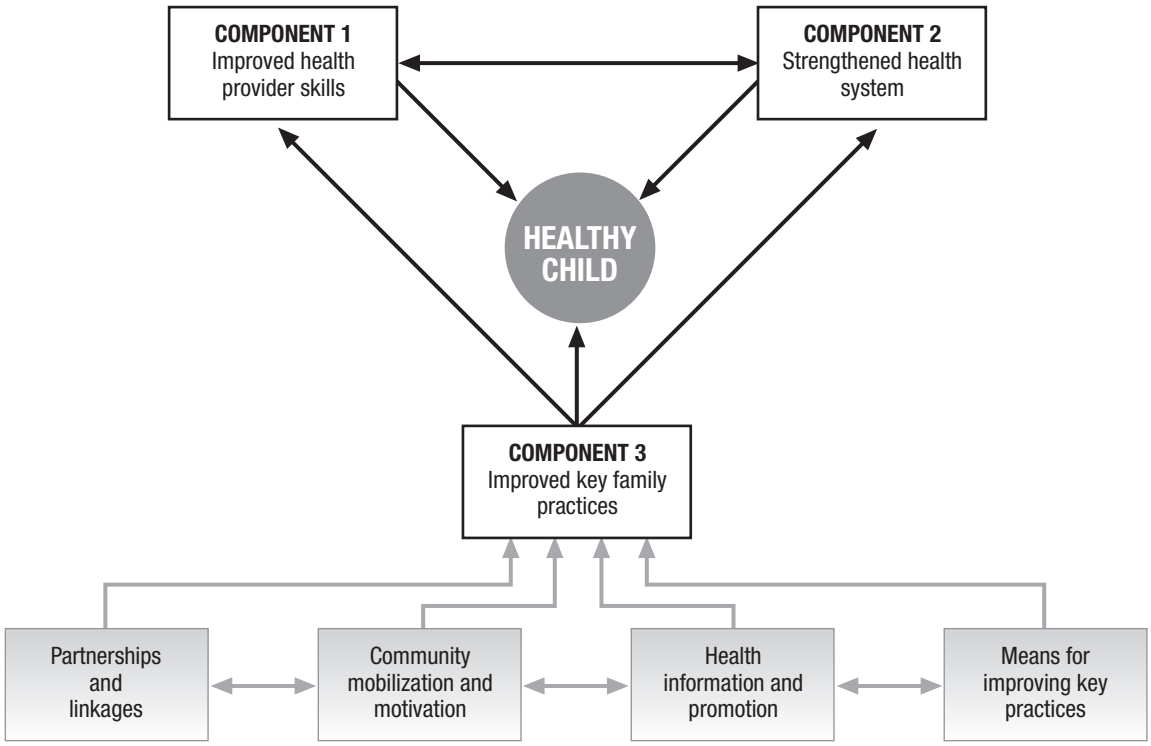
Frameworks for C-IMCI

Some partners have developed implementation frameworks for C-IMCI to support planning interventions to improve family and community practices. These frameworks include the C-IMCI Regional Framework for the WHO Western Pacific Region (WPR) and the C-IMCI Operational Framework developed by the Child Survival Collaborations and Resources (CORE) Group and Basic Support for Institutionalizing Child Survival (BASICS II). The frameworks provide insight into how to approach C-IMCI from somewhat different perspectives – that of process (as in the WPR framework) and that of points of intervention (as in the CORE/BASICS II framework).

The WPR Regional Framework shows how the three components of IMCI work together to improve the health and development of the child. The C-IMCI Framework focuses on improving key family practices. Four areas contribute to improvements in these practices: partnership and linkages; community mobilization and motivation; health information and promotion; and means for improving key practices.

The Operational Framework developed by the CORE Group and BASICS II uses experiences of NGOs in community-based programming to describe the different

Figure 1. C-IMCI Regional Framework for WHO Western Pacific Region



categories or elements of community-level activities necessary for the implementation of a comprehensive child health and nutrition programme. The framework consists of three linked elements supported by a multisectoral platform. These elements facilitate the systematic cataloguing, synthesis and coordination of organizational activities and experience. The three elements and examples of corresponding objectives are listed in Table 2.

Table 2. CORE Group/BASICS II Operational Framework for C-IMCI

ELEMENTS	EXAMPLES OF CORRESPONDING OBJECTIVES
Element 1	
Improving partnerships between health facilities and services and the communities they serve	Form partnership between health facilities and the communities they serve Increase utilization of health facilities and services Establish mechanisms for community feedback on, and/or management of health facilities and services
Element 2	
Increasing appropriate, accessible care and information from community-based providers	Increase quality of care from community-based providers Increase promotion of preventive practices by community-based providers Decrease harmful practices of community-based providers
Element 3	
Integrated promotion of key family practices critical for child health and nutrition	Increase adoption of key family practices for health, nutrition and development Engage communities in selecting behaviours to be promoted and identifyming actions to be taken

Critical issues to consider in planning C-IMCI

C-IMCI will always be introduced and implemented within the context of specific local situations and priorities – whether at national, intermediary, district or community levels. The general principles, as well as the various frameworks, may be used to adapt and integrate C-IMCI to country, region, district and community situations and priorities. The following are the critical issues in C-IMCI planning and implementation:

Policies and guidelines related to child health at the community level

National child survival programme policies and guidelines must clarify the roles and responsibilities of stakeholders at each level for implementation of C-IMCI activities. These should include the definition of the minimum package of community-based services and the list of essential drugs for the management of major childhood diseases. The role of community health providers and other community-based service providers in the management of sick children and the supply and administration of drugs should be defined clearly.

Collaboration and Partnership

Implementation of C-IMCI offers an opportunity for working with other health and development programmes in the private and public sectors. Working together may mean simple collaboration, such as information sharing, or it may take the form of coordination, such as shared planning and allocation of resources. At the community level, nongovernmental organizations and community-based organizations (CBOs) should also see themselves as partners in the implementation of C-IMCI. Effective collaboration often results in coordination of efforts and improvement in mobilizing and utilizing resources for going to scale.

Several kinds of partnerships foster successful implementation of C-IMCI at all levels. These include partnerships between health facilities and the community, between governments and partners at various levels, between health and other sectors (e.g. agriculture, water and sanitation, education), between public and private health providers and among the different organizations implementing C-IMCI. It is important that other sectors in governments come into partnership with C-IMCI. This is because key practices at community level can be improved only when these sectors provide support (e.g. to improve handwashing, potable water must be accessible to the community).

Health facilities and communities should work together to improve the quality of health facilities and to increase their use. For maximum impact all efforts towards reducing child mortality should be coordinated and harmonized with organizations working at community level. The various players in the community and other levels should have an open line of communication.

Involvement of district stakeholders

At district level, local and international NGOs, community-based organizations and the private sector (private health facilities, community service providers) should be encouraged to participate in C-IMCI. To foster the long-term engagement of stakeholders at district level and to ensure sustainability, they should be involved from the beginning in planning, implementation and monitoring of community interventions.

District-level stakeholders should get support from national-level stakeholders in building their capacity, and in the implementation of specific activities, including sustained support for supervision.

Community service providers

Families need access to health providers who treat sick children and who communicate effectively. Health providers also need to work with families and their communities to promote adequate home care and a home environment that supports children's healthy growth and development.

A wide range of people and community groups can contribute to the improvement of child health. Families and individuals often rely on service providers available at the community level (e.g. traditional healers and birth attendants, religious associations, private and public service providers). Some are formal service providers (public and private) who work within a well-defined framework, and others are informal caregivers, without formal training, who are generally recognized by the community and who may not apply normal standards of care. The quality of care offered by these community service providers needs to be addressed to increase their capacity to promote preventive care.

Involving informal service providers in planning and implementation of C-IMCI can help foster a common understanding of the strategic goals. Their involvement from the beginning will enable them, for example, to identify available and potential resources to carry out the interventions, and to estimate the time needed to carry out those interventions and their potential costs.

Capacity development

Developing strategies for capacity building is necessary at all levels – community, district, intermediary and national – for planning, implementing, monitoring and evaluating C-IMCI activities. For example, before carrying out a situation analysis, stakeholders should identify the necessary skills and capacity gaps and draw up a plan for developing these skills. Planning for capacity should be an integral part of developing C-IMCI programmes to ensure and strengthen sustainability.

Essential drugs and equipment supply

If the intervention is to succeed, the minimum package of drugs and equipment necessary to support and sustain the desired changes must be in place and accessible to the community. Policies and guidelines that take into account the needs of the communities are required for adequate and regular supply of such materials. In some cases, communities share costs and participate in other sustainability measures.

Choice of priority practices

Given that behaviour change is challenging, a few key practices should be promoted initially. Implementation of C-IMCI at community level may begin with the identification of three to five practices that not only have the greatest potential impact on child survival, growth and development, but are also seen as feasible and acceptable by the communities involved. Later, communities can evaluate their performance and take up additional practices as they observe positive changes.

Communication

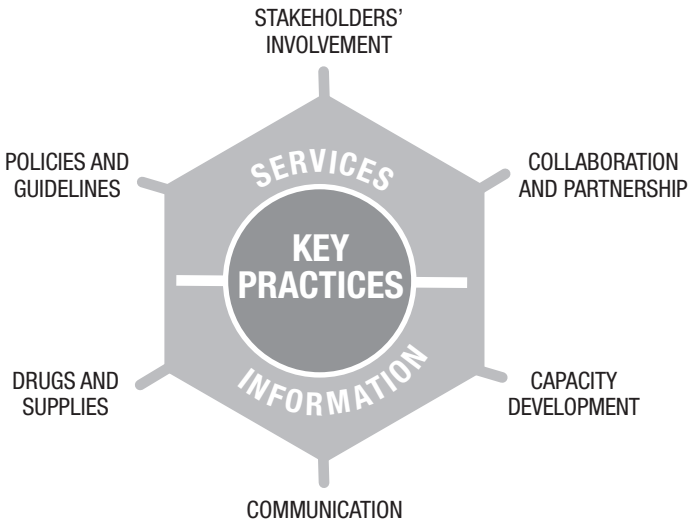
Communication, a central strategy for planning and implementing interventions to improve key practices, is a process of engaging families and community members in discussions that enable them to take an informed decision for behaviour change. In addition to providing information via appropriate messages, communication empowers communities to learn and make decisions about their own development. Families, communities, and decision-makers at all levels and all development stakeholders, including those in health and other sectors, should be involved in interactive communication and dialogue. Various techniques have been developed

to facilitate this process, such as Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA).

Communication activities should enhance the communities' vision for their children, and should be complemented by other interventions such as community mobilization, training, service-delivery improvement, new or improved technologies and policy change.

Figure 2 is a suggested graphic presentation of critical issues to consider when developing a plan for C-IMCI. The key practices are the core; services and information are also central; all other issues support or must be considered during planning and implementation.

Figure 2. Critical issues in planning C-IMCI



CHAPTER 2

C-IMCI planning for implementation at the national level

The type of planning needed for C-IMCI implementation at the national level depends on whether the IMCI strategy has been introduced in the country and its level of implementation. Prior planning experience of government personnel, the existence of relevant working groups, decentralization of government, size and diversity of the population are factors that may affect planning for C-IMCI at national level.

At national level, the government in collaboration with stakeholders develops policies and strategies to support implementation of C-IMCI. In addition, the national level working group conducts an analysis of the situation in the country and develops a plan for supervision, monitoring and evaluation.

This chapter describes how to:

- organize a national C-IMCI orientation workshop with stakeholders to form a working group to lead the planning of C-IMCI;
- conduct a situation analysis and use the results to design a national C-IMCI strategic plan within the overall IMCI strategy;
- share the results of the situation analysis, strategies and plans with other stakeholders and to reach a consensus;
- develop a strategic and operational plan at national level.

Collecting preliminary information

To guide discussion, the facilitator must have background information on the country. Relevant data might include the geography, the size of the population, decentralization policy, health indicators, status of IMCI implementation and health-related policies (see Annex B for further details). The facilitator could obtain the information by paying a preliminary visit to the country or by reviewing documents.

Figure 3. C-IMCI planning at the national level

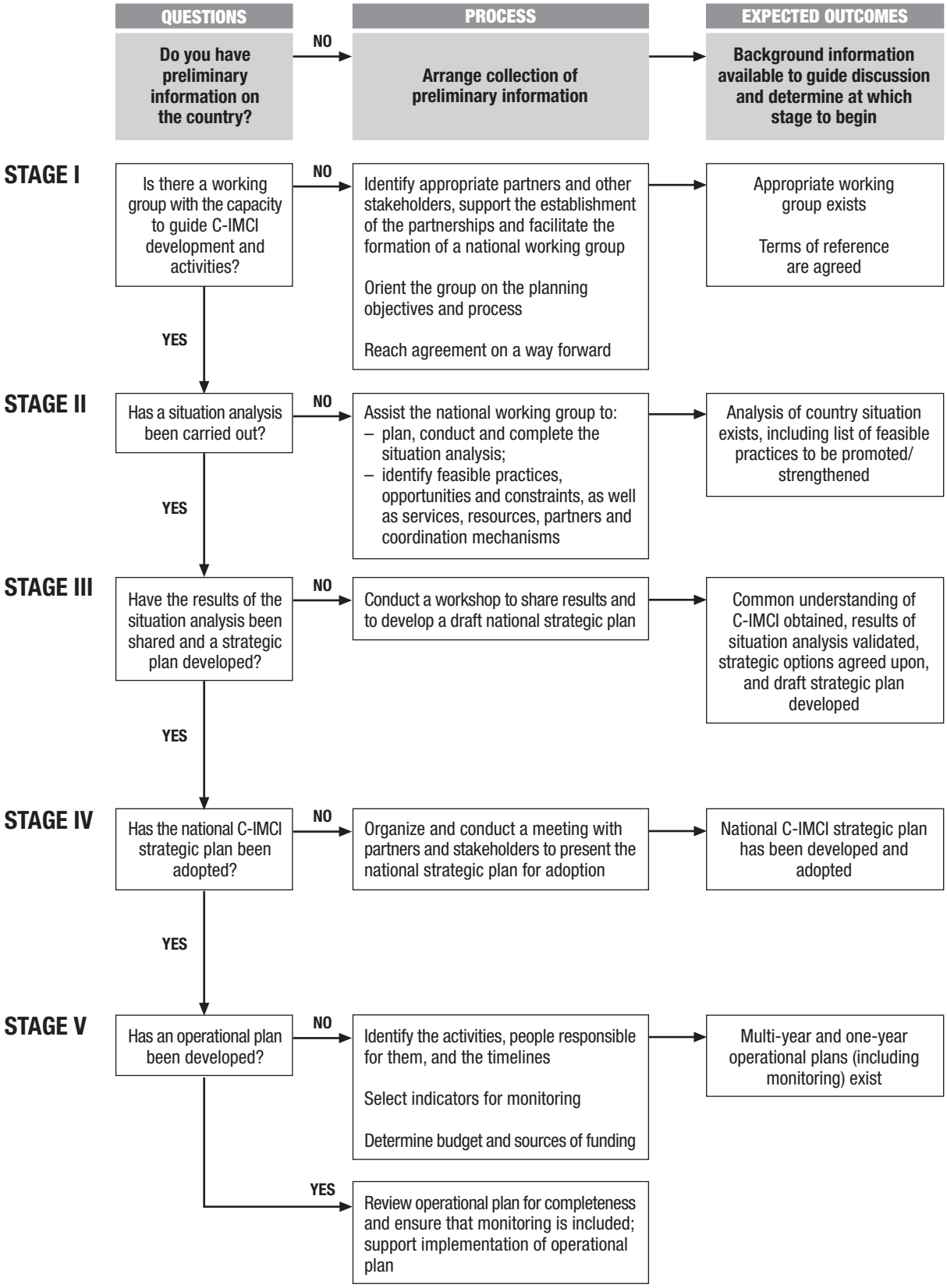
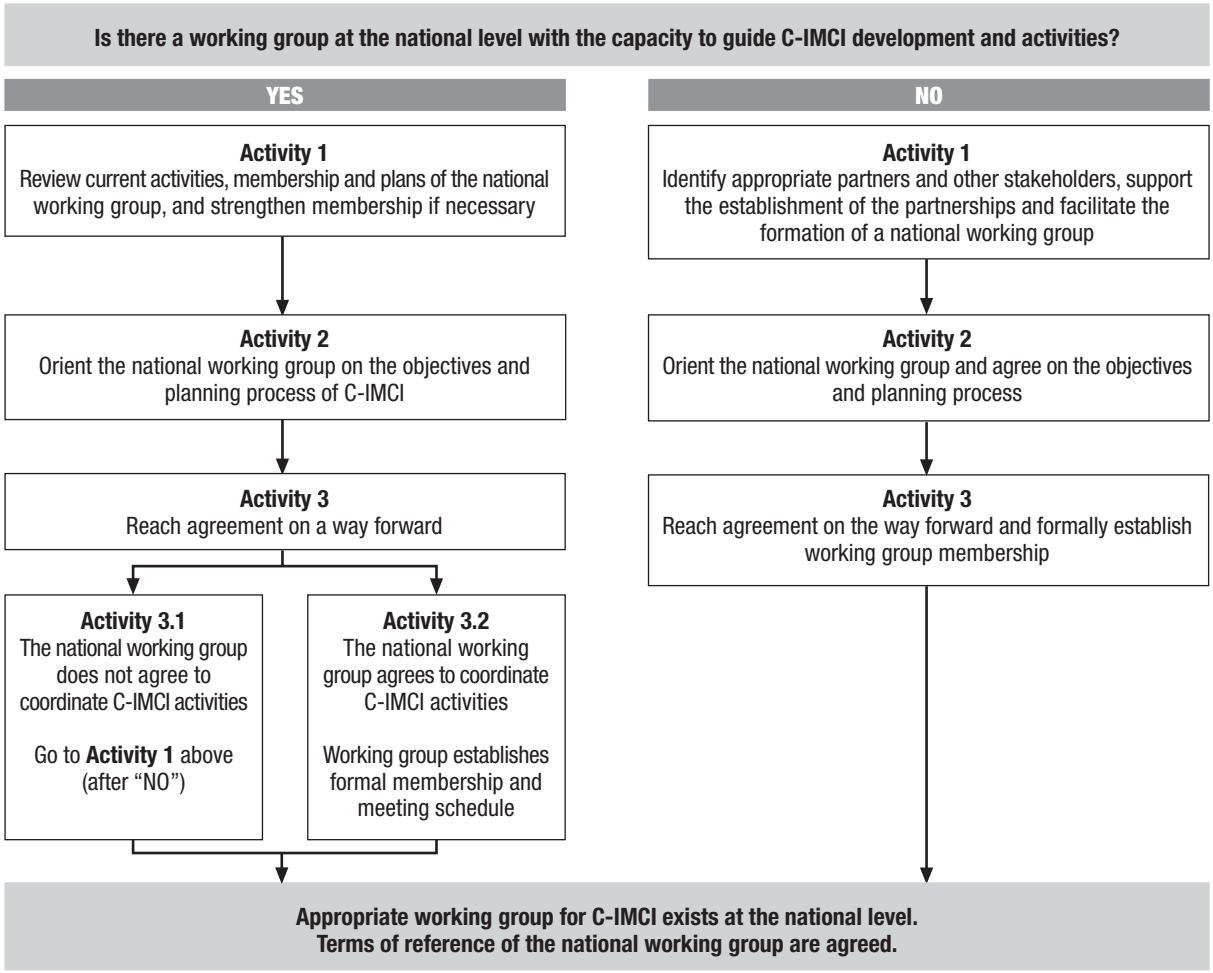


Figure 4. C-IMCI planning at the national level – Stage I



NATIONAL LEVEL – STAGE I: WORKING GROUP FOR C-IMCI

Is there a working group at the national level with the capacity to guide C-IMCI development and activities? **YES**

Criteria that may be used to determine whether a national working group has the capacity to guide C-IMCI include, but are not limited to:

- The group is multisectoral and comprises partners working at national, district and community levels – namely, members from various government sectors such as health, education, agriculture, social welfare, NGOs, and various groups with national representation (private organizations, women's groups, credit organizations, teachers' organizations). Donors and development partners should also be included.
- The group is actively involved in examining and influencing community-level health-related activities and has regular meetings to discuss progress, challenges and constraints.

Activity 1 **Review current activities, membership and plans of the national working group, and strengthen membership if necessary**

The facilitator should find out who the members are, how the working group functions and what activities it is undertaking. This could be done by interviewing group members, by attending group meetings and by reviewing available documents such as minutes of past meetings. See Annex C for a suggested composition of the C-IMCI working group.

Activity 2 **Orient the national working group on the objectives and planning process of C-IMCI**

The facilitator should organize an orientation workshop on the objectives and planning process of C-IMCI, and a discussion of the role of the national level working group in supporting planning and implementation of C-IMCI at all levels. The facilitator should help the group reach a common understanding of how C-IMCI development might be supported by national-level activities, such as efficient coordination of efforts, consensus building, data gathering and analysis and strategy development and advocacy. The group should then compare these activities with their present plans and activities to determine where the gaps are. At this meeting, members should also discuss their activities and abilities and reach some agreement on their roles and responsibilities.

Activity 3 **Reach agreement on a way forward**

The facilitator should assist the working group to reach agreement on whether to coordinate C-IMCI activities.

Activity 3.1

If the working group does not choose to coordinate C-IMCI activities, the facilitator should return to the initial question in the flow chart ("Is there a working group at the national level with the capacity to guide C-IMCI?") and follow the "NO" path.

Activity 3.2

If the working group agrees to coordinate C-IMCI activities, the facilitator should assist in developing a formal membership list, make plans for regular meetings and help members agree on next steps.

NATIONAL LEVEL – STAGE I: WORKING GROUP FOR C-IMCI

Is there a working group at the national level with the capacity to guide C-IMCI development and activities? **NO**

If there is no group that fulfils the criteria the facilitator should carry out the activities below.

Activity 1 **Identify appropriate partners and other stakeholders, support the establishment of the partnerships and facilitate the formation of a national working group**

The facilitator will need to work with the national leadership to identify the major community stakeholders at national level. These might include: members from various government sectors such as health, education, agriculture, and social welfare, NGOs, and representatives from various groups with national representation, such as private organizations, women's groups, credit organizations and teachers' organizations. Donors and development partners such as WHO, UNICEF, USAID, international NGOs, and other bilateral partners should also be included as members of the working group. As potential group members are identified and contacted, the facilitator will need to assess their interest in and their preparedness for a long-term commitment to C-IMCI.

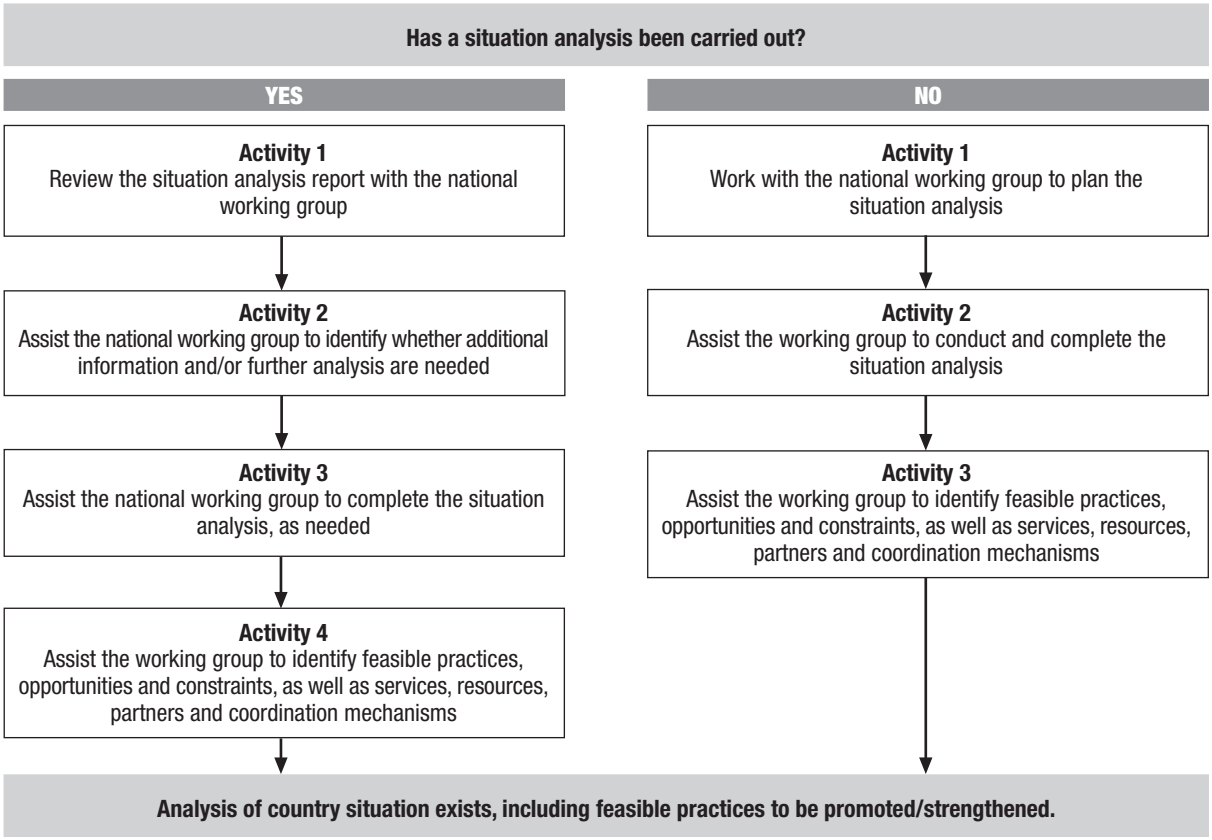
Activity 2 **Orient the national working group on the objectives and planning process of C-IMCI**

The facilitator should orient potential working group members to C-IMCI, including the key practices, planning objectives and process, and linkages with the other two components of the strategy. This meeting should include a discussion of the potential contributions of the national working group to C-IMCI implementation, which might include such activities as efficient coordination of efforts, consensus building, data gathering and analysis, strategy development and advocacy. The facilitator should discuss the activities and abilities of members and reach some agreement on the roles and responsibilities of each stakeholder.

Activity 3 **Reach agreement on a way forward**

Having established a C-IMCI working group, plan regular meetings and agree on the next steps.

Figure 5. C-IMCI planning at the national level – Stage II



NATIONAL LEVEL – STAGE II: SITUATION ANALYSIS

The situation analysis at the national level should give information on three areas that will determine the planning and activities for C-IMCI:

- Common child health and development problems and feasible solutions;
- Available and potential resources (human, technical, financial) and ongoing activities that may serve as entry points;
- Policies that may affect how C-IMCI is implemented (decentralization policy, drug policy, policy of stakeholders).

Has a situation analysis been carried out? **YES**

Activity 1 **Review the situation analysis with the national working group**

The facilitator should review the documentation of the situation analysis and, if needed, request an overview presentation by working group representatives to answer any questions. The facilitator should note areas of weakness or strength in the current situation and areas that have the most potential for successful C-IMCI activities.

Activity 2 **Assist the national working group to identify whether additional information and/or analysis are needed**

The facilitator should share "Questions to consider when completing a situation analysis" (annexes E and F) with working group members. With help from the facilitator, the group should identify whether it needs any additional information or if it should analyse the data further. For example, if a country had a national policy to encourage exclusive breastfeeding, and the resources available to do so, but activities had not been done, further information would be needed to determine why. This type of information is critical for determining C-IMCI priorities and use of resources.

The situation analysis should shed light on:

- the practices that are relevant to each area of the country based on health indicators;
- feasible practices that have been tested with families and/or health providers;
- available services and interventions with potential impact;
- available and possible entry points for the interventions;
- community stakeholders, their roles, their motivation;
- inventory of any existing materials for training, e.g. information, education, communication (IEC) or behaviour change communication (BCC);
- identification of potential partners;
- relevant issues for communication strategies;
- community-based information systems and links with health information systems;
- indicators for monitoring and evaluation based on primary health problems, feasible practices and barriers and supports for each.

A tool for organizing the situation analysis data is shown in Annex G.

Activity 3 Assist the national working group to complete the situation analysis, as needed

If additional data are to be collected, the facilitator should help the working group plan for information gathering and, if necessary, assist with the analysis of new and existing data. To avoid unnecessary data collection, information should first be sought from organizations and working groups at district and community levels, thus establishing closer contacts and forming stronger relationships for C-IMCI activities at different levels.

Activity 4 Assist the national working group to identify feasible practices, opportunities and constraints, as well as services, resources, partners and coordination mechanisms

The review of the situation analysis should enable the working group to identify feasible family and community practices that affect child health. Feasible practices are those that people are willing and able to do with regard to their situation and resources. The group should also use the situation analysis to identify the participant groups (target audiences) based on characteristics such as geographic or cultural variations. The facilitator should assist the group to conduct a thorough review of available services, resources, partners and stakeholders as revealed in the analysis and explore possible coordination mechanisms.

Remember, C-IMCI key family practices are ideal behaviours. Districts and communities will need to tailor these ideal behaviours to make them feasible within the contexts of specific communities.

The facilitator should ensure that the following have been identified:

- description of the principal child health problems in each area of the country, and the key family practices that are relevant to each;
- list of practices that can be promoted, given available interest and resources;
- participant (target) groups;
- illustrative list of services, resources, partners, stakeholders and coordination mechanisms at various levels (i.e., national, intermediary, district, community).

NATIONAL LEVEL – STAGE II: SITUATION ANALYSIS

Has a situation analysis been carried out? **NO**

Activity 1 Work with the national working group to plan the situation analysis

After having been oriented on C-IMCI, the working group should agree on the need for a situation analysis and be asked to support data collection by contributing their time or other resources. The analysis will assist them to make critical decisions about programme priorities and approaches.

At the national level, the situation analysis should encompass the collection of existing data (socio-anthropological research, epidemiological data, knowledge, attitude and practice (KAP) surveys) and a review of data collection and analysis from other (district and local) levels. The facilitator should review these data and the documentation with the group and help it decide whether to conduct further data collection. In most cases, sufficient ethnographic and epidemiological data on child health exist to plan for C-IMCI activities at national level. To avoid unnecessary additional data collection and analysis, the group should request information from organizations and groups working at the community level.

If, however, only limited information is available on feasible practices for the country, or if the information is only for a few communities, it may be worthwhile, and even necessary, to conduct some formative research on current practices, and barriers to and supports for each practice in different types of communities around the country. Please note, formative research may be done at district level or during district/community-level planning.

If additional data are to be collected, the facilitator should discuss the situation analysis tools provided in annexes D, E and F with the working group. Then the facilitator should assist the group to adapt the tool and to plan for the situation analysis. The following steps should be included:

- identify information requirements and record the available information;
- adapt the data collection tools and techniques;
- select the sites to be visited;
- identify the necessary resources (the services of a facilitator may be necessary);
- mobilize resources.

Activity 2 Assist the national working group to conduct and complete the situation analysis

To conduct the situation analysis, the members of the working group will need to contact key partners and stakeholders at the national, district and community levels (e.g. MOH staff, government staff from other ministries, private voluntary organizations, NGOs, community-based organizations, donor agencies) and ask them to share reports, surveys, evaluations and lessons learnt from community-based experiences. Review of those data will yield valuable information for the analysis. In addition, the group will need to interview key informants at national, district and community levels. The facilitator should assist in these activities and perhaps supervise and support the collection and analysis of the data.

Activity 3 Assist the national working group to identify feasible practices, opportunities and constraints, as well as services, resources, partners and coordination mechanisms

The facilitator should assist the working group to review the situation analysis and explore possible coordination mechanisms. The review should enable the group to identify current household and community practices that affect child health and to identify participant groups (target audiences) based on characteristics such as geography or culture. The group should also conduct a thorough review of available services, resources, partners and stakeholders, as revealed through the analysis.

The facilitator and the working group should develop a comprehensive report on the situation analysis and should include recommendations concerning the following factors:

- the practices that are relevant to each area of the country based on health indicators;
- feasible practices that have been tested with families and/or health providers;
- available services and interventions with potential impact;
- available and possible entry points for the interventions;
- community stakeholders, their roles, their motivation;
- inventory of any existing materials for training, e.g. information education communication (IEC) or behaviour change communication (BCC);
- identification of potential partners;
- relevant issues for communication strategies;
- community-based information systems and links with health information systems;
- indicators for monitoring and evaluation based on primary health problems, feasible practices and barriers and supports for each.

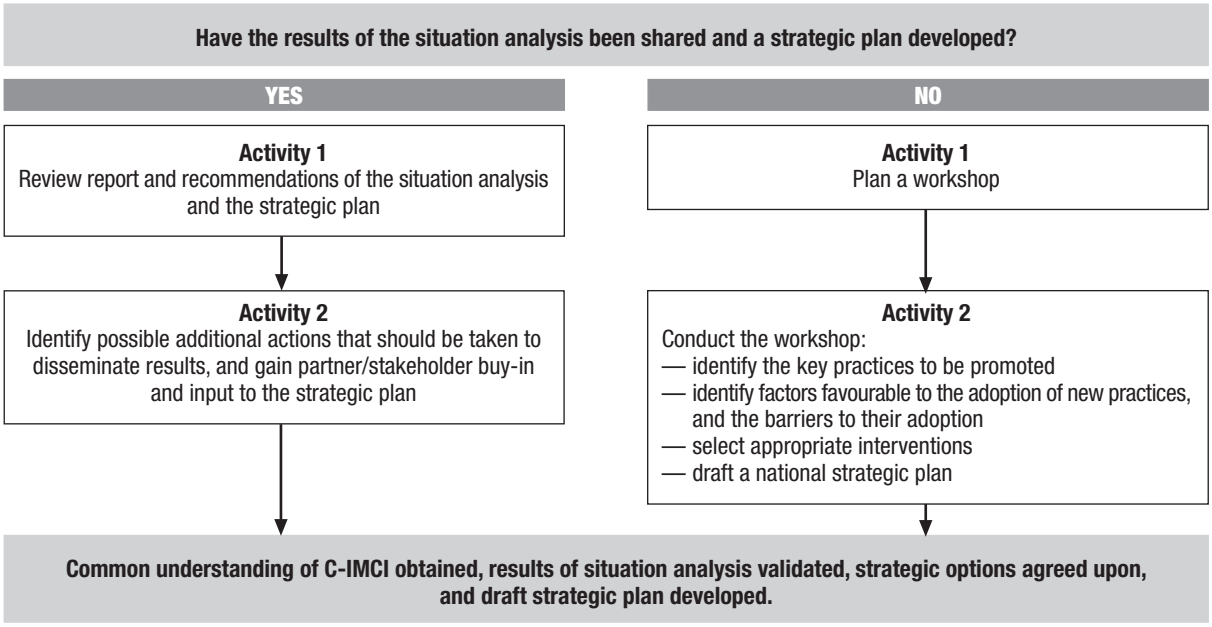
A tool for organizing the situation analysis data is shown in Annex G.

Remember, C-IMCI key practices are ideal behaviours. Districts and communities may need to tailor these ideal behaviours to make them feasible within their own context.

The facilitator should ensure that the following have been identified:

- description of the primary child health problems in each area of the country, and the key family practices that are relevant to each;
- list of practices that can be promoted, given available interest and resources;
- participant (target) groups;
- illustrative list of services, resources, partners, stakeholders and coordination mechanisms at various levels (i.e. national, intermediary, district, community).

Figure 6. C-IMCI planning at the national level – Stage III



Have the results of the situation analysis been shared and a strategic plan developed? YES

Activity 1 Review report and recommendations of the situation analysis and the strategic plan

If a workshop has been held to disseminate the results of the situation analysis, the facilitator should find out who the participants were, how the workshop was implemented, and the outcomes by reviewing the workshop documentation, interviewing members of the working group and participants in the meeting, and reviewing follow-up documents. The facilitator should then assist the national working group to determine whether changes made to the situation analysis, as a result of the review, require any follow-up communication with workshop participants.

Activity 2 Identify possible additional actions that should be taken to disseminate results, and gain partner/stakeholder buy-in and input to the strategic plan

The facilitator should ensure that partners and stakeholders have:

- validated the outcomes of the situation analysis;
- reached a consensus on the different elements of the C-IMCI strategic plan presented;
- agreed on strategies to promote feasible C-IMCI practices for each area of the country;
- reached a common understanding of the concepts, objectives and contents of C-IMCI and its links with the other components of IMCI.

If any of the above have not been achieved, the facilitator should assist in identifying needed actions. For example, if important partners or stakeholders were not included in the workshop and are not involved, the facilitator should assist the group to solicit their participation in C-IMCI activities.

Have the results of the situation analysis been shared and a strategic plan developed? NO

Activity 1 Plan a workshop

The working group will need to organize a workshop to disseminate the results of the situation analysis and develop a strategic plan for implementing C-IMCI. Participants in such a workshop should include all the partners and stakeholders, NGOs and representatives of other sectors who have an interest in community interventions. The facilitator should assist with planning and documenting the workshop. Guidelines are provided in annexes H and I.

If regional or district levels have already developed their strategic plans, their representatives should be given opportunities to share this information at this workshop.

Activity 2 Conduct the workshop

During the workshop, the results of the situation analysis and its recommendations will be shared with the larger group of stakeholders, while a smaller group will undertake to develop the national C-IMCI strategic plan linked with the overall strategic plan for IMCI.

In developing the strategic plan, the facilitator should assist the working group to:

1. Identify the key practices to be promoted, using information from the situation analysis to judge the importance of each key practice by: a) its potential health impact and b) the feasibility of achieving implementation;
2. Identify factors favourable to adoption of new practices and the barriers to their adoption;
3. Select appropriate interventions that will help overcome barriers to the adoption of new practices or that will strengthen their adoption. Use the strategy development worksheet in Annex J and the table for priortizing interventions in Annex K;
4. Design a comprehensive national strategic plan to include all the necessary components (e.g. communication, training and advocacy). See Annex L for an outline.

The facilitator should ensure that by the end of the workshop the participants have:

- validated the outcomes of the situation analysis;
- reached a consensus on the different elements of the C-IMCI strategic plan presented;
- developed strategies to promote feasible C-IMCI practices for each area of the country;
- reached a common understanding of the concepts, objectives and contents of C-IMCI and its links with the other components of IMCI.

If any of the above have not been achieved, the facilitator should assist in identifying needed actions. For example, if important partners or stakeholders were not included in the workshop and are not involved, the facilitator should assist the group to solicit their participation in C-IMCI activities.

Figure 7. C-IMCI planning at the national level – Stage IV

NATIONAL LEVEL – STAGE IV: STRATEGIC PLAN ADOPTION

Has the national C-IMCI strategic plan been adopted? YES

Activity 1 Review the process by which the strategic plan was adopted and ensure all relevant stakeholders support it

The facilitator should assist the working group to review the process of adopting the national C-IMCI strategic plan. If major partners and stakeholders were not involved in this adoption, the facilitator should assist the group to discuss the strategic plan with these partners.

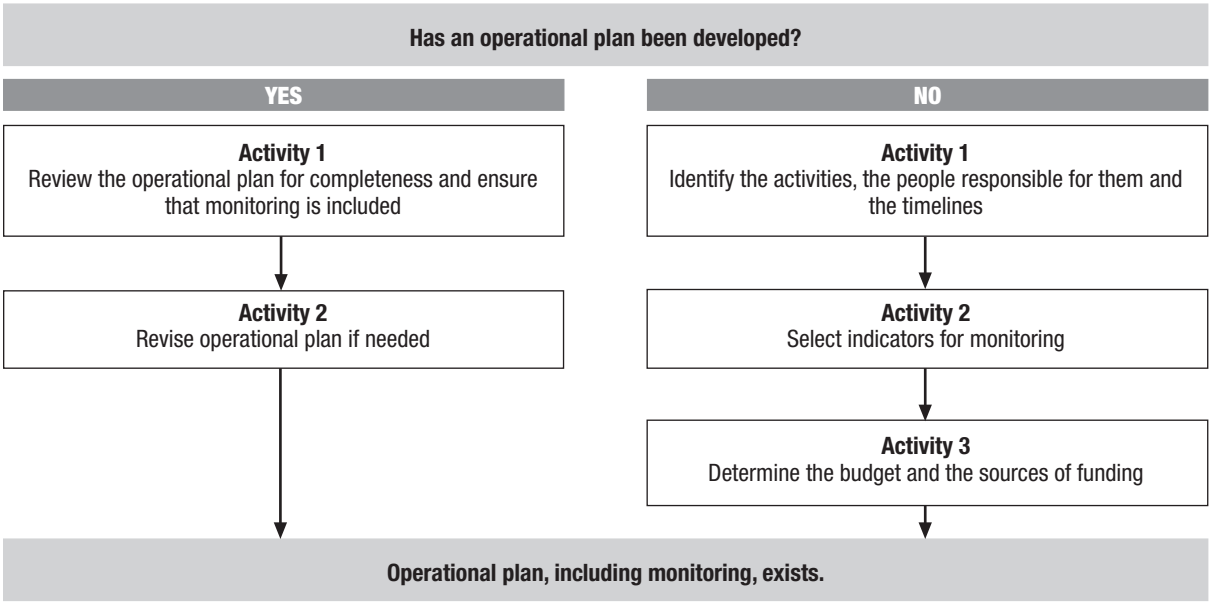
NATIONAL LEVEL – STAGE IV: STRATEGIC PLAN ADOPTION

Has the national C-IMCI strategic plan been adopted? NO

Activity 1 Organize and conduct a meeting with partners and stakeholders to present the national strategic plan for adoption

The working group will need to present the national strategic plan to partners and stakeholders to solicit feedback and suggestions about the activities proposed and to gain their support for the plan. An important goal of the meeting should be the adoption of the national strategic plan by all major partners and stakeholders. The facilitator should assist the group to plan and conduct the meeting. This meeting could be held back-to-back with results dissemination and strategic planning workshop as shown in Annex I.

Figure 8. C-IMCI planning at the national level – Stage V



NATIONAL LEVEL – STAGE V: OPERATIONAL PLAN DEVELOPMENT

Has an operational plan been developed? **YES**

Activity 1 **Review the operational plan for completeness and ensure that monitoring is included**

The facilitator should assist the working group to review the operational plan in light of the list of interventions selected and ensure that it includes monitoring. If changes have been made in stages I–IV above, the facilitator should assist the group to assess how these changes will affect the operational plan and to make the necessary changes. The facilitator should also assist the group to identify gaps, places for revision and changes to the plans.

Activity 2 **Revise operational plan**

Assist the working group to make changes as required.

NATIONAL LEVEL – STAGE V: OPERATIONAL PLAN DEVELOPMENT

Has an Operational plan including monitoring been developed? **NO**

Activity 1 **Identify the activities, the people responsible for them and the timeline**

For each intervention selected to promote the adoption of key practices, the facilitator and working group should identify who will carry out each activity, how, when and where. The stakeholders' abilities and resources should be the determining factors (see Annex M for template).

Activity 2 **Select indicators for monitoring**

The facilitator should assist the working group in selecting: (1) the indicators to determine whether the interventions have improved the health of children in the community; (2) the indices indicating progress towards behaviour change. The group should assign indicators to each of the feasible behaviours, barriers and supports identified in the strategies. The plan should include monitoring to assess whether programme activities are being completed as planned.

Activity 3 **Determine the budget and the sources of funding**

The facilitator should assist the working group in budgeting, identifying and recording the sources of funds to implement each activity.

HONDURAS

An example of an integrated programme at the national level is AIN (Atención Integral a la Niñez). This is an integrated child health programme that the government of Honduras created and adopted as its national community-based child health package of services. It complements the package of services provided through IMCI within the formal health system. The combination offers the children of Honduras a well-rounded health programme at all levels of care.

The AIN programme encompasses activities designed to promote the health and well being of children under five years of age, with particular emphasis on the growth of children under two years of age. The activities – which include monthly weighing of all children younger than two years, counselling their mothers/caregivers to improve child feeding and care practices, and assessment and appropriate referral of all sick children up to five years of age – are carried out within the community by community members. Within a framework designed by the national government and supported at intermediary levels, AIN is empowering communities to improve the health of their youngest members and is helping strengthen linkages between the communities and the health system that serves them.

The design and development of AIN has taken into account the lessons learned from many years of experience with community health programming in different areas of the world. Experience has shown that a child's growth during his or her first two years of life can be used as a measure of nutrition and health, and that measuring growth allows detection and correction of problems before they become serious. As an indicator, child growth is simple enough that caregivers and community workers can grasp it easily, yet sensitive enough to alert them to potential problems in time to make changes to a child's feeding and care. Holding monthly weighing and counselling in the community helps ensure that problems are detected early and can be addressed close to home. The programme helps families and communities collect and use data, thereby strengthening local capacity to plan and carry out activities.

In Honduras, AIN was designed at the national level. Once the basic interventions for communities to implement were identified, an overall plan was made. A pilot experience in a few communities provided valuable insights into programme design and development of programme materials, such as a manual and counselling cards for volunteers, a training guide for those who train and supervise the volunteers, and a training of trainers guide for preparing the trainers to carry out their work. Going to scale was made easier by the structured programme design and the availability of education and training materials. Notably, however, each community that adopts the AIN programme is encouraged to add programme activities according to their local situation. Intermediary levels in the health system provide technical guidance, support, and training, as well as supplies (such as scales) to participating communities.

CHAPTER 3

C-IMCI planning for implementation at the intermediary level

Whether the facilitator begins working at the national level or the district level, the intermediary level will need to be involved as planning expands. In various countries, the intermediary level comprises regions, provinces or states.

When planning begins at the national level, the facilitator should make sure that representatives from the intermediary levels are invited and involved in each step. The intermediary level must often sanction and support activities at the district level.

If the intermediary level is the highest level at which the facilitator will work, or a country is so large or diverse that the programme must be organized on a regional level, follow the steps described in the national level section.

CHAPTER 4

C-IMCI planning for implementation at the district level

The role of the district in improving child health is to provide operational support to the network of health facilities in the district: planning and organization of services, data collection support, resource mobilization, monitoring and evaluation of health-related services. To support C-IMCI implementation at the community level, capacity at the district level may need to be developed.

Implementation of C-IMCI at the district level should start with sensitization of the district authorities/stakeholders on the aims and objectives of the IMCI strategy and the importance of the C-IMCI component. Usually, this is achieved through written communication and/or visits.

An individual or an existing district group should spearhead implementation of C-IMCI at the district level. Such a person or group could be, for example, from the district health management team, a primary health coordination unit, or a district development working group.

A working group should be established for developing and implementing the district's C-IMCI plan. This group should be multisectoral, comprising partners working in the district, such as members from district management (health, education, agriculture, social welfare), community leaders, representatives from health working groups, NGOs and various groups (e.g. women's groups, credit associations, teachers).

A situation analysis at the district level should include a review of all ongoing interventions, as well as the capacity of the health system to support the community-based interventions (e.g. supervision, logistics, drugs distribution systems). The situation analysis will provide the information necessary for the working group and stakeholders to develop an operational plan. Remember that the situation analysis contributes to national data and thus influences national-level strategies and objectives. Districts should look for data from their communities and strengthen the interaction among all different levels to improve efficiency. To ensure sustainability, the district C-IMCI plan must be included in the overall district operational plan.

With future expansion in mind, it is desirable to build capacity at the intermediary/district level. Results from initial implementation districts should be used for advocacy to mobilize additional resources and expand activities at all levels.

Key factors for success at the district level

At district level, various factors will help implement C-IMCI activities to achieve improved child survival, growth and development. These are: building partnerships, mobilizing resources, ensuring sustainability of activities, and scaling-up activities to involve as many communities as possible.

Partnership

Partnerships can be built and strengthened between health facilities and communities, the district and other partners, the various organizations at district level, and between private and public health providers.

Partnerships among those implementing community-based activities will ensure maximum coordination of efforts and impact. The district, through its working group for C-IMCI, should take the lead in coordinating the various partners working at the community level. An open line of communication between partners should be achieved and sustained.

Resource mobilization

The working group should also be involved in mobilizing resources, including cost recovery schemes. The district may encourage establishment of community co-management groups to allow community members to have input into managing and financing health services. This encourages a sense of ownership of services by community members, and helps support financing and use of services.

Sustainability

Ensuring sustainability of C-IMCI interventions must be considered from the initial stage of planning at all levels. Inclusion of C-IMCI activities in the district's overall plan and budget is essential for sustainability and shows the district's willingness to reduce dependence on outside financing.

Other ways of ensuring sustainability of activities at the district level include:

- developing capacity of district staff to plan and implement C-IMCI activities;
- developing capacity of community-based structures such as community development groups, mothers' groups and youth groups;
- building community ownership by involving the community from the beginning of planning;
- building capacity of local NGOs or other organizations to implement and sustain community activities;
- building on or linking C-IMCI to other successful and well-established community-based interventions;
- allocating adequate resources regularly for C-IMCI-related activities.

Community demand for quality services and continued action and participation is necessary to ensure sustainability. Community co-financing and co-management of activities are essential to ensure community ownership and sustainability. Consequently, strong partnerships between district and community levels are needed for C-IMCI to succeed in the long term.

Scaling up

The scaling up of community activities is indispensable to reduce infant and child mortality. It can be achieved by adding activities related to key practices into existing programmes and by expanding activities to cover new geographic areas. Whenever possible, C-IMCI should be implemented simultaneously with the other two components of IMCI.

The district can play a significant role in scaling up C-IMCI activities by sharing experiences with various communities implementing IMCI and by encouraging new communities in the district to initiate C-IMCI.

The C-IMCI working group should plan for scaling-up community activities early in the planning process. Once the initial experience in implementation has been reviewed, and any necessary alterations have been made, a plan can be made for expansion to other communities, taking into account the successes, challenges and constraints of the initial communities. Funding also needs to be allocated or identified for expansion. This may require advocacy with donors and NGOs to make C-IMCI activities a priority.

Figure 9. C-IMCI planning at the district level

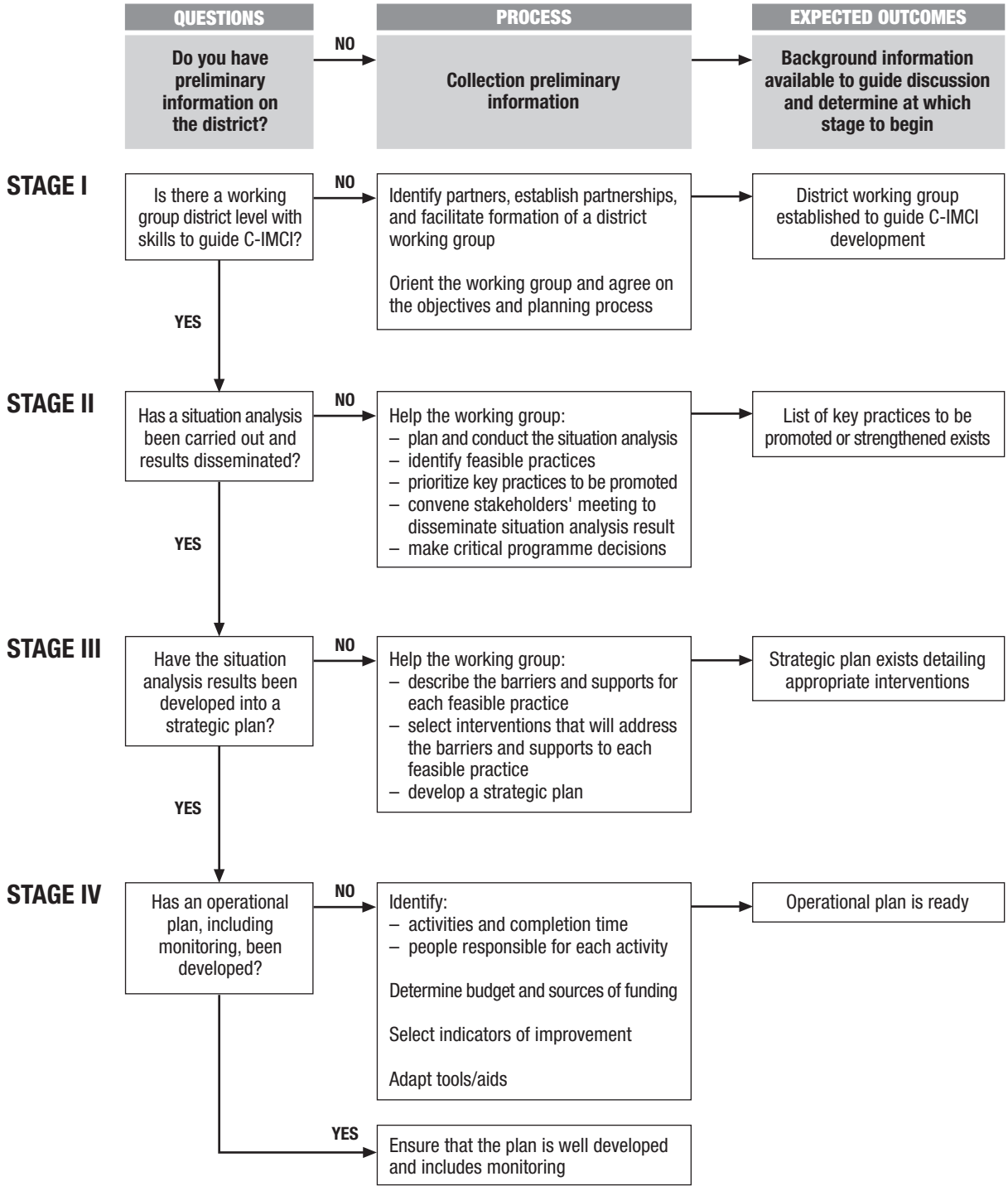
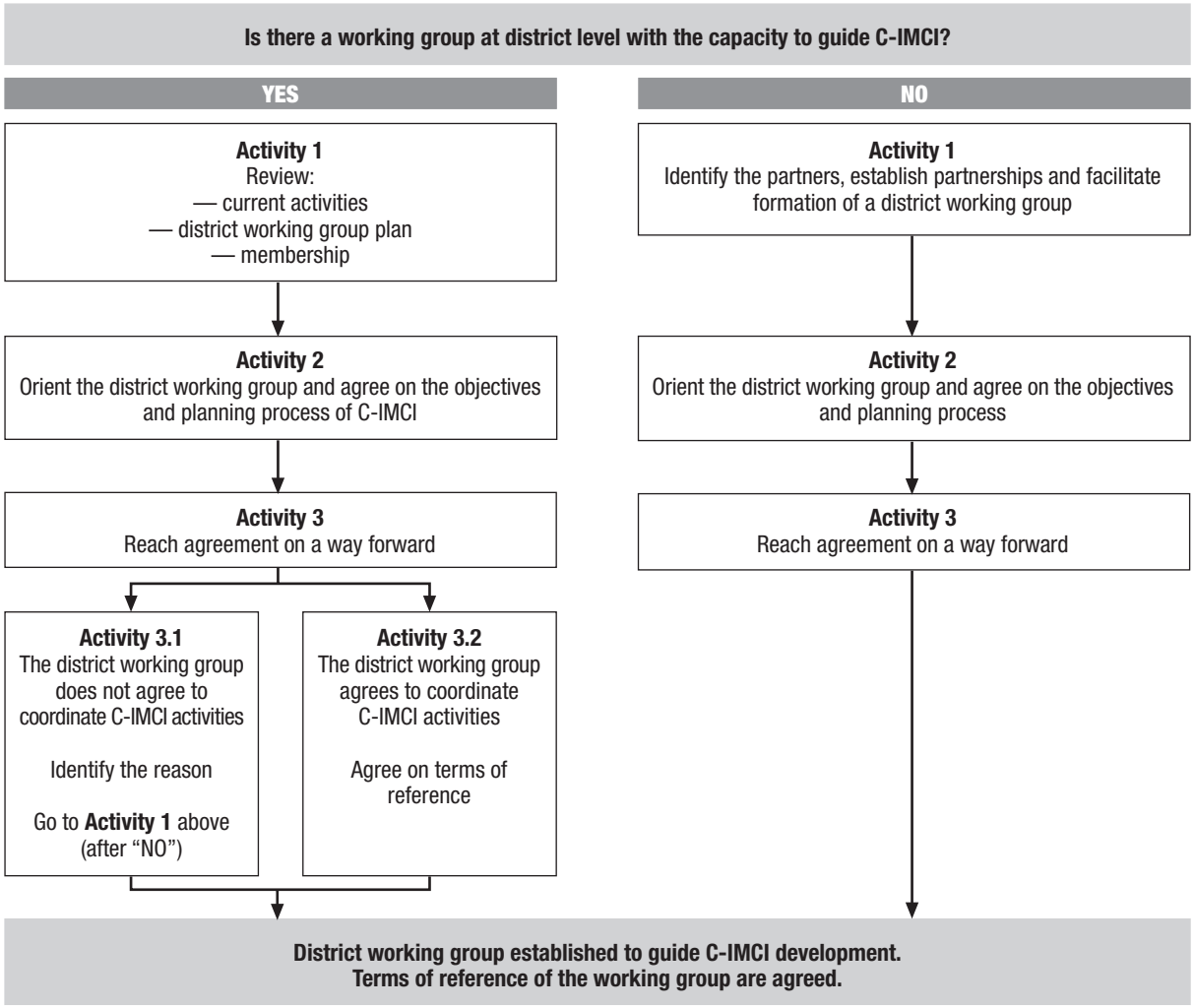


Figure 10. C-IMCI planning at the district level – Stage I



Collecting preliminary information

To have a good understanding of the context they will be working in, facilitators should have background information on the district, including the geography, the size of the population, health indicators, status of IMCI implementation, health-related policies and other relevant information. Facilitators can obtain this information by making a preliminary visit to the country or by reviewing documents.

A district working group should meet the following criteria:

- The group should be multisectoral in its membership, consist of partners working in the district such as district managers (health, education, agriculture, social welfare and others), community leaders, the health working group, NGOs and various other groups (e.g women's groups, credit associations, teachers).
- The group should be involved in leading community-based activities, and hold regular meetings to discuss progress, challenges and constraints encountered.
- Members should be committed to implementing C-IMCI activities.

Is there a working group at the district level with the capacity to guide C-IMCI? **YES**

Activity 1 **Review current activities, membership, and district working group plans**

The facilitator should examine the function of the working group and its current activities, be briefed by member(s) of the group and attend its meetings. Reviewing documents, such as minutes of past meetings, could assist in understanding the type of activities undertaken by the group. The facilitator should also examine the membership of the group to see if all the appropriate district stakeholders are members of this group. See Annex C for membership requirements for the C-IMCI working group.

Activity 2 **Orient the district working group and agree on objectives and planning process of C-IMCI**

The facilitator should then orient the working group on the objectives of C-IMCI, including planning for C-IMCI implementation (See Annex I for guidelines for orienting working groups to C-IMCI). Once an understanding has been reached on the objectives and planning process for C-IMCI, the working group should compare these with their own plans and activities to determine how they can fit in and be accomplished.

Activity 3 **Reach agreement on a way forward**

The facilitator should assist the group to reach agreement on whether to coordinate C-IMCI activities.

Activity 3.1

If the group does not choose to coordinate C-IMCI activities, identify the reason, return to the initial question in the flow chart ("Is there a working group at the district level with the capacity to guide C-IMCI?") and follow the "NO" path.

Activity 3.2

If the working group agrees to coordinate C-IMCI activities, the facilitator should assist in developing a formal membership list, make plans for regular meetings and help members agree on the next steps.

DISTRICT LEVEL – STAGE I: WORKING GROUP FOR C-IMCI

Is there a working group at district level with the capacity to guide C-IMCI? **NO**

A district working group should meet the following criteria:

- The group should be multisectoral in its membership, consist of partners working in the district such as district managers (health, education, agriculture, social welfare and others), community leaders, the health working group, NGOs and various other groups (e.g women's groups, credit associations, teachers).
- The group should be involved in leading community-based activities, and hold regular meetings to discuss progress, challenges and constraints encountered.
- Members should be committed to implementing C-IMCI activities.

If there is no working group that fulfils these criteria the facilitator should:

Activity 1 **Identify the partners at district level, establish partnerships and facilitate the formation of a district working group**

At the district level, there should be a "champion" for C-IMCI implementation. This could be the district health manager or a person/unit on the district health team. The facilitator should discuss the principles of C-IMCI and the need for a coordination body in the district with possible people or groups who could take on this role.

If such a person or group is identified and interested, the facilitator should work with the district champion to identify stakeholders, assess their interests and determine their preparedness for a long-term commitment to C-IMCI. The facilitator should contact stakeholders as potential working group members and assess their abilities and interests in being a member. Usually various stakeholders at the district level are already conducting community-based child health activities or are interested in doing so. These often include the MOH, WHO, UNICEF, other UN organizations, NGOs, and donor agencies.

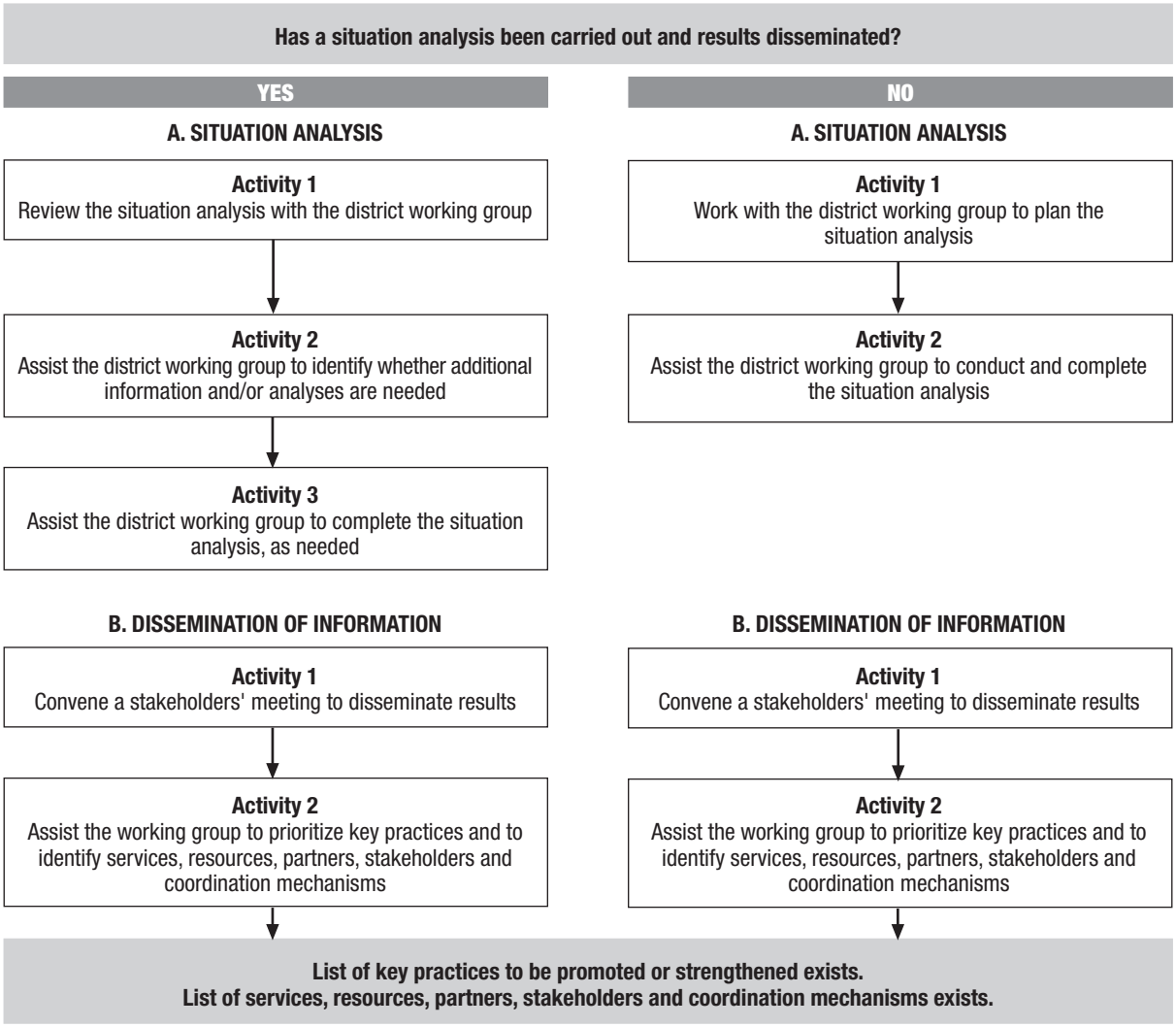
Activity 2 **Orient the district working group and agree on the objectives and planning process**

Because the working group spearheads implementation of C-IMCI in the district, its members need to have a good understanding of C-IMCI. The facilitator should introduce the group to key C-IMCI practices and some of the ways those practices are promoted in other settings. The members should then discuss and agree on the roles and responsibilities of each stakeholder.

Activity 3 **Reach agreement on a way forward**

The newly formed working group should plan regular meetings and agree on next steps.

Figure 11. C-IMCI planning at the district level – Stage II



Has a situation analysis been carried out and results disseminated? YES

A. SITUATION ANALYSIS

Activity 1 Review the situation analysis with the district working group

If a situation analysis has been done already, the facilitator should review the documentation with the working group and, if needed, request a representative to present an overview. The facilitator should note areas of weakness or strength in the current situation and areas that have the best potential for success of C-IMCI activities.

Activity 2 Assist the district working group to identify whether additional information and/or analyses are needed

The facilitator should share "Questions to consider when completing a situation analysis" (annexes D, E and F) with working group members. With help from the facilitator, the group should identify whether it needs any additional information or if it should analyse the data further. For example, if a country had a national policy to encourage exclusive breastfeeding, and the resources available to do so, but activities had not been done, further information would be needed to determine why. This type of information is critical for determining C-IMCI priorities and use of resources.

The situation analysis should have information to:

- identify priority problems of children in the district;
- learn caregivers' definitions and the ways of detecting diseases;
- identify caregivers' perceptions of the causes of common diseases;
- describe beliefs about common diseases;
- learn the current care-seeking practices in the community;
- learn the current home-based care practices for common diseases.

In addition, it should allow the working group to understand current practices, possible practices and programme recommendations, and the barriers and supports to each practice.

Activity 3 Assist the district working group to complete the situation analysis, as needed

If more information is required, the facilitator should assist the working group in planning information gathering and in analysing the additional data once collected. The necessary data and information may already be available at the community level. To avoid duplication, the group and facilitator should look first to community organizations and working groups for data/information.

B. DISSEMINATION OF INFORMATION

Activity 1 Convene stakeholders' workshop to disseminate results

Convene a meeting with all the relevant stakeholders to orient them to C-IMCI (if necessary) and disseminate the results of the situation analysis. The smaller working group can convene immediately afterwards to design the strategies and prepare the operational plan (described in stages III and IV). Then, the larger group of stakeholders can come together again to review the results.

Several countries have done this successfully in a five-day workshop: two days with all of the stakeholders for the orientation and dissemination of situation

analysis results, two days with a smaller group for strategic plan design and operational plan preparation, and one day for sharing these with the larger group. See annexes H and I for a description of how to organize such a workshop.

The agenda may need to be tailored if a C-IMCI stakeholders' meeting has already been held at the national level. In this case, the focus could be on adapting national guidelines to the needs of the district.

During this meeting, stakeholders also need to make critical decisions about programme priorities and approaches or, in other words, what the entry point to the community will be for this initiative. These decisions should be based on existing policies (such as emphasis on community mobilization or decentralization) and current activities (such as a strong community health provider programme or successful mothers' groups).

One important factor to consider is how to link the C-IMCI activities. Many countries use child growth as the linking concept. Young children's monthly weight gain is an excellent indicator of good health and, consequently, growth faltering can be the first sign of a problem. Monthly tracking of young children's growth in the community is one effective way to organize individually tailored counselling and services in support of the relevant C-IMCI practices. A country experience on a programme using this approach is at the end of this chapter.

Activity 2 Assist the district working group to prioritize key practices and to identify services, resources, partners, stakeholders and coordination mechanisms

The working group should now prioritize practices identified by the analysis and review available services, resources, partners and stakeholders. These decisions should be based on the Situation Analysis Data Summary Sheet (Annex G). Practices should be prioritized based on their potential for health impact and their feasibility. Although some communities may already have prioritized practices to address, the district working group should review the situation analysis from the entire district to determine if those already selected are the ones it would recommend for all communities in the district from which to choose. Some level of consistency between communities would make supervision and support more effective.

C-IMCI key practices are general and will need to be made more specific to the context, with the issues of who, how, when, how often and where addressed. These specifications need to be explored with the participants. For example, specific actions to promote complementary feeding will depend on the type of foods available, the quantity and consistency of foods, frequency of feeding and/or feeding style. Much of this information may have already been gathered and analysed when adapting the IMCI feeding recommendations.

Another example is that of washing hands after coming into contact with faeces; this key practice does not specify what cleansing agent to wash with, although soap is clearly the best choice. For families who cannot afford store-purchased soap, the next best alternative would be home-made soap, followed by ash. These alternatives could be promoted on a large scale or at an individual level during counselling and negotiation.

Has a situation analysis been carried out? **NO**

A. SITUATION ANALYSIS

Activity 1 Work with the district working group to plan the situation analysis

If a situation analysis has not been done in the district, the facilitator should assist the working group to conduct such a study. The facilitator should discuss the situation analysis tools in annexes D, E and F. Once the group reviews these annexes, it may require help in adapting the tools and planning the situation analysis to fit the district's needs. To avoid unnecessary data collection and analysis, community-based organizations and working groups should be asked for information already compiled.

The situation analysis may focus on selected family practices, rather than on all practices. The group could use national priorities, district priorities and what is known about the epidemiology of the problems to narrow the focus of the analysis.

Activity 2 Assist the district working group to conduct and complete the situation analysis

In most districts, some community-based activities related to child health are already being implemented. It is essential to identify the partners carrying out these activities, who often include MOH staff, government staff from other ministries, private voluntary organizations, NGOs, community-based organizations and donor agencies.

As part of the situation analysis, the working group interviews key partners and stakeholders at the district level (and at the community level, as needed, depending upon availability of data) to:

- identify priority problems of children in the district;
- learn caregivers' definitions and the ways of detecting diseases;
- identify caregivers' perceptions of the causes of common diseases;
- describe beliefs about common diseases;
- learn the current care-seeking practices in the community;
- learn the current home-based care practices for common diseases.

In addition, the team must speak with community members, including families and health providers to understand current practices, possible practices and programme recommendations, and the barriers and supports to each practice. Often behavioural trials are useful to explore the feasibility of each recommendation.

Where little information exists, data collection can be in-depth and multi-step, or it can be relatively quick and simple when only certain points need to be clarified. Regardless, the working group should guide researchers on whether to use qualitative or quantitative methods, or a combination of the two, to gather the data they need. The available funds, time and human resources as well as expertise will influence the amount and nature of formative research.

A research method known as Trials of Improved Practices (TIPs) can be effective and efficient in testing the promotion of priority practices. Testing with community members helps planners to know which practices will be feasible, i.e. which ones most people are willing and able to do. Recommended practices based on information from this methodology are more likely to be put into practice and sustained.

Information is needed for each region of the country or district and for each distinct group within the region, such as ethnic groups and other characteristics that might affect health practices. Consult Annex 14 for more information on TIPs.

After completing the research, the team, with assistance from the facilitator, should analyse the data. Analysis is likely to reveal important gaps in the information needed to move to the next planning stage or strategic plan design. If this is the case, the working group will need to carry out additional formative research to address those gaps. The amount and complexity of the additional research will depend on how much is known already about current practices, the feasibility of introducing new practices and the resources available. [Note: The time and resources spent in gathering additional information may result in savings in the long term because of more precise targeting of materials and messages.]

B. DISSEMINATION OF INFORMATION

Activity 1 Convene stakeholders' meeting to disseminate results

Stakeholders should be invited to a central location where they will be oriented to C-IMCI, make critical decisions and plan the situation analysis. The agenda for this meeting may need to be tailored if a C-IMCI stakeholders' meeting has already been held at the national level. In this case, the focus could be on orientation and planning for the situation analysis as appropriate. See annexes H and I for a description of how to organize such a meeting.

The critical decisions about programme priorities and approaches and main entry-points in the community should be based on existing policies (such as emphasis on community mobilization or decentralization) and current activities (such as a strong community health provider programme or successful mothers' groups).

One important factor to consider is how to link the various C-IMCI activities. Many countries use child growth as the linking concept. Young children's monthly weight gain is an excellent indicator of good health and, consequently, growth faltering can be the first sign of a problem. Monthly tracking of young children's growth in the community is one effective way to organize individually tailored counselling and services in support of the relevant C-IMCI practices. A country experience on a programme using this approach is at the end of this chapter.

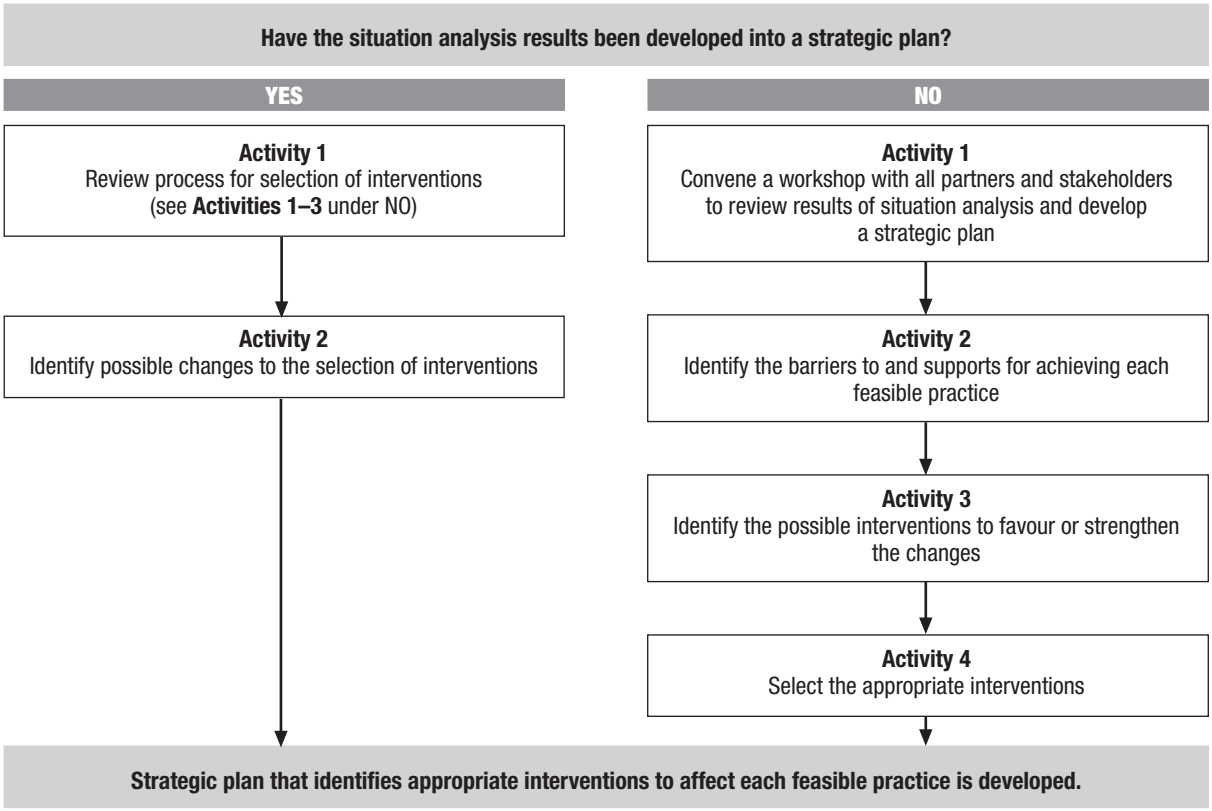
Finally, stakeholders should agree on the need for a situation analysis and be asked to support the data collection with their contribution of time or other resources.

Activity 2 Assist the working group to prioritize key practices and to identify services, resources, partners, stakeholders and coordination mechanisms

From the list of current practices identified from data collected, the facilitator should assist the working group to select those that most need to be improved. Criteria for selection should include practices that could result in significant impact on child morbidity and mortality reduction.

The situation analysis will help to identify which practices are feasible, the ones that will be meaningful and easily acted on by families. The facilitator may assist the group to reach consensus on the key practices to be addressed by C-IMCI at the district level. The working group should also compile an illustrative list of services, resources, partners, stakeholders and coordination mechanisms at the district level.

Figure 12. C-IMCI planning at the district level – Stage III



Have the situation analysis results been developed into a strategic plan? YES

Activity 1 Review process for selection of interventions

In developing the strategic plan, the facilitator should assist the working group to:

1. Identify the key practices to be promoted, using information from the situation analysis to judge the importance of each key practice by: a) its potential health impact and b) the feasibility of achieving implementation;
2. Identify factors favourable to adoption of new practices and the barriers to their adoption;
3. Select appropriate interventions that will help overcome obstacles to the adoption of new practices or that will strengthen their adoption. Fill out the second half of the strategy development in Annex J and the second sheet of Annex J related to the services. Use the table for prioritizing interventions in Annex K;
4. Design a comprehensive national strategic plan to include all the necessary components (e.g. communication, training and advocacy). See Annex L for an outline.

The feasibility of the promoted practices (the extent to which most people are willing and able to take action) and their sustainability are important factors to be emphasized at community level. Interventions that are not sustainable will not produce the desired improvements.

Activity 2 Identify possible changes to the selection of interventions

The working group should review the selected interventions. New interventions may need to be put in place to promote the selected key practices. If this is the case, the facilitator should assist the group to select new interventions to address the key practices. Other interventions may need to be adapted (e.g., they need more community involvement). Use the Table for Prioritizing Interventions in Annex K.

All materials developed to support the strategic plan should focus on feasible practices, not just knowledge, and address the barriers and supports as directly as possible. Consider this when reviewing existing materials to decide what to adapt and what to develop.

Have the situation analysis results been developed into a strategic plan? NO

Activity 1 Convene a workshop with all partners and stakeholders to review the results of the situation analysis and develop a strategic plan

All partners, including the working group, NGOs and others involved, should be invited to review the results of the situation analysis and develop those results into a strategic plan.

If a stakeholders' meeting has already taken place at the district level, then the present meeting could develop a strategic and operational plan (described in Stage IV). If a stakeholders' meeting has not been convened yet, then the meeting can be combined with a general orientation, dissemination of the situation analysis results, strategic plan development and preparation of the operational plan. In this case, the large group of stakeholders only needs to participate in the orientation and dissemination sections.

If this workshop will be taking place or has already happened at the national level, the district-level workshop may focus on adapting the results to the specific needs and context of the district.

Activity 2 Identify the internal and external barriers to and supports for achieving each feasible practice

Complete the behavioural analysis portion of the behaviour-change strategy worksheet in Annex J by listing each selected key family practice, and current and feasible practices related to each. Then describe the barriers and supports to each practice.

Activity 3 Identify the possible interventions to favour or strengthen the changes

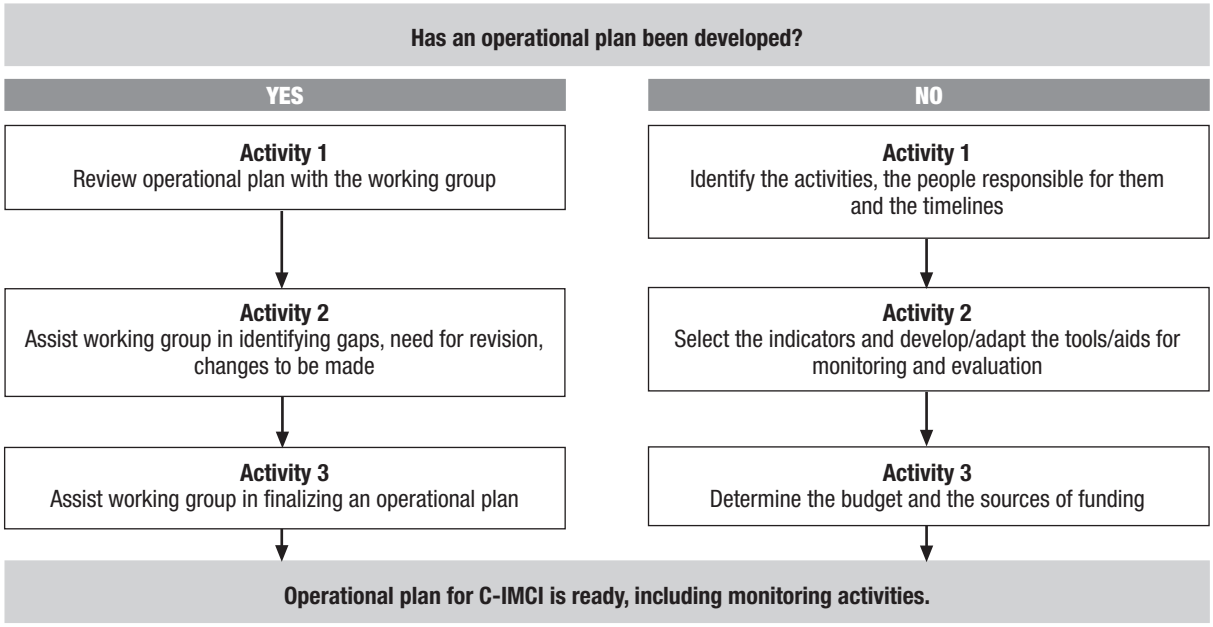
Fill out the two strategy development worksheets in Annex J by identifying one or more appropriate intervention categories (i.e. interventions through communication and interventions through service delivery improvement). Also, use the table for prioritizing interventions in Annex K.

Activity 4 Select the appropriate interventions

For each feasible practice, identify how to address the barriers and supports. To achieve maximum health impact, each intervention must directly reduce the important barriers and take advantage of the supports for each practice.

Any and all materials developed to support the strategic plan should focus on the feasible behaviours and address the barriers and supports as directly as possible. Consider this when reviewing existing materials to decide what to adapt and what to develop.

Figure 13. C-IMCI planning at the district level – Stage IV



DISTRICT LEVEL – STAGE IV: OPERATIONAL PLAN DEVELOPMENT

Has an operational plan been developed? **YES**

Activity 1 **Review operational plan with working group**

If a district operational plan for C-IMCI already exists, the facilitator should assist the working group to review the interventions selected and to ensure that the plan includes who will carry out each activity and when, indicators and tools for monitoring and evaluation and budget with sources of funding. This review should help the group and facilitator to identify gaps and required revisions.

Activity 2 **Revise operational plan**

The facilitator should assist the working group to make changes to the operational plan.

DISTRICT LEVEL – STAGE IV: OPERATIONAL PLAN DEVELOPMENT

Has an operational plan been developed? **NO**

Activity 1 **Identify the activities, the people responsible for them and the timelines**

For each intervention selected, the facilitator and the group should identify who will carry out each activity and when.

Activity 2 **Select the indicators and develop/adapt the tools/aids for monitoring and evaluation**

The facilitator should assist the working group to determine which indicators will enable them to know whether the interventions have improved the health of children in the community and whether the community has made progress towards behaviour change. The operational plan should include monitoring to assess whether programme activities are completed as planned.

Activity 3 **Determine the budget and the sources of funding**

The facilitator should assist the working group to identify and record the sources of funds to implement each activity.

COUNTRY EXPERIENCES TO ILLUSTRATE C-IMCI ACTIVITIES AT DISTRICT LEVEL

Many countries have initiated C-IMCI implementation in their districts. Coordination of activities, capacity development and resource mobilization are some of the key areas they have focused on. The following examples illustrate some of these experiences at district level.

Coordination using growth as an integrating framework
HONDURAS

Districts coordinating with communities are able to promote effective child health services and build community involvement in the care of young children. Monthly growth monitoring brings communities and health services together, teaching mothers about nutritious feeding and care for their children and ensuring that health facilities are closer to the source of health problems and solutions.

AIN (Atención Integral a la Niñez) is an integrated child health programme that the government of Honduras created and adopted as its national community-based child health package of services. It complements the package of services provided through IMCI within the formal health system. The programme is described under country experience, national level.

Each health area works with its health facilities to assess and categorize the communities they serve by their level of health need. Those with the highest need are scheduled first for implementation of AIN. In the beginning, each health centre works with two new communities per year, with the goal of covering all communities in a health area within three to five years. Area staff trains and supervises the health centre nurses and provides technical support and supplies.

AIN makes it easier for health facilities to collect community information and for health areas to look at how health facilities are running their programmes. Programme resources can be targeted to places where children are most in need and can alter the workload of the health centre staff, putting them closer to the source of health problems and solutions. On hearing about AIN, some nurses resisted participation, thinking that it would add to their workload; now however, they report this is not the case. They are reaching their targets in less time because they can tap the organization, talent, and enthusiasm of communities.

Community capacity development
ZIMBABWE

Training district facilitators and community mobilizers in Triple A (Assessment, Analysis and Action) creates a community-based resource of people who can work to solve health problems from within their own community. Creating this resource empowers the community to solve its local child health problems, use its assets effectively, and enhance the lives of those trained.

In one district, a pilot project started with sensitization of district authorities on the aims and objectives of IMCI. The Rural District Council, with the Ministry of Health and Child Welfare in a technical advisory role, coordinated community-level activities. A multisectoral IMCI task force was formed as a sub-working group of the Rural District Development Working Group to ensure that all activities in the sectors were coordinated. The IMCI Task Force then identified key people for training as district facilitators in Community Capacity Development (CCD). The district facilitators were trained for five days in the concepts of CCD, how to conduct community Triple A, and the key family practices of IMCI. District facilitators were selected from government departments operating at the district level (such as health,

education, social welfare, and agriculture) and from NGOs working in the district. In each district, about 30 facilitators received training. In turn, they trained ward facilitators and NGO staff, who in turn trained community mobilizers (people who live in and are selected by the community). Usually these were community-based health providers, but lay people were also selected if the community so wished. The aim was to train at least one mobilizer per village to carry out Triple A with the community. In total about 1,500 mobilizers per district received training.

Next, community mobilizers carried out Triple A with their communities, initially in separate groups of women, men and youths to avoid one group dominating the others. These groups would meet together to agree on the main child health problems in their villages. They also did gap analyses to come up with plans to address the problems and gaps they identified. The emphasis was on communities making plans that they themselves would implement, using their own resources as much as possible, though of course they could look for outside resources.

Coordination and multisectoral collaboration for resource mobilization
MALAWI

Coordinating C-IMCI throughout all levels and with different related sectors strengthens IMCI by using resources effectively, avoiding duplication and taking advantage of each partner's abilities.

Decreasing childhood mortality requires efforts at different levels of the health sector and other developmental sectors. Consequently, the implementation of the household and community IMCI in Malawi is using a multisectoral approach at all levels. To make use of synergies, the C-IMCI component merged with the Early Childhood Care – Survival, Growth and Development project (ECC-SGD). A multisectoral working group called Working Group for Improving Family and Childcare Practices coordinated the work of the merged programmes at all levels. The group comprises the following stakeholders at different levels:

National level

- The Ministry of Health and Population is the chair of the working group, whose members include officials working on IMCI, nutrition, malaria, EPI, and environmental health. The National Economic Council is deputy chair, and the Ministry of Gender is the secretariat.

District level

- The District Commissioner under local government, Department of Gender, Youth and Community Services, Health and Population Services, Judiciary, Information, Agriculture, Environmental Affairs, Water, Forestry, and relevant NGOs operating in the district.
- The stakeholders form the District Executives Working Group, which is the technical arm of the government at the district level. This group, together with community representatives, is responsible for planning, implementation, monitoring and evaluating of the merged household/community IMCI and ECC-SGD activities.

Community level

- The working group at the community level is comprised of local leaders, such as village headmen or their representatives, religious and influential leaders, business and retired civil servants, youth leaders, members of various development working groups and extension workers.

CHAPTER 5

C-IMCI planning for implementation at the community level

Involving families and communities in all C-IMCI interventions facilitates sustainability and scaling-up. Communities and families are the point of convergence of any interventions developed in the context of C-IMCI. The facilitator should help ensure that family and community input are consistently sought and incorporated into all aspects of planning and implementation.

There are many ways to define "community". One proposed definition is:

> *A community is a group of individuals linked by common interests, aspirations and systems of values.*

General principles to guide the overall planning of C-IMCI at the community level are listed in Chapter 1. The design of specific interventions should also be based on the following *guiding principles*:

- Build on efforts and activities already taking place in communities. For example, if communities have already formed mothers' groups, use those as the entry point to launch new activities. If communities already have nutrition counselling, expand that activity to include other issues.
- Use participatory approaches and problem-solving processes to assess needs, opportunities and constraints and to identify appropriate solutions. This will ensure ownership of the interventions by the community. The Triple A approach is described later in this chapter.
- Establish links with other development sectors (agriculture, education, health, and economy) and with other organizations and groups at the local level to foster development of a holistic vision where needs, problems and solutions are interrelated and interdependent.
- Share information and learn from other partners to create synergy and increase participation of all stakeholders, including community-based organizations and NGOs, in developing C-IMCI.
- Link information collected to action. Ensure that data collected lead to action in promoting key practices in the community and family. The community should be involved with all data collection.
- Private and public health providers should support the communities and the families they serve. This support may include capacity building, resource mobilization, monitoring and developing partnerships. Linking health providers and health systems with community capacity development ensures that interest and demand are supported by services.

Once planning and implementation begin at the community level, the facilitator should:

- Assist communities (e.g. community coordinating committee) in identifying resource people to carry out the different steps;
- Assist in community capacity building, including experience sharing.

By definition, C-IMCI activities are implemented at the community level. The district, intermediary and national levels give support by providing quality services

to meet demand and by supervising communities as they seek to improve and introduce new practices. They may also provide technical guidance, financial resources and managerial support in the form of materials, services and supervision. In addition, districts and other levels should be capable of responding if a community needs assistance with infrastructure or high cost items.

Planning steps for C-IMCI at the community level

The facilitator is likely to work with personnel at various levels in the public and private sectors. National and district planning for C-IMCI may have already taken place, in which case community-level planning should focus on adapting the higher-level plans and strategies to the local situation and resources. In many cases, district-level personnel (such as the district health management team or the district development working group) will oversee community-level planning and provide support as needed. Health providers in the public and private sectors will often serve as a link between the health system and communities through activities such as supervision, capacity-building exercises and information sharing. One of the facilitator's tasks will be to help ensure good communication and collaboration among the different levels and among community stakeholders.

Figure 14. C-IMCI planning at the community level

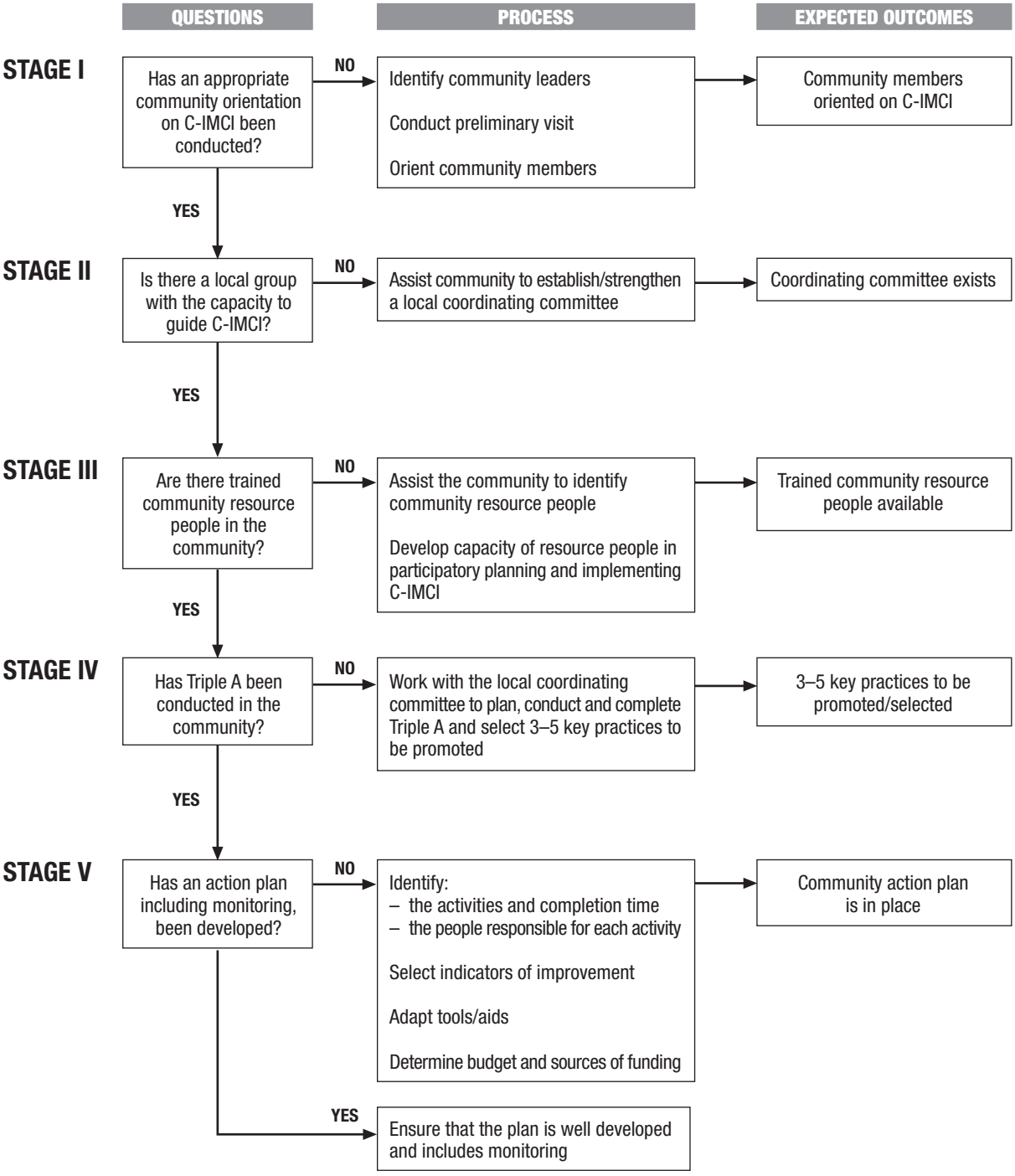
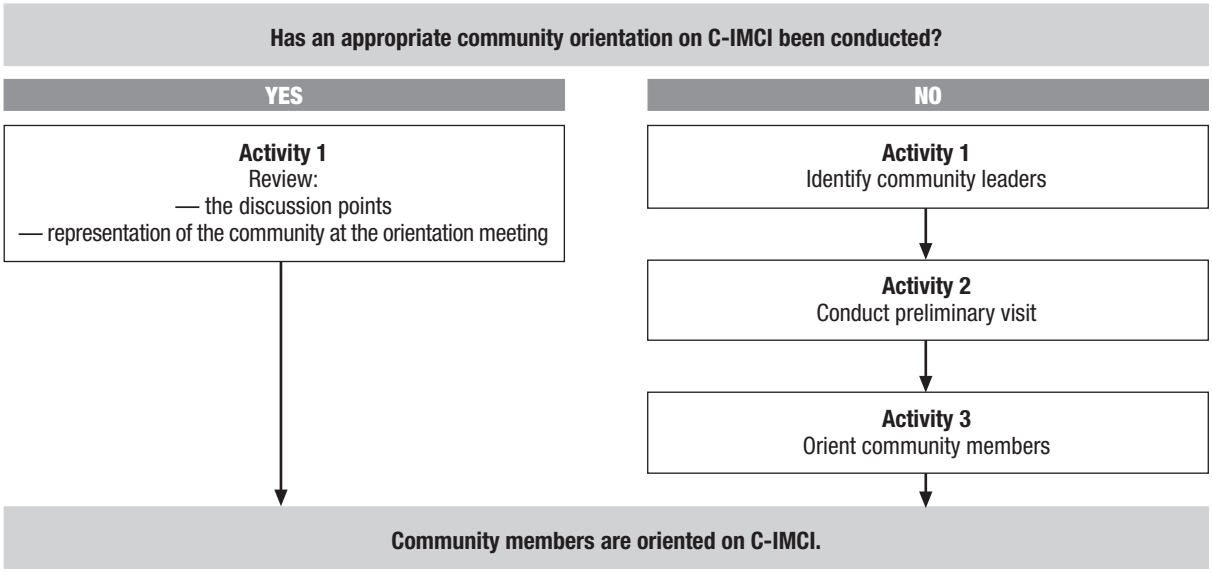


Figure 15. C-IMCI planning at the community level – Stage I



COMMUNITY LEVEL – STAGE I: COMMUNITY ORIENTATION

Has an appropriate community orientation on C-IMCI been conducted? YES

Activity 1 Review the discussion points (or agenda) of the meeting and representation of the community

If a community orientation meeting on C-IMCI has been conducted, review what has been discussed in the meeting. Make sure that the following points were covered:

- Child health, with a focus on children under five years of age;
- The principle causes of morbidity and mortality of children under five years of age in the community;
- Causes of the main diseases in the community;
- Means to prevent the main diseases and to promote growth and development;
- What the community and families can do to prevent illnesses and to manage them effectively when they occur;
- How to identify child health problems and their solutions using participatory approaches such as Triple A.

Review the list of participants at the meeting and ensure that the various stakeholders – including the leaders, community-based organizations, NGOs, private voluntary organizations, women's groups, mothers and other caregivers, youth groups and religious groups – attended the orientation meeting. If they did not, follow the steps under Stage I in the "NO" section, making sure that all stakeholders are included.

COMMUNITY LEVEL – STAGE I: COMMUNITY ORIENTATION

Has an appropriate community orientation on C-IMCI been conducted? NO

Activity 1 Identify community leaders

Start by identifying the various community leaders and establish good relationships with them so that they are included from the beginning. This also provides information on the best entry points for working with the community.

Activity 2 Conduct preliminary visit

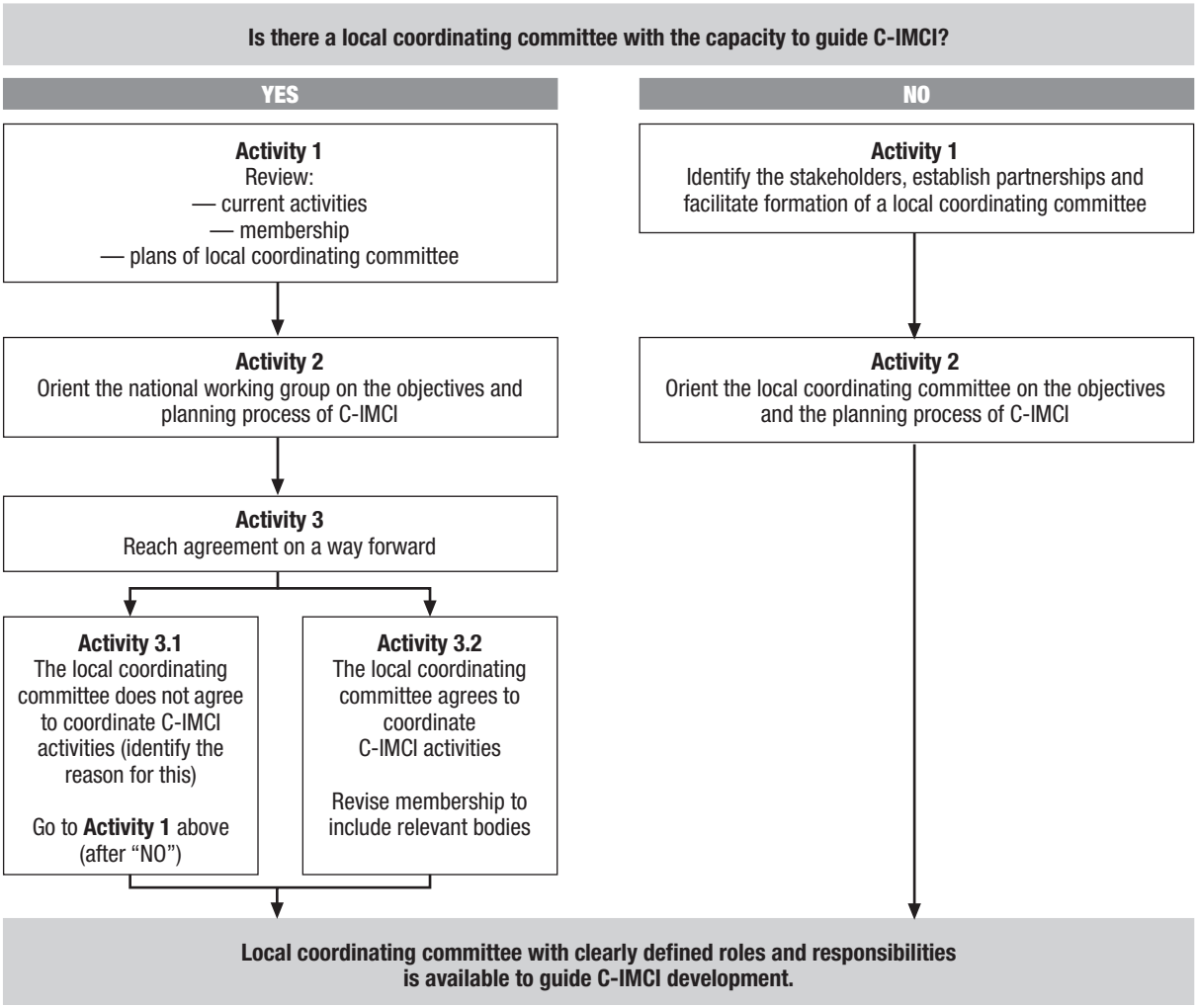
The facilitator should make a preliminary visit to the community in order to meet with community leaders and other stakeholders, including community-based organizations, NGOs, women's groups and religious groups. This will help the facilitator's understanding of the community and, in turn, the community's acceptance of the facilitator. During this visit, the facilitator may also be able to stimulate the community's awareness of and interest in improving child health.

Activity 3 Orient community members

The facilitator and the community leaders should plan to conduct an orientation meeting for the community.

Ensure that the main points mentioned under Activity 1 in the "YES" section are discussed at the orientation meeting and that the main stakeholders are represented.

Figure 16. C-IMCI planning at the community level – Stage II



COMMUNITY LEVEL – STAGE II: COORDINATING COMMITTEE

In order to guide C-IMCI, a local coordinating committee should fulfil the following criteria:

- Knowledge of values, beliefs and culture of the community;
- Good representation of community members (including all stakeholders), taking gender equity into consideration;
- Committed, dynamic members who meet regularly and who have full community support;
- Membership with the full support of the community.

Is there a local coordinating committee with the capacity to guide C-IMCI? **YES**

Activity 1 Review current activities, membership and plans of the local coordinating committee

If a local group exists, the facilitator should determine its current function by obtaining briefings by member(s) of the coordinating committee and by attending coordinating committee meetings. The facilitator should develop an understanding of the type of activities undertaken by the coordinating committee through review of available documents, including minutes of past meetings, and interviews with the community and coordinating committee members. It is also essential to examine the membership of the coordinating committee to see if all the various stakeholders (including community members, NGOs, other sectors involved with child health and development) are members of this coordinating committee.

Activity 2 Orient the local coordinating committee on the objectives and the planning process

The facilitator should provide the coordinating committee with an orientation on the objectives of C-IMCI, including the planning for C-IMCI implementation and the relationship of the community with the district and national-level planning. Once a common understanding is reached on the objectives and planning process for C-IMCI, the facilitator should assist the coordinating committee to compare these with their present plans and activities to determine where to focus efforts.

Activity 3 Reach agreement on a way forward

The facilitator should assist the coordinating committee to identify gaps between what it has been doing and what needs to be done to improve child health in the community and to agree on how to proceed.

Activity 3.1

If the committee does not wish to coordinate C-IMCI activities, the facilitator should return to the initial question in the Stage II flowchart ("Is there a local group with the capacity to guide C-IMCI?") and follow the "NO" wing of the flowchart.

Activity 3.2

If the committee wishes to coordinate C-IMCI activities, the facilitator should assist it to revise membership and include relevant bodies, to make plans for regular meetings and to move to Stage III.

COMMUNITY LEVEL – STAGE II: COORDINATING COMMITTEE

In order to guide C-IMCI, a local coordinating committee should fulfil the following criteria:

- Knowledge of values, beliefs and culture of the community;
- Good representation of community members (including all stakeholders), taking gender equity into consideration;
- Committed, dynamic members who meet regularly and who have full community support;
- Membership with the full support of the community.

Is there a local coordinating committee with the capacity to guide C-IMCI? **NO**

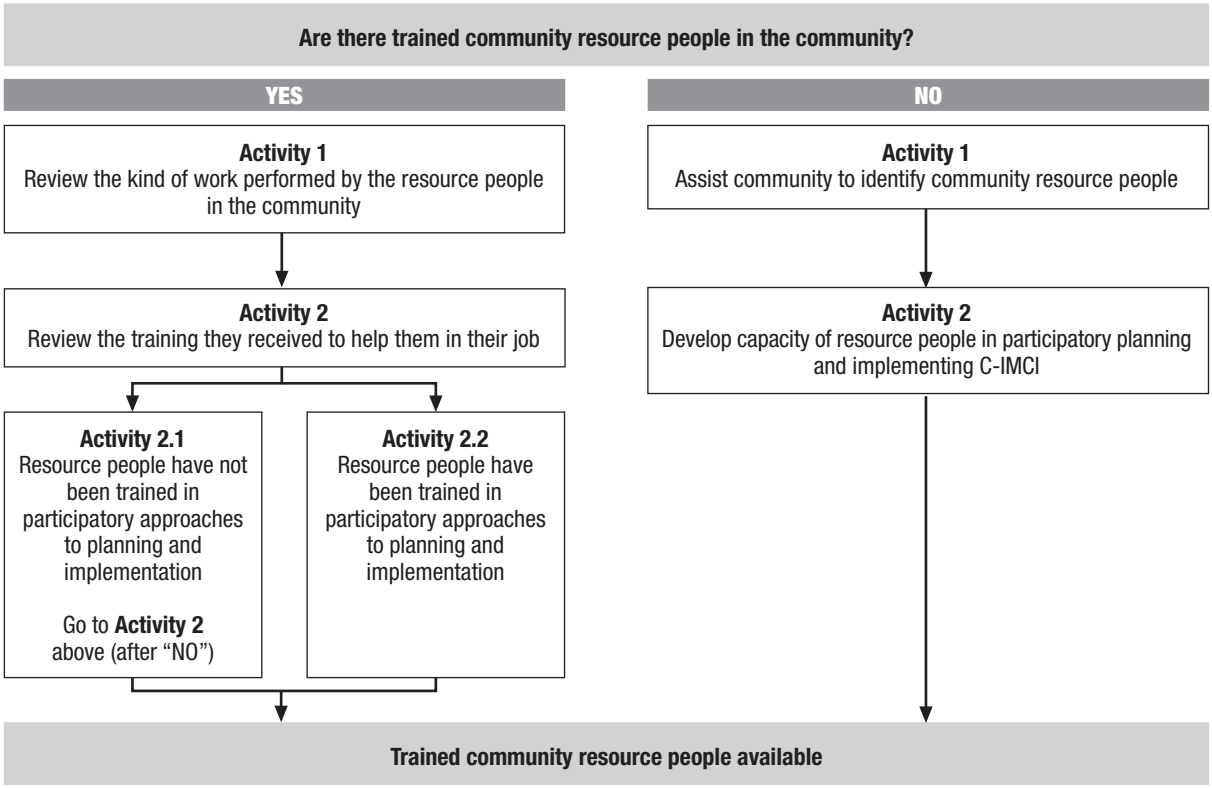
Activity 1 **Identify stakeholders in the community, establish partnerships and facilitate formation of a local coordinating committee**

For a maximum impact on child health, growth and development, all stakeholders and partners at the community level should harmonize their child health-related strategies and interventions. Various groups working at the community level should be identified and partnerships established. The facilitator should assess their interest in and ability to make a long-term commitment to C-IMCI.

Activity 2 **Orient the local coordinating committee on the objectives and the planning process**

Once the various stakeholders in the community are committed to working in partnership as the local coordinating committee for C-IMCI, the facilitator should orient the group about C-IMCI objectives, including the benefits of key family practices. Taking into consideration the activities and capacities of members, the facilitator should help the committee discuss roles and responsibilities of each stakeholder. The coordinating committee should then agree on the next steps to take.

Figure 17. C-IMCI planning at the community level – Stage III



COMMUNITY LEVEL – STAGE III: COMMUNITY RESOURCE PEOPLE

Are there trained community resource people in the community? YES

Activity 1 Review the kind of work performed by the resource people in the community

If trained resource people exist, the facilitator should determine their function. This could be done through briefings by the resource person(s), by interviewing community members (beneficiaries) and by observing the resource person(s) at work.

Activity 2 Review the training they received to help them in their job

The facilitator should determine what type of training the resource person has received, the content of the training and its duration. The facilitator should also assess if the training has been adequate for the person to perform the assigned tasks.

Activity 2.1

Resource people have not been trained in participatory approaches to planning and implementation

At community level, people trained in participatory approaches need to take the lead in participatory planning and implementation of community-based activities.

If no resource person has been trained in participatory methods, go to Activity 2 in the "NO" section to build capacity of resource people in participatory methods.

Activity 2.2

Resource people have been trained in participatory approaches to planning and implementation

If the resource people are trained in participatory methods, assist the local coordinating committee to go to Stage IV.

COMMUNITY LEVEL – STAGE III: COMMUNITY RESOURCE PEOPLE

Are there trained community resource people in the community? NO

Activity 1 Assist the community to identify community resource people

If no resource people have received training in participatory approaches, assist the community to identify people to be trained. The community should feel free to choose such resource people.

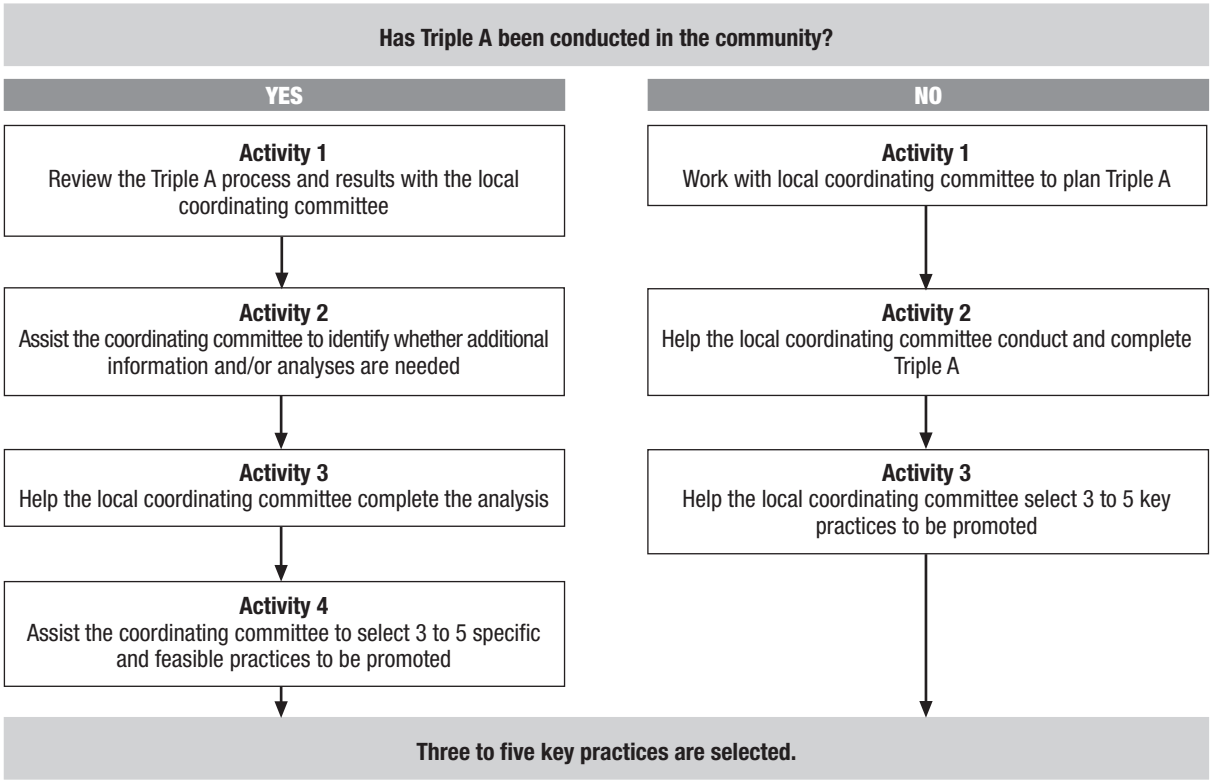
Following are some criteria for choosing resource people:

- a person from the community who knows the values and the culture of the community;
- is well accepted by the community;
- has the ability to mobilize the community;
- is willing and available to do the work.

Activity 2 Develop the capacity of resource people in participatory planning and implementing C-IMCI

The facilitator should identify individuals with skills in participatory approaches with whom to work in order to build capacity at the district or community levels.

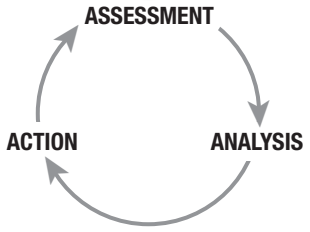
Figure 18. C-IMCI planning at the community level – Stage IV



COMMUNITY LEVEL – STAGE IV: TRIPLE A

The Triple A approach is a mechanism for building community capacity to assess problems, analyse the cause(s), develop plans to resolve or reduce the problems, re-assess the results/impact, re-analyse and include new actions, and so on. The approach follows three steps: Assessment, Analysis and Action. Assessment reviews current health problems, community and family practices and locally available resources. Analysis is a method for the coordinating committee to consider the causes of the situation and to analyse current key family practices in the community. Action is the development of activities that will enable the adoption and support of the key practices and a plan that indicates resources needed, people responsible and a timeline for the activities to be carried out. Communities need to monitor progress and move their plans forward. Triple A will enable the coordinating committee to decide where to focus resources and efforts to improve child health and development.

To apply the Triple A process, several tools have been developed. These include Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA), community dialogue, visualization in participatory programmes (VIPP) and others (see Annex O).



Has Triple A been conducted in the community? YES

Activity 1 Review the Triple A process and results with the local coordinating committee

The facilitator should review the documentation of the Triple A process. An overview presentation by the coordinating committee and the community resource people would be useful to explain details and answer questions.

Activity 2 Assist the coordinating committee to identify whether additional information and/or analyses are needed

The facilitator may discuss the participatory approach or tool used in the community to facilitate identification of process/information gaps. The facilitator should assist the coordinating committee to identify any missing information or items needing further analysis and decide on next steps.

Activity 3 Help the local coordinating committee complete the process of Triple A

If information is lacking, the facilitator should assist in planning additional information collection. The Triple A process can identify current family and community practices that need to be improved and can help determine which new practices need to be promoted through C-IMCI activities. The facilitator should ensure that favourable practices in the community are recognized and encouraged to continue, whilst new ones are introduced.

Activity 4 Assist the coordinating committee to select three to five specific and feasible practices to be promoted in the community

Triple A enables the community, with support from the trained resource person, district staff, and facilitator, to identify family practices that need to be improved and additional ones to be adopted. If some practices are already being promoted, the resource person, facilitator and coordinating committee need to consider strengthening these practices or adding new practices to the ongoing activities. If the number of key family practices has already been narrowed at a national, regional or district level, communities can start by selecting from among these.

The initial promotion of a few practices will yield better results than promoting all of the key family practices. To achieve health impact, it is important to prioritize. The selection of practices to be promoted should be based on three criteria:

1. the potential health impact of changing the practice;
2. the feasibility of changing the practice, including people's motivation to undertake new or modified practices;
3. the extent of the "problem" in the community.

The C-IMCI key family practices are general and will need to be made more specific to the context, with the issues of who, how, when, how often, and where addressed. These specifications need to be explored with the participants. For example, specific actions to promote complementary feeding will depend on the type of foods available, the quantity and consistency of foods, frequency of feeding, and/or feeding style. Much of this information may have already been gathered and analysed when adapting IMCI feeding recommendations.

Promoting specific practices and offering alternative practical choices based on context and ability will allow for success in the beginning, leading to sustainability and acceptance by the community. More practices can be introduced gradually as changes are observed and communities feel ready to take on more challenges.

Has Triple A been conducted in the community? **NO**

Activity 1 **Work with the local coordinating committee to plan Triple A**

The facilitator should first identify guides to be used for Triple A that are available in the country or in specific communities, e.g. PRA and PLA.

Activity 2 **Help the local coordinating committee conduct and complete Triple A**

The aim of this activity is to identify specific, feasible improvements in practices that are needed to (1) prioritize key family practices and (2) promote locally appropriate and realistic actions for each practice selected. These new actions come from a good understanding of current practices, the barriers and supports to improved practices, and skills and resources available to solve the problems.

It is important that the solutions – which become the practices the community will promote – come from members of the community.

The following steps are suggested for the facilitator to help the coordinating committee conduct and complete an assessment:

- The facilitator should lead the committee on a walk through the community, observing together its main characteristics. These might include types of housing, economic activity, agricultural production, source of drinking water and cleanliness of the environment. The committee might need to observe the community several times to gather all the appropriate information.
- The facilitator should assist the committee in drawing a map of the locally available health resources, particularly for children: infrastructure, resource people living within the community, people working in the health sector (formal, informal, public, private) and available services (drugs and equipment, vaccination services, mosquito net treatment centres).
- The facilitator should engage the community members, the health staff and other resource people in discussions using an identified Triple A participatory tool to:
  — identify the priority problems of children in the community;
  — learn the definition and the signs for detection of diseases;
  — identify the causes attributed to common diseases;
  — describe beliefs about common diseases;
  — learn care-seeking practices of the community;
  — learn the home-based care practices for common diseases.
- The facilitator should lead the coordinating committee in summarizing the information gathered and in identifying what additional information is needed to inform the selection of strategies and interventions.

Activity 3 **Help the local coordinating committee select three to five key practices to be promoted**

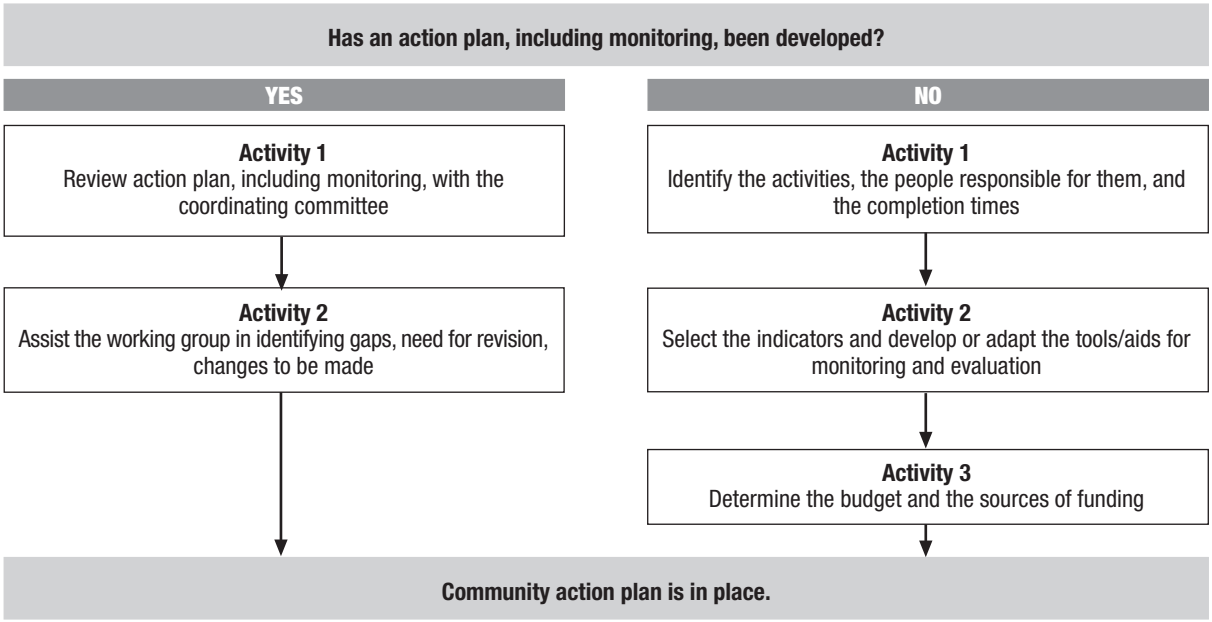
C-IMCI at the community level should begin by identifying three to five key practices. From the analysis, the facilitator and the local working group should be able to identify family practices that need to be improved. If some practices are already being promoted, the facilitator and working group, with each community, need to consider strengthening these practices or adding new feasible practices to the ongoing activities.

The initial promotion of a few practices will yield better results than promoting all the key family practices. To achieve health impact, it is important to prioritize.

The selection of practices to be promoted should be based on three criteria:

1. the potential health impact of changing the practice;
2. the feasibility of changing the practice, including people's motivation to undertake new or modified practices;
3. the extent of the "problem" in the community.

Figure 19. C-IMCI planning at the community level – Stage V



COMMUNITY LEVEL – STAGE V: ACTION PLAN INCLUDING MONITORING

Has an action plan, including monitoring, been developed? YES

Activity 1 Review action plan, including monitoring, with coordinating committee

The facilitator should assist the coordinating committee to review the action plan in light of the list of selected interventions (e.g. how will changes made in stages I-IV affect the existing action plan?). The review should also cover people responsible and a time schedule of activities. This review will allow for identification of gaps and any need for further revision.

The facilitator should ensure that monitoring is included in the plan. Simple community monitoring indicators can be included in routine data collection to reflect implementation of activities. In addition, each of the important practices, barriers and supports should be assigned indicators.

The facilitator and the coordinating committee should also review any lists of indicators from the national, regional or district levels and discuss ways of collecting information from the community level on these indicators, if possible.

Activity 2 Revise action plan and monitoring

After the committee has identified the gaps and determined if the plans need revision, the facilitator should assist in making the changes (see Annex M for a suggested format).

COMMUNITY LEVEL – STAGE V: ACTION PLAN INCLUDING MONITORING

Has an action plan, including monitoring, been developed? NO

Activity 1 Identify the activities, the people responsible for them, and the completion times

For each activity identified, the facilitator should assist the coordinating committee to identify the tasks, who will carry them out, and the period for completion. The roles of the stakeholders and their responsibilities need to be defined clearly (see Annex M for a suggested format).

Activity 2 Select the indicators and develop or adapt the tools/aids for monitoring and evaluation

For each activity identified, the facilitator, the resource person and the coordinating committee should determine which indicators will enable them to know if the selected interventions are working. In other words, are the interventions improving the health of children in the community?

Indicators monitoring implementation of activities can be included in routine data collection. In addition, indicators should be assigned to each of the important behaviours, barriers and supports. Depending on how easy these indicators are to collect, they can be monitored as part of regular community-based information systems that should be put in place with the help of district officers and resource people.

The facilitator, resource person and the coordinating committee should also review any lists of indicators from the national, regional or district levels and discuss ways of collecting information from the community level on these indicators, if possible.

Activity 3 Determine the budget and the sources of funding

The facilitator should assist the coordinating committee in identifying needed funds from within and outside the community to implement each activity.

There is no template for C-IMCI implementation because programme development must respond to local contexts. However, there are needs that are common to all communities, including: community involvement, community capacity development, partnership, health provider motivation, supportive supervision and monitoring, among others. Examining how these issues have been addressed in specific contexts can help planners in other areas consider different options for effective planning and implementation, as in the examples below:

Involving the community
ETHIOPIA

In the district where the Bridge-to-Health Team (BHT) project is running, each *Ketena* (settlement of about 150 households) elected a three-member BHT composed of a *chereti* (wise woman), a *cheresa* (wise man), and young traditional birth attendants, bonesetters, herbalist, and/or circumcisers. During a field visit, one *chereti* volunteered her services to the proposed *WomanWise* project saying, "*I can be your bridge*," inspiring the designation of "Bridge-to-Health" teams.

Men make up at least one third of the membership of the BHTs. The elected men are usually community leaders, traditional healers, herbalists, bonesetters, religious practitioners, or spiritual healers. Such individuals are respected in the community as credible sources of information about health and healing. Moreover, these men act as "gatekeepers" for care-seeking outside of the *olla* or *kebele* (the lowest government administrative unit). Thus, their participation in the bridge-to-health effort is crucial. BHT members receive six weeks of training during the project. The content of their training focuses on the cross-cutting "emphasis behaviours" and prepares them with participatory methodology to deliver or guide behaviour change communication (BCC) messages through various channels, such as home visits or meetings of *olla* and *kebele* leadership.

Once trained, BHT members work at household and community levels to promote child survival through BCC with mothers and caregivers, focusing on prevention, illness recognition, home care, care-seeking, and compliance with quality treatment. Team members receive quarterly supervision from the Ministry of Health and support from Save the Children, USA. They keep simple records (appropriate for non-literate use) of effort and content of activity and report to *kebele* health action working groups.

BHT members receive no monetary compensation for their BCC activities. However, those who are traditional practitioners will receive their normal remuneration, in cash or in kind, adding to project sustainability. Incentives are limited to items of minimal cost that will instil a sense of accomplishment and/or identity (e.g. certificates, cloth wraps, T-shirts, caps).

MADAGASCAR

In all provinces, the community is actively involved in the planning, implementation and follow-up of community-based nutrition projects. For example, community volunteers, under the coordination of working groups elected from members of the community, manage all activities.

Extensive research with participant groups identified feasible practices, and barriers and supports. These practices are promoted at all project sites through specialized folk songs and puppet shows to motivate improved behaviours. As a result, exclusive breastfeeding rates in the community-based nutrition sites are

higher than in other sites; there is improved home care for sick children (especially for those with diarrhoea) and improved sanitation. In some sites, members of the civil society have volunteered to assist the community. Five years after the project began, some sites have become autonomous and have taken over the management of all activities.

MALAWI

To assist the community to identify priority problems and solutions, a single problem is identified during a preliminary rapid assessment. This problem is presented to the community in the form of a short, clear role-play, drama, picture or story. Members of the community are helped to recognize the problem, relate it to their own situation and identify the causes.

The community then discusses possible actions to solve or cope with the problem. They also identify responsible or key duty bearers and capacity gaps. The facilitator gives input about current recommended practices, if the community does not mention them, and stimulates discussion around them.

Selection of the most effective, feasible and appropriate options involves summarizing agreements and reflecting on possible consequences of action or non-action. Preparation of an operational plan for implementation and monitoring follows this exercise.

BENIN

The objective of a health education programme implemented in 12 school districts of Benin is to increase the knowledge of primary school students and to improve their attitudes and practices in the areas of hygiene and health.

The intervention strategy focuses on strengthening the capacity of local NGOs through targeted training to develop school support groups, such as the Associations of Parents of Students, and to sensitize students and communities alike about malaria, nutrition, AIDS, diarrhoea, hygiene and environmental sanitation. Training modules have been developed on these topics, principally for training primary school students.

This experience attempts to stimulate behaviour change in the areas of hygiene and health among students and their families. "Child-to-child" and "child-to-family" strategies can also be interesting in communities that do not have volunteers available.

Community-based monitoring

TANZANIA

C-IMCI is monitored by the Community-Based Management Information System (CBMIS), using a register and follow-up forms at village level. The information is compiled in quarterly indicator reports, which include date of birth and birth weight, deaths and causes, the number, nutritional and immunization status of children under five years of age, the number of pregnant women, orphans, and people with access to safe water and sanitation. The quarterly reports are sent to higher levels (ward, districts) after discussions and compilation at each level.

Mid-year annual reviews are conducted at district level with participation of higher government-level officials. The quarterly Village Health Day is an important event for generating and discussing data at village level.

BENIN

In Benin, 54 communities selected one volunteer worker each to carry out communication activities, sales of ITNs, spermicides, and condoms, treatment of simple malaria cases and referral of the cases beyond their competence, and home visits. The volunteer's management tools, notably the dosage sheets for malaria treatment, have been translated into the local language to make them easier for the volunteers to use.

The project strategy relies on community leaders to support the volunteers and to help ensure successful implementation of project activities. There are 54 follow-up working groups (*comités de suivi* or CDS), each composed of five community leaders, which fulfil this role. It manages, supervises and evaluates the project at the community level. Health professionals and sanitation agents train the community volunteer and the CDS members. The results have been encouraging.

Volunteer incentives

BENIN

In a sub-prefecture of Benin that has 105 voluntary ambulance workers and 105 voluntary midwives, the following incentives are used:

Every month, during a meeting in which volunteers report to the community management working group on their experiences, the group president divides up 10% of the funds generated from that month's sale of medicine in equal parts and gives every volunteer one part.

The project also has development activities, such as: an agronomist provides farmers with technical assistance, and a community bank offers credit, principally to women and to community volunteers to support their development activities. The conditions for obtaining or renewing credit are that profits generated by the credit must be used for the education of children and the improvement of living conditions. Group solidarity has a strong influence on the availability of credit, because the reimbursement of credit by a member of the group enables another member of the group to then receive credit.

Annexes

ANNEX A
Key family practices

The promotion of growth and development of the child

- Breastfeed babies exclusively for six months;
- From six months, give children good quality complementary foods while continuing to breastfeed for two years or longer;
- Ensure that children receive enough micronutrients – such as vitamin A, iron and zinc – in their diet or through supplements;
- Promote mental and social development by responding to a child's needs for care and by playing, talking and providing a stimulating environment.

Disease prevention

- Dispose of all faeces safely, wash hands after defecation, before preparing meals and before feeding children;
- Protect children in malaria endemic areas, by ensuring that they sleep under insecticide-treated bednets;
- Provide appropriate care for HIV/AIDS affected people, especially orphans, and take action to prevent further HIV infections.

Appropriate care at home

- Continue to feed and offer more fluids, including breast milk to children when they are sick;
- Give sick children appropriate home treatment for infections;
- Protect children from injury and accident and provide treatment when necessary;
- Prevent child abuse and neglect, and take action when it does occur;
- Involve fathers in the care of their children and in the reproductive health of the family.

Care-seeking outside the home

- Recognize when sick children need treatment outside the home and seek care from appropriate providers;
- Take children to complete a full course of immunization before their first birthday;
- Follow the health provider's advice on treatment, follow-up and referral;
- Ensure that every pregnant woman has adequate antenatal care, and seeks care at the time of delivery and afterwards.

ANNEX B

C-IMCI planning at the national level: Preliminary information needed

Suggestions for persons to meet

- MOH (IMCI working group, national programme officers, staff of other child health-related programmes); other ministries (education, social affairs, women, water and sanitation, agriculture);
- Representatives or health staff of WHO, UNICEF, UNDP and other partners;
- Representatives of NGOs;
- Community leaders.

Necessary information: Main issues

Decentralization policy

- What is the coverage of health facilities in the country? How do the health facilities work with the communities they serve, to encourage utilization of services?
- Is there a cost recovery policy? How do the community participation structures function?
- What is the extent of the availability of drugs?
- Who can prescribe drugs?
- What is the policy regarding community participation?
- Are there coordination mechanisms for community-based interventions?

National priorities

- What is the progress on the implementation of IMCI?
- What is the average rate of utilization of health services? Which services are most utilized for child health? Which are least utilized for child health?
- What are the current practices and/or behaviours concerning:
  1. child feeding and nutrition
  2. prevention of child diseases
  3. care at home for the sick child
  4. care-seeking.
- What are ongoing interventions that address child health at the community level?
- Which districts carry out health and nutrition programmes (or other child care community-based programmes) at the community level?

Partnerships

- What is the current policy of the government with respect to NGOs? What is the role of NGOs?
- What is the place of the private sector (profit-making, non-profit-making) for the provision of care and services, such as insecticide-treated bednets, ORS and other products?
- What is the relationship between IMCI and other programmes such as Roll Back Malaria, HIV/AIDS Control Programme, and nutrition programmes?
- Who are the community resource persons working for child health? Who has been involved in their selection? How long have they been working? How are they motivated?

ANNEX C

Composition of the national C-IMCI working group (maximum 12 people)

REQUIRED KNOWLEDGE/SKILLS	TYPE OF PERSONNEL / PROFILE
1. Good knowledge of health system	Focal point in MOH at national level / health programme manager
2. Good knowledge/skills of community participatory approaches	Person from community service at MOH / social programme manager/social scientist
3. Good planning knowledge/skills	Planning officer
4. Good communication	Staff from communication division at MOH / communication experts
5. Networking with the community	Focal points in other sectors (social, agriculture, education, etc.); representatives of NGOs and other partners

ANNEX D

Overview of a situation analysis

General objective

Provide necessary information for the preparation of a comprehensive strategy for the improvement of family and community practices for child health.

Specific objectives

The specific objectives are to:

- Describe the epidemiology of common childhood diseases associated with high under-five mortality in the country;
- Identify the level at which the existing key family and community practices are being carried out;
- Determine the services (health, water and sanitation, etc.) available, accessible and utilized;
- Describe the communication strategy in place as well as the tools and available material;
- Identify the available opportunities for intervention (resources, policy, partners, district involvement, etc.);
- Identify the supports for and barriers to key practices.

Information collection techniques

- Literature review;
- Key informant interviews with authorities, programme officers, representatives of NGOs and cooperation agencies (at the national level and in a sample of districts);
- In-depth interviews with community leaders and community relays (in a sample of villages);
- Group discussion.

ANNEX E

Questions to consider when completing a situation analysis

ORGANIZATION AND MANAGEMENT OF COMMUNITY-BASED INTERVENTIONS FOR CHILD HEALTH

AREA	ISSUES	NECESSARY INFORMATION	SOURCE OF INFORMATION
Organization at the national level	Capacity of the MOH to coordinate community interventions for child health	What are the existing coordination structures for community-based child health interventions Do programmes and institutions participate in the coordination meetings? Is the IMCI working group empowered to make decisions?	List of IMCI working group members in charge of the community aspect Minutes of the meetings Interview with the working group
Strategic and organizational support	Relationship between national policy and the community needs	What is the budget allocated for community-based interventions? What services are authorized for child health at the community level? Who is authorized to provide community-based services? What are the standards in terms of community-based activities (CBA)?	Interview with administrative and finance (A/F) departments at national and district levels Policy documents, standards and procedures
Support by the national level to the districts	Involvement of the districts	What are the criteria for the selection of districts for community-based interventions? How is the ownership of interventions ensured and assessed by the district health team (DHT)? What materials and assistance do the districts need?	Interview with MCH, DHT, health providers, NGOs Interview with DHT
Organization at the district level	Capacity of the DHT to plan, coordinate and manage community interventions	Does the district operational plan include community interventions for child health? What are the existing coordination mechanisms for community-based interventions? Does the district have staff trained in preparation of participatory programmes, especially community diagnosis?	District operational plan Interview with the DHT
Community interventions budget	Costs of community interventions for child health	What is the cost of current community interventions? For investment and recurrent expenses? What is the contribution of the communities to the financing of the health sector?	A/F departments at national, district levels Annual district report
Advocacy for financial resource mobilization	Advocacy strategy	What are the financial resources available for the community interventions? (national, district level) What are the potential partners? What are the mechanisms for increasing the resources of community interventions?	A/F departments at national, district levels Interview with the partners and NGOs

AREA	ISSUES	NECESSARY INFORMATION	SOURCE OF INFORMATION
Collaboration with partners	Coordination of community programmes and initiatives	What are the existing mechanisms for coordinating community-based programmes and initiatives? What is the current role of the other sectors of development and other partners? How can they be more actively involved in the planning of activities at the national and district levels?	Interview with the representatives of partners and NGOs, health working groups Interview with partners of other sectors
Expansion of community interventions	Strategy for an optimal coverage of community interventions	What are the different strategies for scaling-up? How can the partners, organizations, NGOs, communities contribute to the scaling-up?	Interview with the MCH department and the DHTs, NGOs, partners of other sectors
Documentation of community interventions	Capacity to control the quality of activities and to assess the overall progress	What are the key indicators (process, outcomes, impact) for assessing community interventions for child health? How are data collected and used at the national, district, community levels? How do the health information system (HIS) and the routine monitoring system integrate information on the key indicators?	Interview with MCH department, DHTs, partners and NGOs Evaluation reports

ANNEX F

Questions to consider when completing a situation analysis

REVIEW OF COMMUNITY-BASED INTERVENTIONS FOR CHILD HEALTH

AREA	ISSUES	NECESSARY INFORMATION	SOURCE OF INFORMATION
Definition of the contents and the scope of application	Choice of priority practices and efficient interventions	Have the current practices been assessed in relation to the priority problems in child health? Was a consensus reached on which key practices to be promoted?	Review of existing data (surveys, ethnographical studies)
		Have the experiences of the ongoing community-based interventions been assessed at the national, district or community level?	Survey report on community-based experiences
		What are the interventions currently occurring at community level?	
		What decisions have been taken to strengthen the on-going interventions?	
		Has an inventory been conducted on available and potential resources for consolidating or strengthening the interventions selected? Was the community involved?	
Community interventions	Quality of community interventions	Who participated in the planning and implementation of the ongoing interventions or those developed within the scope of IMCI? What population is covered by these interventions?	Interview with teams of selected districts.
		Were the needs assessed before the interventions?	Survey report on community-based experiences
		How were community resource persons prepared or trained?	
		Has the programme formalized community involvement in facility-level management decision-making?	Interview with partners and NGOs
		What programmes are helping families to improve key family practices through social and behavioural change strategies?	
		What indicators were used to monitor the progress? What are the strengths and weaknesses of these interventions?	
Health education and advice provided by the health facility and in the community	Consistency and appropriateness of information to the caregivers	Is the information provided by the health provider in the health facility compatible with IMCI guidelines (use of local terms, food recommendations, counselling on when to return immediately)?	Monitoring report of trained health providers
			Analysis report of the existing IEC materials
	Use of appropriate channels	Are the messages conveyed on the existing information education communication (IEC) materials at the community level compatible with the desired key practices?	Analysis report of existing IEC materials
	Knowledge of caregivers	Are the channels used adapted to the community conditions? What is the population covered by these interventions?	Report on the monitoring of trained health providers
		Has caregivers' knowledge on management at home, including signs for referral, been assessed?	

AREA	ISSUES	NECESSARY INFORMATION	SOURCE OF INFORMATION
Supply of essential medicines and equipment	Consistency of available services with desired practices	What is the minimum package of drugs and equipment required to carry out the desired practices? What are the current drugs and equipment available in the community? Who currently prescribes and sells drugs in the community? Have the prices of drugs and equipment been harmonized among various providers? Is the current supply system functioning well? What are the potential channels for increasing the availability and rational use of drugs?	List of essential medicines according to levels Interview with the DHT, health providers
District capacity building	Relation between responsibilities and key skills	What skills are needed at the district level to determine needs, and to plan, monitor and evaluate community interventions? What are the existing capacities and how can they be mobilized? What are alternative strategies for satisfying the needs in prospect of expansion?	Standards and procedures for planning at the district level Interview with health training institutions, DHT and NGOs National strategy document for in-service training, curriculum for DHT training
Relations between health facilities and the community	Increased participation of the community in the implementation of community interventions	Were community health providers used to strengthen the links between the health facility and the community? How were they selected? How were they trained? What are their responsibilities? How are they motivated? Does substantive information sharing between the community and facility occur that affects how and what kind of service is provided? Do the health working groups participate actively in the quality management of the services provided in the health facility and in the community? Has the programme assessed and attempted to improve service quality and demand based on client feedback? Who are the available resource persons who may be used to increase the use of the services and reduce the referral periods?	Interview with the DHT, health providers, community resource persons (CORPS), community leaders

ANNEX G

Sample situation analysis data summary sheet

KEY FAMILY PRACTICES	EPIDEMIOLOGY	CURRENT PRACTICES	INTERVENTIONS/SERVICES (AVAILABILITY, ACCESSIBILITY, UTILIZATION) AND LESSONS LEARNED	COMMUNICATION (BCC, SOCIAL MOBILIZATION, ADVOCACY)	OPPORTUNITIES (PARTNERS, POLICY ETC.)	CONSTRAINTS	RECOMMENDATIONS
PHYSICAL GROWTH AND MENTAL DEVELOPMENT							
Breastfeed babies exclusively for 6 months							
Start complementary feeding from 6 months and continue breast-feeding until 2 years							
Ensure children receive adequate micronutrients							
Promote children's mental and social development							
DISEASE PREVENTION							
Dispose of faeces safely and wash hands at critical times							

ANNEX H

Guidelines for convening a stakeholders' workshop[1]

1. Preparation

Whether planning for national, regional or district level workshops, it is important to identify a key partner or partners to help organize this effort. Ideally, this group of partners should cut across as many types of organizations as possible (e.g. the MOH, private voluntary organizations, bi/multi-laterals, NGOs and community-based organizations). This will demonstrate to the larger group of stakeholders that this initiative has broad support and collective ownership by government and partners. An organizing partner should:

- be known and respected within the focus area (i.e. national, regional or district);
- be able to contribute resources (time/labour, meeting space, or money);
- demonstrate enthusiastic leadership and be supportive about moving the C-IMCI agenda forward.

The role of various partners may include helping to:

- determine whom to invite;
- conduct pre-workshop meetings with the invited participants to ensure their support and motivation;
- manage the logistics and preparation;
- co-facilitate the workshop and small groups;
- contribute resources.

The group should meet two or three times before the workshop to plan and coordinate.

During the workshop, a few small group activities will require the guidance of group facilitators. Identify volunteers among the partners to help facilitate. These are important positions and require good facilitation skills. Once three to four small-group facilitators are identified, meet with them to review the activities and ensure that they understand the objectives and procedures.

2. Participants

Ministry of health participation is essential. At the national level, it would be helpful to invite those engaged in policy decisions and national level planning associated with IMCI. It would also be helpful to invite appropriate leadership from the departmental or provincial level (such as a Regional Director or Regional Chief Medical Officer) who will have the capacity to champion replication of the workshop within the region. District level staff (perhaps those already engaged in Components 1 and 2 of IMCI) may be able to provide some district-level perspective.

For a regional-level meeting seek participation from district-level leadership, and for a district- level meeting, seek sub-district leadership, and so on. Also, invite those involved in collaborative planning (with the MOH, NGOs and/or community-based organizations and others) at each particular level.

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[1] From *Household and Community Integrated Management of Childhood Illness (HH/C- IMCI) Framework: A Tool for Collaboration, Understanding and Local Planning of HH/C- IMCI.* CORE Group with support from the BASICS II Project, funded by USAID.

Local NGOs and community-based organizations should also be invited. At the national level, this might be an umbrella organization representing NGOs and/or community-based organizations or a group that has national coverage. At the regional and district levels it would be leadership of both health and non-health sector organizations. These local partners are critical as their work extends into the community and they participate in the implementation of some C-IMCI strategies.

Private voluntary organizations (PVOs) should also be represented. These are groups that have extensive experience working with communities and have gained valuable skills and knowledge about operating health programmes in the community. At the national level, it would be important to invite the organizational director or director of health programming. They may also want to call in their regional leadership, which would coincide nicely with the MOH regional presence.

Especially at the national level, the participation of bi/multi-lateral agencies is essential. Multi-laterals would include UNICEF, WHO and the World Bank. Bi-laterals include those organizations involved in health-related programming. It is probably sufficient to have them involved only at the national level unless they have a regional or district presence.

While non-health sectors play an important role, there may not be space for them in a national level workshop. However, the closer this process moves down to the operational levels, the more important their participation becomes. We strongly recommend inviting key non-health sector leadership at the district level, for example. This would include representation from the ministries of agriculture, education and religious and political leadership.

Finally, the workshop should include some community representation. Logistically, this may be more challenging at the national level but less so at regional and local levels. A representative(s) who understands health issues (perhaps a community-based health provider or local leadership) and feels comfortable speaking to a large and diverse group should be selected. One way to seek participation may be to ask NGOs and/or community-based organizations or private voluntary organizations to nominate a community representative.

The number of participants will depend on the type of participants selected. It may also depend on each group's capacity to support its own costs (if external support cannot be provided). To keep the number to a manageable level, consider maintaining a limit of around 50 to 60 people.

3. Logistics

As soon as a date is confirmed, the ministry of health should send out an official invitation requesting attendance and asking for a reply. To the extent possible, individual meetings with as many invited organizations as possible should support the invitation. This commitment demonstrates the importance of the meeting and the importance of their attendance.

As can be expected, there will not be a time that is perfect for everyone and you should anticipate losing some due to conflicting agendas. We would recommend that you try to schedule it within two months of making the decision to conduct the workshop. Ask potential participants during the pre-workshop meetings what would be the best time that fits most of the participants' schedules.

Location will depend on a number of factors including capacity and costs. Ideally, it will be a combined conference centre and boarding area (if participants are expected from out of town). It is quite possible that the MOH or other organization could provide space free of charge that meets the needs of the workshop.

As long as participant organizations pay for the transport, room and boarding costs of their members, the operational costs can remain low.

ANNEX I

Guidelines for organizing a C-IMCI orientation, situation analysis results dissemination, and planning workshop

1. Background

Children under five years of age bear a disproportionate share of the global burden of disease. While major gains have been made in reducing childhood mortality during previous decades, stagnation or even reversals of trends have been observed recently in many countries. Most of the nearly 11 million child deaths each year are concentrated in the world's poorest countries in sub-Saharan Africa and South Asia. Diarrhoea, pneumonia, and neonatal conditions are the most prevalent causes of childhood mortality worldwide, with malaria and HIV infections contributing in many areas. Malnutrition is associated with 54% of all child deaths, and measles remains a major cause of death.

WHO and UNICEF responded to this challenge by developing the Integrated Management of Childhood Illness (IMCI) strategy, which includes three main components:

- **Component 1**: Improving case management skills of health providers through training, using locally adapted guidelines.
- **Component 2**: Improving the health system by strengthening district health planning and management, making available essential drugs and supplies required for effective case management, providing quality support and supervision at health facilities, improving referral and health information systems and organizing work efficiently at the health facility.
- **Component 3**: Improving family and community practices by promoting those practices with the greatest potential for improving child survival, growth and development (community IMCI or C-IMCI)

During the first few years of IMCI implementation, the main focus was on the first two components. The third component, improving family and community practices, was officially launched as an essential component of the IMCI strategy in 1997. Since then, many activities have been undertaken by bilateral and multilateral institutions and NGOs to promote and implement community approaches to child health and development.

The main aim of the orientation workshop is to gain a clear understanding of the third component of IMCI and to reach a consensus on the steps of its implementation.

2. Objectives

The objectives of the workshop are to:

- Ensure a clear understanding of community IMCI (C-IMCI) among key stakeholders;
- Disseminate the C-IMCI situation analysis results;
- Develop a strategic plan for implementation, monitoring and evaluation of C-IMCI.

3. Expected results

The expected results of the workshop are:

- C-IMCI key family practices, strategies and implementation steps clearly understood;
- Situation analysis results disseminated;
- Draft national/district strategic plan for the implementation of C-IMCI developed.

4. Organization of the workshop

The workshop is organized in three parts over five days. The first part (days 1 and 2) is for general orientation on IMCI with special emphasis on C-IMCI. The results of the situation analysis will also be disseminated during the second day.

The second part (days 3 and 4) of the workshop consists of presentations and group work on the different steps involved in developing a strategic plan for implementation of C-IMCI, and development of the draft plan.

The first part of the workshop should be attended by a cross-section of stakeholders, including decision makers, high officials from the ministry of health and from other ministries, representatives of bilateral and multilateral organizations, planners both from national and district levels, IMCI working group, etc. Participants in the second part of the workshop should, however, be national- and district-level IMCI implementers (from the government and NGOs) and the IMCI working group.

The last day of the workshop (day 5) will be for presentation of the national and district plans of action. It is suggested that this be attended by a larger group of participants (as on days 1 and 2) to increase awareness and to ensure ownership of the implementation strategies by all concerned.

SAMPLE AGENDA

DAY 1

Registration (15 min.)
Introduction/opening remarks (15 min.)
Objectives and expected outcomes of the workshop (15 min.)
Overview and rationale of the IMCI strategy (30 min.)
Status of implementation of IMCI in the Region (15 min.)
Status of IMCI implementation in the country (15 min.)

Tea break

Session 1: Overview of C-IMCI

Operational definition of C-IMCI, rationale for its implementation and guiding principles (15 min.)
Key family and community practices (30 min.)
Discussion (1hour)

Lunch

Strategies and general implementation steps of C-IMCI (30 min.)
Discussion (30 min.)

Session 2: Linkages between C-IMCI and other community-based child health programmes

HIV/AIDS / Prevention of mother to child transmission (PMTCT) (30 min.)
Nutrition (30 min.)
Roll Back Malaria (30 min.)
Discussion (1 hour)

DAY 2

Session 3: Adaptation of the key family and community practices and strategies and implementation steps of C-IMCI

Presentation of the results of the situation analysis (1 hour)
Discussion (1 hour)

Tea break

Group work to discuss key family and community practices to be selected (2 hours)

Lunch

Plenary discussion (1 hour)

Tea break

Discussion on C-IMCI strategic plan (2 hours)

DAY 3

Session 4: Development of C-IMCI plan

National/district planning for C-IMCI: Introduction (30 min.)
Group work (2hours)

Tea break

Group work continues

Lunch

Group work continues (2 hours)

Tea break

Group work continues

DAY 4

Group work

DAY 5

Presentation of national/district plan of action for C-IMCI
Discussion (3 hours)
Next steps (1 hour)

SAMPLE INVITATION TO A STAKEHOLDERS' WORKSHOP

[Name of person]
[Organization]

Dear Mr/Ms/Mrs [Name]

The Ministry of Health kindly requests your presence (or that of your management staff) at an important five-day workshop to be held on [date] at [location]. We have space available for a maximum of [NUMBER OF STAFF TO BE INVITED].

As you know, the Ministry of Health and its collaborating partners have taken important steps in moving forward community IMCI (C-IMCI). Until now, however, materials and resources that would support individual and collective efforts to train staff in planning for and implementing a C-IMCI programme have been limited.

[NAME OF HOSTING GROUP] will be facilitating a workshop geared towards assisting efforts in planning for C-IMCI at national, intermediary, district and community levels. At the end of the workshop, participants will be provided with a kit for replicating the activities at the regional/district/community levels.

The Ministry of Health considers your participation to be important in this effort. The cost of the workshop location, materials, refreshments and lunch will be covered. We are asking each organization to pay the costs of their own participation (transport/room and evening meals). The conference centre/workshop location has rooms available for [ROOM RATE]. If staff will be coming from out of town and wish to stay at the facility, please call and reserve a room directly [ENTER PHONE NUMBER HERE].

Please also submit an RSVP to [NAME OF WORKSHOP FACILITATOR] at

[CONTACT INFORMATION FOR WORKSHOP FACILITATOR]

Thank you in advance for your participation.

ANNEX J
Strategy development worksheet

Health problem: _____

_____

_____

Participant Group (gender, age, profession, etc.):* _____

BEHAVIOURAL ANALYSIS					COMMUNICATION		
KEY PRACTICES	CURRENT PRACTICES	FEASIBLE PRACTICES	MAJOR BARRIERS	MAJOR MOTIVATIONS AND SUPPORTS	COMMUNICATION FOR BEHAVIOUR CHANGE (BCC)	SOCIAL MOBILIZATION	ADVOCACY

* To be filled out for each participant group and supporting group

Health problem: _____

_____

_____

Participant Group (gender, age, profession, etc.):* _____

BEHAVIOURAL ANALYSIS					SERVICES DELIVERY			
KEY PRACTICES	CURRENT PRACTICES	FEASIBLE PRACTICES	MAJOR BARRIERS	MAJOR MOTIVATIONS AND SUPPORTS	TRAINING SUPERVISION	DRUG SUPPLY	COORDINATION	POLICY CHANGES NEEDED

* To be filled out for each participant group and supporting group

ANNEX K

Table for prioritizing interventions

CRITERIA / INTERVENTION	EFFECTIVENESS	RELEVANCE TO BEHAVIOURS	FEASIBILITY	ACCEPTABILITY	COST–EFFECTIVENESS AND RESOURCES AVAILABLE	SCORE
N° 1						
N° 2						
N° 3						
N° 4						
N° 5						
N° 6						

ANNEX L

Community IMCI (C-IMCI) national strategic plan outline

1. **Introduction**
2. **Background information**
   - 2.1 Progress of IMCI components 1 and 2
   - 2.2 Situation analysis on C-IMCI
     - 2.2.1 Situation of key family practices
     - 2.2.2 Implementation and organization of community child health interventions
     - 2.2.3 Policies related to child health at the community level
3. **Rationale for C-IMCI**
   - 3.1 Operational framework for C-IMCI implementation
4. **Objectives**
   - 4.1 General objectives
   - 4.2 Specific objectives
5. **Guiding principles**
6. **Targets**
7. **Strategies**
8. **Interventions**
9. **Organization and management**
10. **Levels of implementation**
    - 10.1 National level
    - 10.2 Intermediary level
    - 10.3 District level
    - 10.4 Community level
11. **Roles and responsibilities of actors**
    - 11.1 Caregivers
    - 11.2 Community
    - 11.3 Local structures (neighbourhood health working groups)
12. **Monitoring and evaluation**

TARGET	INTERVENTION	INDICATORS
		Process: Outcome: Impact:
		Process: Outcome: Impact:
		Process: Outcome: Impact:

ANNEX M

Example of a template for a plan of action

STRATEGIES	ACTIVITIES	INDICATORS	TIMELINE												RESPONSIBLE PERSONS	BUDGET
			J	F	M	A	M	J	J	A	S	O	N	D		

ANNEX N

Trials of Improved Practices (TIPs):

A method for identifying feasible practices

Key practices that a programme aims to improve must have two characteristics: 1) a significant health impact and 2) be feasible to change. Technical experts can determine the first criterion based on the epidemiological and environmental context. The second criterion, feasibility of change, can only be decided by the participant groups. Being feasible to change means that most people are *willing* and *able* to make the changes. Trials of Improved Practices (TIPs) is a core research method to find out exactly this – what people are willing to try and are able to do. TIPs allow programme participants to try practices and report their reactions (positive and negative) to programmers. Programme managers who use TIPs before implementing their programmes full scale, are able to know what will and will not work in specific situations.

During TIPs, behavioural recommendations that come from earlier exploratory research are tested with a small group of participants (individuals, households, facilities, or other relevant groups). TIPs can be carried out in two or three visits. The three-visit plan is useful when there is not enough detailed information on participants' current practices.

Three-visit TIPs plan

VISIT 1	VISIT 2	VISIT 3
Background information	Feedback on practices	Changes since last visit
Current practices	Recommendations and initial response	Outcome and response to trial
Observation	Negotiation and motivation	Modifications
	Discussion with others, if needed	Adoption of practice
	Agreement on specific practices to try	How participants would explain or recommend to others

When earlier research has identified current practices and/or when interviewers would be able to determine specific recommendations for participants' without extensive observation, two visits can be sufficient.

Two-visit TIPs plan

VISIT 1	VISIT 2
Background information	Changes since last visit
Current practices	Outcome and response to trial
Discussion of recommendations	Modifications
Negotiation and motivation	Adoption of practice
Discussion with others, if needed	How participants would explain or recommend to others
Agreement on specific practices to try	

The advantage of TIPs, particularly for refining behavioural recommendations, is that people have a *choice* of recommendations to act on, are questioned about their reasons for that choice, and are then consulted after the trial to see what actually happened. Did they try the new practice, and if so, how did they feel about it? Did they modify it? How easy or difficult did they find it to be? How did others react? Or, if they did not try it, why not? In this way, the proposed recommendations are tested in a real environment, and information is gathered on their acceptability and doability. Participants are able to provide direct input into the selection of recommendations. This information helps programme planning to set priorities among the many important practices – all of which could have a health impact. Through TIPs, researchers and programme planners discover:

- the relative ease or difficulty in negotiating various recommended practices;
- modifications that make the recommendations more acceptable;
- unanticipated barriers that limit behaviour change, and local solutions to the barriers;
- ways in which recommendations are undermined by other practices, beliefs, perceptions and those of other people;
- the proportion of people who are and who are not able to adopt recommendations.

Similar to other qualitative research, a small sample of participants is all that is required, provided the participants selected are representative of participant groups. All categories of people relevant to the programme should be included such as those living in different geographic areas, those with children of particular ages, those with varying resources, etc.

Task box for Trials of Improved Practices (TIPs)

PREPARATION ACTIVITIES AND TASKS	
Draft a counselling guide on behaviour change recommendations	— List common problems — For each problem, list several realistic recommendations for improving health — Develop the counselling guide
Design the research protocol	— Determine the number and procedures for each visit
Develop question guides and recording forms	— Specify topics that require additional questioning — Draft recording forms
Revise the research plan	— Use guidelines for selecting research plan — Recruit participants
Draft a field plan	— Schedule fieldwork — Assign responsibility
Train the field team and pretest the guides and forms	— Objective of TIPs — TIPs methods and forms — Role-plays and pretesting — Initial analysis in the field

IMPLEMENTATION ACTIVITIES AND TASKS	
Recruit participants	— Identify participants (individuals, households, groups) for TIPs — Obtain consent
Conduct the **initial** visits	— Conduct interviews, observations, and assessment with selected participants — Schedule counselling visit
Analyse initial data and plan specific recommendations	— Review results of initial visit — Identify problems and plan recommendations to suggest in each household — Revise counselling guide as needed
Conduct the **counselling** visits	— Discuss specific recommendations and negotiate with participants to try a new practice — Schedule follow-up visit
Summarize the response to counselling	— Preliminary analysis: what recommendations are participants willing or not willing to try and why? — Document motivations and constraints
Conduct the **follow-up** visits	— Find out how participants followed the suggested practices, why or why not, how they modified the advice and why, and their positive and negative reactions — Review and summarize information

ANALYSIS ACTIVITIES AND TASKS	
Tabulate the results of the trials	— Each recommendation: number agreed to, number tried, number will continue/were successful — Note key constraints and motivations
Revise recommendations	— Revise guide to include most appropriate/successful recommendations, amended according to suggestions — Focus on most common problems
Write a report on the findings	— Summary — Recommendations for programming — Remaining questions/recommendations for further research and the decision on need for checking research

ANNEX 0

Examples of tools for participatory planning at the community level

AVAILABLE MATERIALS	SOURCE	AUDIENCE AND USE
The Care Initiative: Assessment, analysis and action to improve care for nutrition	UNICEF	To assist the members of the community to plan the improved nutrition actions with the full participation of women
Rapid Assessment Procedures (RAP) to improve management of diarrhoea	International Nutrition Foundation for Developing Countries	To assist programme officers in the evaluation of diarrhoea-related behaviours
Emphasis Behaviours / Community Assessment and Planning	BASICS Project	To assist district teams to develop messages, implement a participatory planning process, and to develop intervention, monitoring and evaluation strategies
Use of Structured Observation in the Study of Health Behaviour	International Centre for Water and Sanitation	To assist programme officers to identify risk behaviours for diarrhoeal diseases
Participatory Rural Appraisal / Participatory Learning and Action (PRA/PLA)	International Institute for Environment and Development; Save the Children Federation	A set of participatory exercises to help technical specialists listen to, and learn from, community members and help them assess and analyse their problems and develop action plans
Community Dialogue	UNICEF	A participatory technique to develop village action plans based on the priorities of both community members and local government officials
Participatory Hygiene and Sanitation Transformation (PHAST)	WHO Health and Environment Documentation Centre	A participatory tool that uses a set of pictures to mobilize the community to participate in water and sanitation activities to prevent diarrhoea
A Step-by-step guide: A participatory approach for control of diarrhoeal diseases	WHO Health and Environment Documentation Centre	To assist the CHW to facilitate the community participation in water and sanitation projects
Community-based Management of Information Systems (CB-MIS)	UNICEF	Monitoring performance in specific areas of child health and development by community members
The Sara Communication Initiative (SCI)	Academy for Educational Development	Uses cartoon characters in comic books and videos to explore the situation of girls in Africa
Visualization in participatory planning (VIPP)	UNICEF	Uses cards, games and exercises to ensure more equal participation in workshops with participants who hold different positions of power in communities or governments

AVAILABLE MATERIALS	SOURCE	AUDIENCE AND USE
The string game	UNICEF	A participatory story-telling exercise to show social relationships, especially related to HIV/AIDS or sexual violence in the family
Positive Deviance Inquiry (PDI)	UNICEF	This approach looks for solutions within a community. The use of indigenous knowledge ensures that the intervention is culturally acceptable. In PDI, community members witness practices of neighbours who have well-nourished children, identify successful practices and adopt them

ANNEX P

Gap analysis worksheet

PROBLEMS BEING ADDRESSED	IDEAL PRACTICES	CURRENT PRACTICES	REMAINING QUESTIONS	DATA NEEDED	FROM WHOM	METHODS

ANNEX Q
Community diagnosis

Necessary information: Main issues

Practices

- prevalence and distribution
- relation between knowledge, behaviours, and health status
- behavioural determinants
- perception of the community on the health services and health requirements
- obstacles and supports
- seasonal and geographic variations of behaviours and needs.

Resources

- existing resources within the community (volunteers, midwives, community-based organizations): their role and the perception of the community on their ability and level of commitment
- financial resources
- material resources (drugs, equipment, etc.)
- technical resources.

Relations between the health services and the community

- availability of drugs and equipment at the health facilities
- supervision activities
- referral system
- accessibility to health care in the health area
- involvement of communities in the management of the health facility
- perceptions of health staff by the community and vice versa.

Other issues

- particularly vulnerable groups including marginalized groups.

ANNEX R

Monitoring and evaluation indicators

Process indicators for monitoring C-IMCI interventions

National level

Number of countries with:

- an efficient coordination mechanism
- a consensus building plan
- appropriate situation analysis completed
- a national strategic plan
- a long-term plan including a funding plan.

Intermediary level

- an efficient coordination mechanism
- a consensus building plan
- appropriate situation analysis completed
- a regional strategic plan.

District level

Proportion of districts in a given country with:

- an efficient coordination mechanism (formal and informal)
- situation analysis completed
- a strategic plan (in line with the national strategic plan)
- an operational plan.

Community level

Proportion of districts having at least one community with:

- an identification of the needs and a community diagnosis completed
- a system of co-management of health activities
- a system of sharing the cost of health activities
- the presence of resource persons living within the community and working in the area of health.

Priority community indicators of key practices for IMCI

1. *Child under 6 months of age is exclusively breastfed.* Proportion of infants aged less than 6 months who were exclusively breastfed in the last 24 hours

   Numerator: Number of infants aged less than 6 months (less than 180 days) who were exclusively breastfed in the last 24 hours.

   Denominator: Number of infants aged less than 6 months (less than 180 days) surveyed.

2. *Child aged 6–9 months receives breastmilk and complementary feeding.* Proportion of infants aged 6–9 months receiving breastmilk and complementary foods

   Numerator: Number of infants aged 6–9 months who received breastmilk and complementary foods[1] in the last 24 hours.

   Denominator: Number of infants aged 6–9 months surveyed.

[1] Solid and/or semi-solid foods

3. *Child under 2 years of age who is low weight for age (underweight prevalence).* Proportion of children who are below -2SD from the median weight for age according to the WHO/NCHS reference population.

   Numerator: Number of children under 2 years of age whose weight is below -2SD from the median weight of the WHO/NCHS reference population for their age.

   Denominator: Number of children under 2 years of age surveyed.

4. *Child 12–23 months of age is vaccinated against measles before 12 months of age.* Proportion of children aged 12–23 months vaccinated against measles before 12 months of age.

   Numerator: Number of children aged 12–23 months vaccinated against measles before 12 months of age

   Denominator: Number of children aged 12–23 months surveyed.

5. *Child sleeps under an insecticide treated net (in malaria risk areas).* Proportion of children who sleep under insecticide treated[1] nets in malaria risk areas

   Numerator: Number of children who slept under an insecticide treated[1] net the previous night

   Denominator: Number of children surveyed.

6. *Sick child is offered increased fluids and continued feeding.* Proportion of sick children for whom the caretaker offered increased fluids and continued feeding.

   Numerator: Number of children who were reportedly sick in the previous two weeks and for whom the caretaker offered increased fluids and the same amount or more food.

   Denominator: Number of children surveyed who were reportedly sick in the previous two weeks.

7. *Child with fever receives appropriate treatment.* Proportion of children with fever who received an appropriate antimalarial treatment (in malaria risk areas).

   Numerator: Number of children who were reported to have had fever in the previous two weeks and were treated with a locally recommended antimalarial.

   Denominator: Number of children surveyed who were reported to have had fever in the previous two weeks.

8. *Caretaker knows at least two signs for seeking care immediately.* Proportion of caretakers who know at least 2 signs for seeking care immediately.

   Numerator: Number of caretakers of children who know at least 2 of the following signs for seeking care immediately:[2] child not able to drink or breastfeed, child becomes sicker despite home care, child develops a fever (in malaria risk areas or if child aged less than 2 months), child has fast breathing, child has difficult breathing, child has blood in the stools, child is drinking poorly.

   Denominator: Number of caretakers of children surveyed.

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[1] Insecticide treated net include immersion in an insecticide solution and/or regular direct spraying

[2] Local terms to be identified