case studies

Child health in the community

"Community IMCI"

BRIEFING PACKAGE FOR FACILITATORS

CORE

WORLD HEALTH ORGANIZATION

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Development of a national strategy for the improvement of family and community practices

CASE STUDY: COUNTRY OF FICTICIA

In response to the large demand for implementation of the community component of IMCI, you have been appointed as C-IMCI facilitator to assist the Ministry of Health of Ficticia in planning this implementation.

You have been given the background information below to help you prepare for the assignment.

Basic information

Two years ago, the Ministry of Health of Ficticia adopted IMCI as an essential component of its health development plan in order to reduce under-five mortality. The infant and child mortality rates of Ficticia are among the highest in the Region, and more than half of these deaths occur at home. Malaria, diarrhoea, respiratory infections and malnutrition account for almost 70% of the causes of deaths among children under five.

NATIONAL PRIORITIES

The national health policy emphasizes prevention of disease and transmission of HIV/AIDS, and improvement in nutrition, with a focus on exclusive breastfeeding. Promotion of micronutrients, such as vitamin A, iron and iodine, is also an important component of the Ministry of Health's vision.

In the context of poverty reduction, WHO, UNICEF, the World Bank, United Nations Development Programme (UNDP), NGOs (Plan International, Care, Africare), bilateral partners (Germany, Italy, Japan, the United Kingdom) and other partners (e.g. International Committee of the Red Cross) are working with different ministries, under the supervision of the Ministry of Planning, to develop a common strategy in Ficticia. A component of the strategy aims to reduce child and adolescent mortality and morbidity and promote child and adolescent rights, mainly through community-based interventions. This has resulted in the development of several local NGOs. To assist some of them, the Ministry of Women's Affairs organized women's associations (more than 3000) into a federation and established a partnership with ongoing development projects and programmes at the grassroots level.

Decentralization is an ongoing process within health sector reform. The Bamako Initiative is underway, with advocacy for drugs, community participation and equitable access to health care.

CHILD SURVIVAL PROGRAMMES

National malaria programme

The Deputy-Prime Minister of Ficticia participated in the meeting of the heads of states organized in Abuja in April 2000 and the country adopted the Abuja Declaration on Malaria. As a result, the government reorganized its national malaria programme, with support from WHO and UNICEF, and revised its national strategy. It created a budget line for malaria, allocated funds, and developed a five-year plan

of action. The main domains include prevention and case management of malaria at all levels (at health facilities, community and household levels, public and private sectors). The IMCI guidelines will be used for case management of fever.

Diarrhoeal disease control (CDD) programme

The programme, established six years ago, has developed a national policy and guidelines. In conjunction with field partners, it is promoting improved prevention and care practices for children with diarrhoea. Since the beginning of IMCI activities, the programme has focused on the prevention and management of cholera and has participated in water and sanitation interventions at community level.

Acute respiratory infections (ARI) programme

Although the country started an ARI programme four years ago and drafted national policy and guidelines, the programme has never been evaluated. Two years ago, training courses were organized for first-level health providers in several districts, using standard case management. The launching of the IMCI strategy put an end to the ARI programme because its activities were thought to be integrated into IMCI.

IMCI

After the national orientation workshop, an IMCI working group was set up and a focal person appointed. The adaptation of the training materials was conducted in close collaboration with partners and representatives of the main programmes interested in child health issues. After a national consensus meeting on the IMCI guidelines, implementation started with support from UNICEF and WHO in the four districts (Gonzobe, Likro, Wami and Wawa) selected during the national orientation workshop.

Initially, the working group was active, but since adaptation, and because of other competing priorities, its members now meet irregularly and the membership changes frequently.

In the pilot districts, about 60% of first-level health providers have been trained and followed up. They are using the IMCI guidelines to manage sick children, but their performance with regard to counselling caregivers is poor.

Follow-up after training identified the following problems:

Problems related to health providers' skills

The quality of case management is not optimal:

- General danger signs are checked in only 20% of cases.
- Only one child out of two with severe classification is referred.

Problems related to the health system

- Equipment and skills are limited at referral facilities.
- Shortages of oral drug are frequent at first-level health facilities.

Problems related to improving family and community practices

- Caregivers have inadequate knowledge of home care (only 26% know the three rules of home treatment of diarrhoea).
- Only 25% of mothers of children under two years of age receive appropriate feeding counselling.
- Many activities are ongoing at community level with the support of numerous NGOs and partners. However, the community component of IMCI has not yet been launched.

Health infrastructure

There are:

- 40 districts and 40 district hospitals;
- 356 first-level health facilities, of which 60% are operational;
- health posts at the community level in 15% of the districts.

Sales outlets:

- 42 public pharmacies;
- 39 private pharmacies and drug stores.

Sales outlets sell a variety of products including insecticide-treated nets (ITNs), oral rehydration salts (ORS) and condoms.

Health indicators

- Exclusive breastfeeding rate: 8% of children under 6 months of age (Demographic and Health Surveys – DHS);
- Complementary feeding rate: 75% of children aged 6 to 9 months (DHS);
- Vaccination: 54% of children aged 12 to 23 months are fully vaccinated (DHS);
- Underweight: 20% of children under 2 years of age (DHS);
- Use of ITNs: although 51% of mothers stated there is a bednet in their home, 34% of children under five years of age sleep under untreated nets and less than 10% of children under five sleep under treated mosquito nets; 2.5% of mothers mentioned ITNs as a means to prevent malaria (household survey – HHS);
- 55% of children under five years with fever receive chloroquine, 30% receive adequate dosage and duration (without additional fluids and continued feeding) and 12% receive correct treatment (correct dosage and duration of chloroquine and additional fluids and continued feeding);
- 26% of children with diarrhoea receive additional fluids and continued feeding (HHS);
- 12% of caregivers know at least two signs requiring immediate referral to a skilled care provider (health facility survey – HFS);
- Health services coverage rate: 45%;
- Usage rate of health services: 26%.

Socio–cultural indicators

- About 70% of the population lives in rural areas.
- About 20% of women are heads of households.
- Adult literacy rate is 30% for men and 10% for women.
- Access to safe drinking water is 50%.
- Radios are available in 60% of households; however, more than 85% of women have no access to any source of information.

Identifying appropriate partners and other stakeholders and establishing/strengthening a national C-IMCI working group

The national IMCI working group established after IMCI adoption includes a subgroup for C-IMCI. The C-IMCI sub-group includes partners supporting or interested in supporting C-IMCI (such as UNICEF, WHO, various donor agencies and international NGOs), in addition to representatives from health programmes and projects, and resource persons from other development sectors (agriculture, education, women's affairs). The C-IMCI group comprises 20 members, meets irregularly and reports to the IMCI working group, which is headed by the General Secretary of the Ministry of Health.

Situation analysis

A literature review of the last four years has provided information for the situation analysis. The main findings are summarized below.

Ministry of Health (MOH) policies for community-level activities

Although the Ministry of Health emphasizes the importance of child health, it has not yet adopted the key family and community practices, there is no budget line for IMCI and few resources are allocated to community interventions. Furthermore, health personnel lack experience in community intervention development and management.

The national policy authorizes trained community health workers who work in health posts to distribute or sell specific essential drugs (antimalarials, ORS, antipyretics such as paracetamol and aspirin, iron, folates, etc.). The supply system is inefficient and quality control is poor. Families and community members rely on drug vendors, local drug stores and community pharmacies.

The Child and Reproductive Health Division developed standards for child health including community-based interventions.

Selection of C-IMCI districts

To select districts objectively for implementation of C-IMCI, the Ministry of Health defined the following set of criteria:

- ongoing implementation of components 1 and 2 of IMCI;
- a district management team (DMT), dynamic and willing to implement C-IMCI interventions;
- availability of supporting partners ;
- good collaboration between the DMT and partners;
- easy access to allow close follow-up/monitoring.

At present, the only four districts that may be considered for initiating C-IMCI programme activities are Gonzobe, Likro, Wami and Wawa (the only ones implementing IMCI).

NGO activities

A recent survey of 28 NGOs scattered over 32 districts shows that they target mainly three practices: vaccination (21 districts), promotion of good feeding practices including exclusive breastfeeding (16 districts), and appropriate care at home for sick children (14 districts). Although the intervention sites are usually identified in consultation with the DMTs, health providers are involved in the planning process in only 30% of the interventions.

In most districts, community activities are not supervised on a regular basis. However, in the districts of Wami and Wawa, the Markus Group is providing financial support for community-based activities, including supervision and motivation of its community resource persons (CORPS). In 10 districts, women's groups have developed revenue-generating activities, and some of those resources promote child-growth monitoring activities, including promotion of exclusive breastfeeding and prevention of female genital mutilation. Local NGOs are also active in the country. In order to respond to partners' interest in funding interventions to reduce poverty, these NGOs are setting up networks of organizations and individuals including those working in areas such as HIV/AIDS prevention, promotion of the use of ITNs, women and child rights and abuse, hygiene and sanitation. In Wami and Wawa districts, due to the dynamism of the chairman of the district development committee, several partners (e.g. WHO, UNICEF, UNDP, No-bite NGO) provide funds to the network of local NGOs. Part of this funding goes towards promoting the use

of ITNs, case management of fever at household and community levels, and activities concerning tuberculosis and HIV/AIDS.

Activity reports from 12 districts implementing quality assurance programmes document community participation in the management of the quality of services provided. In these districts, major contributions consist of increasing access to immunization, construction of health posts for inpatients, improved assisted delivery and referral of serious cases to the first-level health facility.

Local development projects

Under the authority of the Ministry of Planning, 10 districts have implemented five-year local development projects. In these projects many multidisciplinary teams were trained to identify needs and design participatory programmes.

Private sector health care

The non-profit private sector has an important role in improving the health of the population. It provides 40% of health care in hard-to-reach areas.

Family and community practices

Diarrhoea

Although the mother is the one who usually recognizes the symptoms of diarrhoea, if it costs money to provide care, the decision about treatment generally falls on the husband. Mothers mention many danger signs, ranging from thirst to continuous crying, and they consider prolonged diarrhoea a risk factor for death. However, they do not consider dehydration a risk factor. Five years ago, when the diarrhoeal disease control programme conducted its Focused Ethnographic Study to develop counselling for caregivers, it could not find appropriate terminology for dehydration. The main causes mentioned for diarrhoea are poor hygiene (pertaining to handwashing and food) and the perception that when a mother is pregnant her milk is contaminated.

Malaria

Caregivers know well the signs of malaria, which they associate with fever, headaches, convulsions and icterus. They consider malaria an unavoidable, severe and deadly disease for children and mention causes such as exposure to sun, anaemia and/or dehydration. Caregivers recognize malaria as the most frequent disease, but none associate mosquito bites with the disease. Few mothers know any of the effects of malaria during pregnancy.

Formative research found that people treat fevers in children differently, depending on what they believe the cause is. They do not always trust chloroquine because it is sometimes ineffective. When the perception of malaria medicine was improved, and health providers and trained shopkeepers encouraged families to seek treatment for all fevers, they were willing and able to give children the correct treatment and dose more often.

Regarding ITNs, mothers are reluctant to have their children sleep under treated nets because of the odour and the heat. In addition, in some districts in Ficticia, including the districts that are implementing IMCI, it is customary to use a white net to protect a dead body from flies. During behavioural trials, families were willing to use treated nets that were blue or green and that had larger holes to prevent the babies from getting too hot (this was especially true if the cost of the net was reduced by half). The primary reason that people liked sleeping under nets with babies was to get a good night's sleep without being woken up by cockroaches and other insects.

The national malaria programme is working with women's groups through the NGOs Care and Africare. The Markus Group and local NGOs are promoting the use

of ITNs, appropriate case management of fever at home and improved care-seeking practices in the community. In several districts, the malaria programme has set up community bed-net treatment units, managed by community health workers under the supervision of a village health committee. Treated nets are not always available, however, and community members find them to be very expensive.

Child feeding

According to recent research, the elderly in Ficticia are reluctant to allow exclusive breastfeeding because they consider colostrum to be "bad". They believe that a newborn baby's stomach needs to be cleansed with traditional medicines during ceremonies that last several days. However, behavioural trials found that families were willing and able to reduce the number of pre-lacteal feeds to one and to shorten the traditional ceremony, particularly when counsellors explained that colostrum actually cleanses the stomach and gets children used to food. Mothers particularly appreciated advice from health providers.

One reason few mothers exclusively breastfeed is that they leave their children at home during the daytime when they go to the gardens to work. Although they are not willing to take the babies to their gardens, mothers are willing to increase the number of times they breastfed in the morning before they leave and in the evenings when they return. Mothers like these new practices because they find that when they breastfeed more frequently their babies cry less at night, they save money on replacement feeds, and their babies experience less diarrhoea.

The nutrition programme now implements an intervention to promote exclusive breastfeeding. The intervention consists of training various agents (health providers, nurses, birth attendants, social workers and community agents) to counsel on exclusive breastfeeding in several districts. All the regions are implementing the programme, and about 45% of the districts carry out community-based nutrition activities in collaboration with various partners, including women's associations. Women's groups are already promoting exclusive breastfeeding and educating women on the impact of female genital mutilation.

The NGOs use various communication channels, including local radio, folk groups and village criers, and take advantage of opportunities to reach groups of people during traditional ceremonies and market days. The NGOs have trained members of women's associations in breastfeeding counselling and infant and young child feeding practices. A recent evaluation of the programme showed that 20% of the growth-monitoring sites are also used as immunization and antenatal consultation sites.

Communication strategies

The communication strategies currently in use rely mainly on dissemination of educational messages through community health workers and, in five districts, through the local radio. Most NGOs have developed educational materials on exclusive breastfeeding, and on the prevention and management of malaria, in collaboration with the IEC Division (information/education/communication) at the Ministry of Health. They have also developed management tools for monitoring the progress of their interventions.

Development of a district strategy for the improvement of family and community practices

CASE STUDY: DISTRICT OF WAWA

Basic information

Same as national level, plus the following:

Two years ago, Wawa District was one of the first to implement IMCI in Ficticia. Health providers were trained and followed up in case management and, during follow-up visits, availability of drugs, vaccines and equipment at the health facilities was improved. Some facilities set up ORT corners. No action was taken on C-IMCI, however, due to lack of clear guidelines.

During the review meeting a month ago, recommendations were made to start implementing C-IMCI whenever possible in order to increase the impact of the strategy. The Wawa district health management team leader, Dr Lokotoro, participated in the review meeting, and decided to start implementing C-IMCI in his district.

In Wawa District, several NGOs were implementing community-based interventions (CBIs). Dr Lokotoro therefore decided to establish a district working group, and invited different NGOs involved in health activities at community level to attend a meeting. Nine of the 12 organizations invited were present, and the meeting proceeded since a quorum was reached.

During the discussions, several participants welcomed the idea of establishing a working group. Among them, two were particularly enthusiastic, namely Stop AIDS and the local women's association. For the women's group, to participate on such a group would present an excellent opportunity to obtain funds for its activities.

However, No-bite NGO and the Markus Group were reluctant. Mr. Bigjoe, the No-bite advisor, argued that IMCI is a set of clinical guidelines and has no place at community level. Furthermore, he said, IMCI implementation has been so complex and expensive in the country that the CBIs risk the same complexity in implementation. Dr Nakya, the team leader of the Markus Group, questioned the benefit of C-IMCI. He said that its group has been implementing CBIs for years and that the Minister of Health had recently acknowledged the importance of the job they are doing. The Markus Group had its terms of reference, a plan of action and targets to reach, and Dr Nakya was concerned about not reaching those targets at the end of the project two years from now. Nevertheless, he was keen to share the results of a survey they had recently conducted to assess the constraints in implementing activities in their area of intervention.

Dr Lokotoro was so committed to IMCI and so convincing that at the end of the meeting all the participants agreed to become members of the working group. He made a quick presentation and distributed information brochures.

The next meeting was scheduled for two weeks later. A subgroup comprised of No-bite, the Markus Group, UNICEF, the women's association and UNDP was asked to draft the roles and responsibilities of the working group and to circulate it before the next meeting.

Identifying partners and other stakeholders, establishing/strengthening a district C-IMCI working group

The district C-IMCI working group includes representatives of various development sectors (agriculture, education, women's affairs, nutrition, and paediatrics), local NGOs, private voluntary organizations (PVOs), project representatives, community leaders, and representatives of the Ministry of Health. The working group meets quarterly to review interventions. Minutes of meetings show that planned community interventions are barely implemented and that the team focuses more on process than on results. In many districts of Ficticia, health management committees provide financial support to activities such as immunization and drug supply and are willing to support more interventions, according to revenue from the cost recovery, if it is justified. Table 1 indicates the coordinating bodies set up in Ficticia in the context of the decentralization.

Table 1. Coordination mechanisms of child-health related activities in Ficticia

LEVEL	COORDINATING BODY	HEALTH SECTOR REPRESENTATIVE	OTHER MEMBERS
National	National development committee	Ministry of Health (IMCI national working group)	Other ministries (planning, finance, agriculture, education), representatives of partners and civil society
Regional	Regional development committee	Regional Direction for Health (IMCI regional working group)	Representatives of other sectors at the regional level, representatives of partners and civil society
District	District development committee	District health management team (IMCI district working group)	Representatives of other sectors at the district level, representatives of partners and civil society
Village	Village development committee	Health providers Village health committee	Village development worker, teacher, agriculture agent, hygiene and sanitation worker, representative of the village
Community	Community development committee	Community health worker	Representatives of the community

Situation analysis

Because of Dr Lokotoro's leadership, the working group was revised to be more representative and a plan of action was agreed on. The group decided to conduct a situation analysis, including a baseline survey, to assess the community-based interventions in Wawa District. The main findings are outlined below:

The district of Wawa is one of 40 districts of Ficticia. The district health management team consists of 5 people:

- 1 medical officer – team leader
- 1 medical officer responsible for clinical services including surgery
- 2 clinical assistants: 1 epidemiologist responsible for documentation and 1 responsible for clinical activities
- 1 midwife.

Health infrastructure

- 10 health facilities
- 20 health posts
- Health providers managing children:
  — 245 community health workers
  — 175 birth attendants
- Sales outlets:
  — 1 public pharmacy
  — 1 private pharmacy
  — 5 drug stores
  — several drug vendors.

Socio–cultural indicators

- 85% of the population lives in rural areas.
- 55% of women are heads of households. Most men emigrate to the neighbouring country, which shares 50 km of boundaries with Wawa District.
- The adult literacy rate is 30% among men, 20% among women.
- 45% of school-age children go to school.
- 45% of the population has access to potable water, although almost all the villages have access to a river.
- Radio is available in 84% of the households and several programmes are broadcast specifically for women.
- Agriculture (40%) and trade with the neighbouring country (60%) are the most important occupations of the population.

Health indicators

- Exclusive breastfeeding rate: 10% of children under 6 months of age (DHS);
- Supplementary feeding rate: 70% of children 6 to 9 months (DHS);
- Immunization coverage: 42% of children 12 to 23 months are fully immunized
- Underweight: 52% of children under three years of age;
- Use of ITNs: 15% of children under five years of age sleep under treated mosquito nets;
- 60% of children with fever receive chloroquine, 40% receive adequate dosage and duration, and only 8% receive correct treatment (adequate dosage, duration, and additional fluids and continued feeding);
- 30% of children with diarrhoea receive additional fluids and continued feeding;
- 25% of parents know at least two signs requiring immediate referral to a skilled health provider;
- Health services coverage: 54% within a radius of 5km, 73% within a radius of 15 km;
- Usage rate of health facilities including health posts: 35%.

IMCI implementation

IMCI was introduced in the district two years ago. Initially, the focus was on integrating the training of health providers and promoting a thorough examination of sick children. To date, 65% of health providers managing children have been trained and 85% followed up. During the review of the early implementation phase, it was realized that the health facility intervention would be of limited impact if not supported by improvements in family and community practices, hence the need to develop C-IMCI.

Partners, including NGOs

- Markus Group supports community-based activities that include growth monitoring, promotion of breastfeeding, training, supervision and motivation of community health workers (financial support).
- No-bite NGO promotes ITNs and appropriate home care of fever, including pre-packaging of chloroquine.
- UNICEF supports: IMCI implementation, women's group revenue-generating activities and growth promotion, breastfeeding, district association against female mutilation, immunization, including outreach activities (fuel for supervision and for activities, motorcycles and bicycles provided to health providers and community health workers), home-based care of diarrhoea, including use of ORS.
- Stop AIDS, a local NGO, promotes the use of condoms and increased awareness of STIs and HIV/AIDS prevention.
- UNFPA supports reproductive health, including men's involvement in the care of children, and the promotion of income-generating activities for women's groups that support STI and HIV/AIDS prevention.
- WHO supports IMCI planning and implementation that includes training, follow-up, and developing guidelines for planning at district level.
- Women's associations: activities depend on donors such as No-bite, the Markus Group, UNICEF and UNFPA. They are promoting breastfeeding, complementary feeding, and the use of ITNs.

Family and community practices

Diarrhoea

Although the mother is the one who usually recognizes the symptoms of diarrhoea, if it costs money to provide care, the decision about treatment generally falls on the husband. Mothers mention many danger signs, ranging from thirst to continuous crying and they consider prolonged diarrhoea a risk factor for death. However, they do not consider dehydration a risk factor. Five years ago, when the diarrhoeal disease control programme conducted its Focused Ethnographic Study to develop counselling for caregivers, it could not find appropriate terminology for dehydration. The main causes mentioned for diarrhoea are poor hygiene (pertaining to hand-washing and food) and the perception that when a mother is pregnant her milk is contaminated.

The initial treatment for diarrhoea given at home includes concoctions made from roots or tree bark, which traditional healers and elderly relatives generally recommend. Many women also use sugar salt solution (SSS), and some women (12%) know about ORS, but it is available only in some communities and from a few shopkeepers. Health providers are consulted when home treatment fails. Caregivers are aware that they need to provide a variety of nutritious foods such as potatoes, eggs and biscuits when a child has diarrhoea. Undercooked rice and fresh fish are considered taboo foods.

Despite parents' knowledge about feeding a sick child, few children receive additional fluids and continued feeding when they have diarrhoea. When counselled about "refilling" the body with liquids, however, families in behavioural trials were willing and able to give additional fluids to sick children. Families were also able to continue to feed sick children by persistently offering them their favourite foods in small quantities.

Malaria

Caregivers know well the signs of malaria, which they associate with fever, headaches, convulsions and icterus. They consider malaria an unavoidable, severe and deadly disease for children and mention causes such as exposure to sun,

anaemia and/or dehydration. Caregivers recognize malaria as the most frequent disease, but none associate mosquito bites with the disease. Few mothers know any of the effects of malaria during pregnancy.

The treatment of malaria depends on the symptoms. In the case of convulsions, caregivers combine modern and traditional treatments. Home treatment combines herbal medications and massage with cocoa oil or butter, depending on the region. In the case of icterus, injections are not recommended because they may result in death. Chloroquine is well known, but the dosage is generally incorrect. Some families save old medicine to give when similar symptoms arise, and often do not administer it correctly. Some people attribute a recent increase in mortality to the withdrawal of chemoprophylaxis. Most care is by self-medication (77%, both modern and traditional). The most frequently purchased drugs are paracetamol and chloroquine and, to a lesser extent, aspirin. 39% of cases seek medical care.

Mothers are reluctant to have their children sleep under treated nets because of the odour and the heat. In addition, it is customary to use a white net to protect a dead body from flies.

Concerning case management, chloroquine, paracetamol, aspirin and sulfadoxine-pyrimethamine (SP) are available from health posts, drug stores and drug vendors and are included in the list of drugs authorized for community pharmacies. At health facilities, chloroquine is pre-packaged, but drug vendors and shopkeepers sell it per tablet (at the expense of quality of care in the community).

Child feeding

A baseline survey showed that the elderly in Wawa are reluctant to allow exclusive breastfeeding because they believe colostrum is "bad" and that a newborn baby's stomach needs to be cleaned with traditional medicines during ceremonies that last several days. As a result, the nutrition programme developed an intervention to promote exclusive breastfeeding. Interventions included training various agents (health providers, nurses, birth attendants, social workers and community agents) in several villages to counsel women on exclusive breastfeeding.

Community approaches

UNICEF and the Markus Group have trained facilitators and community health workers in the Triple A approach (Assessment, Analysis, Action). This approach provides information on key practices, major child-health problems and participatory methods of working with communities.

Triple A is carried out at village level with youths, women and men in their own separate groups. Each group identifies the main child health problems according to their perceptions and then they come together to reach a consensus on the main problems of the village. They develop a plan of action that the village is expected to implement using its own resources as much as possible, with technical assistance from donors when necessary.

To support implementation, UNICEF and the Markus Group developed a communication strategy for use at community level. The tools developed for this strategy include an advocacy tool, a social mobilization tool and a communication programme. The Markus Group focuses mainly on theatre, while UNICEF promotes more diverse channels of communication. UNICEF assisted the national level to develop the Mother's Card used in health facilities to counsel mothers during consultation concerning a sick child.

DISTRICT C-IMCI PLAN OF ACTION: SUGGESTED OUTLINE/FORMAT

Introduction

Rationale for C-IMCI implementation

Narrative

Objectives of C-IMCI in the district:

- General
  —
  —
  —

- Specific
  —
  —
  —

- Strategies
  —
  —
  —
  —

For each strategy, the activities are indicated in the table below, including the timeframe, the people responsible and the cost.

Monitoring and evaluation

Describe the monitoring system agreed upon.

Indicators

- Process indicators
- Intermediary indicators
- Outcome indicators
- Impact indicators, if any

Coordination mechanisms

Describe the coordination mechanisms agreed upon.

Tables

Recall the objective:

Strategies	Activities	Timeframe				Focal point / responsible person(s)	Funds	
		Q1	Q2	Q3	Q4		Cost	Source

Notes:

1. The C-IMCI plan of action should be part of the district IMCI plan of action.
2. The IMCI plan of action is part of the whole district plan of action.

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