Global Health and Nutrition

7-11
START-UP FIELD GUIDE
7-11
START-UP FIELD GUIDE
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Glossary

Acquired immunodeficiency syndrome (AIDS): the most severe manifestation of infection with the human immunodeficiency virus (HIV)

Anaemia: low haemoglobin levels in the blood

Antenatal: the period between conception and birth; same as prenatal

Antiretroviral: a substance that kills or suppresses a retrovirus such as HIV

Artemisinin-based combination therapy: rapid-response medication for people infected with malaria

Bacterial: tiny microorganisms that cause many common infections

Barrier: any condition that makes it difficult to make progress

Behaviour change communication: illustrates the intricate link between individual behaviour and the surrounding community and environmental (cultural, policy and service) contexts

Birth spacing: the time interval between the previous birth and beginning of the next pregnancy for a woman; also known as healthy timing and spacing of pregnancies

Cadre: a small unit of trained personnel around which a larger group can be built and trained

Chlamydia: a sexually transmitted infection that infects the genital tract; frequently shows no symptoms, but if left untreated, can cause sterility in women

Clinical: related to observations, tests or treatment of patients

Cognitive: the mental processes involved in gaining knowledge and understanding, including thinking, knowing, remembering, judging and problem solving

Colostrum: the first thick yellow milk secreted by a woman beginning lactation; contains high levels of proteins and antibodies

Complementary feeding: giving foods in addition to breast milk, to start when exclusive breast-feeding on demand is not sufficient to meet the nutritional needs of the child (6 months old)

Continuum of care: a model that links health care and services from adolescence and pre-pregnancy, pregnancy, birth, postpartum, newborn and infancy to childhood at the home, community, and primary and referral care levels

Diarrhoea: A child is said to have diarrhoea if he/she passes three or more watery stools a day

Empowerment: process through which people gain greater control over decisions and actions

Enabling: to take action in partnership with individuals or groups to empower them, through the mobilisation of human and material resources

Endemic: diseases associated with particular locations or groups of people

Epidemiology: branch of medicine dealing with the study, distribution and determinants of health-related states or events in specific populations, and its application to the control of health problems

Exclusive breast-feeding: giving an infant only colostrum and breast milk (plus micronutrients and medicines when needed) without any additional food or drink, not even water; recommended for the infant’s first six months of life

Fortification: addition of vitamins or minerals to foods in order to meet the nutrient needs of a population or targeted group

Family planning: process which enables a woman and family to plan the birth of their children, and the use of wide range contraceptives facilitating the process of timing and spacing of those births

Gonorrhoea: an infection caused by sexual transmission, which can also be transmitted to newborns during the birth process

Haemoglobin: the red, iron-based pigment in red blood cells that enables them to transport oxygen

Haemorrhage or postpartum haemorrhage: bleeding that occurs after giving birth in the site where the placenta was attached during pregnancy

Helminth: a worm that can live as a parasite in the intestines of humans

Hepatitis B: caused by infection with the hepatitis B virus, which is most commonly spread by sexual transmission and through sharing of drug needles

Human immunodeficiency virus (HIV): the virus recognised as the cause of AIDS

Hygiene: a condition of cleanliness that helps maintain health

Immunity: the body’s natural or acquired defence against a specific disease; may be partial or complete, long lasting or temporary

Immunisation: protection against an infectious disease by vaccination, usually with a weakened form of the disease-causing microorganism

Incidence: the number of new events (e.g. cases of a disease) occurring over a specific period of time

Indicator: a characteristic of an individual, community or environment which is subject to measurement and can be used to describe aspects of health

Indoor residual spraying: the process of spraying the inside of dwellings with insecticide to kill mosquitoes that spread malaria

Infectious disease: an infection capable of being transmitted by direct or indirect contact between people; caused by bacteria, viruses or parasites
Infrastructure: the basic services and facilities needed for the functioning of communities

Intermittent preventive treatment: antimalarial drugs provided to pregnant women which can prevent transmission of malaria from a mother to her child

Intervention: an action or activity that helps in the prevention, alteration or treatment of a problem

Malaria: an infectious disease caused by parasites that are transmitted to humans via mosquito bites

Maternal: relating to or characteristic of a mother or motherhood

Micronutrients: vitamins or minerals that are necessary to maintain health and that the body must obtain from outside sources (e.g. food and, in some cases, supplements)

Minimum acceptable diet: an indicator for the quality of complementary feeding, which combines minimum dietary diversity (see definition) and minimum meal frequency (see definition)

Minimum dietary diversity: achieved when children receive foods from four or more different food groups in the previous day. For non-breast-fed children aged 6–24 months, at least two milk feeds are needed on top of these foods to meet the definition

Minimum meal frequency: the number of times in the day that children receive solid, semi-solid or soft food: twice for breast-fed infants aged 6–8 months, three times for breast-fed children aged 9–24 months and four times for non-breast-fed children aged 6–24 months

Model of ministry: strategic planning tool used to guide World Vision’s distinct contribution to development in different contexts; links with our core documents and principle-level choices to provide overall alignment and integrity with our work across the globe

Morbidity: the condition of being injured, diseased or sick

Mortality: death, or the number of deaths

Neonatal period: the first 28 days of life

Nevirapine: antiretroviral drug used to prevent mother-to-child transmission of HIV

Obstructed labour: condition that arises when labour fails to progress normally and the newborn doesn’t descend through the birth canal properly

Oral rehydration therapy: refers to the use of oral rehydration solution together with continued and increased breast-feeding and continued complementary feeding as appropriate

Outcome: a change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions

Parasite: any organism that lives in or on another organism without benefiting the host organism

Placental malaria: a complication of malaria during pregnancy that poses serious risk to both the mother and the foetus

Pneumonia: infection of the lungs that can be caused by bacteria, viruses or parasites

Prenatal: the period preceding birth during which the foetus develops in the uterus

Pre-term birth: the birth of a baby at less than 37 weeks gestational age

Prevalence: the number or proportion of cases, events, or conditions in a given group of people

Post-natal: occurring after birth, especially during the period immediately after birth

Principle-level choices: four beliefs that provide guidance to choices defining World Vision strategies: tackle the causes of poverty, empowerment, multiple ministry emphasis and ministry priority

Primary health care: essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable

Psychosocial: the mind’s ability to adjust and relate the body to its social environment

Retrovirus: a virus composed of RNA rather than DNA, which can be integrated into the DNA of the host cell to be expressed there

Sanitation: measures for hygiene conditions that help prevent disease through services such as garbage collection and wastewater disposal

Schistosomiasis: infectious disease caused by parasitic worms; affects the liver, kidneys, and other organs

Spontaneous abortion: a miscarriage or the natural termination of pregnancy

Stillbirth: the birth of a foetus who has died in the uterus, or during labour and delivery

Stunting (height/length-for-age): describes children who are shorter in stature than expected for a healthy child of the same age; reflects growth failure, chronic undernutrition and/or poor health. If measured correctly, stunting is perhaps the most accurate measure of overall nutrition status and does not vary by seasons of the year

Sustainable: capable of being maintained to meet the needs of the present without compromising the ability to meet future needs

Symptom: perceived change in the body or its functions that indicates disease; reported by the patient

Syphilis: a primarily sexually transmitted infection, which can also be acquired by a foetus during pregnancy

Transmission: the spread of infection from one person to another
**GLOSSARY**

**Trend:** a long-term general movement or change in frequency, usually upwards or downwards

**Tuberculosis:** a bacterial infection spread from person to person, usually affecting the lungs

**Underweight (weight-for-age):** describes a child who is lower in weight compared to a healthy, well-nourished child of the same age. This may be because the child has not grown adequately in height, weight or both, or that he/she has lost weight. Underweight reflects both stunting and wasting, but cannot distinguish between the two

**Vaccine:** substance given to stimulate the body’s production of antibodies and provide immunity against a disease; prepared from the agent that causes the disease

**Vernix caseosa:** cheesy white substance made up of sebum (consisting of fatty acids and other lipids) and dead hair covering the baby in the womb

**Virus:** a microbe that invades cells and is not subject to antibiotics; causes many common infections

**Wasting (weight-for-height/length):** describes children who are thinner than expected for a healthy, well-nourished child of the same height/length because they have failed to gain or have lost weight; reflects recent, short-term or acute malnutrition or illness. The amount of wasting present in an area may vary by the season, affected by annual periods of food insecurity or seasonal illness
ACRONYMS AND ABBREVIATIONS

ACT: Artemisinin-combination therapy
ADAPT: Analyse, Design, Agree and Plan Tool
ADP: Area Development Programme
AIDS: Acquired immune deficiency syndrome
ANC: Antenatal care
ARI: Acute respiratory infection
ARV: Antiretroviral
BCC: Behaviour change communication
BF: Breast-feeding
BHC: Barangay Health Committees
BHWW: Barangay Health Worker
CBGMP: Community-based growth monitoring and protection
CBO: Community-based organisation
CC: Community Care Coalition
CCM: Community case management
CF: Complementary feeding
CHARMS: Core HIV and AIDS Response Monitoring System
CHN: Child Health Now
CHW: Community health worker
CHW/V: Community health worker/volunteer
CMAM: Community-based Management of Acute Malnutrition
COMMS: Community committees
CSS: Community systems strengthening
CVCA: Citizen Voice and Action
CWBQ: Child well-being outcomes
DADD: Do, Assure, Don’t Do
DHS: Demographic Health Survey
DM: Debriefing meeting
DME: Design, monitoring & evaluation
DOTS: Directly observed treatment short-course
DTP-3: Diphtheria, pertussis, and tetanus immunisation
EBF: Exclusive breast-feeding
ECDC: Early Childhood Care and Development
EPI: Expanded Programme on Immunisation
EWARN: Early Warning Surveillance and Response
FANC: Focused antenatal care
FP: Faith-based organisation
FP: Family planning
GAVI: Global Alliance for Vaccines & Immunisations
GGG: Global GIK Group
GIK: Gift-in-kind
GMP: Grandmother Project
HBLSS: Home-based life saving skills
HGB: Haemoglobin
HI: Health information systems
HIV: Human immunodeficiency virus
H/N: Health and nutrition
HSS: Health systems strengthening
HTSP: Healthy timing and spacing of pregnancy
ID: Infectious disease
IEC: Information and Education Communication
IPM: Integrated Programming Model
IPTp: Intermittent preventative treatment during pregnancy
IRS: Indoor residual spraying
KMC: Kangaroo mother care
LBW: Low birth weight
LEAP: Learning through Evaluation, Assessment and Planning
LLIN: Long-lasting insecticide-treated nets
MCHN: Maternal child health and nutrition
MDG: Millennium Development Goals
MOH: Ministry of Health
M&E: Monitoring and evaluation
MUAC: Mid-upper arm circumference
MVC: Most vulnerable children
NGO: Non-governmental organisation
NO: National office
NCOE: Nutrition Centre of Expertise
NVP: Nevirapine
OCB: Organisational capacity building
ORS: Oral rehydration solution
ORT: Oral rehydration therapy
OVC: Orphans and vulnerable children
PD: Positive deviance
PHC: Primary health care
PMTCT: Prevention of maternal-to-child transmission
PNC: Post-natal care
RH: Reproductive health
RDT: Rapid diagnostic testing
RUTF: Ready-to-use therapeutic food
SBA: Skilled birth attendant
SSF: Small-scale fortification
STH: Soil-transmitted helminths
STI: Sexually transmitted infection
TA: Technical assistance
TB: Tuberculosis
TBA: Traditional birth attendant
TB DOTS: Directly observed treatment, short-course for tuberculosis
TDI: Transformational development index
ToF: Training of facilitators
ToT: Training of trainers
TT: Tetanus toxoid
ttC: Timed and targeted counselling
UNAIDS: The Joint United Nations Programme on HIV and AIDS
UNICEF: United Nations Children’s Fund
VCA: Vulnerable Child Advocacy
VCT: Voluntary counselling and testing
VHC: Village health committee
WASH: Water, sanitation and hygiene
WHO: World Health Organization
WV: World Vision
FOREWORD
It is with great pleasure that I introduce the Global Health and Nutrition 7-11 Start-up Field Guide to you!

This comprehensive field guide is foundational to all of World Vision’s health and nutrition work. It is meant to be your primary reference, designed to give you an overview of our strategic choices, principles, interventions and project models, as well as to summarise the evidence behind these choices. Part 1 starts with an introduction to the guide, while Part 2 unpacks our 7-11 strategy and the facts that support it. Part 3 gives step-by-step instructions towards implementing our 7-11 strategy within the context of the Integrated Programming Model critical path and our LEAP cycle.

This field guide is critical to help us align national office and programme strategies and designs with our Global Health and Nutrition 7-11 Start-Up Strategy. I recommend that everyone involved in health and nutrition across the Partnership read and begin using it as we seek to achieve real results towards our child well-being outcomes and framework. Effective use of this guide in field-level programming will contribute to reaching our aim of mothers and children who are well-nourished and protected from disease, infection and injury. I invite you to jump in and process all that the field guide offers, and to give your feedback to the Global Health Team at health@wvi.org.

I want to give a huge thanks to the global team and our publishing colleagues for their work in producing this important guide. I also thank you, the reader, for joining us on this difficult journey to address the 9 million children who die before the age of 5 every year. Let us unite to end preventable deaths through the ‘Child Health Now’ campaign and call governments and key stakeholders to do the same. God has called us to a ministry of holistic healing, to focus on families and communities and ultimately the children He has created to experience ‘life in all its fullness.’ I trust that the field guide will equip us to realise this vision!

Sincerely,

Martha Holley Newsome
Partnership Leader, Health and WASH

World Vision International
Children under the age of 5 who die each year:

8.8 MILLION

That is 24,000 children each day.

Main causes of under 5 childhood death:

- Neonatal Causes: 41%
- Pneumonia: 14%
- Diarrhoea: 14%
- Other: 17%
- Malaria: 8%
- HIV/AIDS: 2%
- Measles: 1%
- Injuries: 3%

Of these deaths are from **preventable** causes, including pneumonia, diarrhoea, malaria and undernutrition. That is almost **6 million**: more than the entire population of Austria or Somalia dying each year.

Undernutrition contributes to 1/3 of child deaths.
OVER 2 MILLION

babies die on the day they are born.

Another 2 million die within the first month. (In addition around 3 million children are stillborn.)
PART 1

INTRODUCTION TO THE 7-11 FIELD GUIDE
INTRODUCTION

Welcome to World Vision’s (WV) Health and Nutrition 7-11 Start-Up Field Guide! This tool outlines WV’s 7-11 strategy, which aims to improve health and nutrition outcomes for mothers and children under 2. It is based around 7 key interventions focused on the mother and 11 key interventions focused on children under 2, hence “7-11.” This guide provides orientation and implementation guidance to WV technical, operations, DME (design, monitoring and evaluation), ADP (Area Development Programme) staff and interested partners. With this tool, we can work with communities to raise awareness, knowledge and demand for services.

Field Guide objectives
1. Summarise our health and nutrition (H/N) strategy
2. Describe the principles and concepts driving the strategy
3. Define the 7-11 focus issues
4. Describe the core and supplementary approaches to operationalise the H/N Strategy
5. Provide prioritised 7-11 project start-up guidance

After reading this guide, the reader should be able to describe
• major causes of maternal and under-5 child mortality, illness and causes of malnutrition
• our core H/N focus
• 7-11 design principles
• our 360-degree approach to H/N behaviour change
• knowledge of the 7-11 focus issues and the rationale for their selection
• the relevance of assessment to design
• the 7-11 Start-up Strategy core approaches.

Part 1 (this section) provides a summary of global maternal and child health priorities, the strategy used to address them and an overview of the 7-11 start-up conceptual framework. We explain the link between global maternal and child health issues and our recommended response. This link is the basis for our strategic and operational choices and ensures that our organisational investments achieve intended results. Understanding and appreciating strategy should be the driving inspiration for staff and volunteers (practitioners) at all levels.

Part 2 provides an examination of the priorities in primary health care (PHC) approaches and includes a detailed description of the 7-11 focus issues. These issues are described in such a way as to allow non-technical specialists to understand their importance and desired behaviour changes. It is important for our practitioners to appreciate the evidence-based principles developed through decades of global experience in PHC, and for our programming to reflect these lessons learned.

Part 3 follows the Learning through Evaluation, Assessment and Planning (LEAP) cycle, which provides specific recommendations on assessment, design, implementation, monitoring and evaluation. LEAP prioritises the development of project design based on effective assessment and decision-making processes and follows the cycle of programming through managing implementation, monitoring results and evaluating impact. Part 3 also details the recommended core start-up approaches. (See appendix for additional assessment-based interventions.)

The 7-11 Field Guide also references many other resources needed for assessment, design and implementation of our H/N work. This guide should be used as a summary and primer, helping you to align programming strategically and effectively.
GLOBAL HEALTH AND NUTRITION SITUATION

Driven by our ministry framework and development principles, we have chosen to centre our health strategy on child-focused community PHC. This focus provides a framework for our global situational assessment. Global maternal and child H/N statistical summaries tend to focus on primary causes of maternal and under-5 mortality and morbidity.

The 2003 Lancet Child Survival series\(^3\) provided a first-time consolidated epidemiological analysis of global under-5 child mortality. It also prioritised evidence-based and cost-effective interventions to address child survival with early, prompt and simple interventions, many of these focused on empowering parents and communities on how to keep their children healthy. Fifteen of those recommended interventions are preventive approaches, and nine entail treatment.

The 2005 Lancet Neonatal Survival series\(^4\) and 2006 Maternal Survival series\(^5\) subsequently underscored the high proportion of child deaths that occur in the neonatal period, and the importance of continuum of care in time and place to save newborn and maternal lives. They clearly showed that the health and nutrition of the pregnant mother are important determinants of newborn survival, and that improved health systems are key to addressing major causes of newborn deaths.

The 2008 Lancet Maternal and Child Undernutrition series\(^6\) provided new insight into the prevalence and impact of global maternal and child undernutrition and prioritised evidence-based and cost-effective interventions to address malnutrition, which could prevent 3.5 million child deaths each year if implemented at scale. It identified pregnancy to age 24 months as the critical window of opportunity for delivery of nutrition interventions. If children are not helped by age 2, they can suffer irreversible damage that can endure into subsequent generations. Undernutrition is a key factor in impeding child development, maternal health and productivity. The prevention of maternal and child undernutrition is a long-term investment that will benefit the current generation and their children.

**Prevention:** Effective prevention programmes can reduce by 60 per cent the annual cost for treating illness. Effectiveness is dependent upon integrated delivery of core interventions. Equally important to the reduction of maternal and child mortality, preventive PHC has a life-long positive effect on the physical and mental development of children and adults. Children who suffer from nutritional deficiency and infections, both pre- and post-natal, are at risk of reduced cognitive, motor, behavioural, social and emotional development.\(^7\) The harm becomes most apparent in middle childhood.

**Primary-level coverage:** Most national government health expenditure is invested in tertiary care (hospitals), which benefits primarily the wealthier members of societies. There is greater need to strengthen primary and community-level health systems. These services are often delivered by volunteer and community health workers (CHWs) and are an important component of the revitalisation of health systems.\(^8\) Interventions having the greatest effect on neonatal deaths are more dependent on skill than on technology and commodities.\(^9\) For example, if mothers are empowered to immediately breast-feed after birth, significant numbers of neonatal deaths could be prevented.

**Community empowerment** is a cornerstone of improved PHC programme design. Involving communities, rather than ‘targeting’ them, magnifies the effect of interventions. The *Lancet* journal affirms that even in situations with weak health systems, mortality reduction can be achieved through outreach at the family-community level: ‘The greatest contemporary challenge to PHC is not a lack of intervention technology, but to build parental and community knowledge and capacity to keep their children healthy and encourage focus on implementation of the most cost-effective interventions to the families and communities that need them.’\(^10\)

**The Millennium Development Goals (MDGs)** are an agreed-upon mandate that has given renewed urgency to addressing the fate of millions of children and women in the developing world. (See Appendix A for a list of the MDGs.) All of the MDGs impact health,
but goals four, five and six directly address child and maternal health and nutrition, human immunodeficiency virus (HIV) and AIDS, malaria and other diseases. Global leaders, politicians, civil society and others have pledged their intent to reduce global child mortality by two-thirds, reduce maternal mortality by 75 per cent and cut severe hunger by 50 per cent by the year 2015. We are part of this pledge and must work in partnership with communities to mobilise at national and international levels to ensure that communities’ voices are heard. To this end, our Child Health Now (CHN) campaign was launched in 2009, calling the international community to rededicate itself to the MDGs. The Child Health Now Report sets out an agenda for joint action by governments and donors, including measures to eliminate at least 5 million child deaths each year.

**OUR HEALTH AND NUTRITION FOCUS**

In 2006 WV assessed its H/N sector programming. This assessment found serious deficiencies in the investment of H/N along with a lack of an aligned approach in target communities. These results were confirmed in our Transformational Development Index. High percentages of children in target communities suffer from malnutrition and the current levels of maternal and child mortality are unacceptable. More recently, the organisational assessment on our Registered Children reached a similar conclusion.

In response to these findings, in 2007 WV adopted a H/N strategic focus based on low-cost, evidence-based, measurable and preventive interventions in order to combat the primary causes of maternal and child mortality. The health and nutrition ‘Do, Assure, Don’t Do’ (DADD) framework provided a high-level guideline toward reorienting H/N investments in alignment with WV’s new strategic focus. The essential elements of the DADD framework are outlined in Table 1.

<table>
<thead>
<tr>
<th>Do</th>
<th>Assure</th>
<th>Don’t Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess health system performance, including community and PHC systems</td>
<td>• Facilitate and promote equitable access to health care and ensure quality of PHC services for families and communities</td>
<td>• Provide health benefits only to sponsored children, excluding children of similar status within the same programme focus area</td>
</tr>
<tr>
<td>• Mobilise and build capacity of community-level maternal child health and nutrition (MCN) stakeholders</td>
<td>• Ensure access to essential H/N commodities</td>
<td>• Any activity/intervention not linked to assessment findings and priority</td>
</tr>
<tr>
<td>• Build capacity of PHC-level workforce</td>
<td>• Empower sustainable community-level MCHN-facing groups/structures</td>
<td>• Reproductive health interventions abortive in nature: contravenes WV reproductive health policy</td>
</tr>
<tr>
<td>• Monitor core indicators in the areas where we work</td>
<td>• In sponsorship programmes – facilitate equitable access of registered children; assure that child H/N monitoring and emergency preparedness mechanisms are functioning</td>
<td>• ICF within an infant’s first 6 months</td>
</tr>
<tr>
<td>• Support health promotion, disease prevention and free access to PHC services in declared emergency responses</td>
<td>• Mobilise local advocacy efforts on (MCH); promote community-level PHC in international advocacy campaigns</td>
<td>• Annual medical check-ups, acquisition and distribution of medical equipment, and medications not aligned with the core focus and strategy</td>
</tr>
</tbody>
</table>

TABLE 1 | H/N Do, Assure, Don’t Do Guidelines
THE 7-11 START-UP STRATEGY: A POINT OF DEPARTURE

Global Health and Nutrition goal
WV is committed to improving the health and nutrition of women and children in the areas in which we work and contributing to the global reduction of under-5 and maternal mortality and morbidity.

Child well-being outcomes (CWBO)
We are focused on three essential outcomes to achieve this goal:
1. Mothers and children are well-nourished.
2. Mothers and children are protected from infection and disease.
3. Mothers and children access essential health services.

Core interventions
Our strategy is focused on evidence-based, cost-effective preventive practices that address the primary causes of maternal and child mortality and illness. Our core emphasis is on pregnant women, newborns and children under the age of 2 because the greatest burden of mortality, illness and undernutrition lies in these groups. The effects of undernutrition on these targets are irreparable later in life and will have enduring negative effects. We advocate for organization-wide address of a ‘7-11’ framework of prioritized maternal child health and nutrition (MCHN) issues as illustrated in Table 2. These issues have been prioritized through review of global recommendations followed by internal discernment. They reflect the intervention areas found to be most successful and cost-effective and are designed to maximise impact through combining complementary interventions.

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>7-11 Focal Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnant Women: 0–9 months</strong></td>
<td><strong>Children: 0–24 months</strong></td>
</tr>
<tr>
<td>1. Adequate diet</td>
<td>1. Appropriate breast-feeding</td>
</tr>
<tr>
<td>2. Iron/folate supplements</td>
<td>2. Essential newborn care</td>
</tr>
<tr>
<td>3. Tetanus toxoid (TT) immunisation</td>
<td>3. Hand washing with soap</td>
</tr>
<tr>
<td>4. Malaria prevention, treatment access and intermittent preventive treatment</td>
<td>4. Appropriate complementary feeding</td>
</tr>
<tr>
<td>5. Birth preparedness and healthy timing and spacing of delivery</td>
<td>5. Adequate iron</td>
</tr>
<tr>
<td>7. Access to maternal health service: antenatal care (ANC), post-natal care (PNC), SBAs, prevention of maternal-to-child transmission (PMTCT), HIV/tuberculosis (TB)/sexually transmitted infection (STI) Screening</td>
<td>7. Oral rehydration therapy (ORT)/zinc</td>
</tr>
<tr>
<td></td>
<td>8. Prevention and care seeking for malaria</td>
</tr>
<tr>
<td></td>
<td>9. Full immunisation for age</td>
</tr>
<tr>
<td></td>
<td>10. Prevention and care seeking for acute respiratory infection (ARI)</td>
</tr>
<tr>
<td></td>
<td>11. De-worming (≥12 months)</td>
</tr>
</tbody>
</table>
HOUSEHOLD, COMMUNITY AND NATIONAL-LEVEL APPROACHES

**Household:** The delivery approach focuses on primary H/N education and behaviour change at the household level and empowering caregivers and children to keep themselves healthy. The foundational approach is to support the community health workers and volunteers (CHW/Vs).

**Community:** The approach focuses on building the capacity of community groups to address and monitor local causes of illness, death and malnutrition, advocate for quality health service delivery, monitor home-based care services and ensure enabling environments for positive health outcomes. The foundational approach toward this objective is to support the village health committees (VHCs) and child-focused stakeholder coordination (Community Committees: COMMs). These may be WV-mobilised Community Care Coalitions (CCC), ministry of health (MOH)-mobilised VHCs or other appropriate existing community-level groups.

**National:** Our approaches emphasise partnership with national government and other environmental stakeholders to ensure delivery of quality H/N services to the community level.

*All approaches prioritise strengthening existing community-level structures and assets.*

Figure 1 presents a conceptual framework for the 7-11 Start-up Strategy, demonstrating relationships from strategy and approaches to outcomes. This framework serves as the broad outline for much of the Field Guide.
FIG. 1  7-11 Start-Up Strategy Conceptual Framework

Global Strategy

Landscape Assessment (National/SubNational)

Programme/Project Assessment (Community)

Local-Level Issues and Need

Community Committee (CORE) (Local Partnerships for H/N)

Local MOH

CHW Programming/ Timed & Targeted Counselling (CORE)

Contextual Responses:
- CMAM/PD • ECCD
- CB GBP • Grandmother Project • PMT CT
- TB DOTS • Malaria
- css • small scale fortif. • home based fortif. • C-Change

Local-Level Advocacy
- HSS (CORE)

Knowledge Awareness
- Behaviour Change
- Care Seeking
- Emergency Preparedness

Social Barriers
- Key Decision Makers
- Positive Deviance
- CSS
- Surveillance
- Integration

Policy Change
- Resource Allocation
- HSS

Household:
- Children, Mothers, Fathers, Extended Family

Community:
- Leadership, Stakeholders, Interest Groups

Environment:
- MOH, Private Sector
PART 2

WORLD VISION’S 7-11 START-UP STRATEGY FOR HEALTH AND NUTRITION
INTRODUCTION TO PART 2

Part 2 provides readers with a description of our 7-11 strategy, as follows:

Section 1 reviews the major health and nutrition problems affecting mothers and under-2 children, examines the main risks – such as maternal mortality during childbirth, maternal and childhood anaemia, child stunting and numerous infectious diseases – and explains the related 7-11 interventions.

Section 2 reviews the principles that helped guide the development of the 7-11 strategy. These principles define the perimeters and parameters of 7-11 programming, realising that we cannot meet every H/N need in targeted communities. We sought to remain true both to the WV Model of Ministry and principle-level choice, as well as to evidence-based best practise.

Section 3 provides the conceptual foundation for the 7-11 strategy. The strategy is built on an evidence-based theory of behaviour change. It calls for intervening not only with accurate information for individuals but also with targeted action to create a context that enables individuals to implement and maintain positive H/N practices. This section also describes a ‘life-cycle approach’ which highlights critical points throughout an individual’s life when lifestyle choices can impact health outcomes and provide the opportunity to intervene with timed messages and actions.

Section 4 describes the prioritised 7 maternal and 11 child interventions. These interventions were selected based on the global evidence base built over decades of experience in PHC. They have proven to be relatively low-cost means to reduce maternal and child morbidity and mortality. The 7-11 interventions are explained in language that enables non-technical specialists to understand their importance and the related desired behaviour changes.

Section 5 explores the integration of 7-11 programming into overall ADP project designs, recognising that health and nutrition comprise only one of many operational sector focuses. Value is gained through integrated initiatives.

Section 6 takes a quick look at the mandate to expand programming beyond the core maternal and under-2 target groups once the core programming is consolidated and sustained in all coverage areas. This is in keeping with the notion of a full life-cycle approach to improved health and nutrition.
SECTION 1: PROBLEM STATEMENT: IMPROVING MATERNAL AND CHILD OUTCOMES

1.1 Focus on Mothers and Children Under 2

The goal of our global health and nutrition strategy is to improve the health and nutrition of women and children in the areas in which we work and contribute to the global reduction of under-5 and maternal mortality.

To achieve this goal, we have identified three priority CWBOS:

1. Mothers and children are well nourished.
2. Mothers and children are protected from infection and disease.
3. Mothers and children access essential health services.

While these CWBOS are meant to pertain to all children, we focus on mothers and children under 2 as our target groups for the 7-11 start-up strategy. This focus is taken for three reasons: 1) the pronounced vulnerability of the under-2 age group, 2) the critical importance of good health and nutrition at this age to the lifelong development of the child and 3) the proven link between the mother’s health, nutrition and survival to the survival and well-being of her child.

The period of life from conception to 2 years of age is a critical time that lays the foundation for lifelong health, learning and productivity. In the early months and years, the body’s organs, physiological processes and brain structure are established. Poor nutrition and health during this time hinders physical and cognitive development. These largely irreversible and the lifelong effects negatively impact individual well-being as well as community and national development.

If a child has poor health and nutrition and not enough psychosocial stimulation, he/she is less likely to perform well in school and, as an adult, earn a good wage. If parents are poor, under nourished and under educated, their children are much more likely to suffer from poor health and nutrition and a lack of education. The cycle of poor health, nutrition and education is passed from generation to generation.

We aim to ensure that children in our programmes start out in life with a foundation of good health and nutrition. While interventions for older children have benefits, they cannot undo the health and cognitive losses incurred in early life. These losses must be prevented through evidence-based interventions targeted at pregnant mothers and children under 2, taking advantage of this window of opportunity and building a foundation for a healthy and productive life.

1.2 Improving Maternal Outcomes

A mother’s survival is crucial to her baby’s survival. Studies have shown that the baby’s risk of dying is increased by a factor of ten if the mother dies. The outcome of a baby’s health is determined largely by the mother’s health and nutrition, reinforcing the often-quoted statement that ‘survival starts in the womb.’

Some of the most significant maternal health issues include the risks associated with childbirth, the widespread prevalence of maternal anaemia and the mother’s susceptibility to various infectious diseases. The next section describes these three significant risk factors to the mother. The seven interventions targeted at the mother, described in Section 4.1, are designed to work together to minimise these risks.

1.2.1 Improving Maternal Survival in Childbirth

What are the common causes of maternal deaths surrounding pregnancy and childbirth? Worldwide, more than 80 per cent of maternal deaths are pregnancy-related, such as severe bleeding, pregnancy-induced hypertension, infection, prolonged or obstructed labour, and complications from unsafe abortions. These causes lead to death for approximately 342,000 to 500,000 women each year, 99 per cent of whom live in developing countries, primarily in sub-Saharan Africa and South Asia. Poor nutrition contributes to these maternal deaths. Women with severe anaemia in pregnancy, for example, have a 3.5 times greater chance of dying from obstetric complications compared with non-anaemic pregnant women.

- Haemorrhage: 35%
- Hypertension: 18%
- Indirect: 18%
- Other Direct: 11%
- Abortion: 9%
- Sepsis: 8%
- Embolism: 1%

Globally, new estimates show that more than 50 per cent of maternal deaths are directly caused by massive bleeding (haemorrhage, 35 per cent) and high blood pressure (hypertension, 18 per cent) with 18 per cent accounted for by indirect causes such as HIV and AIDS, malaria and heart diseases. These causes lead to death for approximately 342,000 to 500,000 women each year, primarily in sub-Saharan Africa and South Asia. In developed countries, however, the leading causes of maternal deaths are related to complications of anaesthesia and caesarean sections. What accounts for the disparity in causes of maternal deaths? It is access to necessary obstetric care. Developing countries still do not have this access. The major causes of death require emergency obstetric care, which is either lacking or poorly functioning in developing countries. Health systems are often ill-equipped and lack skilled staff able to perform life-saving procedures such as obstetric surgery. There remains an uneven distribution of skilled workforce personnel, an absence or paucity of basic emergency obstetric supplies and equipment, and substandard practices to effectively respond to these life-threatening complications.

Along with weak health care systems, another issue is that pregnant women in developing countries tend not to seek health care, have limited access to services they do seek and have little or no emergency health care. Women choose not to use health services for various reasons, including

- tradition and cultural perception (i.e. perceiving the health facility as ‘a place to die’)
- economic constraints
- poor quality of services, including poor staff attitude
- lack of understanding regarding the importance of accessing SBAs, especially for birthing complications
- lack of decision-making power among women to decide where to give birth, leading to delayed decisions to seek help
- inability to recognise and skillfully treat pregnancy and childbirth danger signs
- poor transport and communication links between facilities and communities.

1.2.2 Reducing Maternal Anaemia

What is anaemia and how prevalent is it?

Anaemia, defined as low blood haemoglobin (HGB) level, is a very common global public health problem. An estimated 1.6 billion people, or one-quarter of the world’s population, are affected. Anaemia prevalence is highest in developing countries. Although both males and females of all ages are affected, the most vulnerable groups are pregnant women and young children. Worldwide, 42 per cent of pregnant women (56 million individuals) suffer from anaemia, with the highest prevalence rates in Africa (57 per cent, or 17 million women), and the highest absolute numbers in South-East Asia (48 per cent, or 18 million women).

What causes anaemia?

Iron deficiency is the most common nutritional deficiency and the major cause of anaemia worldwide. The World Health Organization (WHO) estimates that iron deficiency is responsible for approximately 50 per cent of all anaemia cases. Other significant causes include deficiencies of other nutrients, malaria, helminths infections (usually hookworm), and a variety of other diseases. Effective management of anaemia in high prevalence contexts requires an analysis of the main contributors and implementation of an integrated package of interventions to address all major causes.

What are the consequences of anaemia?

Anaemia in women causes decreased cognitive ability and work productivity and increased fatigue, morbidity and mortality. Women with severe anaemia in pregnancy have a 3.5 times greater chance of dying from obstetrical complications compared with non-anaemic pregnant women. Anaemia is estimated to cause approximately 115,000 maternal deaths annually.

In addition to consequences for the mother, several studies have shown a positive association between maternal iron deficiency anaemia in early pregnancy and a greater risk of preterm delivery and consequent low birth weight (LBW). LBW greatly increases the risk of neonatal mortality and morbidity and is associated with deficits in health, development and cognitive growth for the surviving infant. Even full-term, normal birth weight infants of iron deficient mothers have reduced iron stores continuing into the first year of life, increasing their vulnerability to anaemia. This contributes to compromised cognitive development in early childhood, even if the iron deficiency is later corrected.
How can we prevent anaemia?
Anaemia among pregnant women can be reduced and prevented through the following interventions (both promoting and ensuring availability):

- eating adequate iron-rich foods that enhance iron absorption and fortified foods (e.g. liver, animal foods, dark green leafy vegetables, fortified staples)
- iron/folate supplementation
- de-worming, in areas with high worm loads
- antimalarial prophylaxis during pregnancy in malaria-endemic areas
- sleeping under a long-lasting insecticide-treated net (LLIN) in malaria endemic areas.

The various proven interventions for maternal anaemia are further described in Section 4.

Addressing Maternal Anaemia – Bertha’s Story

Bertha needed access to the iron and folate tablets that her government had tried to make available to all pregnant women. She was one of many women unable to access this service. Fortunately, a WV programme began working with the health extension workers and community health volunteers in her community and an Iron Supplementation Hut was soon built not far from her house. She was already on a register for women of child-bearing age and was able to begin taking weekly iron and folate tablets. When she became pregnant, the volunteer transferred her name to the pregnant women register and referred her to the trained birth attendant for early pre-natal care and for her supply of daily iron and folate tablets. Through this programme, Bertha was able to take regular iron tablets before she was pregnant as well as throughout her pregnancy. This helped her to remain anaemia free and have a healthy pregnancy and deliver a healthy baby girl.

1.2.3 Protecting Mothers from Infectious Disease

What are the consequences of infectious diseases?
Infectious diseases are major causes of death, disability, diminished quality of life, reduced productivity and increased financial burden for families.35 Fourteen to seventeen million people die due to infectious diseases each year, nearly all in developing countries. Poor women in rural areas are affected most. Infectious diseases account for approximately 25 per cent of maternal deaths, while incidence of infectious disease reaches 40 per cent in developing countries. Infectious diseases are largely preventable and treatable and can be addressed through well-known and evidence-based interventions at a community level.

What are the common infectious diseases?
To reduce maternal and child mortality, our main approach to infectious disease in the 7-11 strategy is on prevention, early detection and access to early management of infectious disease among pregnant women and children under 2 years. The following is a review of the most common infectious diseases, the consequences of these diseases for mothers and children and the recommended interventions to reduce their prevalence.
Malaria
Half the world’s population is at risk of malaria. It is endemic in 107 countries, with sub-Saharan Africa most severely affected. An estimated one million malaria-related deaths occur each year, with more than 80 per cent of these deaths occurring among African children under age 5.

Pregnant women are highly vulnerable to malaria because immunity to malaria is reduced during pregnancy. Malaria puts the mother at risk of death and increases the risk of spontaneous abortion, stillbirth and premature delivery. In areas where malaria is common, a reduced immune response during pregnancy can lead to placental malaria, often resulting in maternal anaemia and LBW, which are leading causes of infant mortality.

Tetanus
Tetanus, a vaccine-preventable disease, causes approximately 309,000 deaths annually. An estimated 90 per cent of the neonatal tetanus deaths occur in developing countries, where women often give birth in unhygienic conditions, allowing tetanus bacteria to enter their bodies. Tetanus is frequently spread to the newborn through the use of non-sterile instruments to cut the umbilical cord.

HIV and AIDS
Globally, HIV and AIDS is the leading cause of mortality in women of reproductive age. For nations with high HIV prevalence, AIDS has become a major contributor to death during pregnancy and post-partum (maternal mortality). There is also some evidence that women living with HIV are at greater risk of maternal death. The Joint United Nations Programme on HIV and AIDS (UNAIDS) and WHO reports show that, despite a reduction in HIV infections, the AIDS epidemic remains one of the most significant infectious diseases and continues to pose enormous challenges to health and development. AIDS-related illnesses are leading causes of death for both men and women, and are expected to continue as a major global cause of mortality in the coming decades. The continuing rise in people living with HIV is a coupled effect of continued high rates of new infections, plus prolonged life due to antiretrovirals (ARVs). Many new infections are due to transmission during pregnancy, delivery or breast-feeding, making HIV and AIDS a prime contributor to child mortality. There is great need to increase focus on early diagnosis in children and effective treatment through paediatric ARVs. Currently, most HIV-positive children have access to ARVs and effective management only after the age of 5, which is too late. Without treatment, half of all babies born with HIV die before their second birthday.

Tuberculosis
Along with HIV and AIDS, tuberculosis is a leading cause of death among women of reproductive age and is the single biggest infectious killer of women in the world. TB causes more deaths among women than all causes of maternal mortality combined, and more than 900 million women are infected with TB worldwide. A majority of these women will die or live with debilitating symptoms due to TB. Poverty, overcrowded housing and malnutrition are underlying causes of TB infection and the disease aggravates poor nutrition and poverty. Women of reproductive age are more susceptible than men of the same age to develop active TB disease once infected. Women living with HIV are especially vulnerable to TB and it is the leading cause of death among HIV-positive individuals.

TB/HIV co-infection
HIV and AIDS have adversely affected the TB epidemic. HIV-positive individuals have a much higher chance to develop active TB, which causes faster progression to AIDS. In one study in South Africa, nearly 25 per cent of children with HIV developed TB during the course of a year. TB/HIV collaborative services are the key to address the co-infection. Counselling and TB screening of individuals newly diagnosed with HIV and HIV tests for TB patients are crucial to treating both diseases.
HIV/Malaria co-infection
HIV and AIDS weaken one’s natural immunity to malaria, and the biological response to malaria infection increases progression to AIDS. Children and pregnant women are both adversely affected by HIV/malaria co-infection. HIV and AIDS increase the risk of clinical malaria and severe illness and can decrease response to treatment. Malaria causes a temporary increase in viral load and may worsen clinical disease and transmission in adults. HIV-positive pregnant women have increased chances of becoming infected with malaria and malaria-related anaemia. Malaria infection in HIV-positive women can also increase the risks of mother-to-child transmission during pregnancy and breast-feeding. Some medications used to treat HIV-positive persons can be harmful for malaria treatment in certain settings.

HIV/TB/Malaria with other Neglected Tropical Diseases
Malaria and intestinal worm co-infections occur commonly among pregnant women. Soil-transmitted helminths (STH) and schistosomiasis can severely weaken the immune system of women and children and leave them more vulnerable to other infections. Malaria and worm infection both cause anaemia in pregnant women and leave women worse off than those infected with a single disease.

Other Sexually Transmitted Illnesses (STIs)
Spread through person-to-person sexual contact, sexually transmitted illnesses are transmitted by parasites, viruses (HIV, genital herpes) and bacteria (syphilis). It is a global health problem, and WHO estimates that every year about 333 million new cases of treatable STIs (syphilis, gonorrhoea, chlamydia and trichomoniasis) occur in adults 15 to 49 years, occurring predominantly among the younger 15-to-24 year age group, and is highest among ages 20 to 24. These are the same age groups registering the highest HIV incidence in countries with generalised epidemics.
WHO estimates that each year there are 700,000 to 1.5 million new cases of congenital syphilis in newborns born to 2 million syphilis-infected pregnant women world-wide. Syphilis can infect the baby while in the womb. Depending on the duration of the mother’s infection this may result in stillbirth or, if the live birth baby is not treated right away, he/she could die within weeks, suffer from seizures or have delayed development. Untreated early syphilis in pregnancy accounts for one in four stillbirths and 14 per cent of newborn deaths. In Africa, approximately 4–15 per cent of pregnant women tested positive for syphilis.

**Soil-Transmitted Helminths (STH) and Schistosomiasis**

Soil-transmitted helminths and schistosomiasis are the most common intestinal worms. According to some estimates, 70 per cent of the worm population is harboured in 15 per cent of the human-host population. These carriers are heavily infected and are at risk of developing severe diseases. The major source of transmission is environmental contamination, including poor hygiene practices, poor sanitation and unclean drinking water. Schistosomiasis transmission may vary by season and is dependent on contact with contaminated water.

Worm infestations have a dramatic impact on reproductive health. Many cases of unexplained loss of pregnancy are due to undiagnosed diseases like malaria and worms. Malnutrition or anaemia caused by intestinal worms worsens during pregnancy and does not only adversely affect the mother but also the unborn child. Worm infections, especially those due to STH, increase and worsen iron deficiency anaemia in pregnant women, resulting in low pregnancy weight gain and poor growth of the unborn child. It is followed by LBW, with greater risks of newborn infection and a higher infant mortality rate. Women of child-bearing age, pregnant women, lactating mothers and their infants and children often experience cycles of infection and re-infection which can continue from one generation to the next.

The proven interventions listed for infectious disease are further described in Section 4.

**Part 2**

SEE TOOL REDUCING MATERNAL ANAEMIA (NCOE) (under development) Field-friendly set of tools (i.e. facilitator’s manual, participant’s workbook and visuals) aimed at training front-line community workers to address prioritised nutrition issues for achieving CWBOs in the 7-11 strategy

**1.3 Improving Child Outcomes**

**1.3.1 A Healthy Start for Newborns**

**Why newborns?**

Without a substantial reduction in deaths among newborns, MDG four, which aims to reduce mortality among children 0 to 50 months by 50 per cent, will be difficult to achieve. WHO estimates that nearly 40 per cent of all deaths among children under 5 (about 3.7 million) occur in the first month of life, with 75 per cent dying within the first week and 25–45 per cent dying within 24 hours after birth.

Approximately 99 per cent of these deaths occur in low- and middle-income countries, with the highest rates in sub-Saharan Africa and highest absolute numbers of deaths in south-central Asia. At least 50 per cent of deaths occur at home.

**What are the main causes of newborn deaths?**

As seen in Figure 3, approximately 80 per cent of newborn deaths are due to infections, asphyxia and pre-term birth.
Global causes of death among children ages 0–59 months, 2008

- **Under 5**
  - Pneumonia: 14%
  - Diarrhoea: 14%
  - Malaria: 8%
  - Other Infections: 9%
  - Preterm: 12%
  - Asphyxia: 9%
  - Sepsis: 6%
  - Other Neonatal: 5%
  - Congenital: 3%
  - Tetanus: 1%
  - Diarrhoea, Neonatal: 1%
  - Injuries: 3%
  - Measles: 1%

- **Neonatal**
  - Neonatal Pneumonia: 4%
  - Neonatal Other Infections: 5%
  - Neonatal Asphyxia: 9%
  - Neonatal Meningitis: 2%
  - Neonatal Other: 1%

Undernutrition contributes to one-third of child deaths

For a long time, little attention was given to the intricate link between the mother and her newborn baby. Consequently, the continuum of care (a model that links health care/services from adolescence and pre-pregnancy, pregnancy, birth, postpartum, newborn and infancy to childhood at the home, community and primary and referral care levels51) between the mother and her baby was largely ignored. Moreover, newborns did not receive the attention they required despite the existence of proven, low-cost interventions to prevent newborn mortality.52 This is partly because community-based health workers were not sufficiently trained; nor were mothers and other family members sufficiently knowledgeable of aspects of essential newborn care.

Kangaroo Mother Care in Peru – Paulina’s Story

Paulina, a mother of five, lives in one of the highlands in Peru. To reach the nearest health centre, she must walk two hours on narrow footpaths. During her last pregnancy, Paulina gave birth at the clinic to low-birth-weight twins. She immediately exclusively breast-fed the twins and began a method called Kangaroo mother care (KMC). With KMC, the mother wraps the infant skin-to-skin against her chest, which provides the warmth, easy access to on-demand breast-feeding, and intimate care that infants with low birth weight need. Once home again two days later, Paulina continued to exclusively breast-feed and alternated wrapping her twins with skin-to-skin contact for an hour at various points throughout the day. Paulina’s husband, a volunteer health worker, helped as well. While Paulina held one of the newborns skin-to-skin against her chest, he wrapped and held the second twin against his. Over the next two months, Paulina continued to practise KMC and watched as her twins gained weight and strength! The twins, now 5 years old, are both very healthy. After witnessing the power of KMC first hand, Paulina’s husband is now an informal KMC advisor for families with low-birth-weight infants.

1.3.2 Reducing Stunting in Children under 2

The World bank warns that malnutrition continues to be the world’s most serious health problem and the single biggest contributor to child mortality.53 Undernutrition accounts for one-third of under-5 mortality, or 3.2 million deaths per year.54 Stunted children are up to four times more likely to die from easily preventable and treatable diseases than well-nourished children.55 Thus, the 11 interventions aimed at children, described in detail in Section 4.2, include evidence-based interventions targeted to reduce undernutrition.

What is stunting and how prevalent is it?

Stunting is defined as chronic restriction of height growth and is a measure of undernutrition in children under age 5.56 A stunted child has significantly lower height than normal for his/her age, even considering natural variations in body size. Although stunting is extremely prevalent and has significant negative consequences, it is a largely invisible, and therefore largely ignored, form of malnutrition.57 For example, a stunted 3-year-old child may look just like a 2-year-old who has grown normally, so most may not notice that the 3-year-old is chronically undernourished. Stunting is highly prevalent compared to other major forms of malnutrition and illnesses, and is very common in developing countries (10–80 per cent of children under 5 years of age), with a global estimate of 178 million children under 5 suffering from stunting.58

What causes stunting?

Stunting is a result of poor diet during pregnancy and the first two years of a child’s life. A ‘poor diet’ is defined as one lacking sufficient nutrients. This may or may not be coupled with common infectious diseases, such as diarrhoea or malaria.59 Stunting is largely irreversible after 2 years of age, highlighting the importance of good nutrition in pregnancy and early in a child’s life. The window of opportunity for preventing stunting is from conception through 24 months of age.60
What are the consequences of stunting?
Stunting has serious individual and national consequences. Stunting significantly increases a young child's risk of death, and contributes to 14 per cent of all deaths in children under age 5. Stunted children who survive are more vulnerable to disease and illness, and have increased risk of chronic disease later in life. Children who are stunted have poorer cognitive development, complete fewer years of schooling and earn less income as adults. Lower income, poor health and reduced access to proper nutrition continue to negatively impact the health of children born in the next generation.

How can we prevent stunting?
There are several effective interventions that prevent stunting, including the following:

For the mother:
- Ensure an adequate diet for pregnant mothers, which may include food and micronutrient supplements
- Promote appropriate birth spacing (greater than 24 months apart)
  - A recent study found that children born less than 24 months apart have a 1.52 greater chance of being stunted than children born 24–36 months after their older sibling.
- Promote use of intermittent preventative treatment during pregnancy (IPTp) in malaria-endemic areas
  - Assumed to reduce the risk of term intrauterine growth restriction by 43 per cent in babies born to the first or second pregnancy of women in malaria-endemic areas.

For the child:
- Encourage appropriate breast-feeding
- Promote appropriate CF
- Promote intake of adequate vitamin A (vitamin A capsules) and zinc
- Promote effective prevention and treatment of common childhood illnesses (e.g. diarrhoea)
  - Hygiene interventions assumed to reduce incidence of diarrhoea by 30 per cent and reduce odds of stunting (every incidence of diarrhoea increases odds of stunting by four per cent)
- Promote appropriate feeding during and after illness

Magic Flour in Malawi – Atupele’s Story
Atupele was a 2-year-old orphan who lived with her grandparents in a small village in Malawi. Atupele became too weak to walk or talk like the other children her age. She was so ill her grandfather worried that she could die. When her grandparents took her to a health centre, the staff found that Atupele was very malnourished. She weighed only 4.3 kg, when she should have weighed closer to 12 kg. She had a HBG level of 5.3 g/dL, when it should have been more than 11 g/dL. Community health volunteers gave Atupele’s grandparents information on appropriate feeding for young children. They also provided some fortified maize and soy flour mix to feed her, and gave the family two rabbits and some indigenous vegetable seedlings in order to help them provide an adequate diet for Atupele. Her grandparents were very happy with the help given by the volunteers. They began feeding Atupele the specially fortified food and animal-source foods such as goat’s milk and eggs. They referred to the fortified flour as ‘magic flour’ because after only a month, a difference could be seen in Atupele. She became more energetic, her eyes got brighter and she began to move around more. She was able to play with other children again and, according to her grandfather, the best of all was that she began to smile and laugh again.
1.3.3 Reducing Anaemia in Children under 2

What does anaemia look like and how prevalent is it among children under 2?

As discussed in section 1.2.2, anaemia is one of the world's most widespread health problems and is sometimes described as 'hidden hunger.' Yet, as with stunting, the adverse consequences are largely invisible, and thus largely ignored. Anaemia most often goes unnoticed, especially in children. Although pale tongue and lips are signs that some health workers can recognise, this method of identifying anaemia is not very reliable. Thus, to know whether a child is anaemic or not, the amount of HGB in their blood must be measured. Worldwide, almost one-half (47.4 per cent) of all children under 5 years of age are anaemic. However, children under 2 years of age are at highest risk for anaemia. WHO regional estimates indicate that the highest proportion of affected children under 5 are in Western Pacific (90.4 per cent), South-East Asia (85.1 per cent), the Americas (76.7 per cent) and Africa (74.6 per cent).

What causes childhood anaemia?

The most common cause of childhood anaemia is iron deficiency, or lack of the nutrient iron needed to make HGB. Iron deficiency anaemia is a nutritional anaemia, and therefore is preventable. Globally, it is estimated that 50 per cent of anaemia is due to inadequate dietary iron intake, the physiologic demands of rapid growth and iron losses due to parasitic infections (e.g. hookworm). Other significant causes of anaemia in children include malaria, nutritional deficiencies other than iron (e.g. folate, vitamin A, riboflavin, copper and vitamin B12), genetic conditions (e.g. thalassemia in parts of the Mediterranean, sickle cell in Africa) and infections (e.g. HIV and AIDS, TB, diarrhoea) that increase requirements for iron and other micronutrients.

From 0 to 6 months

Iron deficiency anaemia in children under 6 months of age is usually limited to low-birth-weight children and babies who are not breast-fed. Babies born at a normal weight have iron stores from their mothers and the iron in breast milk is very well absorbed.

Low-birth-weight infants have smaller iron stores than normal-birth-weight infants and may become iron deficient after 2 to 3 months of age. Babies who are not breast-fed exclusively may become anaemic for the following reasons: baby formula often does not provide sufficient iron, tea interferes with iron absorption and iron in animal milk is insufficient for humans and may cause gastrointestinal bleeding leading to iron loss. Babies fed on animal milk alone are likely to become anaemic by 4 months.

From 6 to 24 months

By 6 months of age, a baby is growing fast, iron needs are increasing, the store of iron from birth has been used up and the supply from breast milk is no longer enough. The child must now start to get iron from other foods. Many children become iron-deficient between 6 months and 2 years, so this is the key target age for prevention. Complementary foods often do not have enough iron (e.g. watery porridge) or have iron that is difficult to absorb (e.g. maize porridge). Infections common at this age interfere with absorption, storage and use of iron, and can also result in a reduction of food intake.

What are the consequences of childhood anaemia?

Children suffering from iron-deficiency anaemia during their first 2 years of life have poorer cognitive development than do non-anaemic children. Most consequences of anaemia are irreversible after the age of 2. Some of the adverse effects in infants are altered behaviour and cognition, such as increased fearfulness/wariness, irritability and unhappiness. Other effects include lower IQ scores, altered motor development, such as decreased exploration of environment, decreased willingness to leave a caregiver’s side, increased fatigue and stunting. These consequences decrease intellectual capacity and productivity later in life, leading to reduced schooling and overall economic losses for the individual and family, thereby continuing the cycle of poverty.
How can we prevent anaemia?
To effectively combat anaemia, contributing factors must be identified and addressed, and an integrated approach to prevention must be used. There are several effective interventions that will prevent anaemia, but interventions may vary by setting (e.g. malarial area vs. non-malarial area):

- ensure appropriate dietary iron intake for children under 2
- promote early initiation and exclusive breast-feeding to 6 months of age
- ensure LBW infants are given iron supplements from 2 months of age, as well as breast-feeding
- promote appropriate CF
- increase iron-rich foods (e.g. meat, liver, kidney, fish, dark green leafy vegetables)
- increase foods that boost iron absorption (e.g. citrus fruits, tomatoes, meats, fermented porridge)
- avoid foods that inhibit absorption (e.g. tea at meals)
- promote use of fortified foods or home fortification (e.g. Sprinkles).

These practises are all promoted as part of the 7-11 strategy, as further described in Section 4.

1.3.4 Protecting Children from Infectious Disease

What are the major causes of death among children?
Nearly 50 per cent of deaths among children under age 5 in the developing world are caused by four infectious diseases: pneumonia, diarrhoea, malaria and measles. Three out of four children seeking health care are suffering from one of these diseases and most have more than one infection concurrently. Malnutrition is an underlying factor for all of them and contributes to children’s increased risk of mortality in most of the cases. Most of our ADPs are situated in countries where these four major diseases are highly prevalent.

What are the causes of high prevalence of these diseases?
There are many reasons why these four diseases are a common and consistent threat. Substandard and overcrowded housing, poor water supply and poor hygiene promote rapid spread. This is further complicated by insufficient response from the mother/caregiver who may not even recognise that the child is critically ill. Limited access to health care (due to lack of staff, medicines and equipment, and inability to recognise and manage signs and symptoms) results in early deaths. Other social factors include harmful traditional practises, drug misuse, and inadequate feeding practises with particular reference to the use of breast milk substitutes; all of which heighten the risk of infection and can lead to death.

What can be done about the common infectious diseases?
In order to reduce maternal and child mortality, the main approach to infectious disease for the 7-11 Strategy, as described in section 1.2.3, relies on prevention, early detection and access to early management of infectious disease among pregnant women and children under 2. The following paragraphs review the most common infectious diseases affecting children under 2 and the recommended interventions to minimise the risk of these diseases.

Pneumonia
Pneumonia kills more children than AIDS, malaria and measles combined, causing 70 per cent of child deaths. Nevertheless, it has become the ‘forgotten killer,’ with the United Nation’s Children’s Fund (UNICEF) and WHO affirming that it is under-diagnosed and under-treated. Preventing and treating pneumonia is critical to the MDG four targets to reduce child deaths. Children’s lives lost to pneumonia can be saved through proper case management.

Approximately 2 million children under 5 die from pneumonia each year, accounting for nearly one in five child deaths globally. Pneumonia requires urgent treatment. Children can die very quickly from pneumonia because of their weak immune systems, or because of concurrent infections such as HIV, malaria, diarrhoea, measles or underlying malnutrition. Acute respiratory infections (ARIs) often manifest as coughs, colds and sore throats and are symptoms of pneumonia in many cases. ARIs should be closely watched to ensure that pneumonia does not develop. Many children die at home because caregivers do not recognise the danger signs and the need for immediate medical care.
**Diarrhoea**

Diarrhoea is the second largest killer of children under 5. It is caused by spread of germs or parasites through unsafe disposal of faeces, poor hygiene and unclean drinking water. Children are more likely to die from diarrhoea because they become quickly dehydrated through the loss of body fluids. If treated properly, 90 per cent of children with diarrhoea can be saved.

Clean water, proper hygiene and sanitation, along with exclusive breast-feeding to 6 months are the three most important preventive measures. In addition, as measles causes severe diarrhoea among children, immunising children against measles will prevent this cause of diarrhoea. Finally, wherever possible, rotavirus vaccine should also be promoted and given to children in a timely manner.

Deaths due to diarrhoea can be reduced by preventing and treating dehydration. Caregivers must understand that a child requires extra fluid along with continued breast-feeding or CF as soon as diarrhoea begins. The caregiver must recognise the signs of dehydration, including a quiet and undemanding child, sunken eyes, dry lips and loose skin, and must take action by seeking care at the nearest health centre for treatment. Caregivers must also recognise that bloody diarrhoea requires immediate medical attention.

**Malaria**

Where malaria is common, repeated exposure to infection leads to partial immunity in older children and adults, but young children are most vulnerable to malaria because they have relatively little immunity. Nearly 850,000 children under 5 die of malaria each year. Malaria is transmitted by the bite of the female *Anopheles* mosquito. Malaria continues to pose serious problems around the world, with an estimated 3.3 billion people at risk, 247 million cases and 1 million deaths annually – 85 per cent in children under 5. Fever, chills and back and joint pain are frequent symptoms. An estimated 25 per cent of children under 5 and non-immune adults will die if not treated.

Children may be affected by malaria in three ways: acute malarial illness, chronic malaria resulting in anaemia, or LBW due to maternal malaria during pregnancy. Frequent malarial infection can slow a child’s growth and cause poor brain development. HIV-positive children are at much higher risk of malaria and have more severe malarial illnesses compared to other children.

Fever among young children is often ignored or misdiagnosed. Rapid detection of malaria and prompt treatment are crucial for saving lives, but malaria diagnosis still frequently relies on symptoms and old methods of microscopy – limitations that affect the timely provision of medical care. While new rapid diagnostic testing (RDT) responds to the urgency and importance of proper diagnosis of malaria, these tests are not yet readily available in all countries. It is crucial for caregivers to seek care for fever in a young child. It is best to start treatment at home assisted by a CHW/V and to take the child to a health facility for proper assessment and treatment with an appropriate anti-malarial medication. It is also important that a child with or recovering from malaria be given plenty of fluids and continue to breast-feed.

Most importantly, simple interventions can help protect children from malaria. LLINs, if used properly, can reduce malaria deaths among children by 35 per cent. One of WV’s goals is for all individuals in malaria-endemic communities to sleep under an LLIN every night.

**Measles**

According to WHO estimates in 2000, measles accounted for approximately 777,000 deaths worldwide, with approximately 60 per cent in sub-Saharan Africa. Virtually all unimmunised children will get measles during childhood. Malnourished children with measles face severe complications. In 2001, WHO and UNICEF started a Measles Mortality Reduction Plan. One of the major strategies was to enhance routine measles coverage through immunisation campaigns and measles catch-up campaigns. Due to intensive efforts, measles has become rare in many parts of the world, but this disease still kills 2,000 children per day, often in association with pneumonia, diarrhoea and malnutrition.

**HIV and AIDS**

In 2007, global estimates showed 1,000 infants becoming infected with HIV each day, equivalent to about 370,000 new paediatric HIV cases per year. Infants from Africa accounted for 90 per cent (330,000) of these infections, mostly acquired from HIV-positive mothers during pregnancy, birth or breast-feeding. HIV-positive mothers carry the virus in their bodily fluids. About 90 per cent of infected children will die before age 5 if not treated. New WHO guidelines recommend early infant screening and virologic testing of all HIV-exposed infants by 6 weeks of age or the first antenatal visit so that they may immediately begin to receive treatment. Currently less than 15 per cent of children have this early diagnosis.

**Soil-transmitted helminths (STH) and schistosomiasis**

Approximately 300 million people, 50 per cent of them school-aged children, are ill because of worms. Although intestinal worms do not cause large numbers of deaths, they contribute significantly to poor health outcomes. There is growing evidence that STH affect growth and development of children under 24 months of age. Once infected, these children live with anaemia, vitamin A deficiency, stunting, malnutrition, poor cognitive functions and poor intellectual development.
Vaccine-preventable diseases
More than 10 million children below 18 years of age in low- and middle-income countries die every year due to vaccine-preventable childhood illnesses. Infant immunisation is considered essential for improving infant and child survival. The six vaccine-preventable diseases are measles, diphtheria, pertussis, tetanus, polio and TB. WHO launched the Expanded Programme on Immunisation (EPI) to prevent these six diseases and thereby reduce the mortality that they cause. Children who are not fully immunised by their first birthday are at high risk of contracting these infectious diseases.

The Global Alliance for Vaccines and Immunisation (GAVI) has set up specific milestones for EPI. The most important milestone is that, by 2010, 90 per cent of children under age one worldwide will receive routine immunisations. Non-immunised children are defined as children who have not received the third dose of DTP-3 by their first birthday.

Section 4 will further describe proven interventions for each disease.

Immunisations in the Philippines
Trained community members in the Philippines called Barangay (village) Health Workers (BHWs), supported by Barangay Health Committees (BHCs), have played positive roles in increasing universal immunisation coverage. For many years prior to any health intervention, smaller island provinces and their municipalities remained dangerously vulnerable to disease due to poor immunisation rates. Cases of measles and whooping cough were frequently reported. Most often, children were not immunised because their families were too busy or did not have the means to attend a clinic or participate during immunisation outreach. With the help of a USAID-funded child survival project, BHWs and BHCs have been trained to step up immunisations. Each month they are supported by municipal health providers to identify families who have defaulted on their children’s immunisations. A few days prior to their next scheduled immunisation, the BHC sends a reminder letter to the defaulting family, and a tricycle is made available to the BHWs to fetch the child for vaccination. The efforts have proved to be incredibly effective, increasing the uptake of immunisations to almost 100 per cent each year, with no reported disease outbreak.

SEE TOOL REDUCING CHILDHOOD ANAEMIA (NCOE) (under development) Field-friendly set of tools (i.e. facilitator’s manual, participant’s workbook and visuals) aimed at training front-line community workers to address prioritised nutrition issues for achieving CWBOs in the 7-11 strategy

SEE TOOL REDUCING STUNTING IN CHILDREN UNDER TWO (NCOE) (under development) Field-friendly set of tools (i.e. facilitator’s manual, participant’s workbook and visuals) aimed at training front-line community workers to address prioritised nutrition issues for achieving CWBOs in the 7-11 strategy
SECTION 2: PROGRAMMING PRINCIPLES

Introduction

When developing the health and nutrition 7-11 strategy, we considered the following questions:

• What is our role in community health and nutrition?
• What will we do with regard to H/N programming?
• Should programmes be tightly focused on a limited number of messages and interventions, or more inclusive of the broad range of interventions that exist?
• What is the relationship between the 7-11 strategy and national MOH programmes?

In response to these questions, we sought to remain true to the following two guidelines:

• The strategy should be aligned with our Model of Ministry and principle-level choices and should reflect our priorities and strengths.
• The strategy should be aligned with evidence-based best practice to achieve the greatest impact.

This section reviews the programming principles resulting from decisions around each key question.

2.1 Programming Principle #1: Empowerment vs. Service Delivery

We view health through a development lens, focusing on health promotion and prevention, bearing in mind that prevention programmes are never 100 per cent effective in reducing illnesses and deaths among vulnerable groups. The existence of quality health services will always be necessary.

Empowerment vs. Service Delivery is one of our Model of Ministry principle-level choices. Through capacity building and an enabling environment, we seek to empower individuals and groups to make informed decisions and practise positive H/N behaviours. We do not, however, provide the health services.

We recognise, however, that quality health services are essential to improve maternal and child health outcomes. Emphasizing empowerment does not deny the critical importance of health services. Rather, it recognises that government health systems and health service specialised partner organisations are better equipped to meet this need. We help to create demand among households for these services, assisting community members to advocate for them, facilitating access to these services as needed.

Our role in promoting good health and nutrition includes:

• empowering families to keep themselves healthy and, as needed, to seek health care through the interactive activities of timeded and targeted counselling (tTC)
• building the capacity of CHW/s/Ns and community groups to co-design, deliver, monitor and assess their own progress in the implementation of 7-11 interventions and to advocate for quality health services, including outreach, where non-existent
• strengthening household/community-facility referrals and linkages to underscore the continuum of care that spans promotion, prevention and treatment
• partnering at various levels with existing groups, organisations, institutions and ministries of health to ensure delivery of quality health services, avoid duplication, enhance synergy and reach more children effectively and sustainably.

2.2 Programming Principle #2: Prevention and Improved Access to Health Care

This programmatic principle is linked to the previous one. Because we do not provide health services, our focus is on prevention. Because we know prevention programmes are not completely effective to eliminate all illness, however, we work to ensure access to health care, as appropriate, as a key element in our programming.
Prevention is Justified

As discussed, approximately nine million children under the age of 5 die each year due to mainly preventable causes. Almost two-thirds of these deaths can be averted with simple, proven interventions at the community level, together with strong referral systems. In 2006, interventions including ORT, long-lasting insecticidal mosquito nets and vaccinations were linked to a reduction in annual deaths among children under 5 for the first time since mortality data have been gathered.87

Until now, our health programmes in ADPs have generally focused more on facilitating treatment through local schools, building or renovating local health facilities and providing medical check-ups for children than on the proven preventive interventions that could save many lives. The 7-11 strategy shifts the emphasis to a more intensive focus on malnutrition and disease prevention, which will contribute to significantly fewer children dying and to the improvement of overall health outcomes.

A preventive approach carries the following advantages:
1. Preventing disease has a greater impact on health outcomes than treatment. Sick children are more vulnerable to other diseases. For example, a malnourished child suffering from measles or living with HIV is more likely to develop pneumonia.
2. Prevention is more cost-effective than treatment. Most preventive measures are low cost but high impact. For instance, initiating breast-feeding within the first hour of birth can improve the chances of newborn survival by 22 per cent,88 but it costs nothing.
3. Prevention has long-term positive outcomes on overall well-being. A healthy child who is not fighting illness has a better opportunity to fulfil his/her full potential. Reducing malnutrition, preventing infectious disease among young children and averting maternal deaths due to pregnancy and childbirth are examples of early investments that produce long-term results.

Access to Treatment

A renewed emphasis on prevention does not negate the importance of access to quality health care when needed. We aim to integrate prevention and access to treatment across a prevention-to-care continuum in order to ensure improved H/N outcomes for mothers and children.

Most community health needs are meant to be addressed in a primary-care setting. Investments in PHC systems significantly improve access to health care. In order to increase access and promote the prevention-to-care continuum, programmes need to link with primary health centres and promote these as the first place to go when facing health problems. Increasing access will also involve addressing the obstacles individuals face in seeking care.

Potential ways to improve access to care include
- working with CHW/Vs to foster connections between community facilities and the community itself
- assisting community groups to set up community health emergency transport mechanisms
- building the capacity of communities to carry out advocacy activities.

2.3 Programming Principle #3: Intervention Bundling

Intervention Bundling is a programme design that includes multiple interventions that, taken together, will benefit the health and nutrition of mother and child more efficiently than each would do separately. Programmes should be as comprehensive as possible to achieve the best results.

Much evidence exists to show that high-impact, low-cost interventions can significantly reduce deaths among mothers and children 0–59 months, particularly among newborns.89 The bundling of high-impact interventions within a continuum of care – from adoption of healthy home practises (prevention) to provision of services (treatment) – dramatically lowers maternal, newborn and child malnutrition, illnesses and deaths. It is important to understand that in most cases, illness and death among these target groups are not due to a single cause but to multiple causes acting together. A single intervention may affect more than one cause of death, and deaths attributable to one specific cause may be prevented by multiple interventions. Additionally, interventions affecting mothers have long-term effects on newborns/children's health and nutrition. A failure to bundle interventions across the continuum of care risks neglecting one or more essential actions that could save lives. A package of essential newborn care can reduce most common causes of death among this group by about 50 per cent, while single interventions cannot.
2.4 Programming Principle #4: Partnering with the Ministry of Health

H/N programming should always be carried out in partnership with ministries of health (MOH). While each country may form partnerships differently, certain partnership principles should be followed in all cases. We should develop close relationships with all levels of MOH officials to establish effective dialogue and decision-making in the development and implementation of partnership.

**Partnership Principles**

- **Work within MOH policy frameworks:** High-level dialogue with MOH officials is necessary to ensure that no programmatic decisions contradict Ministry policy. (For example, while we advocate for zinc micronutrient supplementation, many MOH policies do not yet allow for this.)

- **Avoid duplication:** Our H/N programming should not duplicate MOH programming. This is particularly important regarding the 7-11 household-level ttC approach. National offices (NOs) should dialogue with MOH officials to learn about the types of household outreach programmes carried out by the ministry, if any, as well as the materials used for such programmes. Further discussion around this point is provided in Part 3, Section 4.3.3.

- **Build MOH capacity:** Where feasible, we should be involved in building the capacity of MOH staff, both to enable the institutionalisation of certain elements of 7-11 programming (i.e. ttC), and to strengthen the broader health system.

**Partnering for Strategic Decision-making: ‘What are our optimal contributions to national H/N programming?’**

A good relationship with the MOH at all levels will enable NOs to make more informed decisions around 7-11 programme design. High-level discussions with MOH officials will provide information about

- **MOH programmes and gaps:** What is the nature of MOH community outreach programmes, household services, prevention-related efforts, CHW recruitment and training, etc. In which areas can we help to address those gaps? How does this affect the selection/adaptation 7-11 approaches?

- **Health service gaps:** How can we help to address gaps or weaknesses in health services? How does this affect the selection of interventions within a health systems-strengthening approach?

- **Advocacy issues:** What types of policy or political shortcomings do MOH officials identify as critical to the success of their work? What advocacy issues, if any, would MOH wish to see us engaged in?

**Operational Partnership: ‘What can we do together with MOH?’**

When feasible and approved by Ministries of Health, NOs should seek to build the capacity of MOH staff to carry out 7-11 approaches, instead of carrying them out on our own. This is especially the case for ttC. Ideally MOH staff would train and supervise their CHWs who implement counselling with households. Part 3, Section 2.5 fully describes this type of partnership.

National offices should also explore building the capacity of MOH staff to implement one or more of the optional additional 7-11 approaches, as feasible. Finally, we should work together with MOH to develop and advance health-related advocacy agendas.
SECTION 3: CONCEPTUAL BACKGROUND: BEHAVIOUR CHANGE FOR HEALTH AND NUTRITION

Introduction: Individual and Contextual-Level Interventions

Our 7-11 strategy is based on a behaviour change communication (BCC) approach, recognising that the practise of key H/N behaviours at the individual level, many of which were reviewed in Section One, is fundamental to improving maternal and child outcomes. While practised by individuals, BCC theory illustrates the intricate link between individual behaviour and the surrounding community and environmental (cultural, policy and service) contexts. An individual’s ability to sustain positive behaviours is greatly influenced by the support of his/her surrounding context. Individual-level interventions alone are not sufficient to support sustained positive change. Rather, interventions must also focus at the contextual level to help ensure a context supports, rather than inhibits, individual positive behaviour.

Our 7-11 strategy recognises, therefore, that interventions are needed at three levels: the individual, the community and the environment. Intervening for positive change within these concentric contextual circles provides 360 degrees of support to household members, enabling them to practise and sustain essential H/N-related behaviours. (See Figure 5.)

The BCC approach described in Part 3, Section 4.3.3 focuses messages primarily on the main caregivers of the child. Caregivers are provided with information, counselling and support to enable them to practise critical H/N-related behaviours, from exclusive breastfeeding to hand washing with soap to care-seeking for illness. While this type of teaching and counselling is a necessary intervention, information alone is not enough to ensure that an individual will practise and sustain a new behaviour.

One well-documented behaviour change framework, popularised by Family Health International, holds that an individual must move through a series of changes on the way to practising sustained behaviours: from unaware, to aware, to concerned, to knowledgeable, to motivated to change, to practising trial behaviour change, to practising sustained behaviour change. See Figure 4 below.
Whether the individual can proceed through these stages depends on the relative force of the existing barriers and enablers/motivators. A good BCC programme will work to maximise existing enabling factors. At the same time, there are barriers that will make it more difficult for an individual to practise and sustain the positive change. For example, a mother may wish to exclusively breast-feed her child based on the ttC recommendations, but she may be very much influenced by her own mother, grandmother and mother-in-law, who all believe that the child requires additional water. These types of contextual barriers will make it much more difficult for the individual to persevere in practising a new behaviour. Lack of information is only one of a number of potential barriers to change. A good BCC programme will assess the common contextual barriers and work to reduce these.

**Community Level**

At the social level, a mother's behaviour is normally very much influenced by her husband, family and friends. The support of these and other community members is a motivating factor to proceed through the stages of behaviour change. Positive behaviours are difficult to sustain, however, if this community reinforcement and support do not exist. Section 2.4, which discusses coverage and working at scale, emphasises the importance of achieving a ‘critical mass’ of people practising healthy behaviours to create the favourable community context needed to support others who are trying to change. Part 3 Section 4.2 describes the community structures that 7-11 programmes will work through to mobilise and build community capacity to address potential contextual barriers and to provide the supportive community context that households require to maintain their behavioural changes.

**Environmental Level**

At the enabling environment level, cultural and gender norms create either barriers or motivating factors for positive behaviours. In cases where the prevailing cultural and gender norms create barriers to positive behaviours, interventions and methodologies aimed at transformation of these norms are needed.

Behaviour is also influenced by the availability of enabling services in the community and the economic factors that enable or constrain an individual’s access to these services. It is naïve to assume that lack of knowledge (e.g. information at the individual level) is always the reason that a recommended action is not taken. A family may know that malaria can kill, for example, and that putting the child under an LLIN is the best way to prevent malaria-carrying mosquitoes from biting the child. However, the family may not be able to do this because there are no providers of nets in the area or because the family cannot afford to buy one. A mother may understand the importance of prevention of mother-to-child transmission (PMTCT) of HIV, vitamin A supplementation and de-worming, but if these services are unavailable in her area, or if she lacks money to reach a service site, she will be unable to practise the recommended behaviours.

At the environmental level, the policy context should seek to ensure the provision of quality health services in communities. Failures here are sometimes caused by the absence of policies to ensure adequate levels of care for all children. In other cases robust policies may be in place but may not be implemented to the standards indicated in many areas. Health personnel shortages, budget shortfalls, personnel misconduct and other such examples may result, thereby constraining the ability of household members to access the quality services they require.

**3.1 Summary: 360 Degrees of Support: Intervening at Multiple Levels**

An effective H/N strategy for improved maternal and child outcomes must both consider the individual household member’s knowledge and skills and work to strengthen the daily support the individual receives from those closest to them in the community to help them practise and maintain new behaviours. Household members and the community must also receive consistent and reinforcing support through appropriate services and policies as well as and favourable beliefs and norms, within the wider enabling environment. See Figure 5 below.
FIG. 5  ‘360 Degrees’ of Support

- Social and Gender Norms
- Traditional Leaders
- Environment, Natural Forces
- Economy
- Policy
- Health Services

- Mother and Child
- Family

- Individual
- Community
- Environment
Strengthening these concentric circles provides 360 degrees of support for household members, reducing common barriers and enhancing the motivators that help an individual to move through the stages of change and practise and sustain H/N key behaviours.

The main 7-11 approaches for responding at all three levels are summarised on the following page, and described in detail in Part 3, Section 4.

### 3.2 Overview of 7-11 Strategy: Responding at Three Levels

**7-11 Core Approach at Individual Level**

At the individual level, the 7-11 strategy targets household members, with primary emphasis on the main caregivers, including husbands, grandmothers, mothers-in-law, etc. The main approach at this level is **timed and targeted counselling** carried out by CHW/Vs, described in detail in Part 3, Section 4.3. The ttC approach aims to introduce household members to the key H/N messages at appropriate intervals during pregnancy and early childhood, discussing their experiences with these practises and agreeing on ‘trials’ of improved practises over time.

**7-11 Core Approach at Community Level**

At the community level, we aim to achieve Civil Society Strengthening around health and nutrition by building the capacity of Community Committees – groups we mobilise, such as CCCs or other existing equivalent community groups. We works with the COMMs to assess the community context, identify potential barriers to positive H/N practises (socio-cultural, service provision, policy) and take appropriate action to respond. The COMM structure and this specific civil-society-strengthening approach, are described in Part 3, Section 4.2.

**7-11 Core Approaches at Environmental Level**

At the environmental level, we target the structures that support or constrain the practise of positive behaviours, namely the key services, the policy environment, and cultural and gender norms needed for households to implement the practises recommended through ttC. Our community-based advocacy approach works with COMMs and other community members to identify and address service and policy gaps. If gaps are identified in the health system, programmes also may choose to work through partners or with consultants to implement health systems strengthening (HSS) interventions. The community-based advocacy approach is described in Part 3, Section 4.4.1, and potential HSS interventions in Part 3, Section 4.4.2.

**Additional Approaches**

Based on project assessment described in Part 3, Section One, projects may choose to implement any number of additional approaches and interventions to respond appropriately to identified local and contextual issues. Some possibilities include, for example, the well-known Positive Deviance (PD)-Hearth model aimed at the rehabilitation of moderately malnourished children, intensive community surveillance and treatment adherence around malaria or TB (the malaria CSS and directly observed treatment, short-course for tuberculosis [TB-DOTS] approaches), micronutrient fortification initiatives, Grandmother Projects (GMPs) to gain the support of these ‘influencers’ of behaviour, and more. Summary descriptions of these and other possible additional models are found in Appendix G.

### 3.3 Overview of 7-11 Strategy: Intervening Across a Continuum of Care

Besides the BCC framework, another component of the 7-11 Strategy is that it promotes a **continuum of care**, from the household through CHW/Vs and the community-based mechanism of the COMM to formal health clinics. See Figure 6 below.
Promoting an effective continuum of care ensures not only that prevention begins in the household but also that households are linked—through health workers, volunteers and community committees—to health care and treatment services required when preventive efforts are not enough. A full continuum of care moves in both directions—from the household through the community to the formal health sector, and back again, through the community to the household—ensuring that individual household members receive post-treatment follow up as needed. The 7-11 strategy works to build and strengthen these links so the continuum of care is solid, with little or no breakdown.

3.4 The Life-Cycle Approach: Intervening at Appropriate Times

In addition to intervening at multiple levels, the 7-11 strategy draws on a life-cycle approach to understand the vulnerabilities and opportunities to invest in health and development at different times throughout the life course. As shown in the two diagrams in Appendix B, critical points exist in the course of an individual’s development, having the potential to produce severe, often irreversible outcomes for these individuals and their offspring. The life-cycle approach highlights these critical points and the corresponding windows of opportunity for 7-11 interventions. The approach reflects the generational span of health outcomes at each stage of life. Poor health and nutrition in adolescence and pregnancy can be seen to negatively impact the health of infants, creating a vicious cycle of poor health. Understood in this way, it is seen that protecting mothers and unborn babies during pregnancy has a long-term benefit. In the same way, early childhood gains in H/N status extend to subsequent stages of life, leading to healthier life-long outcomes.

Core and Expanded Life-Cycle Programming

The 7-11 strategy targets mothers and children under 2 because they are at critical points in the life cycle. Full adherence to a life-cycle approach, however, requires comprehensive and expanded programming (described in Section 6) to enable interventions at additional critical periods beyond the maternal and under-2 stages. Health interventions must be oriented toward the specific vulnerabilities and intervention opportunities throughout the entire life cycle.
SECTION 4: THE 7-11 STRATEGY: KEY INTERVENTIONS

As outlined in the problem statement in Part 2, Section 1, the 7-11 strategy aims to achieve improved H/N outcomes for mothers and children under 2, including working to improve maternal survival in childbirth, ensure a healthy start for newborns, reduce stunting in children and anaemia in mothers and children and protect mothers and children from infectious disease.

As discussed, approximately nine million children under the age of 5 die each year due to mainly preventable causes. Drawing from the global evidence base, we work with communities to raise awareness of and increase the knowledge and demand for the supply of services around 7 key interventions focused on the mother and 11 key interventions focused on children under 2. Taken together, these proven interventions will contribute significantly to reduced morbidity and mortality in the communities where we work. The 7 interventions for the mother and 11 interventions for children are detailed on the pages to follow.

4.1 Mother: 7 Interventions

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>The 7 Interventions for the Mother</th>
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<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td><strong>Definitions</strong></td>
</tr>
<tr>
<td>1. Adequate diet</td>
<td>• Increased amount, quality and frequency of food during pregnancy and lactation</td>
</tr>
<tr>
<td>2. Iron/folate supplements</td>
<td>• Access to iron/folate is facilitated during pregnancy</td>
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<tr>
<td></td>
<td>• Pregnant woman takes one tablet of 60 mg of iron and 400 mg folic acid daily for a minimum of 6 months during pregnancy, staring as early as possible in the pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Promote locally available iron/folate-rich foods, such as animal-sourced foods, and vitamin A- and C-rich foods</td>
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<tr>
<td></td>
<td>• Responsible health service staff actively manage stocks of iron/folate supplements to meet the needs of pregnant women in the community</td>
</tr>
<tr>
<td>3. Tetanus toxoid (TT) immunisation</td>
<td>• Two doses of TT during pregnancy as per national guidelines</td>
</tr>
<tr>
<td>4. Malaria prevention, treatment access and intermittent preventive treatment</td>
<td>• Intensified focus on LLIN usage</td>
</tr>
<tr>
<td></td>
<td>• LLIN distribution and proper hanging</td>
</tr>
<tr>
<td></td>
<td>• Intermittent preventive treatment during pregnancy according to national guidelines</td>
</tr>
<tr>
<td></td>
<td>• CT/artemisinin-combination therapy (ACT) access for mothers with malaria</td>
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</table>
5. Birth preparedness and healthy timing and spacing of delivery

- Birthing and emergency plans in place
- Understanding and recognition of complications surrounding pregnancy, delivery and immediately after delivery
- Use of proven methods to limit or space subsequent pregnancies based on informed decisions limiting pregnancy to the healthiest years: 18 to 35 years old

- Pregnant woman attends at least four ANC visits
- Household prepares for birth with clean supplies at home for mother and infant, transportation pre-arranged
- Pregnant woman considers giving birth at a health facility, especially when complications are identified
- Husband/family have access to financial resources
- Pregnant woman chooses to get tested for HIV
- Couple learns about the health, risks and benefits of using a family planning (FP) method
- Couple who desires next pregnancy after a live birth waits 24 months (preferably 36), but no more than 53 months

6. De-worming

- Availability and use of de-worming tablets (based on national policy)
- Provide regular de-worming tablets to the whole family, specifically pregnant women, according to national guidelines

- Pregnant woman seeks and takes de-worming tablets according to national guidelines
- Pregnant woman wears shoes
- Mother is free of worm infestations during her pregnancy

7. Access to maternal health services: antenatal care (ANC), postnatal care (PNC), SBAs, prevention of maternal-to-child transmission (PMTCT), HIV/tuberculosis (TB)/sexually transmitted infection (STI) Screening

- Registration and delivery at facility
- Primary HIV prevention education among men and women, testing, and condom usage
- Symptomatic mothers screened for TB, SM+ register for DOTS
- Pre & post test counselling for HIV+ mothers and husbands/partners, with attention to discordant couples
- Mother and infant receive Nevirapine (NVP)
- Post partum counselling to include infant feeding (exclusive breastfeeding [EBF] for six months) with continuation of ART

- Mother attends at least four ANC visits, with husband/partner as much as possible
- Mother chooses to get HIV testing and deliver at facility
- HIV+ mother delivers at health facility and has newborn infant tested for HIV at 4–6 weeks, commences cotrimoxazole prophylaxis and chooses most appropriate regimen for newborn infant (NVP+AZT+3TC, NVP+AZT, or AZT) based on mother’s treatment regime
- Mother provides EBF for six months (following national guidelines)
- Mother gets timely diagnosis of TB, registers with DOTS and follows treatment completion of drug regime

### TABLE 3

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Definitions</th>
<th>Target Behaviours/Results</th>
</tr>
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</table>
| 5. Birth preparedness and healthy timing and spacing of delivery | - Birthing and emergency plans in place  
- Understanding and recognition of complications surrounding pregnancy, delivery and immediately after delivery  
- Use of proven methods to limit or space subsequent pregnancies based on informed decisions limiting pregnancy to the healthiest years: 18 to 35 years old | - Pregnant woman attends at least four ANC visits  
- Household prepares for birth with clean supplies at home for mother and infant, transportation pre-arranged  
- Pregnant woman considers giving birth at a health facility, especially when complications are identified  
- Husband/family have access to financial resources  
- Pregnant woman chooses to get tested for HIV  
- Couple learns about the health, risks and benefits of using a family planning (FP) method  
- Couple who desires next pregnancy after a live birth waits 24 months (preferably 36), but no more than 53 months |
| 6. De-worming | - Availability and use of de-worming tablets (based on national policy)  
- Provide regular de-worming tablets to the whole family, specifically pregnant women, according to national guidelines | - Pregnant woman seeks and takes de-worming tablets according to national guidelines  
- Pregnant woman wears shoes  
- Mother is free of worm infestations during her pregnancy |
| 7. Access to maternal health services: antenatal care (ANC), postnatal care (PNC), SBAs, prevention of maternal-to-child transmission (PMTCT), HIV/tuberculosis (TB)/sexually transmitted infection (STI) Screening | - Registration and delivery at facility  
- Primary HIV prevention education among men and women, testing, and condom usage  
- Symptomatic mothers screened for TB, SM+ register for DOTS  
- Pre & post test counselling for HIV+ mothers and husbands/partners, with attention to discordant couples  
- Mother and infant receive Nevirapine (NVP)  
- Post partum counselling to include infant feeding (exclusive breastfeeding [EBF] for six months) with continuation of ART | - Mother attends at least four ANC visits, with husband/partner as much as possible  
- Mother chooses to get HIV testing and deliver at facility  
- HIV+ mother delivers at health facility and has newborn infant tested for HIV at 4–6 weeks, commences cotrimoxazole prophylaxis and chooses most appropriate regimen for newborn infant (NVP+AZT+3TC, NVP+AZT, or AZT) based on mother’s treatment regime  
- Mother provides EBF for six months (following national guidelines)  
- Mother gets timely diagnosis of TB, registers with DOTS and follows treatment completion of drug regime |
Mother Intervention 1: Adequate Diet
During pregnancy, there are significant demands on the mother's body to provide for the development needs of the growing baby. In order to meet these needs, a pregnant woman must consume more nutritious food. It is recommended that a pregnant woman add an extra meal to her normal routine and consume a nutritious snack every day. These practices should continue after birth, while the mother is exclusively breast-feeding. In addition, the mother should use iodised salt. Women who are deficient in iodine during pregnancy may have miscarriages or stillbirths, LBW babies or babies with congenital deformities. The best way to get enough iodine is normally through using iodised salt. 7-11 programming promotes appropriate messages about the mother’s need for an adequate diet, based on locally available foods.

Mother Intervention 2: Iron/Folate Supplementation
Iron deficiency is the most common micronutrient deficiency and it predominantly affects women. Women who have iron-deficiency anaemia are more likely to have poor birth outcomes. The best way to prevent iron-deficiency anaemia is to ensure that all women are iron replete, through adequate diets, throughout their reproductive years. Where this is not happening, pregnant women should be targeted first for iron deficiency because this deficiency severely affects infants. Folate helps to produce and maintain new cells in the body and is also important in preventing anaemia. It is recommended that all pregnant women take daily iron/folate supplements as soon as they find out they are pregnant to protect against the effects of iron-deficiency anaemia. Supplementation should continue for at least six months, though it is best to continue supplementation throughout the pregnancy. This additional iron should be complemented with increased iron intake through iron-rich, or fortified, foods. The best iron-rich foods are animal-source foods, but iron can also be found in dark green leafy vegetables. 7-11 programming ensures that pregnant women are aware of the importance of iron/folate supplementation and iron-rich foods. It will also encourage these women to seek appropriate ANC where these services are provided.

Mother Intervention 3: Tetanus Toxoid Immunisation
Maternal and neonatal tetanus is easily preventable through the immunisation of women of child-bearing age and pregnant women. WHO recommends giving two properly spaced doses of TT in selected high-risk areas. Many countries routinely immunise pregnant women during ANC visits. For those women who were not vaccinated against tetanus earlier in life, or whose immunisation status is unknown, a total of five doses is recommended: two doses one month apart during the first pregnancy, and one in each subsequent pregnancy, or at relevant intervals, to a total of five doses. 7-11 programming will provide education and information for TT immunisation during pregnancy, encouraging pregnant women to seek appropriate ANC where immunisation services are provided.

Mother Intervention 4: Malaria Prevention and IPTp
Malaria in pregnancy has adverse effects both on the mother and on the unborn child. An integrated approach is needed for malaria prevention and prompt case management of pregnant women with fever and malarial illness. Antenatal clinics can easily provide preventive measures, prophylaxis, treatment and counselling and these should be integrated with maternal and child health interventions. Additionally, widespread distribution and use of LLINs is a cost-effective and highly successful intervention that reduces malaria and save lives. 7-11 programming will seek to achieve universal coverage of LLINs, including information regarding installation, care and use. Programming also promotes appropriate intermittent preventive treatment through ANC visits (at least two doses in sub-Saharan Africa), and increases awareness as to the importance of prompt care-seeking for fever during pregnancy in malarial areas. It also promotes appropriate treatments with artemisinin-based combination therapy (ACT) in the second and third trimesters, following national guidelines. Additional programming might include facilitating the ‘malaria competency approach’ (or community systems strengthening [CSS]) to promote community ownership of the response to malaria.
Mother Intervention 5: Birth Preparedness and Healthy Timing and Spacing of Pregnancy

Birth preparedness: Since it is impossible to predict who will have an obstetric emergency, it is important that pregnant women and their families are prepared for the various scenarios that might arise at the time of delivery. As part of a birth plan, families should decide where to give birth (preferably at the health facility), identify transport to the health facility, organise the supplies they will need for the delivery and decide what they will do in an emergency. It is safest for all women to deliver with an SBA in a health facility. This message is always reinforced as part of the 7-11 strategy. In cases where a family cannot or chooses not to deliver in a facility, it is even more important that they are prepared for a safe home birth and have contingency plans and resources in the event of an emergency. A good birth plan will reduce confusion at the time of delivery.

HTSP: Healthy timing and spacing of pregnancy helps women and families make informed decisions about pregnancy-related healthy practices, including delaying first pregnancy and spacing or limiting subsequent pregnancies. Recent data show a compelling relationship between a child’s well-being and the length of time between the child’s birth and the birth of the next sibling. Infant and child death rates can be lowered by more than half if children are born 3–5 years apart, and spacing of pregnancy is an effective strategy for reducing maternal deaths.

Figure 7 shows the important effect of birth spacing in reducing stunting and wasting among children. Research shows that children born less than 18 months apart (a birth-to-pregnancy interval of less than nine months) were 1.5 times more likely to be stunted or wasted than those born three years apart.91 The longer the birth-to-pregnancy interval, the healthier the child (and the mother) will be. With HTSE, infants are at lower risk of being delivered stillborn, preterm or with a LBW and are at decreased risk of dying. All women are less likely to suffer from anaemia, eclampsia, miscarriage, induced abortion and death due to pregnancy and childbirth complications if they space births in this way.

As part of the 7-11 strategy, women and their families are informed about the health risks and benefits, including the social benefits, of healthy timing and spacing of pregnancies, and are provided with information regarding the birth spacing methods available to them.
Mother Intervention 6: De-worming

7-11 programming includes education about intestinal worms, the connections between worm infestations and maternal anaemia, and the importance of de-worming. Pregnant women are encouraged to seek appropriate ANC where de-worming tablets will be administered according to national policy and guidelines. WHO and UNICEF recommend that albendazole or mebendazole be given to pregnant women after the first trimester of pregnancy.

Mother Intervention 7: Access to Maternal Health Services, ANC, PNC, Skilled Birth Attendance, and PMTCT and TB/HIV/STI Screening

Focused antenatal care

During the late 1970s, the risk assessment approach to ANC did not produce a reduction in pregnancy and childbirth-related death, since it could not predict who would have an obstetric emergency. Current best practice, known as focused antenatal care (fANC), links ANC with causes of maternal deaths. Goal-oriented, fANC uses screening to detect a problem rather than screening to predict a problem, and it treats any problem that can complicate pregnancy. It is recommended that all mothers attend four focused antenatal visits attended by a skilled provider in order to ensure that they

- detect and manage any conditions and complications, such as STIs, TB, malaria, HIV or anaemia
- receive counselling around healthy timing and spacing of pregnancies, breast-feeding, maternal nutrition, pregnancy danger signs, birth preparedness and complication readiness
- receive services such as PMTCT, TT immunisations, IPTp, de-worming treatment, iron/folate and other micronutrients as needed.

Skilled birth attendance

Given that every pregnancy is at risk and it is impossible to predict who will have life-threatening complications, every pregnant mother should be encouraged to deliver in a health facility by an SBA. Knowing that most maternal deaths are caused largely by pregnancy/delivery-related complications that require effective health systems and skilled care, the 7-11 strategy includes facilitation of access to skilled birth attendance. Skilled birth attendance is delivery attended by an SBA and includes supporting resources such as supplies, drugs, equipment, etc. An SBA is defined as a person with midwifery skills (e.g. doctor, midwife and nurse) who has been proficiently trained in the internationally accepted standard competencies necessary to manage normal (uncomplicated) pregnancies, deliveries and the immediate post-natal period. He/she must also have the requisite knowledge to diagnose and manage or refer complications.

In a vast majority of cases, complications occur because labour and delivery happen at home or on the way to a health facility, without the presence of an SBA. Instead, traditional birth attendants (TBAs), or community-based care providers during pregnancy and childbirth, are often available. TBAs usually learn through apprenticeship and are not proficiently trained in the skills necessary to manage or refer obstetric complications. When a pregnant woman decides to deliver at home, the woman and her family, along with a TBA where available, should be trained on the “6” cleans (including a clean birth kit) and how to recognise danger signs and complications. They should be equipped with home-based life saving skills (HBLSS) and encouraged to promptly seek care and prepare emergency funds. TBAs can help in the following ways

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11 A midwife, nurse or doctor to detect and manage any co-existing condition or complication, counselling and preventive services.
• identify and encourage pregnant women to seek FANC
• support and encourage women to adopt maternal health practises, e.g. receipt of HIV testing and PMTCT services, ART adherence, TT, intake of iron/folate supplements, use LLINs, have adequate nutrition and rest, etc.
• prepare a birth plan
• promote the use of SBAs for pregnancy, birth and post-natal period; where feasible, assist SBAs during ANC, delivery and PNC of both mother and baby
• promote exclusive breast-feeding and family planning.

Post-natal care
The most critical time for both mother and baby is the postpartum period, especially the first 24 hours and the following 7 days. This period is when the majority of deaths occur. During this time the leading cause of postpartum deaths among mothers, heavy vaginal bleeding, can be detected. This is also the time when most mothers lack effective care. Although a consensus regarding a standard package of PNC has not yet been reached, two key practises will significantly reduce maternal deaths: 1) closely monitor every woman for haemorrhage every 15 minutes after delivery for the first two to three hours and regularly thereafter during the first 24 hours; 2) as infection is the second most common complication after childbirth, monitor the mother’s temperature for fever and chills to rule out infections. In cases where the mother delivers at home, families and birth attendants should know the above signs and symptoms and should know where to seek care should they arise.

PMTCT
To reduce the possibility of HIV transmission from mother to child, an HIV-positive pregnant woman must receive additional antenatal services. These include treatment with ARVs starting at 14 weeks of pregnancy to reduce her viral load and increase her ‘fighter’ cells; administration of drugs against opportunistic infections such as TB; and nutrition counselling and support with particular regard to safe infant feeding practises. The HIV-exposed baby should be started on ARVs and cotrimoxazole prophylaxis until HIV infection is excluded. The baby should be tested for HIV at 4 to 6 weeks to enable prompt appropriate treatment if indicated. New evidence also shows that exclusive breast-feeding for six months, accompanied by continued ART for mother and child is effective in reducing HIV transmission while giving the benefits of breastmilk. Countries with generalised HIV epidemics must implement the PMTCT actions. Without access to these services, mothers living with HIV will pass the virus to their babies in 30–45 per cent of cases. More than half of these infants will die before their second birthday, and up to 60 per cent will die by the age of 3. Comprehensive PMTCT using the new guidelines can actually reduce vertical transmission to 5 or even 1 per cent, virtually eliminating this threat to children. 7-11 programming includes counselling to households around the specific PMTCT-related messages appropriate to their contexts, training for community health workers, primary care providers and TBAs to improve quality and access to services, and will recommend and help facilitate access to health services and will promote community-led advocacy for the provision of these important services in communities where they are unavailable.

HIV/STI screening
Routine screening for HIV together with other STIs both during pregnancy and as part of a broader maternal, newborn and child health programme is needed on an opt-out basis, especially since new STI cases – particularly HIV and syphilis – occur predominantly among the younger age group (15 to 24 years). HIV and syphilis are also the two STIs that most commonly affect newborns. Early screening for HIV should be done to ensure that HIV+ women can start a regime of prophylaxis by 14 weeks of pregnancy. Since an uninfected woman could sero-convert during pregnancy or breast-feeding, and since risk of vertical transmission is greater immediately following sero-conversion, women should consider re-testing close to delivery or during the post-partum period. If screening for syphilis is effectively done and prompt treatment is administered to the infected pregnant women, an estimated 492,000 stillbirths could be prevented. Unlike HIV, syphilis is curable with effective, inexpensive drugs. 7-11 programming makes all of this information known to households and will refer pregnant women to the health facilities where they can access the services needed.

Tuberculosis
7-11 programming includes awareness-raising around TB, with recommendations for early diagnosis and initiation of treatment. Some 7-11 programmes may choose to engage in community-based directly observed treatment short-course (DOTS) implementation; a rigorous approach normally needed to bring TB levels under some control.
### 4.2 Child: 11 Interventions

#### TABLE 4 | The 11 Interventions for the Child

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<tr>
<th>Intervention</th>
<th>Definitions</th>
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| 1. Appropriate breast-feeding (BF) | - Initiate breast-feeding immediately, within first hour of life, feeding infant colostrum  
- Exclusive breast-feeding (EBF) for six months with no additional food or use of bottles  
- Continue breast-feeding up to 24 months  
- Depending on MoH guidance, HIV+ mothers will either exclusively breast-feed for six months and continue breast-feeding with complementary foods for 12 months while on ART to reduce HIV transmission during breast-feeding or avoid all breast-feeding where infant feeding options are affordable, feasible, sustainable and safe | - Birth attendant supports mother to breast-feed immediately  
- Mother feeds the baby only breast milk for six months (continuing ART for both mother and infant if mother is HIV+)  
- Mother continues to breast-feed for up to 24 months  
- Mother continues and increases breast-feeding during child’s illness  
- Mother breast-feeds on demand  
- Caregiver does not give the child any bottles  
- Caregiver takes child to growth monitoring and promotion as soon as possible after birth, then monthly to assess appropriate growth |
| 2. Essential newborn care | - Essential care during the first few hours of life  
- Skin-to-skin with the mother for warmth; wrapping infant with the mother  
- Clean eye & cord care  
- Counselling on exclusive breast-feeding for six months and in the context of HIV  
- All HIV-exposed infants to go on immediate ART and co-trimoxazole until HIV is ruled out  
- Early infant diagnosis using virologic testing (PCR) at 4–6 weeks and immediately start ART if positive | - Mother puts baby to breast, wraps and cuddles baby skin-to-skin  
- Mother gives colostrum and provides no liquids or pre-lacteals  
- Mother practises cleaning of eye and cord care  
- Mother practises appropriate breast-feeding  
- If HIV-exposed, bring baby to facility for testing by 4 weeks, or mother-baby pairs to be traced by CHW/V |
| 3. Hand washing with soap | - Both hands rubbed with soap, ash, salt or lime/lemon and rinse with running water: before cooking, eating, handling the baby and after using the toilet or disposal of faeces | - Caregiver washes hands with soap before cooking, before eating, before feeding the baby and after toilet and disposal of faeces  
- Household has washing station with running water, soap or soap equivalent |
| 4. Appropriate complementary feeding (CF) | - Attend growth monitoring  
- Responsive feeding with continued breast-feeding  
- Diet includes minimum acceptable diet
t Breast-fed infant:  
- 6–8 months: small frequent feeds through the day and no watery foods  
- 9–11 months: increase the frequency and amount of foods as the child gets older  
- 12–24 months: increase variety and density of food – foods that can stay in the spoon Non breast-fed infant:  
- 6–24 months: Give 4–5 meals +1–2 snacks per day from 4 food groups | - Caregiver provides variety of food that includes animal-source foods** using responsive feeding techniques  
- 6–8 months: small frequent feeds through the day and no watery foods (2–3 meals/day)  
- 9–11 months: increase frequency and amount of foods (3–4 meals/day)  
- 12–24 months: 3–4 meals +1–2 snacks/day  
- Caregiver takes child to growth monitoring and promotion every month until immunisations are complete and then every 2–3 months, to ensure appropriate weight gain and identify problems before the child becomes undernourished |

1 Minimum Acceptable Diet includes Minimum Dietary Diversity (children receiving foods from four or more different food groups in one day) and Minimum Meal Frequency (the number of times per day that a young child receives solid, semi-solid or soft food)  

2 Examples of animal-sourced foods: eggs prepared appropriately for the age group, fish paste, cooked animal flesh pounded to a paste, dried or desiccated fish, or other locally available and culturally appropriate animal-sourced food items.
### TABLE 4  The 11 Interventions for the Child

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| 5. Adequate iron | • Child’s intake of iron is enough to meet physiological requirements  
• In malaria-endemic areas and areas with anemia prevalence >40 per cent: iron-fortified complementary foods for child 6–24 months, with malaria control and treatment efforts  
• In non-malaria-endemic areas without anemia prevalence >40 per cent: daily iron supplementation (e.g. syrup, crushed tablets or Sprinkles) for child 6–24 months  
• Diversified diet with iron-rich foods (animal-sourced foods and dark green leafy vegetables) and fortified complementary foods  
• For LBW infant, start iron at 2 months | • Caregiver recognises local iron-rich foods (animal-source foods, including insects and fish, and dark green leafy vegetables) and gives the child supplemental iron (syrup or crushed tablets) or fortified complementary food according to guidelines and malaria prevalence  
• LBW infant is provided with iron supplements (syrup) beginning at 2 months of age |
| 6. Vitamin A supplementation | • Child 6–24 months old receives a vitamin A capsule every 6 months. | • Post-partum mother takes single, high-dose vitamin A within four weeks of delivery, following national guidelines  
• Caregiver gives vitamin A-rich foods to child, including fruits or vegetables yellow or orange in colour and animal-source foods  
• Child 6–24 months takes a vitamin A capsule every 6 months |
| 7. Oral rehydration therapy (ORT)/zinc | • Health education on hygiene, sanitation, hand washing, cleanliness for diarrhoea prevention  
• Increased BF during diarrhoea episode and continued BF after for < 6-month child  
• Early use of oral rehydration solution (ORS)/appropriate household solution during diarrhoea  
• Continued CF and BF during and after diarrhoea episode for a child 6–24 months old  
• 20 mg zinc given to child for 10–14 days (10 mg for < 6-month child) | • Caregiver practises three-fold ORT approach: ORS, zinc, continued BF and/or CF  
• Caregiver knows definition of diarrhoea (three or more liquid stools/day) and recognises signs of dehydration  
• Caregiver recognises signs of severe dehydration and takes the child to health facility for skilled care |
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| 8. Prevention and care seeking for malaria | • Child sleeps under an LLIN every night  
• Caregiver and CHW provide community-based management of mild to moderate fever, and ensure continued BF and CF  
• Recognise danger signs of malaria and seek care when a child with fever needs treatment outside the home from CHW or health facility | • Caregiver keeps child under LLIN every night  
• Caregiver provides BF and/or CF  
• Caregiver recognises when sick child needs treatment outside the home and seeks care from appropriate provider  
• Caregiver recognises danger signs of severe malaria (change in consciousness, seizures, inability to drink, persistent vomiting, high fever, fast or difficult breathing) and takes child to health facility  
• Caregiver follows the health provider’s advice on treatment, follow up and referral |
| 9. Full immunisation for age        | • Promote immunisation according to national guidelines  
• Immunisation at ANC and national immunisation clinics/centres | • Caregiver seeks immunisation at health facility and keeps the card safe |
| 10. Prevention and care seeking for acute respiratory infection | • Prevention = Interventions 1, 6 and 9  
• Recognise danger signs of pneumonia (rapid or difficult breathing, chest in-drawing, nasal flare and/or fever)  
• Home-based management of cough, cold and fever  
• Referral to health facility for high fever with danger signs | • Prevention = Interventions 1, 6 and 9  
• Caregiver recognises danger signs of pneumonia (rapid or difficult breathing, chest in-drawing, nasal flare, and/or fever)  
• Caregiver seeks medical care and takes child to health facility immediately  
• Caregiver continues to BF or CF based on age  
• Caregiver knows that the child is treated with appropriate antibiotics |
| 11. De-worming                      | • Child 12–24 months is given periodic de-worming tablets according to national guidelines | • Caregiver ensures child takes de-worming medication by attending either mass de-worming campaigns or the local health facility  
• Caregiver ensures that when child begins to walk, he/she wears shoes |
Child Intervention 1: Appropriate Breast-feeding

Breast-feeding could reduce all child deaths by 13 per cent. In order to optimise the benefits of breast-feeding, appropriate breast-feeding is the term that encompasses the three key components of breast-feeding. The first is that the infant begins breast-feeding soon after birth (within one hour), with the mother feeding her infant colostrum (i.e. does not throw away the colostrum). This requires support from the birth attendant. The second phase of optimal breast-feeding is for the mother to provide nothing but breast milk to the infant for the first six months of the infant’s life. This recommendation includes ensuring that the infant does not take a bottle or ingest any other food or liquid, including water. For this, the mother requires the support of not only the health worker but also other key influential family members, such as grandmothers, who may hold different beliefs around this practise. The third stage is for the mother to continue to breast-feed her child for up to 24 months with appropriate CF 7-11 programming emphasises all three of these components.

In order to track the infant’s growth, caregivers need to monitor their infant’s weight gain by participating in growth monitoring and promotion programmes, starting as soon after birth as possible and continuing on a monthly basis until their infants have completed their immunisations.

Unless MoH guidelines recommend alternative feeding, it is recommended that HIV-positive mothers also exclusively breast-feed for six months while both mother and infant continue on ART to reduce HIV transmission. Breast-feeding should continue with appropriate complementary foods for the first 12 months of life as long as the mother can continue on ART. Support for adherence to ART, as well as breast-feeding support, is required from healthworkers and volunteers.

Child Intervention 2: Essential Newborn Care

Most newborn deaths can be prevented by mothers and CHWs carrying out the following healthy practises:

- cleaning airway and stimulating crying
- drying the baby with a clean, dry cloth, covering the head, without wiping the vernix caseosa, and refraining from bathing the baby for 24 hours
- immediate warming by placing baby in skin-to-skin contact with mother (use KMC for LBW baby)
- cleaning umbilical cord and wiping eyes with a clean cloth
- immediate and exclusive breast-feeding
- recognition and care-seeking for special care (see “danger signs” below).

Having been nourished by the pregnant woman for nine months in the womb while bathing in a moderately warm amniotic fluid, the most important need of a newborn for the first 24–48 hours is protection. Unlike adults, who can readily adjust to changes in temperature, newborns become hot or cold more quickly and can easily die from rapid changes in temperature. A newborn also does not have a mature system to fight infections. Immediate, exclusive breast-feeding, which provides colostrum combined with warming (skin-to-skin contact and the act of loving care), is a measure to protect the baby from these elements. Before handling the baby, the mother and other family members should practise proper hand washing.

If the baby is born at home, the mother should take the baby to the health facility for first immunisations (BCG, polio and Hepatitis B if available) and vitamin K administration during the first few days after birth. The baby must also be taken to a health facility if any of the following danger signs are present:

- breathing problems or gasping
- difficulty feeding or sucking
- fever
- cold to touch
- fits or convulsions
- yellowish skin or eyes (jaundice)
- red, swollen eyelids and pus (yellowish discharge) in eyes
- swelling/redness of skin, pus or foul odour around the umbilical cord.

HIV-exposed infants should be tested for HIV using a virological assay (measures the presence of virus rather than antibodies) at first post-natal visit or by 4–6 weeks. In most instances these tests must be sent to central labs, and results will not be received for 3–4 weeks. To avoid needless deaths, all HIV-exposed infants should be provided with ART and cotrimoxazole immediately, until infected is ruled out, and enrolled on life-long treatment if infection is diagnosed.
Part 2

Child Intervention 3: Hand Washing with Soap
Proper personal hygiene is one of three key strategic elements of sanitation. The other elements are clean water (safe treatment and storage of drinking water) and safe removal of excreta. Research has shown that improved sanitation results in a reduction in diseases, such as intestinal parasites, skin diseases, guinea worm and diarrhoea.

Proper personal hygiene practice refers to hand washing by rubbing both hands with soap (or soap alternatives such as ash, salt or lemon/lime) and rinsing with running water to wash the germs away. The critical times for hand washing are before cooking, before eating, before handling the baby and after using the toilet or disposing of faeces. Proper hand washing can reduce diarrhoea-related deaths by almost 50 per cent and deaths from ARIs among children by 25 per cent.99

Child Intervention 4: Appropriate Complementary Feeding (6–24 months)
As with breast-feeding, child deaths can be reduced by 6 per cent by improving complementary feeding.100 Complementary feeding (CF) is one of the top three preventative interventions impacting child mortality. Appropriate complementary feeding refers to the requirements for feeding an infant. Appropriate CF refers to the requirements for feeding an infant and includes timely introduction of solid, semi-solid or soft foods in the period of 6–8 months of age in addition to, or complementary to, breast milk. It is important to emphasise that CF is taken together with continued breast-feeding. It also includes the Minimum Acceptable Diet which has two separate components:

1) Minimum Dietary Diversity – receiving foods from four or more different food groups in a single day
2) Minimum Meal Frequency – the number of times per day that a young child receives solid, semi-solid or soft food. The appropriate number of times per day differs by age group, as follows:
   - 6–8 months, breast-fed: 2–3 meals/day
   - 9–11 months, breast-fed: 3–4 meals/day
   - 12–24 months, breast-fed: 3–4 meals + 1–2 snacks/day
   - 6–24 months, but not breast-fed: 4 meals + 1–2 snacks/day.

Appropriate CF also includes iron-rich foods. This includes iron-fortified foods that are specially designed for infants and young children, home-based fortified products, such as Sprinkles, and foods naturally rich in iron, such as animal-source foods and dark green leafy vegetables. 7-11 programming raises awareness around all of these appropriate CF components, especially promoting locally available foods.

Again, in order to ensure that the child is eating appropriately and is healthy, the caregivers should participate in a growth monitoring and promotion programme. Once the child has completed his/her immunisations, he/she should be taken for weighing every two to three months, which provides another opportunity to reinforce the above messages.

Child Intervention 5: Adequate Iron
The Copenhagen Consensus 2008 Report101 identifies addressing micronutrient deficiencies as the number one solution to the challenge of hunger and malnutrition. Addressing iron deficiency through fortification shows one of the highest cost-benefit ratios. Of the 40 priorities considered, the Copenhagen Consensus also ranked micronutrient supplements as the top development priority.

Adequate iron for children means that each child consumes enough iron to meet his or her physiological needs, which are high for young children due to their rapid growth. Consuming enough iron to meet their needs includes iron from dietary sources as well as from supplements, such as syrup or tablets, or through fortification in either a home-based fortification form (e.g. Sprinkles) or a commercially prepared food specially designed for infants and young children. The decision to address iron deficiency in a population through mass supplementation must be made in consideration of the prevalence of infectious disease and malaria. Where the prevalence of anaemia is over 40 per cent, additional iron is required on a population-wide basis. The mode of distribution will differ depending on the infectious disease and malaria status of a particular area. If infection and malaria are high, then it is safer to provide the iron in low doses more frequently, as through fortification (i.e. iron-fortified complementary foods). If malaria prevalence is low, then supplementation is recommended. In either situation, significant increases in iron consumption can also be achieved through dietary approaches. However, it is very difficult to provide a diet sufficient in iron to a young child without fortification or supplementation.

In addition, it is important to remember that LBW babies have lower body iron stores than full-term babies and should begin receiving additional iron (syrup) by the age of 2 months. All of these considerations enter into 7-11 programming.
Child Intervention 6: Vitamin A Supplementation

Vitamin A is essential to health. When the body does not have enough vitamin A, the immune system function is compromised, making the child more susceptible to disease, and more likely to die from that disease. By providing vitamin A (through supplements, fortification or adequate diet) to children under 5 years in vitamin-A-deficient areas, mortality rates in general could be reduced by up to 23 per cent.\textsuperscript{102}

As with iron, there are two primary ways to increase the intake of vitamin A: 1) dietary improvements such as animal-sourced foods and the consumption of red palm oil, and yellow and orange fruits and vegetables; 2) vitamin A supplementation. Children should receive their first vitamin A capsule at the age of 6 months. Between 6 and 9 months, children should receive a vitamin A capsule every six months. 7-11 programming makes this information known to households and make appropriate referrals to health clinics to access the supplements.

Child Intervention 7: Oral Rehydration Therapy/Zinc

A child is said to have diarrhoea if he/she passes three or more watery stools a day. Children become easily dehydrated due to loss of fluids during diarrhoea and, given their lower resistance, are more likely than adults to die from it. The conditions that cause diarrhoea are preventable. Diarrhoea is caused by germs that are swallowed, with underlying causes including poor hygiene, lack of clean drinking water and/or giving infants replacement feeding. In contrast, infants who are exclusively breast-fed seldom get diarrhoea. Death due to diarrhoea is also easily preventable through administering ORT and zinc. ORT refers to the use of ORS together with continued and increased breast-feeding and continued CF as appropriate.

Zinc supplementation during a diarrheal episode has been proven to be beneficial, helping to reduce both the duration and the severity of the diarrhoea. WHO recommends 20 mg zinc supplements daily for 10–14 days for children with diarrhoea, and 10 mg per day for infants under 6 months.

7-11 programming promotes correct handwashing among caregivers for diarrhoea prevention and will counsel caregivers to recognise the danger signs of dehydration among children and to seek appropriate care. Access to both ORT and zinc are promoted, as per national guidelines.

Child Intervention 8: Prevention and Care Seeking for Malaria

In malaria-endemic areas, any fever in a child under 5 should be considered malaria until proven otherwise. WHO now recommends that all suspected malaria cases be confirmed with either microscopy (gold standard) or RDT. Presumptive treatment based on clinical diagnosis should only occur if microscopy or RDTs is not available. Children under age 5 with malaria and weighing more than five kg should be treated with ACT. This can be provided by a CHW/V for uncomplicated malaria in some countries. These young children lack immunity and are at risk of severe malaria illness and death within 24 hours. As such, the caregiver needs to seek care for fever from an appropriate provider within a one-day time frame. In the absence of diagnostics, children under 5 with fever and weighing more than five kg should be treated with an ACT. In countries with malaria, early care seeking with appropriate treatment is critical in reducing malaria mortality. It is also vital to adhere to the full course of treatment, even after the fever is resolved and symptoms have improved.

Caregivers must also recognise the danger signs of severe malaria (change in consciousness, seizures, inability to drink, persistent vomiting, high fever, fast or difficult breathing) and take the child to a health facility immediately. CHWs are not equipped, and ACTs are not appropriate, for severe malaria.

Malaria prevention among pregnant women and children lies in well-known approaches. LLINs are one of the most effective ways to prevent transmission of malaria, and indoor residual spraying (IRS) is effective for controlling mosquito populations. Keys to reducing malaria illnesses and deaths lie in scaled-up malaria interventions through intensified community-owned responses. This will help reduce malaria illness, as will integrating malaria programmes into existing service delivery mechanisms such as antenatal services, immunisation programmes and others.

7-11 programming emphasises all of these messages, promoting malaria prevention, care seeking for fever, and ACTs for treatment of malaria according to national guidelines. Programmes may promote and support CHW training for malaria and promote community case management (CCM) where approved by the MOH. Some programmes may also choose to facilitate the ‘malaria competency approach’ (or CSS) to promote community ownership of the response to malaria.
**Pneumonia and malaria overlap**

Pneumonia and malaria overlap is common in areas where malaria is a major cause of sickness and death among young children. The symptoms of malaria and pneumonia often overlap. Both diseases frequently present with fever. WHO now recommends that, whenever possible, all fever cases in malaria endemic areas be confirmed with a diagnostic test. Fast breathing or chest in-drawing/difficult breathing is a strong indicator of pneumonia; however, malaria may also cause a cough and fast breathing among young children. In malaria-endemic areas, a child with a fever and fast breathing may be diagnosed with pneumonia when in fact he/she has malaria. Alternatively, the child may have both malaria and pneumonia infections at the same time, which necessitates immediate assessment and treatment. RDT at peripheral health facilities and in the community will assist in differentiating these two common diseases, leading to better treatment and outcomes for pneumonia and malaria.

**Child Intervention 9: Full Immunisation for Age**

Many infectious diseases that kill millions of children are easily preventable through timely immunisation. Children must be immunised early in life, starting from the first week after birth and with completion of the full schedule before the first birthday. The effects of immunisations are maximised if given at specific ages, meaning that proper scheduling and complete doses are critical. Nevertheless, if a child has not been fully immunised by his/her first birthday, it is extremely important to follow through with the immunisations as soon as possible. It is safe to immunise children with minor illnesses or disabilities and those suffering from moderate malnutrition.

WHO has developed standard immunisation schedules for TB, diphtheria, pertussis, tetanus, polio and measles. In all countries, however, national protocols must be followed. 7-11 programming intensifies awareness-raising around immunisation and uses every opportunity to increase immunisation coverage among one-year olds. It is also important to trace drop-outs and unimmunised children.

**Child Intervention 10: Prevention and Care Seeking for Acute Respiratory Infections**

Although coughs and colds are common among children, and most can be easily treated, sometimes coughs and colds are danger signs of pneumonia, which is the biggest killer of children. A child with cough and cold accompanied with rapid breathing, difficulty in breathing and fever may have pneumonia and require immediate attention. Many children die of pneumonia because the mother or caregiver does not recognise the seriousness of the symptoms. The danger signs of pneumonia include:

- rapid breathing: for a child 2–12 months old, 50 breaths or more per minute
- difficulty in breathing: nasal flare
- chest in-drawing: lower part of chest sucks in when child breathes
- child has cough for more than two weeks
- child is unable to breast-feed or drink, and vomits frequently.

A child with any of these danger signs needs to be taken to a health clinic or to a trained health worker immediately. Pneumonia cases can be reduced through exclusive breast-feeding for the first six months of life, vitamin A supplementation and complete immunisation—especially measles. Regular hand washing and reducing exposure to indoor smoke are also important in preventing ARIs.
Child Intervention 11: De-worming

Many children are likely to be infected with intestinal worms (i.e. helminths) from the time they stop breast-feeding, and they can be continually infected and re-infected for the rest of their lives. School-age children have the highest intensity of worm infections. Infants usually do not carry the burden of helminth infestations as long as they are not yet mobile. Once they begin crawling and walking, however, the risk of exposure increases. It is usually recommended that a child receive de-worming medication at 12 months of age. For children 12–24 months, treatment should be undertaken as prescribed by national guidelines. Due to the likelihood of re-infection, it is important to treat the whole family. In communities where intestinal worms are common, all children should be offered treatment. There is no need to screen or examine each child to confirm the presence of worms. Screening is much more expensive, and treatment is safe for uninfected children.

Besides accessing periodic treatment, caregivers need to ensure that the child’s surroundings are kept clean and sanitary, that proper hand-washing techniques are used by everyone in the family and that appropriate sanitary facilities are available and in use. All of these messages are included in 7-11 programming.

SECTION 5: INTEGRATION

What is integration and why should we integrate?

Integration may be defined as the act of combining into an integral whole. The principle aim of integration for H/N programming should include addressing child well-being holistically. Both programmatic efficiency and effectiveness require the employment of multi-sector outcomes in H/N programming, and vice versa. The determinants of health are represented multi-sectorally in the socio-ecological community. To ignore health determinants is to treat the symptom, not prevent the cause. Our mandate to focus on community requires H/N projects that identify and address root causes of health issues.

How do we integrate?

The Integrated Programming Model (IPM) process is helping ADPs prioritise ‘enabling’ community platforms such as CCCs, COMMs and community-based advocacy capacity. These platforms serve across sectors and need not be duplicated for each sector. A group of CHW/Vs visiting families at the household level may diversify their messages to capture issues such as child protection and birth registration. Peer groups at the community level can also diversify their focus. Evidence demonstrates that successful groups often start with focus on a singular issue but grow to address multiple issues.

Table 5 provides examples of H/N integration possibilities with other WV sectors. This list is not meant to be comprehensive but should simply catalyse creative thinking in programmatic design. Implementers should see integration as an opportunity to expand health, nutrition and CWBOs.

Integration requires consideration of the CWBO framework in ADP programme design. Multi-sector needs must be identified through assessment, and the collective of proposed projects reviewed for potential to assimilate prioritised activities. Each project should review the indicators, within all outcome categories, that may be viable to address within their activities. Each project should seek synergy and opportunity in the others.
### TABLE 5 Possibilities for H/N Integration within Various Sectors

<table>
<thead>
<tr>
<th>Sector</th>
<th>Other sector activity to include in H/N design</th>
<th>H/N activity to include in other sector design</th>
<th>Example of shared CWBO indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water, Sanitation and Hygiene (WASH)</td>
<td>Hand washing with soap</td>
<td>Education on hygiene</td>
<td>per cent children aged 0–59 months who have suffered a bout of diarrhoea in the past two weeks</td>
</tr>
<tr>
<td>Agriculture</td>
<td>Crop diversification counselling</td>
<td>Health, HIV and nutrition education</td>
<td>per cent children 6–23 months who received food from at least four food groups during the previous day</td>
</tr>
<tr>
<td>Economic Strengthening</td>
<td>Community insurance schemes</td>
<td>Micro-credit for businesses with explicit health outcomes (such as public latrines)</td>
<td>per cent parents or caregivers with children under 18, who report that members of the household are able to access credit when needed for investment in business or for cash-flow problems to pay for household needs</td>
</tr>
<tr>
<td>Education</td>
<td>Early childhood care and development activities</td>
<td>PHC and RH/lifeskills topics coverage in school curriculum</td>
<td>per cent girls 12–18 years old currently pregnant or already mothers</td>
</tr>
<tr>
<td>Child Protection</td>
<td>Birth registration education and monitoring</td>
<td>Inclusion of health focus in children's participatory dialogues</td>
<td>per cent children in the community aged 0–18 who are identified as most vulnerable children (MVC) or orphans and vulnerable children (OVC) according to UNICEF definition of OVC and WV definition of MVC</td>
</tr>
<tr>
<td>Sector</td>
<td>Other sector activity to include in H/N design</td>
<td>H/N activity to include in other sector design</td>
<td>Example of shared CWBO indicator</td>
</tr>
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</tr>
<tr>
<td>Gender</td>
<td>Focus on the role of the husband/father in PHC counselling</td>
<td>Focus on family planning</td>
<td>community members report that harmful traditional or customary practises which violate the rights of children and women (e.g. early or forced marriage, female genital mutilation, gender-based violence) are no longer practised openly by everyone</td>
</tr>
<tr>
<td>Disability</td>
<td>Counselling messages on injury/disability prevention</td>
<td>Focus on ensuring disabled access to health services</td>
<td>per cent children aged 12–18 who report that they feel safe from danger or violence in their neighbourhood</td>
</tr>
<tr>
<td>Peacebuilding</td>
<td>Application of Do No Harm principles in assessment design</td>
<td>Mobilise health providers as peace advocates</td>
<td>communities where members, including children, are aware of and can describe the dangers and impact of conflict and know how conflicts can arise and how to build peace</td>
</tr>
<tr>
<td>HIV</td>
<td>Counselling and testing during pregnancy and breast-feeding</td>
<td>Nutrition, TB and malaria co-infection education</td>
<td>per cent reduction in children born of HIV+ mothers who are HIV+ 18 months after birth</td>
</tr>
</tbody>
</table>
SECTION 6: EXPANDED PROGRAMMING

Core Programming
Section 1.1 provided the rationale for focusing on mothers and children under 2 as the critical target groups for core 7-11 H/N programming. We chose this because of the pronounced vulnerability of the under-2 age group, the critical importance of good health and nutrition at this age to the life-long development of the child and the proven linkage of the mother’s health, nutrition and survival with the survival and well-being of her child. By focusing our efforts on the prenatal period and first two years of life, WV aims to ensure that children in our programmes start out life with a foundation of good health and nutrition. Evidence shows that prevention is more effective than treatment at reducing the prevalence of undernutrition. While interventions for older children have benefits, they cannot undo the health and cognitive losses incurred in early life. Instead these losses must be prevented through evidence-based interventions targeted to pregnant mothers and children under 2, in order to take advantage of this window of opportunity and set the stage for a healthy and productive life.

It is our intention that all 7-11 programmes begin by working with this specific focus on the core maternal and under-2 groups. The nC approach is specifically designed to provide information and support to households during this critical 9-to-24 month time period. Programmes are urged to avoid the temptation of expanding 7-11 H/N activities to encompass other age groups during Phase I programming, as this carries the risk of diluting the impact of the work with the critical targets that WV has intentionally chosen as its core focus.

Expanded Programming
Nevertheless, it is not our intention to limit programming indefinitely to the core maternal and under-2 target groups. Section 3.4 described the concept of the ‘Life-Cycle Approach’ that recognises and reflects the generational span of health outcomes at each stage of life. Full adherence to a life-cycle approach will ultimately require comprehensive and expanded programming to enable interventions at additional critical periods outside of the maternal and under-2 stages. Once core programming is satisfactorily established and addressed in all coverage areas, programmes will move forward through subsequent life-cycle stages (additional interventions appropriate to other age groups) and will address contextually specific diseases which threaten children’s well-being at different times. Examples of possible Phase II interventions include Early Childhood Care and Development (ECCD) and Life Skills for Youth programming.

Further guidance around expanded programming will be provided once the core ‘Jump Start’ initiative has been consolidated.
PART 3

IMPLEMENTING THE 7-11 STRATEGY
**INTRODUCTION TO PART 3: LINKS WITH LEAP AND IPM**

For the purposes of Part 3, 'Implementation' refers to the full range of processes needed to undertake 7-11 programming. The processes described here follow the LEAP cycle and fit within the IPM approach.

**Links with LEAP and IPM**

7-11 interventions will usually be designed and implemented as part of a wider, multi-sectoral programme, an Area Development Programme.

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The LEAP cycle has six components: assessment, design, monitoring, evaluation, reflection and transition. Assessment in LEAP refers to programme-level assessment, meant to determine whether a programme is necessary and feasible. Our LEAP programme assessment is a broad-context assessment focusing on social, physical and political issues and covers all four CWBOs. It leads us to a principled commitment to support the programme and a decision on whether or not to continue with a more detailed design phase. The assessment also makes a recommendation on the feasibility of child sponsorship and other funding means. Because assessment is conducted before a commitment is made to implement a programme, it is important that we manage the expectations of communities and potential partners during the process. For this reason, community engagement is kept to a minimum. Programme assessment is conducted using secondary data wherever possible and as few key informant interviews as necessary.
It is during the programme design phase that community engagement and mobilisation occurs and we conduct a detailed root cause analysis. During the design phase, we investigate and analyse the health issues that were identified during the programme assessment in more detail. This process results in the production of a Programme Design Document, which describes the rationale and goals of the programme as well as the details of our projects that will be implemented within the programme.

IPM describes the design phase using the Critical Path. The first six steps give details on how we work with communities and potential partners to

- identify priorities for action on child well-being
- identify community assets
- analyse root causes
- plan joint projects together

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**FIG. 9 | The Critical Path**
This process of community engagement and analysis normally runs in repetitive cycles. For example, the results of monitoring information (and reflection on this information) may lead to project redesign, or to changes in project plans during the course of implementation, to ensure that we stay on track to achieve our objectives. This Part 3 of the Field Guide provides staff with guidance on each stage of 7-11 project (as opposed to the broader ADP programme) implementation, as follows:

**Section 1** provides recommendations on ensuring that our assessment will provide the data needed – both quantitative and qualitative – to help us better understand the contexts into which 7-11 programming will be introduced, the H/N needs and assets we seek to address and the contextually appropriate ways of intervening around the problems we have identified.

**Section 2** provides guidance on using the results of our assessment to design the context-specific content and details of the 7-11 interventions. Categories of decisions include selection of potential additional interventions based on the specific needs of the project area and details in regard to each intervention and partner selected to implement one or more project components. This section also outlines various scenarios for partnering with the MOH and/or other organisations or groups and the different staffing arrangements that would match these scenarios. Transition is described as a natural partnering process.

**Section 3** discusses monitoring and evaluation norms that a 7-11 project will need to establish. It will link these norms to the high-level indicators that form part of our system of measurement of progress toward CWBOs. This section provides guidance for ongoing project monitoring, periodic evaluation and information flow within communities.

**Section 4** describes the delivery approach that we will take to bring the 7-11 interventions forward into communities or, in other words, implementation of the 7-11 core approaches. This section reviews the ways that we will

1. engage appropriate community structures – mobilising these where necessary – in overseeing 7-11 programming and responding to contextual, community-level barriers to change
2. bring necessary H/N information and support into households via volunteer CHWs
3. enable community groups to advocate for important structural changes related to root causes of H/N problems
4. respond in ways that are feasible for us as an organisation to identify HSS needs
5. incorporate any number of additional interventions identified as relevant to local contexts into overall programming.

**SECTION 1: 7-11 PROJECT ASSESSMENT**

**A Foreword on 7-11 Assessment**

The demonstration of accurate ‘evidence’ in public health work is challenging due to the interaction between complex social interventions and complex social systems. The impact of our programming relies on the context in which it is being implemented, and the effectiveness of an intervention can not be distinguished from the context in which it is applied. Thus, our assessment practice must contribute to a solid understanding of the contexts in which we operate, both for effective design purposes and so we may evaluate our intervention effectiveness.
1.1 Relationship with LEAP Programme Assessment

As described above, the LEAP Programme Assessment is completed before we make any decision to embark on 7-11 programming and before we carry out a 7-11-specific project assessment. It is important to understand that the LEAP Programme Assessment is broader than health and nutrition and 7-11 alone. However, the questions and thresholds in the LEAP Programme Assessment Tool relating to health and nutrition are the same as the questions and thresholds found in the HIV and AIDS and Health & Nutrition Triggers for Action tool, which was developed as part of the 7-11 strategy. The threshold decisions that we will make about H/N programming as a result of carrying out the LEAP Programme Assessment and applying the Triggers for Action tool are macro-level programming decisions.

The LEAP Programme Assessment serves as our tool to provide this threshold-level information and enable decisions about our overall programmatic framework. The LEAP Programme Assessment is not, however, intended to produce data for the detailed design of our H/N (or other sector) projects. We must conduct additional sector-specific research. The sections below describe this resulting assessment, aimed at gathering detailed information to specifically inform 7-11 project design.

1.2 The 7-11 Project Assessment

We have developed the 7-11 Analyse, Design, Agree and Plan Tool (ADAPT) to assist with carrying out detailed research to feed into the design of a 7-11 project. This research should be done after reviewing the results of the LEAP Programme Assessment, which will provide the justification to proceed to the 7-11 project assessment and design phase. Implementation of ADAPT should occur together with Step 5 of the IPM critical path. ADAPT incorporates the following levels of analysis: Sections 1.2.1–1.2.5.

1.2.1 Landscape Assessment (Macro-Level)
Landscape assessment is partly aimed at understanding the broad patterns of epidemiology in the country. It usually relies heavily on secondary data gathered through a review of national reports and datasets that are available to the public, such as Demographic Health Surveys (DHS) and data produced by other multi-lateral and peer practitioner organisations. Whenever it is possible, we can look at these data in addition to our (WV’s) own information gathered through the LEAP Programme Assessment, the Triggers for Action tool and/or other evaluations we have carried out for other programmes. It can also be useful to meet with key individuals (key informant interviews), within the MOH, for example, to supplement the literature-based information.

In addition to analysing the broad patterns of epidemiology, landscape assessment also helps us in understanding the root, structural issues that lie beneath H/N shortfalls. These include economic, policy, gender, cultural and service-provision issues. Our findings related to these issues will help us to inform advocacy agendas at local and national levels, as well as deepen the dialogue in communities and households. Specific guidance as to how to carry out a landscape assessment is provided in the ADAPT tool.
I.2.2 Local Level: Quantitative Household/Community Assessment

We must also gather detailed information at the specific project area level so that we adapt project design to the local context. Based on information from the local-level assessment, we will choose potential additional interventions to include with the core 7-11 programming. Quantitative assessment at this level should provide a narrowed sub-set of priorities from the landscape assessment, which will provide the basis for much of the detail of the 7-11 core approaches. For example, the landscape assessment may reveal that skilled delivery at birth is inadequate in national statistics, but there may be an exceptional clinic reasonably close by a target community, eliminating the need to focus on this area in the ADP design. On the other hand, though national statistics reviewed in the landscape assessment may demonstrate an acceptable immunisation rate, isolated and vulnerable communities may have extremely lower coverage of immunisations. We should not assume that all of the 7-11 messages and interventions are equally applicable in every setting. Instead, we should identify from the overall menu of 7-11 messages and approaches those that are most in need of reinforcement based on local patterns of behaviour and practise. The ADAPT tool provides guidance for carrying out this quantitative local level assessment and for reaching decisions on project design based on it.

I.2.3 Local Level: Qualitative Household/Community Assessment

Our assessment at the local level is meant to guide the specific design for a setting (e.g. choice of core and additional approaches, and decision-making toward design within each approach). Quantitative assessment provides us with some information for these decisions by detailing behaviours practised and services provided. However, some qualitative assessment is also important and helps us begin to understand some of the reasons for such behaviours and practises.

Qualitative assessment helps us to uncover the social and cultural barriers, as well as structural constraints, that may get in the way of positive behaviours. These are important factors in our project design. For example, while the quantitative assessment may indicate that malnutrition is prevalent, focus-group discussions may reveal that agricultural variety and dietary norms are not adequate. This assessment provides detailed information around the reasons for the malnutrition, which is useful when designing appropriate responses. Our engagement with members of the community in a qualitative way helps to provide this type of rich description.

Note: We recommend barrier analysis-type assessments, where they are feasible, to further understand and appreciate root causes and determinants of behaviour. However, these assessments are intense and sometimes expensive. We should acknowledge that there is a significant global understanding of issues affecting behaviours concerning the 7-11 focus areas and there are common ‘stories’ relating to these behaviours. For example, the ‘4-Delays’1 are commonly understood to affect household behaviours regarding care seeking for illness, antenatal, delivery and post-natal complications. We can use this understanding as a realistic platform when beginning counselling services, even when a full barrier analysis assessment cannot be carried out.

The ADAPT tool includes guidance on carrying out a limited number of focus-group discussions and key informant interviews aimed at gathering qualitative information, but it does not incorporate a full barrier analysis. We recognise that a more complete understanding of deep-seated community issues will evolve over the life of the project, as engagement with the community develops. The results of the assessment will usually generate enough data for us to move forward to project design.

I.2.4 Health Services Checklist

Our project assessment should include a quantitative appraisal of health services as they relate to 7-11 focus areas. This information might include, for example, proximity of health facilities, numbers and types of health staff available and whether health supplies are routinely provided. Other examples might include availability of public transport to health facilities, availability of private-sector options for health services, and supply and availability of food. Our awareness of these contextual factors, which are critical to positive health outcomes in a community, is essential to our design of appropriate interventions. Sample health services checklists are provided in the ADAPT tool.

I.2.5 Stakeholder Mapping

For the purposes of 7-11, stakeholders may be broad and representative of

- maternal and child health-related government ministries
- private-sector health service providers
- peer non-governmental organisations (NGOs)
- community-based organisations (CBOs)
- faith-based organisations (FBOs)
- community and district/provincial leadership and administrators
- various other community members whose interests and professions may influence MCHN.
- inclusion of MOH stakeholders in assessment and design is a minimal requirement.

1 Delayed recognition of the problem; delayed decision to take action; delayed care seeking; delayed treatment.
A Note on Ongoing Monitoring and Feedback: The ‘Dialogue’ Counselling Approach

While it is important to build a project design on solid quantitative and qualitative information, it is also important to recognise that no project design will be ‘perfect,’ fully responsive to all needs or fully able to predict what will happen in the course of project implementation. Our ongoing attention to increase progress, increase new learning and allow for unexpected and evolving situations or outcomes must be an integral part of all projects. We must remain flexible enough to allow mid-course corrections in response to such emerging issues and learning. A mechanism for supporting this type of ‘feedback loop’ and design adjustments is built into the ttC approach, as follows:

Our ttC methodology emphasises that household-level counselling be conducted through a ‘dialogue’ approach. This means that in discussion with families, during counselling visits, CHW/Vs use open-ended conversation to understand what influences the family’s behaviour. For example, if a mother reports that she is not exclusively breast-feeding her child, the CHW/V inquires as to what has influenced this practise. The mother may report that she does not have adequate breast-milk. This opens up a specific set of behavioural recommendations for the mother. Further, this set of recommendations is completely different than had the mother reported that she does not appropriately breast-feed because of contrary social norms.

As CHW/Vs debrief together on their counselling visits – an important part of the ttC approach – they will share the results of their family dialogues, highlighting common behavioural practises. As these results are collected and analysed, they may demonstrate behavioural trends in the community which might not have been captured in the pre-project assessment, and which call for specific and focused responses either back through the household counselling or through focus-group/community interventions. In this way, the dialogue approach serves as a continuous implementation of barrier analysis. If CHW/V debriefing reveals complex or unexplained behaviours, more intensive and directed barrier analysis mid-project may be appropriate. The CHW/V dialogue approach, with subsequent monitoring, debriefing and response ability, implements continuous mid-project reflection per LEAP guidelines and significantly brings the reflection concept to life.

The table found in Appendix C presents an overview of the types of information that is collected through the ADAPT tool, the section of the tool in which the information is generated and the types of programme design decisions to which the information can be applied. Note: This table may change pending tool finalisation.
**SECTION 2: 7-11 PROJECT DESIGN**

**Introduction**

We will use the data and information coming out of the 7-11 project assessment to make many decisions around project design. The many categories of decisions are outlined in the sections to follow.

The same 7-11 Analyse, Design, Agree and Plan Tool referenced in the previous section will also guide us through the decision-making and design steps, based on the information and data gathered through the assessment process.

**SEE TOOL 7-11 ANALYSE, DESIGN, AGREE AND PLAN TOOL**

**2.1 Decision Category #1: Threshold ‘Macro Programming’ Decisions**

**Additional Data Sources:** LEAP Programme Assessment Report
HIV and AIDS and Health and Nutrition
Triggers for Action

As discussed in Section 1.2.1, the results of the LEAP Programme Assessment, together with the application of the HIV and AIDS and Health and Nutrition Triggers for Action tool, will enable us to make ‘macro-level’ programming decisions. In all cases, the assumption is that 7-11 H/N programming will be carried out. In certain threshold situations, however, it will also be appropriate to implement either Community-based Management of Acute Malnutrition (CMAM) or PD-Hearth programming in addition to 7-11 programming, following the ‘If-Then’ process of the first section of the tool. The ‘If-Then’ summaries are repeated here:

**Decision Category #1:**

Do malnutrition levels, as per trigger indicators and LEAP Assessment results, warrant the implementation of CMAM or PD-Hearth approaches in addition to core and supplementary 7-11 programming?

| If Trigger Indicators show greater than 10 per cent global acute malnutrition or if community is in post-emergency or with frequent periodic emergencies then consider CMAM approach. | CMAM (Additional Approach #1) |
| If Trigger Indicators show community with high prevalence of under-weight children; with either 30 per cent of all community children, or >90 per cent of children under 5 years mildly or moderately malnourished (low weight for age) then consider PD-Hearth approach. | PD-Hearth (Additional Approach #2) |

A description of the CMAM and PD-Hearth approaches is found in Appendix G.
2.2 Decision Category #2: Prioritising 7-11 Additional Interventions

Once we have determined whether or not CMAM or PD-Hearth programming is required in addition to 7-11 programming, we move the decision process on to the second stage: determining the possible additional interventions to include within the 7-11 design.

As discussed, our 7-11 strategy is made up of core approaches to enable interventions at individual, community and environmental levels, all of which are needed to support positive behaviour change. To repeat, these core approaches are CHW/ttC at the individual level, Community Committees at the community level, and both advocacy and HSS at the environmental level. All of our 7-11 project designs should include these core components.

In addition, the assessment results will point to the need for additional interventions to be included in the project design. The 7-11 ADAPT tool will assist us in going through a decision-making process to select these additional interventions. We will use the information collected during the assessment in order to make the necessary decisions. A list of possible additional interventions is provided here. Descriptions of all additional interventions can be found in Appendix G. This list does not reflect the many potential inputs necessary to support the 7-11 framework. Additional examples would include malaria bed-net distribution, Vitamin A and ORT campaigns, community-level health workforce support (for example, nurse midwives), de-worming campaigns, etc.

**Example Additional Approaches**

For growth monitoring
- Community Based Growth Monitoring and Promotion

For behaviour change
- ECCD
- GMP
- Community-CHANGE
- School of Parenting
- Channels of Hope2 or MCHN (in development)

For group formation around specific issues
- PMTCT support groups
- CSS-Malaria
- TB-DOTS

For food and micronutrient availability
- Diet diversity/modification
- Small-scale fortification
- Home-based fortification

2.3 Decision Category #3: Detailing the Core Approaches

Once we have decided whether to include selected additional approaches into the 7-11 project design, the decision process moves on to the next step. We must make many decisions now with regard to the details of each of the core approaches.

Below are some examples of the types of decisions that we must make with regard to Community Committees, the CHW Programme, the content of ttC, key prioritised issues for the local-level advocacy agenda and prioritised actions for HSS. Detailed assessment tools related to each approach are included in their model packages.
A. Sample Community Committee Decisions for Project Design

- What is the appropriate community structure to work through in the project area? If there is none, we will mobilise one.
- What are the capacity building needs of the COMM?
- How can the capacity building of the COMM be adapted to include the development of COMM action plans for addressing identified community-level barriers to the practise of recommended H/N behaviours? An example might be the COMM-led development of a community emergency transport fund to respond to economic and logistical barriers to access to emergency health care.
- What will be the role of the COMM with regard to CHW/V support, management and supervision?
- What is the COMM's relationship with local health structures?
- What additional key stakeholders should be represented on the COMM?

B. Sample CHW Programme Decisions for Project Design

- Identification of CHW/V types available in project area, and requisite support needed
- CHW/V management and supervision structures based on MOH and COMM capacities
- Specification of CHW/V to household ratios based on existing workload of CHW/Vs, population density and geographic access
- Appropriate incentives for CHW/Vs
- Relationship of CHW/Vs to COMM

C. Sample ttC Content Decisions for Project Design

- MOH vs. WV curriculum; some mixing of content from both sources is possible.
- Based on assessment, projects should identify from among the complete ‘menu’ of 7-11 recommended H/N behaviours (1) those not widely practised in the project areas, to prioritise for ttC and (2) those generally practised in the project areas, for positive acknowledgement and reinforcement in ttC.
- We should design ttC sessions to include dialogue around the specific economic, cultural and social barriers to the practise of positive H/N behaviours, starting with those identified in the assessment.
- We should describe myths and beliefs affecting 7-11 recommended H/N behaviours.
- The health-service-access recommendations that form part of ttC must be based on actual health service and health commodities available. This information is gathered as part of the 7-11 design assessment process.

D. Sample Advocacy-Related Decisions for Project Design

- We should identify prioritised issues for community advocacy agendas, based on the economics, local policy and social and health service delivery-related barriers to the practise of positive H/N behaviours identified in the assessment. Note that these assessment results should feed into advocacy work but not pre-empt what is meant to be a community-led and experience-based process of identifying issues for themselves, and should remain based on evidence.
- Assessment may identify stakeholders with specific advocacy concerns or those with specific competencies in advocacy work.

E. Sample HSS-Related Decisions for Project Design

- We should identify needed actions, if any, to strengthen the technical capacity of health staff as appropriate, and/or to strengthen procurement, supply chain management and/or logistics, based on the specific gaps in community-level health service delivery.

2.4 Decision Category #4: Partnering: General

In principle, our primary role in H/N programming is to support community and government stakeholders to ensure positive health outcomes. Our ‘Do’ activities in the DADD document all reflect partner support and strengthening, versus direct service delivery (with the possible exception of emergency situations). In fact, our intention is to deliver service – to our partners. No activity we implement should be in isolation or in absence of consultation with critical stakeholders at the community, and other administrative levels. The Partnering section of the IPM Handbook provides an excellent overview of partnering principles and priorities, including the following definition:

An active relationship between organisations or groups reaches a mature, defined stage of cooperation that is outlined and governed by an informal or formal agreement, to combine their resources and expertise to carry out a specific set of activities toward the well-being of children and for mutual benefits.
Our starting point in assessment and design should always be with two groups: 1) MOH and other ministries concerned with our prioritised H/N outcomes and 2) community stakeholders. Building from these engagements, stakeholder mapping is critical in identifying additional stakeholders who may be assets or barriers to positive outcomes. These stakeholders should include churches, the private sector and other existing community-based organisations. Each stakeholder may have a valuable contribution to health and nutrition. If so, we must be careful to encourage and support their contributions, and certainly not to duplicate them.

Ideally, we should provide our services in collaboration with peers and according to a commonly held set of objectives. Every country in which we work has a national health strategy. Many have additional compacts such as through the International Health Partnership+, Global Fund National Strategy Applications or US Millennium Challenges Corporation. Many have advisory groups with civil society representation. If we are to be a credible part of national H/N programming, it is essential to be engaged and aligned with these groups and processes.

A partnering approach to our H/N programming is a responsible way of empowering local stakeholders sustainably. Partnering does not relieve us of work but changes the nature of our inputs toward capacity-building practises, such as those reflected in the 7-11 core approaches.

2.5 Decision Category #5: Partnering with the Ministry of Health

The most important partnership arrangement that NOs should pursue when designing 7-11 programming is with the MOH. We should enter into high-level dialogue with MOH officials to determine the ways in which our programming can contribute to broad, national H/N goals and outcomes, and NOs should take MOH strategies and programming frameworks into consideration when designing our 7-11 interventions. Basic principles for partnering with ministries were reviewed in the previous section.

MOH officials at national, sub-national and local levels should be informed of the work that we are doing. Beyond simple information sharing, it is ideal if NOs and MOH enter into formal agreements that will see 7-11 programming carried out jointly between them. Such arrangements will ensure that the programming is embedded and integrated into the government health system – as opposed to carried out in parallel and in isolation by us – thereby leading to improved sustainability.

With regard to the core approaches, we strengthen community stakeholders in the COMM and Advocacy activities. TtC, on the other hand, is an approach that is best carried out by and within the MOH where possible. Any HSS activities will logically be carried out in partnership with the MOH. With regard to any additional approaches that we choose to undertake, we must explore the extent to which MOH can take the lead in implementation. The scenarios below summarise those approaches for which MOH partnership should be the norm.

Scenarios for MOH Partnership for TtC Implementation

In order to provide projects with guidance, four scenarios are presented below for the type of partnership arrangement that may be forged for implementation of TtC. These are examples, with the understanding that similar decisions will need to be reached with regard to the nature of the WV-MOH partnership in implementing other 7-11 project approaches besides TtC.

Scenario 1: Most favourable: TtC carried out by MOH health staff with CHWs, using MOH curriculum

As part of the initial dialogue process with MOH officials, we should review the types of household H/N counselling materials in use by the MOH in the country, if any. In many cases there will be locally produced, MOH-approved and sanctioned Information and Education Communication (IEC) materials available and we should make every effort to review these materials to determine their fit to the TtC approach. It is not suitable to introduce our TtC curriculum if similar and equally comprehensive materials already exist locally. In such cases the TtC approach may be carried out using the MOH-sanctioned curriculum instead of our TtC manual. The value-add that we will bring to the process in this case will include assisting the MOH to package the materials into information sets to be delivered at specific times as part of a ‘timed and targeted’ approach and ensuring positive supervision of the CHWs.

In these cases, it is ideal if approval can be gained from the MOH to introduce the timed and targeted approach (using the MOH curriculum) to government health staff, who will go on to train and supervise CHWs. This institutionalises the programming into the formal health system.

Scenario 2: Favourable: TtC carried out by government health staff with community health workers, using WV TtC curriculum

In this scenario we will arrange with the MOH to introduce the TtC curriculum and household counselling approach to MOH-linked CHWs. MOH approval will be necessary for this, as the CHWs will need to add the 7-11 counselling to other community-based health activities they are involved in. Ideally, we will be able to arrange for MOH health staff at zonal/district or community level to train and
supervise the CHWs, so that capacity to carry out ttC becomes institutionalised within the formal health system. For this to happen, MOH approval will be needed to allow health staff to add these training and supervisory responsibilities to their workloads. If this approval is granted, we should enter into a formal partnership agreement with the MOH, in which we (WV) commit to carrying out training of trainers (ToTs), with the MOH health staff, to prepare them for their new 7-11 ttC functions.

For the MOH to agree to and approve the adding of a new programming model to the workloads of its clinic-based health staff and community-based health workers, we should consider programme designs that will see 7-11 programming carried out in geographically neighbouring areas and at a scale large enough to be significant to the MOH. Small-scale, scattered projects will be less likely to gain the attention of the MOH, and ministries will be less willing to take on a new programming model. These considerations must be factored into the 7-11 design process in NOs.

**Scenario 3: Less favourable: ttC carried out by WV staff with CHWs, using WV or MOH curriculum**

In some cases the MOH will agree to allow us to introduce ttC as an additional job responsibility for CHWs, such that ttC will be carried out by these individuals at community level. But they will not agree that their own health staff should be the trainers and supervisors of the CHWs for this programming. If this is the case, the reason will normally have to do with the workloads of the health staff and their inability to take on additional functions. Although this scenario is less ideal because the institutional capacity for ttC programming is not built within the government system, it is still positive given that we can work through official CHWs at community level, as opposed to other community volunteers with less technical background.

In these cases, responsibility for training the CHWs will rest with our sub-national H/N coordinators. Ideally, the CHWs will continue to report their work within the formal health system such that some degree of supervision of the CHWs can be handled by the health staff, jointly with us.

**Scenario 4: Least favourable: ttC carried out by WV staff with other Community Volunteers, using WV or MOH curriculum**

The least favourable scenario is when ministries have no capacity to carry out 7-11 programming through government health staff or CHWs. In these cases, we will carry out ttC programming using our own staff and working through COMM-linked or other community volunteers. The disadvantage is that we set up programming isolated from government integration. On the other hand, one advantage of this scenario will be the rapid scale-up that will be possible given that, as of FY09, there were close to 70,000 CCC-linked community volunteers active in our project areas around the world. This fourth scenario cannot be considered to be one of partnership with the MOH except in the very limited sense of information sharing.

It should be noted that this fourth scenario must be the exception and not the norm; to be considered only in those instances when projects are operating in remote areas without a local MOH presence, or when the MOH strictly cannot take on the ttC implementation responsibilities due to internal staffing, resource and/or protocol constraints.

**2.6 Decision Category #6: Core Staffing**

As with any programming, our 7-11 start-up strategy requires a minimum staffing cadre. The following recommendations in Table 6 describe technical specialist requirements at national and sub-national levels, and non-technical but dedicated staff at the ADP/community level. These positions work in tandem with NO and ADP staffing patterns, which provide routine programmatic support. The functions contributed by these positions are either specialised or additional to core staff (NO and sub-national levels), or required to assure enough dedicated capacity (ADP level). The minimum recommendation means that the staff members represented is the absolute minimum needed to implement our 7-11 start-up strategy with a level of quality assurance and alignment with our WV principles. Exact staffing, roles and responsibilities will need to be determined in each programme based on staff numbers, capacity, workload, nature of partnerships and availability of resources.
<table>
<thead>
<tr>
<th><strong>National Level</strong></th>
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<tbody>
<tr>
<td><strong>H/N ADVISOR</strong> (may include HIV in low-prevalence countries)</td>
</tr>
<tr>
<td>• Programme-level oversight</td>
</tr>
<tr>
<td>• Support and monitoring of DME and implementation</td>
</tr>
<tr>
<td>• Develop national strategy</td>
</tr>
<tr>
<td>• Liaise and ensure positive relationship with MOH and related ministries</td>
</tr>
<tr>
<td>• Identify national-level advocacy issues</td>
</tr>
<tr>
<td>• National-level partnership building</td>
</tr>
<tr>
<td>• Leverage impact through data analysis</td>
</tr>
<tr>
<td>• Build communities of practise</td>
</tr>
<tr>
<td>• Serve as our H/N spokesperson and representative</td>
</tr>
<tr>
<td>• Link in to our regional and global health networks</td>
</tr>
<tr>
<td>• Programmatic quality assurance</td>
</tr>
<tr>
<td>• Facilitate ToTs for and co-manage sub-national staff</td>
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**NUTRITION ADVISOR** (high malnutrition-prevalence countries; i.e. children 6–59 months underweight >30 per cent, stunted >40 per cent, wasted >15 per cent) |
| • Involvement in assessment, analysis and design of H/N programmes |
| • Programme-level oversight, support and monitoring of DME and implementation, national-level representation and advocacy, ToTs, technical assistance to ADPs |

QUALIFICATIONS: Each of these positions requires senior-level technical qualification and experience to allow programme leadership and representation internally and externally.

<table>
<thead>
<tr>
<th><strong>Subnational Level</strong></th>
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<tbody>
<tr>
<td><strong>H/N COORDINATORS</strong> (1 per cluster of ADPs)</td>
</tr>
<tr>
<td>• Liaise and ensure positive relationships with Sub-National MOH authorities and related ministries</td>
</tr>
<tr>
<td>• Provide direct support to ADPs in 7-11 assessment, DME</td>
</tr>
<tr>
<td>• Carry out trainings, as appropriate, of MOH staff, CHW/Vs, CCCs</td>
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<tr>
<td>• Provide technical backstopping as needed in ADPs</td>
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</table>

<table>
<thead>
<tr>
<th><strong>ADP Level</strong></th>
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<tbody>
<tr>
<td><strong>DEDICATED ADP DEVELOPMENT FACILITATORS (NOT SPECIALISED IN H/N)</strong></td>
</tr>
<tr>
<td>• Supervision and mentoring of CHW/Vs</td>
</tr>
<tr>
<td>• Community-level liaisons and partnerships.</td>
</tr>
<tr>
<td>• Represent H/N in ADP development processes</td>
</tr>
<tr>
<td>• Provide mentoring and support to CCCs</td>
</tr>
<tr>
<td>• Activity and data monitoring</td>
</tr>
<tr>
<td>• Coordination and oversight of additional interventions</td>
</tr>
</tbody>
</table>
We may need additional technical staff according to the types and intensity of interventions implemented. CMAM, for example, requires additional technical support for a short duration; HSS activities such as supply chain management analysis and capacity building may require specialists. In such cases partnering with other organisations may meet the needs and should be pursued as priority.

In some countries we have significant numbers of dedicated HIV programme staff, and there is often a reaction to assume that our staff can assume health programming responsibilities. In fact, synergies should be developed between these sector positions, and duplication of responsibilities avoided. However, HIV-dedicated staff with currently full workloads and objectives can not be assumed to expand their responsibilities. This will only serve to weaken both HIV and health programming. Staffing allocations must always be made following careful workload analysis.

SECTION 3:
7-11 Monitoring and Evaluation

Introduction

An essential part of our project design includes the design of an effective monitoring and evaluation (M&E) system. It is important for us to recognise that much of the work in M&E design has already taken place at higher organisational levels, and that the design that projects will be responsible for has mainly to do with setting up the necessary systems to feed into these higher-level processes. This will be further explained in the sections to follow.

3.1 The Three Aims of Monitoring and Evaluation

A good M&E system should serve at least three purposes, or aims, as follows:

• Aim 1: To refine programme performance in the field and compare this with investment patterns (financial and manpower)

• Aim 2: To benchmark our health programming in the context of global health metrics standards

• Aim 3: To complement our commitment to community-level empowerment

Aim 1 is focused on the question of scale and efficiency, which is tied to one of our core values of showing good stewardship. Here we are not focused on making statements about how our programming has ‘caused’ a change in health status; rather, we are showing that funds and talent have been allocated appropriately.

Aim 1 relies more heavily on monitoring and hinges on rapid access to information summarised to the ADP level at least. The highest priority should be on making this information available in an easy-to-interpret format (some call this a ‘dashboard’) that makes it fast and easy for managers to identify where our programming needs mid-course corrections or a strategic re-alignment. The regional and global-level analysis is similarly required in a dashboard format and should also enable managers to assess simple cost-effectiveness metrics at a glance. Project monitoring is discussed in Section 3.2.2.

Aim 2 is focused on making a cautious statement that our efforts have made a difference in improving maternal and child health. The assurance with which we can make this statement varies. Our confidence around these sorts of statements must be tempered by recognition that, in most cases, we are unable to definitively demonstrate a cause-and-effect relationship between our work and any change in health outcomes. In other words, we must remain humble when we frame interpretations related to causality.

Aim 2 relies more heavily on evaluation. It is less demanding in terms of timeliness but will make the most impact in terms of defending the effectiveness of our programming to the world and thereby greatly impact our international credibility in development work. Project evaluation is discussed in Section 3.2.3.

Aim 3 is to promote systems that feed suitable analyses of M&E information to the community level. This essential part of any M&E system is described in Section 3.4.
3.2 WV Monitoring and Evaluation Systems

3.2.1 The Link between 7-11 Programming and the CWBOs
Our development of a set of CWBOs constitutes an organisational effort to operationalise the Christian, child and community-based focus that is central to the organisation's mission. The CWBOs consist of four major child-oriented goals. 7-11 programming contributes mainly to the first CWBO which, in turn, has three sub-objectives, as shown in Table 7.

<table>
<thead>
<tr>
<th>Child Well-being Outcomes</th>
<th>Compendium of Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Children enjoy good health</td>
<td>Indicators for CWBO #1</td>
</tr>
<tr>
<td>• Children are well-nourished</td>
<td></td>
</tr>
<tr>
<td>• Children are protected from infection, disease and injury</td>
<td></td>
</tr>
<tr>
<td>• Children have access to essential health services</td>
<td></td>
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<tr>
<td>2. Children are educated for life</td>
<td>Indicators for CWBO #2</td>
</tr>
<tr>
<td>3. Children are cared for, protected and participating</td>
<td>Indicators for CWBO #3</td>
</tr>
<tr>
<td>4. Children love God and neighbour</td>
<td>Indicators for CWBO #4</td>
</tr>
</tbody>
</table>

**Indicators to measure the CWBOs**
We have developed a comprehensive set of indicators to measure the four CWBOs. The *Compendium of Indicators* is a tool that has been developed to help us select and measure indicators for CWBOs. The sub-set of indicators specific to CWBO #1 will form an integral part of any 7-11 project logical framework (log frame), and will be used to assess project performance and contributions toward the CWBOs. At the same time, indicators related to other outcomes are also often important to H/N programming, and their inclusion leads to more integrated outcomes.

**SEE TOOL CWBO COMPENDIUM OF INDICATORS**
Indicators for child well-being: classification

**Summary indicators:** For every outcome, there is one summary indicator. A summary indicator is broad enough to be measured in any context or country. If a programme or project has selected a particular CWBO in its log frame, the summary indicator is strongly recommended. Summary indicators can be easily summarised for reporting on child well-being at the national, regional and global levels.

**Context-specific indicators:** For every outcome, there are several context-specific indicators. These are indicators that may be useful in some contexts but not in others. These indicators can be selected according to what is relevant for the programme or project plans, appropriate for the local context and in line with NO strategy for child well-being. National or regional offices or the chosen project models may also recommend or require certain indicators as a priority for measuring contribution to child well-being. There are between 3 and 30+ context-specific indicators for each of the CWBOs.

**National-level indicators:** A selection of national-level indicators is included for each CWBO. These are indicators that are not to be measured by us but are taken from secondary sources, such as UNICEF or DHS. These indicators are not required for measurement but are included in case they are useful for advocacy programmes or for NOs in strategies or reports, as a reference or comparison group.

### 3.2.2 WV Monitoring Systems for 7-11 Programming

**Our monitoring framework**

Our interest globally lies primarily with tracking the two types of indicators that serve to measure progress against the CWBOs: (1) high-level core universal indicators and (2) core context-specific indicators. The Global Centre is in the process of developing a monitoring framework with mandatory indicators that all 7-11 projects will report on. By keeping to this framework, we can compare information from both core universal and core context-specific indicators. We are currently developing a tool similar to the Core HIV and AIDS Response Monitoring System (CHARMS) tool used for reporting on HIV and AIDS projects; the *Africa Health and Nutrition Monitoring Indicators* is the first-draft attempt at setting up this tool.

When designing projects, we use a log frame to outline M&E frameworks per LEAP guidelines. After choosing the main areas to focus on, we look carefully at what additional information is needed in order to choose context-specific indicators for monitoring. These indicators together constitute our project monitoring framework.

**Our monitoring system**

**Data collectors**

We will design projects so that CHWs, volunteers and COMMs will routinely collect information and feed it into the monitoring system, using the appropriate monitoring framework. They will collect the information

- from counselling sessions (outputs)
- by observing people’s practices and behaviour in their own home (outcomes)
- from activities within communities (outputs)
- from other project activities (outputs; may be outcomes).

**Data-collection tools: forms and registers**

We will design reporting forms and registers for CHW/Vs, COMMs, and WV staff to use in recording information. These forms should be tailored to the ability of those responsible for collecting the information. When we design these forms, we will

- work with the people responsible for collecting the information to make sure forms are easy to use
- make sure forms and registers are in the language of the people collecting the information and that they are easy to understand (including for illiterate or low-literate people).

The tTC curriculum and training materials for COMMs include sample forms for community-level data collection, but we will need to tailor these to their own information needs and those of the MOH.

**Data-collection systems**

We will set up systems to bring together all the information collected and to create the necessary ‘dashboard’ summaries needed so we can see whether the projects we run are doing what we intended. The Global Centre will be providing guidance on how we should develop the way we collect and analyse information on our projects over time.
3.2.3 WV Evaluation Systems for 7-11 Programming

**SEE TOOL CWBO COMПENDIUM OF INDICATORS**

**Quantitative evaluation: baseline and follow-up surveys**

There are many reasons why quantitative measures are important, including the fact that ways of measuring the effectiveness of the ‘evidence-based’ interventions included in the 7-11 strategy have been around for a long time. There is a great deal of collective experience in how to monitor and evaluate these interventions alone and, to some extent, in combination. What we are introducing is the combination of these individually proven effective interventions delivered in a community-based programming context and at scale.

Our baseline survey should be linked to our project’s log frame created at the time of project design. The baseline will establish the benchmark patterns of behaviours, as outlined in the log frame, against which eventual evaluations of change over time will be measured. As such, baseline indicators need to be aligned with specific issues that a project proposes to influence.

For the purposes of 7-11, baseline and follow-up surveys should include a sub-set of the compendium of indicators relevant to 7-11 (i.e. a sub-set of the indicators for CWBO #1), as relevant to the context and determined through assessment and design. The compendium of indicators is meant to provide a ‘menu’ of indicators from which projects will select those applicable to their project as the basis for developing the survey. The Global Centre will be producing some guidelines with respect to those core indicators that should always be reflected in a survey. The baseline should measure all the indicators at the outcome and goal level and a limited number of relevant, valuable indicators at output level. This follows the process of prioritisation of issues that results from the initial assessment. We will make survey design decisions based on an assessment of those priority behaviours that we seek to influence and the indicators that will serve to measure them.

The Compendium of Indicators Tool for CWBO #1 contains the exact survey question wording that should be used for each indicator. This makes our survey development a straightforward matter. Once we have selected the indicators for measurement (combination of the core indicators required for global reporting and a selection of additional indicators of particular interest to our project), we can pull the survey questions from the Compendium of Indicators Tool for CWBO #1 and develop the survey tool. The Compendium of Indicators indicates the frequency at which evaluation should be repeated. Time frames are normally set at intervals of 3–5 years. As such, we will plan for midterm and final surveys as follow-ups to the baseline at the appropriate times over the span of our project.

Although baseline surveys are not carried out as part of pre-project assessment, it may sometimes be the case that the data collected through the baseline reveals new, important issues needing to be addressed, which were not previously identified through the assessment. We should always be free to revisit our design documents and project plans and make adaptations as needed when new information comes to light, either through quantitative or qualitative processes.

**Qualitative evaluation**

Statistics are one of many tools to demonstrate the value of our programmes. Statistically significant change is important not just to our partnership but also to potential funding sources. Funders will take into consideration evidence of this kind of track record when they decide whether or not to support our programmes. This does not refer solely to multilateral or bilateral donors but, increasingly in today’s world, individuals not unlike us, who choose to donate their funds based on their potential impact.

However, we must also value qualitative information that is gathered by skilled individuals and analysed systematically, for many reasons including the following:

- Qualitative information provides a credible example of how a numeric pattern plays out in real life. In other words, it provides a ‘ground truth’ for our work.
- Qualitative information will always deepen our understanding of the ‘whys’ behind numeric patterns and hence has enormous potential to refine our programming at the field level.
- Qualitative information has an invaluable role to play in developing better quantitative measurement and tools.
- Qualitative information is one of the most agile ways to explore the nature of a problem and thereby seek innovative solutions for potential scale up.

We should also seek to build in qualitative evaluation, through qualitative interview work carried out by external consultants, through structured feedback mechanisms involving our staff and community members and through informal dialogue processes with project beneficiaries.
3.3 Integrating WV’s Monitoring and Evaluation System with Government Reporting Systems

For an M&E system of any H/N intervention, project or programme to be sustainable, it will ideally be linked to the existing Health Information Systems (HIS). In any given country, the government health systems provide comprehensive health services, and we work in collaboration with the existing system to implement activities. It is critically important that we work synergistically with the MOH and that our M&E systems are relevant to national health systems.

Because our intervention delivery platforms are adapted to working at the community level, sometimes our M&E systems may look different from the national M&E standards. In these situations we should strive to preserve the integrity of our internal M&E standards but add high-value, national M&E elements to our system where the greatest gaps exist. For example, it may be possible to add a few additional indicators to the contextualised log frame, which both complements our existing list of indicators and contributes to our partners’ information needs.

Some ways of achieving this synergy between the WV 7-11 M&E system and national governments’ HIS are as follows:

- Review, both prior to project design and on an ongoing basis, policy and protocol documents that describe national and district-level HIS.
- Review and understand the sources of information used by national and district-level HIS.
- Whenever possible, accommodate the routine (e.g. monthly) reporting cycles of the national and district systems to make it easier to identify trends and allow complementary interpretation of information from different sources. This can improve the efficient management of resources.
- Use information gathered from community-based monitoring or evaluation work to offer an alternative perspective to health facility managers that can help improve health worker performance.

3.4 Developing Community-Based Monitoring and Feedback Systems

![Information Flow System Diagram](image-url)
Flow of Quantitative Information

1. CHW collects quantitative information during household visits, using forms developed jointly between us and MOH, according to the information needs of both. (See Section 3.2.2: WV Monitoring Systems.)

2. CHW delivers forms to our staff. This information serves to fulfill our reporting requirements (see Section 3.2.2: WV Monitoring Systems), as well as to enable ‘mid-course corrections’ to project design upon careful and timely analysis of the information.

CHW delivers the same forms to MOH supervisors. This step embodies the sustainability of the community-based quantitative monitoring system, following our exit at the end of the project. MOH uses the information to feed into its overall HIS.

3. We or the MOH collect and summarise the monitoring data and present results to the Community Committee during periodic debriefing meetings (DMs), attended by COMM members, CHWs, MOH representative(s) and our staff. The COMM thereby gains experience in understanding the purpose of quantitative data collection and is empowered to use this data to inform its community responses. Our involvement in this process should phase out over time, with this function remaining with the MOH.

Flow of Qualitative Information

1. CHW engages in ‘dialogue counselling’ with households during household visits. (See Section 1.2 for a description of the dialogue counselling approach.) This dialogue approach is a form of qualitative learning, as the CHW comes to understand many of the constraints or barriers that households may face when attempting to practise new recommended behaviours.

2. CHWs share their learning gained as a result of engaging in dialogue counselling, with others during the periodic DMs. Common themes/issues/barriers may emerge as all the CHWs share their learning. The discussion of these common issues may lead to additional community action in response to identified barriers, and/or may be included in the COMM’s advocacy agenda.

3.4.1 The Debriefing Meeting: The Centrepiece of Community Information Flow

Figure 10 above illustrates the recommended flow of both quantitative (orange) and qualitative (blue) information between and among the various stakeholders in 7-11 programming, to include us, the MOH, the COMM, CHWs and households. For this system to be effective, projects will need to ensure that the COMM hosts periodic (perhaps quarterly) DMs, attended by all CHWs, COMM members and representatives from WV and the MOH. These meetings will have at least three purposes:

- CHWs share (qualitative) learning gained through their dialogues with families.
- WV and/or MOH representative shares monitoring results (quantitative), summarised from the data collected by CHWs.
- Participants in the meeting assess both quantitative and qualitative learning and determine the need for new or additional project and/or community responses. As all stakeholders are present at the meeting, action plans can be developed on the spot.

3.4.2 The Flow of Quantitative Information

The quantitative data collected by CHWs serves the informational needs of WV and, ideally, of MOH partners. This monitoring information is, in part, required for our reporting systems. In addition, it is meant to inform ongoing project implementation, enabling mid-course corrections if results indicate that these are needed. To the extent that the quantitative data-collection system was set up from the outset to meet the informational needs of the MOH, this monitoring system will be sustainable within the community, circulating between CHWs and their MOH supervisors, and maintained by the MOH.

It may not be necessary in a first phase to train the COMM to collect and analyse this quantitative data. The more appropriate end-user of this data is the MOH, and it is better if this partner can analyse the information and present the results to the COMM at the DMs. Our experience has shown that a great deal of time is required to build the capacity of COMM members to a point where they can effectively collect and analyse quantitative data; this is a function better left to MOH partners.

The dotted lines connecting to and from WV (2A) and (3A) are meant to represent the fact that our involvement in the flow of information will phase out over time. The responsibility for the sustainability of the flow of quantitative information will rest with the MOH.
3.4.3 The Flow of Qualitative Information

Whereas the MOH will retain responsibility for ensuring the flow of quantitative information, responsibility for qualitative learning and appropriate response will rest with the COMM. The COMM is responsible for organizing the periodic DMs and inviting all CHWs as well as one or more representatives from the MOH and, in early stages, one of our representatives.

Qualitative information originates from the dialogues that CHWs carry out with families. Qualitative learning may also result from the activities that the COMM carries out at community level, or from the results of local-level advocacy efforts. All of these experiences should be debriefed during the DM. Appropriate community responses to the qualitative learning can be planned at that time.

SECTION 4: IMPLEMENTING 7-11: DELIVERY OF THE CORE APPROACHES

4.1 Introduction

The Structure of the Delivery Approach

We set the 7-11 strategy into motion by working through community structures, in partnership and, where possible, with the MOH. It is not possible for us to carry out the various 7-11 component approaches without the existence of the community group (the Community Committee, or COMM) to provide programmatic oversight and carry out other related functions. It is important to understand this distinction. ‘Community-level,’ as it is used in this document, refers to one of the three levels of intervention for BCC (i.e. individual, community and environment). It also refers to the intermediary link in the continuum of care between household, CHW and health facility. Civil society strengthening through the COMM is the primary approach for responding at this community level within the 7-11 strategy.

‘COMM’ as it is used in this document, however, also refers to the necessary structure required to operationalise the 7-11 strategy. It is in this usage that, in this section of the document, we present the COMM as a pre-requisite for implementing those levels of interventions. We need to ensure that all 7-11 projects identify an appropriate community group – or mobilise this group where non-existent – prior to undertaking the remaining core and, where relevant, optional additional approaches.

Summary of the 7-11 Delivery Approach

• The COMM is the pre-requisite structure for operationalising our 7-11 strategy, and civil society strengthening through the COMM is our core approach for responding at the community level. While the COMM will take on responsibility for overseeing 7-11 programming, it is best if local MOH staff take responsibility for training and supervising CHWs to carry out trtC programming where possible. Both structures are important to the success of our 7-11 strategy.

• CHW-led trtC, or a similar ministry-sanctioned programme, is our core approach for reaching households with accurate information and support; leading to knowledge, awareness-raising, demand creation for services and behaviour change at the individual level.

• Local-level advocacy, along with interventions aimed at HSS, are our core approaches for acting at the environmental level, aimed at promoting policy change and/or improved implementation, appropriate resource allocation and quality health service delivery.

• In addition, pre-project assessments will often indicate the need for, or the desirability of, additional contextually prioritised interventions. We will choose to include additional interventions to the overall 7-11 programming based on specific assessed needs of each locality.

The four core approaches (COMM, CHW/trtC, Advocacy and HSS) are described in detail in the following sections, while summary descriptions of the optional additional approaches can be found in Appendix G. The ADAPT tool is also considered a core approach to H/N project development.
4.2 Community-Level Operational Structure and Core Approach: COMM

The Community Committee, or COMM, represents the collective of stakeholders in the community focused on MCHN outcomes. The COMM is an integrated, child-focused civil society structure empowered to coordinate and manage activities leading to and ensuring child well-being. Our first priority is to always work with, strengthen and support pre-existing stakeholder groups with a focus aligned with 7-11 objectives, regardless of whether these groups were first mobilised as ‘CCCs’ through us or were formed and created independently, through the MOH or through other initiatives. In some countries there are government-sponsored VHCs. In others there are civil society equivalents. Where there is no equivalent, our initiative is to help the community unite such groups. The COMM represents an important opportunity for civil society strengthening: to empower a community entity – versus our own offices – to assume responsibility for H/N outcomes.

Critical Roles of the COMM

The existence of a COMM is a necessary pre-requisite structure needed to support and oversee 7-11 programming and to serve as the critical link between the various 7-11 stakeholders, as follows:

Links

- The COMM is the critical link between WV and the community. In the initial stages of our community engagement, the COMM will play an important role in guiding our staff in the community – in issues to focus on and in designing options for addressing them. Over time, COMMs will assume more project coordination and management responsibilities.
- Scenario 1: COMM supervision of CHWs. (This scenario arises when MOH does not have the manpower at local level to play the supervisory role.) In this scenario, the COMM will be the critical link between CHWs and local health facilities.
- Scenario 2: MOH supervision of CHW/Vs. In this scenario, the COMM will be the critical link between the CHWs and the community.
- The COMM will be responsible for organizing periodic DMs with the participation of CHWs and representatives from MOH and WV. In this and other ways, the COMM is the critical nodal point for bringing all stakeholders together.

Functions

- The COMM will, in Scenario 1, oversee the CHW/trtC programming.
- The COMM will identify, plan and implement appropriate community action around prioritised issues (e.g. organisation of peer groups, creation of emergency funds, organizing community to clean stagnant water, etc.).
- We will work with the COMM – later reaching out to include the wider community – to identify and address issues requiring action of an advocacy nature and will train the COMM to increasingly take on the role of the ‘voice’ of the community around these issues.
- The COMM members will participate in the periodic DMs, aimed at convening CHWs to share experiences of their work with households, to identify successes and constraints in behaviour change and to plan community action around identified ongoing barriers.

COMM Relationship with Local MOH

Where MOH has a community-level presence (local clinics, local health staff), they should be represented in the COMM. These MOH staff may also participate in the quarterly DMs noted above. As described in Section 4.3.3, the counselling of families in 7-11 messages as part of the trtC approach will be carried out either by ministry-linked CHWs or by other volunteers. Responsibility for the supervision of these CHW/Vs will vary by country depending on the agreements reached and arrangements made with the MOH. The two scenarios are as follows:

Scenario 1: MOH supervision of CHW/Vs carrying out trtC (more favourable)

If the MOH approves the programming and has staff available to carry out the CHW supervisory function, this is the preferred approach. In this case, the CHWs will be trained in the trtC methodology by MOH staff (who will have previously gone through a training of facilitators (ToF) carried out by WV technical specialists), will be supervised by these MOH staff and will report to them, using MOH forms and systems. The COMM in this scenario will not have a direct supervisory relationship with the CHWs but will receive summarised reports of their work from the local MOH and will remain involved through their participation in the monthly DMs.
Scenario 2: COMM supervision of CHW/Vs carrying out tTC (less favourable)
In some cases, the MOH will be supportive of our efforts to train ministry-linked CHWs to carry out tTC, but will not have sufficient staff availability to enable MOH supervision of their work. In these cases, the COMM will take on the supervisory responsibility, providing quality assurance of the work that the CHWs are carrying out. The COMM will collect reports from them, using MOH reporting formats as possible, and will present summarised reports to the local MOH.

In other cases, there will either be no existing cadre of MOH-linked CHWs to perform the tTC tasks, or those CHWs working in communities may not have sufficient time – or MOH approval – to add tTC to their existing responsibilities. In these cases, the COMM will then be responsible first for recruiting volunteers and then for carrying out the same supervisory functions vis-à-vis these volunteers as described above.
Our Roles vis-à-vis the COMM

• In the initial stages of community engagement, we will identify existing community groups and dialogue with the group(s) regarding its interest in engaging with 7-11 programming.

• In cases where no such groups exist, we will undergo a community mobilisation process, as described in The CCC Guide, to effectively catalyze the formation of a COMM. Such mobilisation will include foundational training of the COMM.

• Our H/N technical staff will carry out 7-11 related training with existing or newly mobilised COMMs, based on the 7-11 supplement to the CCC Guide (to be developed), to orient these groups around the 7-11-specific functions they will be carrying out.

• We will carry out organisational capacity building (OCB) with COMMs on an as-needed basis, using The OCB Guide.

• We will carry out community-level advocacy training, using either the OCB advocacy module or the Citizen Voice and Action (CVA) manuals, to empower COMMs to take the lead in identifying issues of an advocacy nature and to carry out advocacy-related activities to respond to these issues.

• Our ADP-level dedicated H/N development worker will establish an ongoing supportive and mentoring relationship with the COMM.

Note: The Relationship of COMMs to CCCs

As already discussed, we will choose the most appropriate community group to work with for 7-11 implementation. In some cases, the only existing community group may be a CCC that WV has mobilised as part of the Hope Initiative for purposes of HIV and AIDS-related response. It is perfectly acceptable for a 7-11 project to work through CCCs, using the Supplement to the CCC Guide (see tool below) to train these groups in their new H/N-related responsibilities. In other cases, a community may not have a CCC but there may be an existing VHC, perhaps mobilised by the MOH, for example. In other cases, there may be both a CCC and a VHC operating in the same community, although the preference is to avoid group duplication where possible. We will need to identify existing community groups as part of the pre-design assessment phase and make appropriate decisions around the origin and composition of the COMM, building from the organisational structure of Hope Initiative-mobilised CCCs where appropriate.
4.3 Individual-Level Core Approach: CHW/V Programming for Timed and Targeted Counselling

4.3.1 WV vs. MOH Implementation of the CHW/V and ttC Programming

In keeping with the principle of MOH partnership, it will always be our preference to institutionalise CHW/ttC programming within the MOH, wherever possible. A full treatment of the considerations that will determine whether or not a MOH in a particular country can take full responsibility for the CHW/ttC component of the 7-11 strategy was provided in Section 2.5. A summary of the possible scenarios is provided here, as follows:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>ToF carried out by:</th>
<th>Training &amp; Supervision of CHWs/ Volunteers</th>
<th>MH CHWs or Other Volunteers</th>
<th>Curriculum</th>
<th>Desirability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WV Technical</td>
<td>MOH</td>
<td>MOH CHWs</td>
<td>MOH/WV</td>
<td>Most favourable</td>
</tr>
<tr>
<td>2</td>
<td>WV Technical</td>
<td>WV and COMMs</td>
<td>MOH CHWs</td>
<td>MOH/WV</td>
<td>More favourable</td>
</tr>
<tr>
<td>3</td>
<td>WV Technical</td>
<td>WV and COMMs</td>
<td>Other volunteers</td>
<td>MOH/WV</td>
<td>Less favourable</td>
</tr>
</tbody>
</table>

We will need to make decisions around the forms that CHW/ttC programming will take in each country context, with this document recommending a flexible approach to selecting from among possible models (WV or MOH), curricula and other programming elements. This document is not suggesting that the implementation of CHW/ttC as the core approach at household level means the implementation of a pre-defined and rigid model. Rather, it is perhaps more accurate to say that we should select from among programming options while adhering to the programming standards that the evidence base points to as important to the success and impact of household-level counselling. These programming standards and principles are reviewed in the following sections.
4.3.2 CHW/V Programming

The CHW/V Programme Functionality Assessment

SEE TOOL CHW/V PROGRAM FUNCTIONALITY ASSESSMENT TOOL

In order to effectively carry out ttC, we will first have to ensure the functionality of a CHW/V programme. A complete CHW/V programme is a pre-requisite for introducing the ttC curriculum in communities. A ‘complete’ programme refers not only to the selection/recruitment and training of CHW/Vs, but also to the structures and systems that are necessary to support the CHW/Vs in their work. It is not enough to train CHW/Vs and ‘set them loose’ without first ensuring that the essential components of a functional CHW/V programme are in place. The CHW/V Programme Functionality Assessment Tool provides projects with a framework for setting up such a programme.

To the extent that CHW/V programmes already exist in the project area, the project must consider whether to work through these existing programmes or through a different cadre of volunteers. Any existing CHW/V programmes through which the project is considering working should be assessed as to their functionality, in order to feed into subsequent design decisions. Project design will then include plans to strengthen those areas of functionality that are found to be weak, as the necessary pre-requisite for launching the 7-11 CHW/V programme and related ttC. Projects will use the CHW/V Programme Functionality Assessment Tool developed for this purpose. A list of the 15 programming components is given here. Full guidance on carrying out the assessment is provided in the tool.

CHW/V programming components for assessment
1. CHW/V recruitment
2. CHW/V roles
3. Initial training
4. Ongoing training
5. Equipment and supplies
6. Supervision
7. Individual performance evaluation
8. Incentives
9. Community involvement
10. Referral system
11. Professional advancement
12. Documentation and information management
13. Linkages to health systems
14. Programme-performance evaluation
15. Country ownership

4.3.3 Timed and Targeted Counselling

SEE TOOL FACILITATOR’S MANUAL TO TRAIN COMMUNITY HEALTH WORKERS IN TIMED AND TARGETED COUNSELLING AND ACCOMPANYING CHW WORKBOOK (UNDER DEVELOPMENT)

Introduction
Timed and targeted counselling refers to a CHW/V approach to extending PHC counselling to the household level. The important distinction and expectation of ttC is that this counselling be targeted to households that have specific needs, at specific times. To achieve this, CHW/Vs make a series of visits to households when women become pregnant, and through the child’s infancy or longer, organizing all of the 7-11 messages (reviewed in the ‘Mother Intervention’ and ‘Child Intervention’ tables in Part 2, Sections 4.1 and 4.2) into message sets to be communicated at the most appropriate times, using a counselling and dialogue-based approach. Evidence demonstrates...
that this approach has improved impact over randomly timed counselling. ttC is our primary strategic vehicle for addressing household-level education and behaviour change. It represents a largely preventive approach to PHC and helps to develop appropriate ‘demand’ for services. Effective ttC implementation should lead to health-risk mitigation and increased resilience at the household level.

**Selecting the ttC model and curriculum**

It is important to understand that while the 7-11 strategy calls for ttC as the core delivery approach at household level, this does not imply that all projects will use our ‘branded’ ttC model and corresponding curriculum. In keeping with the principle of MOH partnership, NOs must first enter into discussion with national-level MOH officials to understand the types of MOH-led and sanctioned household outreach programming that may already be ongoing in the country, and review the corresponding manuals and/or IEC materials developed around such programmes. It is always preferable to work with, and help to scale up, MOH-led household outreach programmes than to introduce parallel, WV-developed models and curricula. If suitable ministry-produced household counselling materials are available, these should be reviewed for alignment with our 7-11 messages. Ongoing dialogue will be needed to decide if these materials would benefit from additions to fill potential message gaps or adaptations, specifically with regard to organizing such materials into message sets to enable the timed delivery that the ttC approach recommends.

**Principle elements of timed and targeted counselling**

**Timing of message delivery**

When behaviour change approaches are built around the calendar year or around the providers’ work weeks, messages often reach the ‘doers’ either too late or too early. This aspect of timing of communicating messages is critical for outcomes such as initiation of breastfeeding or measles immunisation, which require precise timing. ttC is designed to enable messages to be appropriately timed: neither too early, lest they be forgotten, nor too late for the behaviour to be practised. The ttC approach organises the many 7-11 messages into message sets to be delivered at scheduled times during pregnancy and infancy.

**Targeted audience**

ttC is designed to be delivered at the household level. Messages are appropriately targeted to those who may practise these behaviours, as well as to members of the household who would influence the decision to adopt these behaviours, such as husbands, grandmothers, mothers-in-law and others.

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**Impact of ttC in north-east India – Jess’s Story**

Jess is the young and energetic community health worker of Meisavaih village of Nagaland state in north-east India. Meisavaih has a population of 2,578. After being trained in home visits and counselling, Jess has tracked 54 pregnant women for timely counselling and linking them with health services. Out of this, at least 40 women who delivered have consumed iron/folate tablets and received tetanus vaccinations during their pregnancies. Jess also ensured that they obtained and ate the extra meal provided from the government’s supplementary nutrition programme. She herself accompanies these pregnant women to the health centre for antenatal checkups. All these mothers gave birth to babies with normal weight. This is significant, as LBW is a huge problem in all the north-eastern states of India, including Nagaland. Her home visit register shows that she visited each mother at least five times during pregnancy. Jess says she does this in order to make them confident about doing the behaviours she promotes, remove doubts from their mind and check whether they are consuming iron/folate daily. She continues to carry on with this work with dedication and makes an extremely positive impact in Meisavaih.
**Household vs. group sessions**

In some cases, the geographic distribution of households may mean that individual household visits will be difficult to arrange and carry out on a regular basis, such as in very sparsely populated project areas. In such cases, it might be necessary to design the ttC component around group, rather than individual counselling sessions. While household-level, one-on-one counselling remains the ideal, group sessions carry the advantage of exposing many community members to the same messages and ideas at the same time, leading to the building of a ‘critical mass’ of people able to consider together the benefits of adopting a new behaviour. This type of peer support often makes it easier and more acceptable for an individual to take the risk of trying something new, lessening the risk of this individual being seen by others as an ‘outlier.’ In both cases, however, the principle of targeting messages to those individuals best in a position to practise new behaviours, along with targeting the influencing persons in that individual’s life, remains the same, be it in a household or group setting.

**Emphasis on counselling and dialogue**

As ttC is normally delivered at the household level, it enables messages to be communicated in a secure environment that encourages open discussion with a skilled and knowledgeable provider. This is critical for those behaviours for which local myths and misconceptions keep caregivers and households from practising the behaviours. It is also an approach that is in keeping with principles of adult learning that recognise that adults are never ‘passive recipients’ of information imparted by ‘experts.’ Instead, adults bring a host of life experiences to bear on the learning process and hence learn best through interactive, dialogue-based methodologies. Household visits enable this type of one-on-one discussion and reflection around the 7-11 messages and promote the suggested behaviours. CHW/Vs will be trained in effective dialogue-based counselling techniques, with these techniques built into the ttC curriculum and corresponding materials/job aids.

**Scheduling of counselling sessions**

While the exact counselling scheduling and sequence may vary based on the choice of ttC curriculum (i.e. WV vs. MOH), a total of eleven scheduled visits – four during pregnancy, one after childbirth, and six during infancy – have been found sufficient to deliver the key 7-11 messages, to follow up on previously delivered messages and to document services utilised and changes in behaviour reported or observed. Figure 13 depicts a suggested scheduling of the eleven sessions.
Integration of additional messages
Due to the intensity of the engagement with families, we recommend incorporating a number of additional objectives into the ttC plan. For example, birth registration would be relatively simple for a CHW/V to counsel on and monitor while engaged with the family around birthing and newborn issues. Certain activities aimed at promoting infant stimulation and early childhood development are other examples. See Appendix D for a discussion of the importance of birth registration and the potential for its incorporation into ttC sessions.

Counselling job aids and household tools
CHW/Vs will make use of job aids to assist in transmitting messages and stimulating dialogue. Whether these are the visual materials produced by WV or similar MOH produced and/or sanctioned IEC materials, the job aids will be simple, pictorial and suitable for both literate and illiterate CHW/Vs and will illustrate and provide details around each of the key 7-11 behaviours. The visuals will make use of 'story sequences' to dramatise key H/N situations. These will enable household members to reflect on their own, perhaps similar, experiences and to dialogue around solutions and positive, preventive behaviours. As part of the CHW/V training, volunteers will develop lists of local myths, misconceptions and constraints related to 7-11 behaviours, along with facts and explanations that can help to surface and transform such beliefs. This will enable the CHW/Vs to effectively address them. Finally, the household members themselves will be provided with a household handbook to serve as a reminder prompt, made up entirely of visuals corresponding to those visuals used by the CHW/Vs to transmit the key messages.

Quarterly reflective meetings
An effective mechanism for mentoring and the formative development of CHW/Vs is the establishment of periodic review and reflection meetings (DMs), led initially by our ADP dedicated H/N development worker, with the participation of the CHW/Vs, the COMM members and MOH staff. At these meetings, volunteers should be encouraged to share their experiences in counselling households, identifying both successes and ongoing barriers to behaviour change, and providing an opportunity for responsive programming adaptations in light of the lessons learned. Over time, the responsibility for organizing the DMs will be transferred over to the COMM and/or the MOH.

4.4 Environmental Level

4.4.1 Core Approach: Advocacy

Introduction
Achievement of improved maternal and child H/N outcomes is within reach if there is sustained continuum of quality care being carried out from household/community to facility and back to community/household. One of our roles in ensuring that this continuum is in place requires facilitating access to basic health services through advocacy by influencing change or formulation of policies affecting the especially vulnerable: mothers and children. When addressing evidence-based gaps in health services, our advocacy work should be integrated within our community-focused work (COMMs, etc.) and extend to sub-national and national levels. This is much needed in these contexts as communities are frequently not aware of their rights to demand quality services and are not informed of developments in the health sector. Therefore, there is a low level of participation in decision-making processes and actions taken by concerned citizens to demonstrate their support for an issue.

Our 7-11 strategy seeks to enable a community-led, evidence-based advocacy approach, building an advocacy agenda for the community based on their specific and prioritised needs. Agenda items are identified through district and local-level assessment and through community experience in attempting to access resources. This approach empowers the community to develop its own voice and message and provides the capacity with which their agendas can be forwarded to decision-makers in order to influence changes in policy.
Advocacy within the 7-11 framework responds in an empowering way to multiple-level H/N policy issues, resource allocation and improvement of health system delivery to the community. As such, we focus primarily on development of health system ‘supply’ of services. Community-led advocacy might address, for example,

- citizen rights to proximate health care infrastructure and health staffing
- improvement in health commodity pipelines
- improved water and sanitation infrastructure
- improved national policies to include minority or marginalised groups in social protection schemes
- improved policies around PMTCT
- inclusion of zinc in national drug protocols.

As multiple ADP communities generate advocacy agendas, these might be consolidated to form national advocacy platforms forwarded by WV and other civil society partners. This advocacy approach evokes our commitment to human rights and children’s rights specifically and also addresses the injustices of inequities between services to the wealthy and the poor.

The community-based advocacy models form part of a bi-directional process, from community up to national and global levels, with policy changes made at one level affecting child well-being back in the community. Community and national advocacy contributes to regional and global advocacy by providing evidence about required changes of policy and practises to influence policy making. It also can take international policy commitments and frameworks and translate them into meaningful actions at the community level. Advancing community-based advocacy requires employment of dedicated staff at both community and national levels to facilitate the processes.

**Selection of a community-led advocacy model**

As with the trC approach, we are not suggesting that naming a community-led advocacy approach as a core response to environmental issues means that a singular, strict model should be implemented. Instead, we encourage understanding of the types of ongoing advocacy initiatives in the country, either through WV or through other civil society organisations. We also encourage consideration of such initiatives alongside the models we have developed here, and to select a model or a way of working that is best-suited to project objectives and local contexts.

To date, we have developed and gained experience in implementing a number of community-level advocacy models. One of those is an advocacy-specific training module created as part of our OCB programme for community groups. Another is known as Citizen Voice and Action, involving longer community engagement, training and support around advocacy-related issues. A third is called Vulnerable Child Advocacy (VCA). Together these models emphasise the following:

- community ownership
- individual citizenship
- child participation
- civil society networking
- influencing government policy
- changing community attitudes and behaviours
- improving services

**Local-level advocacy**

and interventions aimed at health systems strengthening are core approaches at the environmental level
**Model 1: advocacy within organisational capacity building**

Our OCB approach is aimed primarily at community-based organisations such as COMMs, and focuses on strengthening their general organisational capacities rather than H/N-specific technical skills. Examples of organisational capacities include action planning, organisational structure and procedures, leadership, monitoring, recordkeeping, budgeting, etc. Advocacy is included as an important capacity that enables an organisation to work toward transformative action, responding to root causes of problems.

The advocacy module within the OCB Guide seeks a powerful, transformational outcome of the work that the COMM is doing through introduction to the concepts and methods of advocacy-related action. As part of the module, WV facilitators assist COMM members in developing critical awareness, in analysing the root causes of the problems their communities face (in this case, with respect to health and health service delivery), as well as the power relations that might be contributing to these, and in researching and developing an action plan to address pressing issues through advocacy.

This module may be carried out with COMMs at any stage of their organisational development. Although the basic training itself requires only two or three days to complete, the follow-up advocacy-related activities are intended and expected to be long term in nature. COMMs will often require the support and assistance of our staff as they increasingly engage with complex structural issues and with the individuals who have the power to address and improve them.

**Model 2: Citizen Voice and Action**

Citizen Voice and Action (CVA) is an approach that aims to increase dialogue between ordinary citizens and the organisations that provide services to the public. It also aims to improve accountability from the administrative and political sections of government (both national and local) in order to improve the delivery of public services. The approach seeks to empower communities to influence the quality, efficiency and accountability of public services.

Educated, empowered and mobilised citizens are encouraged to assess the performance of public services that are provided in their communities. They are encouraged to compare actual services with the standards of service that their government has committed itself to providing. Citizens, together with service providers, government and local partners identify actions that are necessary to improve public services.

The practise of CVA should include the following core elements:

- information (increasing accessibility and transparency of information)
- voice (strengthening the voice through education and empowerment)
- dialogue (providing opportunity of sharing views)
- accountability (promoting power holders take responsibility for their actions)

**Model 3: Vulnerable Child Advocacy**

The goal of VCA is expanded and strengthened civil society participation at community, national and international levels in developing and implementing policies and programmes that support the well-being of children. Examples include advocacy with the health sector for access to quality newborn and child health care, advocacy at local level for gender-equitable care of girls and boys in nutrition and health care, policy engagement for nutritional policies that are appropriate for children living with or exposed to HIV, advocacy for expansion of ECCD and advocacy and support for implementation of birth registration for all children.

At the community level, VCA assists communities in the identification and verbalisation of issues of injustice facing vulnerable children and works to bring about lasting change. At community and district levels, focus is on identifying advocacy issues of concern to vulnerable children and enhancing partnerships for coordinated advocacy activities. Community-level actors interact directly with government and non-government actors to change individual and community attitudes and behaviour, practises, systems, traditions, laws and policies that perpetuate inequality and deny justice.
4.4.2 Core Approach: Health Systems Strengthening

Introduction
The provision of quality health services and the uninterrupted stocking of basic health commodities are essential components of the ‘supply’ side of the health equation. A full 7-11 strategy will not be entirely effective if the health system is unable to provide the health services and commodities being demanded by the community. WV will need to take action to fill any gaps in the health system with the projects identifying feasible ways of contributing to the strengthening of these systems. The goal is to create the ‘enabling environment’ that will allow the positive H/N recommendations to be practised.

While many of the full range of actions that are normally associated with an HSS approach fall outside the parameters of our organisational strengths and mandates, there are still concrete ways in which NOs can incorporate some elements of HSS into 7-11 programming. HSS can be pursued both indirectly as a beneficial outcome of other core programming activities, and directly via targeted interventions aimed at addressing weaknesses and gaps in health services. These possibilities are reviewed here.

VCA in Action – Peter’s Story

Sexual cleansing is a common traditional cultural practise throughout Zambia, though rituals differ from one ethnic group to another. It is believed that this practice removes the spirit of the dead from a living spouse and if not done, then when the widow or widower remarries or has sex with someone else, both will become incurably insane. Children are often used in sexual cleansing because of their innocence, making them vulnerable to sexual abuse, HIV infection and other sexually transmitted diseases. Through the VCA approach, WV staff in Zambia have equipped advocacy committees to lobby traditional leaders to eliminate this deeply rooted traditional practise. Because of these efforts in Keembe ADP, a by-law was enacted in December of 2009 that outlawed sexual cleansing. In April of 2010, Teddy Mulowa, a rural farmer and chairperson of his local advocacy committee, faced a huge challenge when a 10-year-old boy named Peter was given the task of having sex with a widow who was old enough to be his great-grandmother. “When I heard about it, I quickly mobilised some of our committee members and we used the by-law on sexual cleansing to safeguard Peter’s health and psychological well-being. The family accepted that such cultural practises not only spread diseases like HIV and STIs, but also promote promiscuity among children who we expect to be the leaders of tomorrow,” he said.

SEE TOOL FACILITATOR’S MANUAL FOR ORGANISATIONAL CAPACITY BUILDING (‘THE OCB GUIDE’): MODULE 27: ADVOCACY

SEE TOOL CITIZEN VOICE AND ACTION GUIDELINES

SEE TOOL VULNERABLE CHILD ADVOCACY GUIDELINES
Indirect: Health systems strengthening as a result of implementing the core and additional 7-11 approaches

Examples:

- **Community systems strengthening**: CSS may be considered an extension of HSS insofar as a full continuum of care must stretch beyond the perimeter of the formal health system, reaching into communities and households and beginning with prevention. Community outreach and effective prevention campaigning are frequently gaps in health systems and are areas in which our 7-11 programming can contribute effectively to strengthening the continuum of care and, thus, to the overall health system. The core CHW/trC approach achieves precisely this by training CHWVs to reach households with preventive H/N messages, while the core COMM approach further strengthens the ability of communities to take some degree of responsibility for the health outcomes of their members.

- **Health workforce capacity building**: In some cases NOs will reach agreements with Ministries of Health for the CHW/trC approach to be carried out entirely by MOH staff, with MOH staff training and supervising CHWVs to carry out their household counselling roles. In these cases, the capacity of the MOH will be built to effectively institutionalise, supervise, monitor and sustain ongoing CHW/trC programming, resulting in a stronger health system. Assessment may also demonstrate need to support other cadres of the health workforce, such as midwives or traditional birth assistants.

- **Advocacy**: Community-led advocacy is a core 7-11 approach, with the results of advocacy action intended to result in improved health services. Examples of the types of successes that advocacy action might achieve might be the inclusion of zinc in national drug protocols, improved policies around PMTCT or adherence to health staffing quotas. Any of these successes would result in a more robust health system.

- **Gift-in-kind (GIK)**: The supply of GIK as a programming option is described in the Section 5 on Management. If programmes identify important gaps in essential health commodities through pre-project assessment (i.e. vitamin A capsules, de-worming tablets, LLINs, etc.), it may be possible for an NO to request GIK to fill such gaps. While not contributing to the strengthening of the health system, such as, in the long term, GIK can nevertheless improve the ‘enabling environment’ for the practise of positive health behaviours for as long as it is provided.

Direct: health systems strengthening as a 7-11 programming decision

In addition to the HSS outcomes that will come about as a result of implementing the CHW/trC, COMM and Advocacy core approaches, programmes may also decide to add certain HSS interventions or activities to their 7-11 programming. Two examples are provided here:

- **Train MOH staff in H/N technical skills**: We have developed technical training manuals around a range of nutrition topics to include reducing maternal anaemia, reducing anaemia in children, reducing stunting in children, and anthropometrics. While these technical trainings will often be carried out for WV staff, NOs may also choose to include an MOH capacity-building component into 7-11 project design, offering these trainings to MOH staff at appropriately identified levels.
**4.5 Additional Interventions**

Additional interventions include evidence-based models, or intervention types, proven to achieve impact in relation to specific H/N issues identified in communities. They represent a broad array of PHC approaches pioneered and implemented successfully over the years, and represent important resources for addressing context-specific H/N needs in ADPs.

The need for these models is identified through local-level assessment and the prioritisation of H/N issues to be addressed in the community. For example, community consultation may have identified that a major barrier to exclusive breast-feeding is traditional beliefs enforced by mothers/mothers-in-law. In this case a GMP or Community-CHANGE-type intervention might be appropriate. In an area of high HIV prevalence, an intensified PMTCT initiative would be recommended; in high malaria prevalence areas, the CSS (for malaria) approach would be appropriate, while where chronic malnutrition is prevalent, PD-Hearth might be indicated. These interventions build on our core delivery platforms.

A description of many of the possible additional models and interventions is provided in Appendix G.

**4.6 Managing Gifts-in-Kind (GIK)**

**Introduction**

Health and nutrition gifts-in-kind (GIK) are composed of medical equipment, supplies and medicines that are donated to us and that can be used to enhance 7-11 projects. Other products, such as baby clothes and soap, are also of great relevance to health interventions. Table 8 lists the 7-11 interventions, examples of the products that can support these interventions, and their general availability as GIK. The availability of de-worming tablets, micronutrients and soap is generally limited only by the funds available for paying the handling and shipping costs associated with donations of these items.

WV US is currently implementing a new International Health GIK Strategy and is actively trying to secure more or all of these items, including those marked ‘not currently available.’ WV US will update NOs as the GIK product range changes. In 2010 the planning spreadsheets were changed to include these items. In the meantime, NOs can use the ‘other’ category on their planning sheets to request products that are not listed under the medical section of the planning spreadsheet.
### TABLE 8  Availability of 7-11 Related GIK

#### MOTHERS

<table>
<thead>
<tr>
<th>Product</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adequate diet</td>
<td>Micronutrients</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>2. Iron/Folate supplementation</td>
<td>Ferrous sulphate</td>
</tr>
<tr>
<td></td>
<td>Available in small quantities</td>
</tr>
<tr>
<td>3. TT immunisation</td>
<td>Syringes and needles</td>
</tr>
<tr>
<td></td>
<td>Often available</td>
</tr>
<tr>
<td>4. Malaria prevention and IPTp</td>
<td>Insecticide-treated bed nets</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td>5. Healthy timing &amp; spacing of pregnancy</td>
<td>Contraceptives</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td>6. De-worming</td>
<td>Albendazole, mebendazole</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>7. Maternal health services, ANC, PNC, skilled birth attendance, PMTCT, HIV/STI</td>
<td>Simple home delivery kits, HIV tests</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
</tbody>
</table>

#### CHILDREN 0–24 MONTHS

<table>
<thead>
<tr>
<th>Product</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appropriate breast-feeding</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>2. Essential newborn care</td>
<td>Blankets, baby clothes</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>3. Hand washing with soap</td>
<td>Soap</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>4. Appropriate complementary feeding (6–24 months)</td>
<td>Mid-upper arm circumference (MUAC) straps, RUTF (for CMAM)</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td>5. Adequate iron</td>
<td>Ferrous sulphate</td>
</tr>
<tr>
<td></td>
<td>Available in small quantities</td>
</tr>
<tr>
<td>6. Vitamin A supplementation</td>
<td>Vitamin A capsules 100,000 and 200,000 IU</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>7. ORT/zinc</td>
<td>ORS</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
<tr>
<td>8. Care seeking for fever</td>
<td>Analgesics, antipyretics, penicillin, antibiotics</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td>9. Full immunisation for age</td>
<td>Syringes and needles</td>
</tr>
<tr>
<td></td>
<td>Cold chain equipment</td>
</tr>
<tr>
<td></td>
<td>Often available</td>
</tr>
<tr>
<td>10. Malaria prevention</td>
<td>Insecticide-treated bed nets</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td>11. De-worming (+12 months)</td>
<td>Albendazole, mebendazole</td>
</tr>
<tr>
<td></td>
<td>Not currently available</td>
</tr>
<tr>
<td></td>
<td>Generally available</td>
</tr>
</tbody>
</table>
**Required processes for requesting and receiving GIK**

GIK is always sent to NOs in response to their requests. Every January/February the Global GIK Group (GGG) sends a planning sheet to all NOs which lists the products that the GGG is generally able to secure from WV’s donors. Each year this list is updated to include any new products. Requesting GIK for 7-11 projects should follow this annual planning procedure, allowing the GGG to plan and budget for securing and shipping GIK to NOs in the following year. NOs should provide information on how the GIK will be incorporated into the 7-11 programme, confirm that it is cost effective to supply the product as GIK rather than produce it locally and confirm that the GIK will not harm local markets or the environment. As is the case for all GIK, 7-11 products should be monitored and evaluated as part of the overall programme. Once NOs complete the annual planning spreadsheets, the GGG reviews each submission and uses it as the basis for efforts to obtain the GIK requested through its corporate donors. The GGG recognises that not all GIK needs will be known at the time the annual planning spreadsheet is completed, and will try to respond to requests it receives at other times in the year.

**Note:** All requests made on the annual planning document may not become available during the fiscal year. Because GIK comprises donated products, the WV GGG cannot always guarantee that a particular item requested will in fact be available in the requested quantities. However, some common health GIK (e.g., adhesive bandages or rubber gloves) are generally available in large quantities. Other items are produced to give to WV and can be guaranteed if funds for handling and shipping are available. Finally, there are a number of strategic products that have not yet been donated to WV, which the GGG is working to secure from donors.
END NOTES

39 WHO. Women and Health: today’s evidence, tomorrow’s agenda. 2009.
42 UNICEF Technical Note No 6, Malaria and HIV, February 2003.
44 Ibid.
50 Ibid.
55 Ibid.
56 UNICEF. Tracking progress on child and maternal nutrition. 2009.
57 Ibid.
59 UNICEF. Tracking progress on child and maternal nutrition. 2009.
Ibid.


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