

PLANNING STEPS FOR THE IMCI COMMUNITY COMPONENT AT NATIONAL LEVEL

This unedited, working document has been prepared to guide the planning process for the community component of the IMCI strategy. The steps highlighted in the process are based on the “Framework for the community component of the integrated childcare strategy” developed by the World Health Organization Eastern Mediterranean Regional Office. The document has already been used by many countries in the Region to plan for the IMCI community component.



World Health Organization
Regional Office for the Eastern Mediterranean
Child and Adolescent Health and Development Unit

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Planning process at national level

❖ MANAGEMENT AND COORDINATION STRUCTURE

1. Has an IMCI working group/committee been established specifically for the community component?
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If so:

When was it established? (month, year)

Was it established by a formal written decree, circular or other document of the Ministry of Health? (If yes, please, indicate the reference)

What is the composition of the working group? (Profiles and designations of the members and their position within the group, within and outside the Ministry of health)

Are partners included? (Civil organisations, non-governmental organisations, academic institutions, professional societies, international organisations, etc.)

Are there any resource persons who are not members of the working group?

Framework steps 1 & 2:
Gather existing information & Situation analysis

I **Review of available information on key family childcare practices**
([Example 1 - below](#))

1. Were the recommended 12 key family childcare practices systematically reviewed in the country? (see list of practices attached as annex)

If so:

- ▶ When and how was the review conducted?
-

- ▶ What were the findings of the review and which sources/documents were used for the review (by practice reviewed) – please, list the findings for each of the 12 practices -
-

- ▶ What conclusions were made from the review?
-

EXAMPLE 1: Review of available information on key family childcare practices

- **Country:** ZED
- **Date of Review:** Workshop 13-17 January 2002; Steering Committee Meeting 19 January 2002;
- **Method used:** Workshop with MOH programme managers and district staff, selected members of the IMCI adaptation group, and universities (participants divided in working groups on feeding and nutrition, home care and care-seeking, hygiene and antenatal care)
- **Findings:**
- **Key practices No. 1: EXCLUSIVE BREASTFEEDING**
- **Sources of information:** (Note: you may have additional or different sources of information to which to refer):
 - Source1: *Patterns of exclusive and complementary breastfeeding in selected communities*, CDD/Breastfeeding household survey, Ministry of Health and WHO, District X, Province/Governorate Y, year yyyy;
 - Source 2: *Study on early initiation of breastfeeding*, National Nutrition Research Institute, District X, Province/Governorate Y, year yyyy;
 - Source 3: *Study on feeding patterns in children below two years of age*, NGO, Province/Governorate Y, year yyyy
 - Source 4: *Household trials of IMCI feeding recommendations*, MOH, Province/Governorate Y, year yyyy

- Source 5: *Evaluation of breastfeeding support groups in the community*, MOH and UNICEF, Province/Governorate Y, year yyyy
- Source 6: *Household survey on home management of diarrhoeal diseases*, Province/Governorate XY, year yyyy
- Source 7: *Annual statistics report*, MOH, year yyyy

↩ **Review outcome (1. Exclusive breastfeeding):** 20% of mothers exclusively breastfeed their children for up to 6 months and most mothers keep breastfeeding them for more than 12 months, supported through active community breastfeeding groups [Sources: 1,2,3,5]. However, colostrum is discarded, as it is culturally believed not to be good to the child, and breastfeeding is started late in most cases on day 3, when the “milk comes” [Source: 2]. These patterns seem common throughout the country, although urban-rural differentials exist. Diarrhoea is highly prevalent and contributes to 20% of all under-five deaths [Sources: 6,7].

➤ Key practices No. 2: COMPLEMENTARY FEEDING

- **Sources of information:** same sources as for practice 1 (exclusive breastfeeding).

↩ **Review outcome (2. Complementary feeding):** 40% of mothers introduce complementary food too early – around 2nd and 3rd month after child’s birth – while 15% introduces it too late, after the 6th month [Sources: 1,3]. The type of food introduced is most often inadequate in energy and nutrients [Source: 4]. There is a high prevalence of stunting in young children [Sources: 3,6]. Breastfeeding support groups currently concentrate on promoting breastfeeding [Source: 5]. Data suggest that most mothers would have access to appropriate complementary food but lack adequate nutrition knowledge [Sources:3,4,6].

(...)

➤ Key practices No. 5: IMMUNIZATION

- **Sources of information:** (Note: you may have other sources of information to which to refer):
 - Source1: *EPI cluster surveys*, Ministry of Health, Province/Governorate Y, year yyyy;
 - Source 2: *Annual Statistical Reports*, MOH, years yyyy, yyyy, yyyy
 - Source 3: *Joint MOH/WHO/UNICEF EPI review*, year yyyy;
 - Source 4: *Study on accessibility to, and use of, key health services*, MOH and Donor agency, year yyyy.
 - Source 5: *Communicable diseases surveillance system – Data from sentinel sites*, MOH, years yyyy, yyyy, yyyy

↩ **Review outcome (5. Immunization):** 90% of children 12-23 months old was fully immunized in 2001: 95% of children under 1 year of age were immunized against measles, 97% received BCG, 95% OPV3 and 92% DPT3 [Sources: 1,2,3]. Immunisation coverage in the past 5 years has constantly been high and at a similar level than 2001 [Source: 2]. Access to EPI services is very good: there are no differences in the coverage between boys and girls, and the urban-rural differential is negligible, with immunisation coverage rates in rural areas being close to those in urban areas. No significant differences in coverage are reported between the North and the South of the country [Sources: 1,4]. A review of the

cold chain, vaccine and other supplies for immunisation, has reported availability of functional equipment and adequate supplies in 93% of facilities visited [Sources: 3,4]. No major outbreaks of vaccine-preventable illnesses have been reported in the past 3 years [Sources: 2,5]. There is strong political commitment to immunisation at the level of the President, with the polio initiative driving substantial resources also for other EPI antigens [Source: 3].

➤ **Key practice No. 10: CARE-SEEKING**

• **Sources of information** (Note: you may have additional or different sources of information to which to refer):

- Source 1: *Community survey on care-seeking practices, Province/Governorate Y, W, Z, year yyyy*;
- Source 2: *ARI Focus Ethnographic Study, District X, Province/Governorate Y, year yyyy*
- Source 3: *Validation of local terminology of illness in in-patient settings, Province/Governorate Y, year yyyy*
- Source 4: *Childhood mortality survey, year yyyy*
- Source 5: *Annual Statistics Report, MOH, yyyy*

↪ **Review outcome (10. Care-seeking)**: Pneumonia is the leading cause of deaths in under-fives [Sources: 4,5]. Difficult breathing would appear to be the sign triggering care-seeking only for 30% of mothers of children below five years old with pneumonia; however, even in these cases, there would usually be a tendency to wait for 2-3 days since the recognising of difficult breathing before going to the health centre or the hospital, trying first home remedies (self-medication) and seeking advice from traditional providers [Sources: 1,2,3]. Up to 30% of infant deaths would have received no medical care from an appropriate provider before dying, more so in rural areas [Sources: 1,2]. Up to 60% of infant deaths would occur at home or on the way to the hospital [Source: 4]. Caretakers' lack of knowledge of signs indicating severity in their sick children would be among the main factors delaying care-seeking, together with accessibility (distance and economic constraints), in rural areas, where infant mortality is higher [Sources: 1,2,4].

(...)

📖 **CONCLUSIONS:**

(1) Given the high incidence of diarrhoeal diseases and inadequate feeding practices, there is a need to promote early initiation of breastfeeding and exclusive breastfeeding.

(2) Given the high prevalence of stunting, inadequate feeding practices and caretakers' lack of nutrition knowledge among caretakers, there is a need to improve complementary feeding practices.

(...)

(5) Given the high immunisation coverage rates for all antigens, regular availability of EPI equipment supplies, good control of vaccine-preventable diseases, strong EPI programme and political support at high level, there is no need for additional IMCI input, apart from what already provided through the IMCI guidelines to minimise missed immunisation opportunities for sick children taken to health facilities.

(...)

(10) Given the major contribution of pneumonia to the overall infant mortality and the likely role that caretakers' lack of knowledge about the signs of severity in children with ARI plays in causing risky delays in care-seeking from appropriate providers, there is a need to improve care-seeking practices for children with ARI, especially in rural areas.

(...)

II *Review of existing interventions at community level and lessons learnt* **(Example 2 - below)**

1. Which specific, existing community interventions were reviewed? (e.g., Community development project, Community health volunteers, School teachers as health promoters, Breastfeeding support groups, etc.) – Please, list also the specific sources of information used in the review (community intervention reviews, evaluations, monitoring visits, etc.).

2. Which lessons were learnt from that experience, for example on turnover of community health workers, motivation schemes, supervision, linkages of the community and community health workers with the health system, monitoring, availability of resources, measured outcomes, etc.? (strengths, weaknesses, barriers, constraints, sustainability, project-led initiatives, partnership experience, etc.)

EXAMPLE 2: Review of existing interventions at community level and lessons learnt

Example A:

- **Sources of information:**

- Source 1: *Joint MOH/WHO/UNICEF/Donor CDD Programme Review*, year YYYY

In many areas in the country, including rural and remote areas, there are community health volunteers (CHVs). They are mainly responsible for health education and have been provided with some pamphlets on key messages. Some have received some training in CDD to learn how to prepare ORS and promote ORT and have been provided with ORS packets. There is no standard supervisory system for their performance and little is known about the impact of their work. There are criteria for their selection, that have been agreed upon with the community. In general they are respected by the community; their role has been enhanced recently when they have been provided with chloroquine for patients with fever in remote areas. They must be literate, there are no motivation schemes, they work mostly on their own and this in part explains the high turnover of volunteers.

Strengths: CHVs are present in many parts of the country, including remote areas, are accepted and respected by the community that participates in their selection.

Weaknesses: CHVs receive only some briefing; their terms of reference are broad; their activities are not strongly linked with the activities of the health centres in their areas and they are not regularly supervised and supported. The fact that they must have middle-level literacy makes them more susceptible to dropping out after a short period (on average 4-6 months); there are no motivation schemes in place yet.

Example B:

- **Sources of information:**

- Source 1: *Joint MOH/WHO/UNICEF/Donor Nutrition Programme Review*, year YYYY

Teachers have been involved by the MOH nutrition programme in many districts in the country to help identify children with malnutrition by weighing children 12 to 23 months old and referring those underweight-for-age to the health centres for action.

Strengths: Teachers have welcomed the initiative. They are highly respected in their communities. They tend to stay in the same place for an average of 3 years. Resources to support the initial orientation of teachers are provided by an NGO.

Weaknesses: Teachers' involvement is limited to weighing children; they are not involved in the nutrition rehabilitation of nutrition education of the families affected once they have identified the malnourished children. This project is not regularly monitored or supervised – no feedback from health centres - and has not been formally evaluated. Its impact is unknown. The project is fully funded through external resources and is due to end in one year: no resources to continue to support it after then have been identified. A rapid assessment on a small sample conducted by the NGO has shown a reduced level of interest among the teachers interviewed, who initially thought they would be more involved in the whole process rather than be confined to weighing children.

(...)

III **Review of existing health education and communication materials and activities**¹

([Example 3 - below](#))

1. Were any health education² materials reviewed in detail?

¹ With "health information, education and communication activities" we refer here broadly to any approach aiming at changing (or reinforcing) health-related behaviours in a community, concerning a specific problem and within a pre-defined period of time (definition adapted from "*Information, education and communication – Lessons from the past: perspectives for the future*" by Elayne Clift for WHO, 2001 – Occasional Paper 6).

² See footnote (¹)

If so:

- ▶ Which ones?
-

- ▶ How are these materials used and by whom?
-

- ▶ Has the impact of these education materials been evaluated formally, to see whether they have contributed to improve family childcare practices?
-

- ▶ What was the conclusion from the review?
-

2. Was a comprehensive communication³ plan developed for childcare? (e.g., see items B and C in the example below)

If so:

- ▶ Please, describe the plan briefly and attach a copy of the plan.
-

- ▶ Does the plan specifically describe who will be responsible for what? (if so, please describe)
-

- ▶ Have the financial resources needed to implement the plan been identified? If so, where would most of the funds come from?
-

- ▶ Does the plan include activities that are being undertaken by different programmes, projects and partners? (If so, list these activities by programme)
-

EXAMPLE 3: Review of existing health education and communication materials and activities

A. Were any health education materials reviewed in detail? The IMCI Community Group has reviewed a large number of health education materials produced by MOH containing messages related to child health to make them

³ See footnote (1)

consistent with the IMCI home care messages. The review was carried out during the IMCI adaptation work from October 2000 to February 2001. The following materials were reviewed: a) "Get healthy with a shot", by the national EPI; "Water is life", by the CDD programme; c) "Breast is best", by the nutrition programme; (...) [etc.] (Note: these are just made up examples here).

- B. Was a comprehensive communication plan developed on childcare?** There are many posters, pamphlets and other traditional materials that contain messages on child health. They have usually been developed at central level, in few cases with a simple pre-test on a very small sample of people, and are supposed to be distributed to health facilities and, through health providers, to families. These materials are the initiative of individual programmes or projects and are not part of a comprehensive communication plan on childcare. Financial resources have been allocated only for their initial printing. The target group is not specified, the problems addressed are many and no specific targets have been set. There is no monitoring mechanism nor has any formal evaluation been conducted. It is unknown whether they have reached the community, whether the community finds them useful and use them and whether they have contributed in any way to improving the concerned childcare practices.
- C.** A radio communication project, targeting mothers of young children, was carried out for the CDD programme in 1995: a selection of key radio messages was developed in a workshop with representatives of various programmes and communication experts. The project was funded through external, international sources. The only source of information available is the report of the workshop. No monitoring was carried out. It is unknown whether the messages were broadcast, when they were broadcast, whether they reached the target audience, whether they lead to a change in practices and so on.
(...)

IV Review of existing, successful approaches to involving communities actively

1. If this aspect was reviewed: How was it possible to involve communities actively in community interventions? (please, note that the emphasis in this question is not on what the community did but what methods/approaches = i.e., "how" = succeeded in stimulating the community to participate in the intervention, become actors rather than simply recipients).

2. Was the community involved in all phases of the process (from planning through evaluation)? (please, specify in which phases of the intervention the community was involved actively)

3. Did the community contribute any resources? If so, what type of resources? How was it made possible?

4. Was the community able to see the final outcome of the intervention (and therefore the result of their actions)?

5. How feasible would it be to use these successful approaches on a large scale?

V Review of data on caretaker satisfaction

1. Are data available on how the community perceives the quality of services provided by both public and private providers? (if data are available, please, mention references)?

▶ What does the community value most?

▶ Which services are used most: public or private? Why? (if data are available, please mention references)

VI Review of information on community health provider satisfaction

1. Are there any motivation schemes to keep community health workers in their positions (e.g., performance awards, commitment certificates, participation in training courses, attendance to meetings, literacy or continuing education programmes, etc.)?

2. Do they receive regular feedback on their performance and regular 'refresher training'? If so, how often and who gives them feedback?

3. What is on average the turnover of community health workers?

VII Identification of existing or potential community structures and linkages between the community and health system

1. Are there "active" (functional) community committees or other community structures that are concerned with the health of the community? (e.g., village health committee, etc.)

If so:

- ▶ Please, describe them.
-

- ▶ How are these community structures linked with the health system?
-

- ▶ Is the IMCI working group/committee considering linking with them for the IMCI community component? If so, how?
-

VIII Identification of information gaps and collection of additional information if needed for decision making and planning (e.g., community assessment).

1. Has the situation analysis identified any areas for which there is insufficient information that would be vital for planning?

If so:

- ▶ Which ones?
-

- ▶ How will (has) this information be (has been) collected? (which tools)
-

- ▶ How will this information be used specifically for planning for the IMCI community component?
-

Step 4:
Set country priorities (needs and family practices)

1. Which of the recommended key family practices have been selected as initial focus of the IMCI community component? (please, list them below)

2. Which specific criteria have been used to select them?

Step 5/a:
Identify potential community interventions

1. After reviewing existing community interventions in the country, which ones have been found to have the greatest potential for the IMCI community component? Why?

2. Will the IMCI community component build on these interventions and/or make use of existing community structures? (if so, please explain how)

3. What would the IMCI community component 'add' to these existing community interventions?

4. From data available from the country, what impact on the selected key family practices would you expect by implementing the IMCI community intervention that you have chosen?

[Example: a study in the country showed that the promotion of the use of mosquito bed-nets through community health volunteers and a local NGO led to an increase by 30% in the use of insecticide-treated bed-nets in a period of 12 months, which was accompanied by a 10% reduction in the number of malaria episodes in young children in the community in the same period...]

5. Does the plan for the IMCI community component include activities carried out also by different 'actors' (partners, programmes etc.), to achieve the desired outcome = to improve selected family practices? (If so, please, describe them)

6. How is the IMCI community component intervention going to strengthen the link between the community and the health system?

Step 5/b:
I identify potential approaches to community involvement

1. Based on the situation analysis, have some approaches been identified to involve the community actively? (If so, please describe them)

Step 6/a:
Define indicators and targets

1. Have indicators been identified to monitor the process and outputs of the IMCI community component intervention, and to measure intermediate and final outcomes?

If so:

▶ Please list them

▶ Have targets been set for each of these indicators? (If so, please state them)

Step 6/b:
I identify monitoring tools

1. Which tools will be used to monitor progress regularly (recording and reporting information)? (please, list the tools and the indicators that each tool would be able to measure)

Step 7:
I identify tools for integrated supervision

1. How will the intervention be regularly supervised?
-

Step 8:
I identify resources

Human resources:

1. Have human resources been identified for the implementation of the IMCI community component intervention? (if so, please describe which ones)
-
2. Is a high turnover expected with these human resources? If so, how will this be overcome?
-

Financial resources:

3. Have financial resources been identified for the implementation of the IMCI community component intervention? (if so, please list them by source)
-
4. Will there be a mechanism to sustain the intervention financially in the long run? (if so, describe how this will happen)
-

Step 9:
Define criteria to select priority communities

1. Which criteria have been set to select priority communities for the IMCI community component?
-

Step 10:
Develop strategic plan⁴ within national integrated childcare
strategy

1. Has a (strategic) plan⁵ for the "IMCI strategy" been prepared? If so, kindly enclose a copy.

2. Has a (strategic) plan⁶ for the "IMCI community component" already been prepared? If so, please enclose a copy.

3. Is the plan for the IMCI community component clearly and fully integrated with the plan for the implementation of the whole IMCI strategy? (If so, please explain how)

PARTNERSHIP

1. Were partners involved in the situation analysis? If so, which partners? – e.g., which MOH programmes and projects, academic and research institutions, other ministries, civil society, NGOs, multi- and bi-lateral organisations, etc. - Which role did they play?

2. Were the results of the situation analysis discussed with partners?

If so:

▶ When and how were the results shared?

▶ Which partners were involved (specify)?

⁴ The expression "Strategic plan" is used here to refer to a formal plan that sets out the policies, directions and sets of activities (i.e., "a plan for the strategy") that will be followed to achieve long-term objectives. On the other hand, the expression "plan of action" usually describes the specific activities of a plan in detail.

⁵ See footnote (⁴)

⁶ See footnote (⁴)

- ▶ Was it agreed to form a partnership for community childcare with all main partner actors? (If so, please, describe which type of partnership was established and whether this was formalised by an official MOH written document, e.g. memorandum of understanding)
-

3. Which specific role, responsibility and resources will each partner (MOH programmes, other ministries, civil organisations, NGOs, international agencies, etc.) have, according to the plan for the IMCI community component intervention? (please, briefly describe or attach the plan of action)
-

Annex 1: KEY FAMILY PRACTICES ON CHILDCARE ⁷

1. Exclusive breastfeeding

Breastfeed infants exclusively for up to six months

2. Complementary feeding

Starting at about 6 months of age, feed children freshly prepared energy and nutrient rich complementary foods while continuing to breastfeed up to two years or longer

3. Micronutrients

Ensure that children receive adequate amounts of micronutrients (vitamin A and iron in particular) either in their diet or through supplementation

4. Hygiene

Dispose of faeces, including children's faeces, safely, and wash hands after defecation before preparing meals and before feeding children

5. Immunisation

Take children as scheduled to complete a full course of immunisations (BCG, DPT, OPV, and measles) before their first birthday

6. Malaria: use of bednets

Protect children in malaria-endemic areas by ensuring that they sleep under insecticide-treated bednets

7. Psychosocial development

Promote mental and social development by responding to a child's needs for care and through talking, playing and providing a stimulating environment

8. Home care for illness

Continue to feed and offer more fluids including breastmilk to children when they are sick

9. Infections

Give sick children appropriate home treatment for infections

10. Care-seeking

Recognise when sick children need treatment outside the home and seek care from appropriate providers

11. Compliance with advice

Follow the health worker's advice about treatment, follow-up and referral

12. Antenatal care

Ensure that every pregnant woman has adequate antenatal care

[This includes having at least four antenatal visits with an appropriate health care provider and receiving the recommended doses of tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the post-partum and lactation period]

⁷ *Improving family and community practices – A component of the IMCI strategy.* Geneva, World Health Organization, 1998. (WHO/CAH/98.2)

Annex 2: The 10 steps of the planning process for the IMCI community component at national level

NATIONAL LEVEL

