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**INCREASING IMPACT AT THE COMMUNITY
LEVEL: ASSESSING EXPERIENCE
TO DATE AND CONSTRUCTING
A FRAMEWORK FOR FUTURE ACTION**

September 17-19, 1997

Sam A. Orisasona

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The author traveled from Nigeria to BASICS/Headquarters in Arlington, Virginia, to attend a 3-day conference regarding impact at the community level. He presented the Nigeria country program to the conference participants. The entire conference was very informative and interesting. This trip also gave the author a chance to interact with the Nigeria cluster members at Headquarters and to meet the Headquarters staff that he did not know.

The author's notes on the conference and his trip are included in the attached appendix.

APPENDIX

TRIP REPORT TO THE UNITED STATES OF AMERICA

**BY SAM. A. ORISASONA
BASICS/NIGERIA COMMUNITY DEVELOPMENT PROGRAM OFFICER
(CDPO)**

ON THE

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT/BASICS
SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL (USAID/BASICS)
ORGANIZED COMMUNITY MEETING**

ON

**INCREASING IMPACT AT THE COMMUNITY LEVEL: ASSESSING EXPERIENCE
TO DATE AND CONSTRUCTING A FRAMEWORK FOR FUTURE ACTION**

SEPTEMBER 17 - 19, 1997



ACKNOWLEDGMENTS:

I would like to express my gratitude to God for his divine direction, and infinite blessings, on everybody who has been working on BASICS/N Project from inception to date, in and out of Nigeria, because it is our belief that without Him, nothing would have been made possible.

This presentation is entirely, a product of team work, as usual, by my colleagues in Nigeria and in Arlington. Therefore, I thank you all for your contributions.

It was good that USAID organized a meeting of this kind, at a time like this, when the BASICS Nigeria Project is hopping towards the PY 5. It gave us the opportunity of a quick review of the process.

To me, it was a great academic challenge to face experts in the field of Community Development or Approaches. The discussion was very timely, and well digested. It was especially nice meeting the lovely Nigeria team in Arlington, but on a serious note, everybody in the BASICS Office in Arlington is wonderful. The visit to America itself was an un-expected fulfilment of a personal ambition. It has also satisfied one of the requests in my first year evaluation performance.

The USAID/N mission's logistical input, particularly that of the AAO, Mr Felix Awantang, and Dr. A.E. Oleksy-Ojikutu, the Project Manager/Administration is hereby acknowledged.

Finally, I thank BASICS/Nigeria Country Advisor, Dr J.O. Ayodele for giving me the privilege to attend an important meeting of this nature, which he himself, could have attended, but because, he was too committed to leave the pressing assignment on ground then, he entrusted the assignment to me. I have tried my possible best, and I am sure by the grace of the Almighty, I have not disappointed the teams (Nigeria/Arlington).

God bless you all.

Sam. A. Orisasona
CDPO - BASICS/N

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TRIP SUMMARY:

PURPOSE OF MEETING:

To assess what has been learned from BASICS' work at the community level in several countries, and draw upon the experiences of others, in order to derive concrete guidelines and models which can be applied in the future.

LONG TERM OBJECTIVES:

- ★ To achieve greater health impact at the household and community level
- ★ To more effectively promote the emphasis caretaker behaviors
- ★ To work more effectively with communities on child health issues
- ★ To identify and promote collective action which solves or mitigates child health problems
- ★ To strengthen community action within current behavior change methodologies
- ★ To delineate models for community action which are sustainable and replicable

DESCRIPTION OF THE MEETING:

- ★ A two-day intensive meeting, with a welcome session, and a visual presentation of each of BASICS Country Community Program on the first day
- ★ Participatory process facilitated by a Consultant - Sandra Granzow
- ★ Working session which provided concrete guidelines, and models which can be used in the future
- ★ Documentation

PARTICIPANTS:

20 - 25 participants primarily from BASICS and USAID with a small number of external resource persons including representatives from PVOs, and selected experts in Community Health.

EXPECTED OUTPUTS:

- ★ An assessment of BASICS community experience to date in several countries
- ★ A framework for guiding community work in the future, including graphic visualization of the framework analogous to the pathway
- ★ Guidelines for using the framework in BASICS' PY5 programming including steps to take and issues to resolve
- ★ A follow up plan

**ACTIVITIES:
TRAVEL TIME:**

Departure Nigeria:	15/09/97
Arrival Washington	16/09/97
Departure Washington:	21/09/97
Arrival Nigeria:	22/09/97

DAY ONE: 17/09/97

On the 17/09/97, I was welcome by Pat Taylor and the entire team for the Nigeria Project. I briefed the team about the current status of the project in Nigeria, and what would be presented for the meeting. Later I had a chat with Karabi Bhattacharyya, and Nancy Mc-Charen who explained the mode of presentation at the meeting to me, that the presentation would be seven minutes rather than fifteen minutes which I had earlier prepared for, followed by a question and discussion session.

At about 1300 Hours, with twenty eight participants present, a briefing was made on Madagascar Nutrition Project. The Project involves the Health Education and Social Welfare Department. Its focus is to influence changes at four levels: National Policy, District, Health Center, and Community.

The remaining part of the day was spent preparing for the visual presentation materials with our colleagues.

DAY TWO: 18/09/97

WELCOME: BY RON WALDMAN

The formal opening was done by Ron Waldman. In his opening remarks he recognized the import of community development approach to child survival, which he said should not be treated as a second class approach. However, it must be lively, and innovative. Secondly, the indicators for each cell of the Pathway to Survival must be universal. Thirdly, he noted that the IMCI approach is yet to be recognized in many countries, he was delighted to declare the meeting open, hoping that the outcome will be justified by the enthused contribution of everybody.

VISUAL PRESENTATION OF EACH COUNTRY PROGRAM:

The latter part of the day was used for each country program visual presentations which included poster, flip chart, pictures in a 15 - 30 minutes formal presentation, followed by individual participants follow-up discussion with presenters. In addition to the above, the Nigeria team made available recorded video, copies of CPHs Brochures, MOU, Constitutions, CBE M & E preliminary findings, Photo Albums of CPHs activities

DAY THREE: 19/9/97

SCHEDULE REVIEW BY FACILITATOR: SANDY GRANZOW

- ★ Norms, presentation format, review of name tag folder
- ★ Review of focus areas, transparency, and other materials
- ★ Visual presentation of every country to be left behind for documentation
- ★ Time keeping: 7 minutes presentation, 5 minutes for Questions
- ★ Total Presentation - 9, Nigeria was second.
- ★ There would be four working groups after the presentations
- ★ There would be four facilitators

COUNTRY PROGRAMS IN ORDER OF PRESENTATION:

- ★ MADAGASCAR: COMMUNITY IEC - BY MARY CARNELL
- ★ NIGERIA: COMMUNITY PARTNERS FOR HEALTH - SAM A. ORISASONA
- ★ ZAMBIA: COMMUNITY PLANING AND NGO - ELLIE BURLIEGH
- ★ HONDURAS: MAIN PROGRAM - MARCIA GRIFFITHS AND VICTORIA DE ALVARADO
- ★ ETHIOPIA: PARTICIPATORY COMMUNITY PLANING - JOHN MURRAY AND KARABI BHATTACHARYYA
- ★ MALAWI: PROJECT HOPE, HEARTH - BART BURKHALTER
- ★ BANGLADESH: COMMUNICATION MODEL - IGBAL HASSAN
- ★ INDIA: SAREANI CHAKRABORTY
- ★ BOLIVIA: COMMUNITY SURVEILLANCE: BART BURKHALTER
- ★ PVO APPROACHES: BART BURKHALTER

Note: Bart Burkhalter presented a three-in one paper

Note that details about each program will be published in a report to be circulated by BASICS Arlington Documentalist.

KEY ISSUES AND LESSONS LEARNED SO FAR:

- ★ The Nigeria Program shares similarities with the Zambia's, although Zambia's intervention is both rural and urban, both must figure out going to scale. The Honduras Program Process is also similar to that of Nigeria
- ★ Projects which offered no direct financial support to the community such as Nigeria's, and Ethiopia need careful study
- ★ Programs, particularly Nigeria needs intensive documentation because of its successful peculiarity for replicability
- ★ A cross-country comparison of programs can be done for Nigeria/Zambia
- ★ The participatory approach used by the Ethiopia Program is like a powerful intervention on its own where the community controls the process of partnership

- ★ Malawi made three presentations on Employer-based MCH in Tea Estates, Project HOPE, and the Haiti, Viet Nam, Bangladesh - HEARTH Project which is about four decades old. Learning has been a self-discovery process in most communities, for instance public breast feeding created opportunities for people to learn about the importance of breast feeding
- ★ The Communication Model of Bangladesh, an urban slum EPI project targeting about 24 million people has used advocacy, social mobilization, and program communication to shift Islamic attitudes, and behaviors which are not in favor of immunization practices. This approach is quite different from others, as is, a top-down approach
- ★ Models that have worked effectively need dissemination and evaluation at various levels
- ★ In the use of community approaches, study can be carried out on the effect of using either existing organizations or creating new ones
- ★ In India, where IEC has been merged with Mass Media, and Interpersonal Communication Strategies for Child Survival, the relationships must be studied
- ★ Community participation means, or should lead to community empowerment: in most cases should assist political development processes
- ★ The use of participatory evaluation approach was recommended for any USAID development program

PLENARY SESSION:

ISSUES OR PROBLEMS TO CONSIDER:

- ★ Magnitude of scaling up by who, and what vulnerable group should be reached by scaling up versus national impact
- ★ The MOH and PVOs could assist in the scaling up of projects
- ★ Need to make a comparative strength of BASICS and the PVOs
- ★ Need to use a range of models and not a single model
- ★ What will be the criteria for selecting the models to be used?
- ★ What comes naturally versus labor intensive?
- ★ What is the role of process versus model, for instance process looks at the critical elements, whereas model is overly laborious
- ★ What will be the role of USAID henceforth? (This, it was described as lifting those who are not being lifted or forgotten, targeting the needy, putting the ladder on the right wall)
- ★ Targeting the neediest or targeting the outcomes: which will need the broader resources of the community?
- ★ Defining the neediest or poorest may be in terms of areas where government's presence is not felt at all (schools, health services, social amenities etc)
- ★ There will be need to look at programmatic issues which have successfully crossed sectors, such as AIDS, TB, Gender Issues that can be adjunct to Child Survival Program
- ★ What happens when country program staffing constrains a program? May be necessary to work with the unconventional partners
- ★ Donors need investment strategies and trade offs
- ★ Need to determine minimally essential elements for choosing a model
- ★ Need to determine minimally essential elements for successful community approaches

GROUP FORMATION:

GROUP 1	-	IMPLEMENTATION 1
GROUP 2	-	IMPLEMENTATION 2
GROUP 3	-	MONITORING AND EVALUATION
GROUP 4	-	SCALE UP

Each group was to draw from field experience, and make generalizations facilitated by facilitators and rapporteur, while discussion should not be individual focused

Sam fell into the Scaling Up Group with Nahib, Iqbal, Suzanne, Sarbani

GROUP PRESENTATION:

GROUP 4 - THE ISSUES OF SCALING UP IDENTIFIED:

DEFINITION:

An institutionalized system, which can implement community-based approaches on a scale compatible with country capacity, and with child survival within a given time frame.

CONSTRAINTS AND BARRIERS:

- ★ National Policy and political will
- ★ Organizational structure - It should be noted that in a decentralized system, no central structure may be left to promote, or facilitate scale up, for instance in Bangladesh, there is lack of health manpower at the Municipal level to implement programs
- ★ Shortage of health manpower and resources at various levels of the systems, such as national, regional, and local
- ★ Weak and contentious relationship between government and NGOs
- ★ Inadequate or poor management capability of NGO partners

STRATEGIES:

- ★ Advocacy at the top to generate political will, and influence policy (Note that a good program can sometimes drive policy rather than vice-versa)
- ★ Capacity building at all levels of the systems, such as PVOs, MOH, (National, Regional, Local)

ROLE OF BASICS:

- ★ Strengthen collaborative relationship between government and NGOs (learning from experience, sharing tools)
- ★ Need to create new PVO Coordinating Group as in the case of Nigeria where the existing NGO group are tending towards autocracy
- ★ Capacity building in both MOH and PVOs in the areas of child survival, evaluation,

- documentat:on and dissemination of information
- ★ Management training for PVOs to assess coverage, effectiveness, as well as in using tools to assess and evaluate coverage
- ★ Bring donors of NGOs on board in order to catalyze dialogue
- ★ Encourage districts to solicit bids from government as in Zambia, involve the community in the process
- ★ Simplify grants proposal formats as in the case of Zambia
- ★ Encourage inter-change of ideas amongst NGOs
- ★ Need to consider expansion of programmatic scope
- ★ Need to consider use of mass media to create awareness, demand, support and extend impact

GROUPS 1 & 2 IMPLEMENTATION: GENERAL ISSUES TO CONSIDER

- ★ Situation analysis (by whom?)
- ★ What has been effective
- ★ Components of planing, organizing, managing the project, for instance, who are the stakeholders in decision making: MOH, USAID, BASICS, Community, Other Program Sectors; who determines sites, problems to be addressed, partners to be involved, the population to be served, and how?
- ★ Interaction with the community
- ★ Negotiation
- ★ Assessment of feasibility of importation
- ★ What sustain able incentives can be given to implementors when stake holders withdraw approval? (cash, promise of promotion, training
- ★ What potential for political threat exists in each country?
- ★ What personal turn over or retention possibilities exists?
- ★ How can enthusiasm be maintained
- ★ Performance, monitoring and evaluation, may be affected by unrealistic planing, lack of incentives, and lack of need to research into this area
- ★ When to combine /integrate with other programs, when to add to programs, channels, elements to give credibility, reinforce in community strata
- ★ Examine factors that may affect the local health staff, such as conflict, systems/logistical support, environmental factors, timing, pace, scale, over all time available for the project (5years), political environment

STRATEGIES:

Different strategies, such as:

- ★ Social marketing
- ★ Media
- ★ Theater
- ★ Counseling cards
- ★ Competition
- ★ Training, etc

PATTERNS: MODELS

MODEL 1:

- ★ Recruitment of community, a continuum can be through (1) Advocacy (2) Participatory
- ★ Decision making
- ★ Ownership
- ★ Menus

MODEL 2:

- ★ Bringing something to the community, while others join
- ★ Already existing, has life of its own
- ★ AIDSCAP/BASICS collaborating, act of documenting, standardizing
- ★ Scaling up

OTHERS:

- ★ Success
- ★ Flexibility

EFFECTIVE COMPONENTS OF IMPLEMENTATION:

- ★ Participatory planning
- ★ Supervision
- ★ Focused targets
- ★ Clarity of expectation, goals, roles
- ★ Logistic supply, and equipment

WHAT ARE THE ADDED VALUES OF USING A PARTICIPATORY PROCESS?

- ★ Positive outcomes
- ★ Ownership
- ★ Meeting individuals needs
- ★ Data is used to stimulate community decision making and action

WHAT DETERMINES A SUCCESSFUL MODEL?

- ★ An outsiders' view of the project: explanatory model
- ★ Improved (HSB) Health Seeking Behavior (in the form of treatment or care seeking behaviors)
- ★ A frame work for IMCI intervention
- ★ Focus: utilization of services, geographic, demographic, economic, educational, quality of care
- ★ When it comes to decision making and HSB, a good model must be able to aggregate recognition, labeling, and resort to care adherence.

Examples of **recognition** can be recognition versus biological, locally recognized signs

and symptoms, severity, and perceived severity.

Examples of **labeling** can be folk illnesses taxonomies, organized signs and symptoms, built on principles of classification, not biological.

Examples of **resort to care** may be simultaneous resort, sequential resort, diagnosis affected resort, or affected by availability and distance, quality of services, and economic status.

Examples of **adherence** can be, adherence not compliance, appointment keeping, giving medication, supportive home care.

CHANNELS FOR INTERVENTION:

- ★ Enhanced communication
- ★ Community Health Workers (CHWs)
- ★ Mother Support Groups etc

CRITICAL CRITERIA FOR SELECTING CHWs:

- ★ Personal status, gender
- ★ Age and education (older and better educated is better)
- ★ Social standing and commitment to community
- ★ Ability to influence mothers
- ★ Availability

LEVELS OF IMPLEMENTATION:

- ★ DONOR - discussion, evaluation
 - ★ PROJECT
 - ★ COMMUNITY - locally adaptable situation, demonstrable effect
- Note: PYS should address: documentation properly - specific instruction, specific resources, and make publications.

CONCLUSIONS:

- ★ Public health intervention plus social network, group or community based component yield change better than those relying on individually focused intervention
- ★ Success depends on different levels of supervision: grassroots, national
- ★ Both philosophy and tools count
- ★ Multiple models can be introduced at different stages and not a single model
- ★ Using model may in fact be wrong but approaches
- ★ Emphasize elements/components, functions, characteristics
- ★ Need for systematic research
- ★ Evaluation
 - Participatory: Need to use grassroots units as evaluators
 - Measure effects from other elements

GROUP 3 - MONITORING AND EVALUATION MAJOR ISSUES:

- ★ Designs
- ★ Involving the community
- ★ Ideas about indicators
- ★ Issues for future resolutions

CONCERN ABOUT M & E:

- ★ Why? What? (Behavior) How? Who? (Responsible) When?
- ★ Cost - benefit
- ★ How do you determine success?
- ★ How simple should instruments be?

TOOLS TO USE DURING PLANING PROCESS:

DETERMINED BY CATEGORIES OF INDICATORS:

- ★ IMPACT
- ★ BEHAVIOR
- ★ PROCESS
- ★ INPUTS
- ★ SUSTAIN ABILITY
- ★ EQUITY
- ★ PARTICIPATORY (at any or all levels)

AUDIENCES:

- ★ COMMUNITY LEVEL
- ★ LOCAL MANAGEMENT
- ★ REGIONAL/NATIONAL
- ★ DONORS AGENDA

USES OF M & E: CRITERIA:

- ★ Monitoring for feedback
- ★ Audit reporting requirement
- ★ Validation for continuation/replication/scaling up
- ★ Validation
- ★ Advocacy
- ★ What is the use of information sharing at the various levels?
- ★ See illustrative examples of key child, health, and nutrition indicators

But considering the time frame of projects what is the best M & E tools that can be used at this stage? The following were suggested:

- ★ Changes in Morbidity/Mortality may be difficult to measure
- ★ UPSI
- ★ CBE
- ★ IBHS or IH3S

- ★ FBQA or FQA
- ★ PROCESS
- ★ ROUTINE
- ★ BEHAVIOR CHANGE?
- ★ COMMUNITY PARTNERSHIP PROGRAM COSTS

SUMMARY: GENERAL COMMENTS AND RECOMMENDATIONS:

SCALING UP GOAL:

Implement a coordinated package of complimentary strategies to maximize impact on a broad scale; compatible with locally defined child survival problems, time frame, country capability, not limited to high risk groups only, sustain able, and measurable.

- ★ BASICS should advise MOHs, Governments, and USAID on what can be done/cannot be done now
- ★ BASICS should be ready to give technical assistance across countries
- ★ Need to focus on operations research to change policy
- ★ Scaling up may increase coverage, but may not affect mortality, therefore in a nation-wide program it may not be cost effective
- ★ It should be noted that urban may be different from rural approach
- ★ Readiness factor can be determined through operations research: Maslow's Hierarchy of needs
- ★ Encourage cross-country collaboration: Zambia/Madagascar/Nigeria
- ★ Must scaling up be national?
- ★ Can pilot project be scaled up to national project?
- ★ Need to have this kind of meeting regularly on the field for more participation
- ★ More field staff should have been allowed to attend this kind of meeting
- ★ Micro-credit is a catalyst that can be linked to nutrition and other child survival programs
- ★ Need for every country to document what is being done
- ★ Need to have technical meetings
- ★ Need to have information sharing among PVOs with successful programs
- ★ BASICS could assist countries to design phased implementation plans
- ★ M & E design should be from onset, not later conceived
- ★ Training of local/district staff in community approaches is crucial
- ★ Next steps: What is the right thing for BASICS/USAID in the next generation, for instance if the news of the day said that AIDS cases are going down in the US, but not HIV?
- ★ How do we add value to what we are doing without duplicating or recreating?
- ★ What is the meaning of IMCI component aimed at families and children?
- ★ If these questions cannot be answered in this forum what next?
- ★ Should a follow up meeting look at theory, implementation, and future?
- ★ It will be pertinent for everybody to get involved in community approaches
- ★ This meeting has cumulated in a rich experience that is rare to come by

- ★ Point of reminder: BASICS should systematically document all the experiences, lessons learned
- ★ It was nice to have field people around who have been working so hard
- ★ Thanks to the organizer of the meeting: Happy birth day to one of the HQ staff who participated in planning the meeting
- ★ Ron Waldman opined the need to package all that had been discussed for action
- ★ Appreciated the highly impressive response by field staff to the short notice given to country representatives
- ★ Nice to know that the discussion on M & E covers all indicators
- ★ Country Programs need a longer time frame for NGOs survival
- ★ The communities need to share out of the outcomes of the meeting
- ★ Need to have elements in place before catalyst come in
- ★ Impressed about what is being done in Nigeria
- ★ The breadth and dept of discussion had been vast
- ★ Tremendous enthusiasm of the participants was encouraging

- ★ **FOCAL POINTS:** Should include:
 - 1 The commercial sector:
 - identification of opportunities available

 - 2 Private sector companies: Products:
 - identify products, geographic areas, and technical areas of collaboration
 - Look at supporting small scale interventions that if successful, can be expanded by the private sector
 - Build on existing functional market structure to reach target population
 - Facilitate collaboration with partner organizations, government, and PVOs
 - Look for corporate sponsorship/support
 - WIIFM - What's in it for me? Somebody remarked that there is the need to get out of our cell to find out what is somewhere else

 - 3 NGOs/CBOs:
 - Needs assessment
 - Advocacy
 - Capacity building

 - 4 Private Providers services:
 - Delivery points

 - 5 Employer - based Programs: For example, PATH had been paid by companies in Indonesia to introduce FP in industries

 - 6 Mass media:
 - Use media to create awareness/demand in areas where community approaches

- are being implemented
- Work with national IEC groups to develop plans/materials
- Train other organizations such as pre-service institution, schools, workers on approaches for working with communities

★ **PROPOSED CRITERIA FOR SUCCESSFUL PROJECT:**

- 1 High impact: in terms of reduced Morbidity and Mortality, efficiency, democracy,
- 2 Flexibility:
 - Not a blue print
 - Allows for timely mid-course adjustments based on lessons learned
 - Compatible with broader trends
 - Compatible with population dynamics (migration/urbanization)
 - Amenable to evaluation
 - Capable of being scaled up
 - Sustainable
 - Simple
 - Of service to the community

EXIT:

- ★ Finally, credit was given to USAID, BASICS HQ staff who had worked tirelessly to ensure success of the meeting, the Consultants used, invited Experts for their expert contribution, the field staff for their worthy experiences, and brilliant presentations in spite of the short notice, and tight schedule on the field, in fact, the meeting was going to be postponed at a point, when it was discovered that the field was too busy for key presenters to travel. To show appreciation, all the participants were invited to the kitchen for dinner.
- ★ Eat, drink, merry, and socialize. Traveling mercies.

REFERENCES:

- ★ Guidelines for presentation at the meeting: BASICS Arlington
- ★ The Nigeria Community Partners for Health Child survival Initiatives. Video Cassettes, Albums, CPH MOU, Constitution, Brochures. Sam. A. Orisasona, BASICS, Nigeria
- ★ Key Child Health and Nutrition Indicators
- ★ Examples of evaluation Tools
- ★ Thinking about M & E
- ★ Integrated Care of the child
- ★ Definitions
- ★ Slum strategy in Bangladesh: Dr. Iqbal Hossain, Dr Youssef Tawfik, BASICS/Bangladesh
- ★ Community Approaches in Madagascar
- ★ Community Assessment and Planing for MCH Programs: A Participatory Approach in Ethiopia
- ★ Draft: Community Assessment and Planing for MCH Programs: A Participatory Approach in Ethiopia Technical Report: Karabi Bhattacharyya, John Murray April, 1997.

- ★ Community Monitoring of Private Providers- Results from an Operations Research Study in Bihar, India: Sarbani Chakraborty, JHU, School of Public Health
- ★ Mortality Surveillance: An Analytical Approach to How and Why Children Die: Ana Maria Aguilar-Liendoi & Co Authors.
- ★ Performance Monitoring and Evaluation TIPS: Conducting A Participatory Evaluation: USAID Center for Development Information and Evaluation
- ★ Health Model: Haiti, Viet Nam, Bangladesh.