



BUILDING ON COMMUNITY-IMCI

COMMUNITY APPROACHES THAT STRENGTHEN THE CAPABILITIES
OF INDIVIDUALS, FAMILIES AND COMMUNITIES
TO IMPROVE CHILD HEALTH IN HIGH-MORTALITY SETTINGS



Desk review prepared for WHO's IMCI Strategy Review

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GLOSSARY

Capability to be healthy

Drawing on Sen's Capability framework, Venkatapuram defines the capability to be healthy as "a person's ability to achieve or exercise a cluster of basic capabilities and functionings, each at a level that constitutes a life worthy of equal human dignity in the modern world."^{1,2,3} Venkatapuram's conception of social justice considers health as its first priority. He also highlights the tension that arises when expectations of compliance (with treatments or behaviors) are placed upon people in the absence of the material resources (e.g. drugs or social protection safety nets) and capabilities to access and use these resources (e.g. women being unable to access treatment because of mobility restrictions). Both resources and capabilities are necessary to achieve functionings and ultimately, wellbeing.

Community

A neighbourhood and/or group with shared interests and identity.⁴

Community capacity (in health promotion)

Labonte and Laverack defined capacity building as an "increase in community groups' abilities to define, assess, analyse and act on health or any other concerns of importance to their members".⁵ There have been debates about whether community capacity should be seen as means or as end to health promotion. Gibbon and Laverack see it as both: programs that achieve their goals *while* building community capacity are more better than those that do not.⁶ Increases in community capacity are more likely to make programs and gains sustainable and have non-health benefits. Community capacity is both a product of individuals' and families' capabilities, and in turn enables them to flourish further.

Community Dialogue

Community Dialogue is an approach that engages community members in discussing problems and identifying locally feasible solutions.⁷ It includes seven steps, which overlap with the four phases of a Participatory Learning and Action cycle, its 'parent' method: (1) problem identification; (2) analysis; (3) identification of best options; (4) prioritisation of options; (5) planning together; (6) acting together; (7) evaluating together and providing feedback.

Community mobilization

Howard-Grabman and colleagues define community mobilization as: "a capacity building process through which community members, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others".⁸

Continuum of community participation

A framework developed by Rifkin and Pridmore. At one end of the continuum, we find interventions where information is simply shared with the community (the lowest level of participation), then consultation, collaboration, and at the highest level of participation, full responsibility or shared leadership for planning activities.⁹

Frontline workers

Community health workers (in the broadest sense, with the heterogeneity described by several reviews) and NGO-supported workers working in the community.^{10,11,12}

Intervention types and platforms

Single intervention

A single clinical, nutritional, behavioural or environmental action¹³

Examples: taking a pill; breastfeeding within an hour of birth

Intervention package

A collection of single interventions organised into small or large packages

Examples: the 56 essential interventions for RMNCH recommended by PMNCH and WHO¹⁴

Intervention platform and approach

The setting and approach through which a package of interventions is delivered

Examples: counseling during postnatal home visits, women's groups practicing participatory learning and action

I use the term 'platform' because it is often employed in Lancet Series in reference to engagement opportunities such as home visits or group meetings. Every platform is approached with a particular theoretical model of social and behaviour change (see theoretical models of social and behavior change), either explicitly or implicitly.

Health committees

Governance structures (either community or facility-based) that link community members, community health workers and health facilities with the aim of improving governance and health at a local level. Examples include village health committees, health advisory boards, local stakeholder groups and health facility committees.

Participatory Learning and Action (PLA) group

A PLA group is composed of community members who meet regularly and go through a four-phase cycle of participatory meetings under the guidance of a local facilitator (a CHW or NGO-trained worker/volunteer). In the first phase, group members identify locally salient health or development problems, analyse their immediate and more distal causes using their own knowledge and external knowledge, then prioritise the problems for which they want to take action. In the second phase, they discuss and prioritise strategies to address the prioritised problems. In the third phase, they implement their chosen strategies, individually, as a group, and with their community. In the final phase, they evaluate their progress. PLA has a long history in community development, with a number of [tools](#) developed as part of Rapid Rural Appraisal, in collaboration between International Institute for Environment and Development and the Institute of Development Studies. Research on PLA groups in RMNCH has mainly focused on women's groups and Community Dialogue to catalyse individual, family and community-level action.¹⁵

Social and Behaviour Change Communication (SBCC)

Communication to promote behaviors that lead to improvements in health outcomes.¹⁶ SBCC intends to foster actions in the home, community, health facility or society that improve health outcomes using an appropriate mix of individual, group, and mass media methods. SBCC usually relies on formative research with beneficiaries to understand the context, the issue from their perspective and factors that influence practices, then tailor a response. The addition of 'Social' to BCC is used to describe approaches that use a socio-ecological model of behaviour emphasizing the interdependency between individual knowledge, attitudes and behaviors, interpersonal elements (family, friends and social networks), community, organisational (local institutions) and policy environments.

Theoretical models of social and behavior change

There are multiple models of social and behavior change.

Overall, the interventions surveyed in this review had three main theoretical orientations.

The first is the **Health Belief Model (HBM)**.⁴ Interventions that use this model convey the risks or benefits of specific behaviors to those at risk (e.g. "breastfeeding protects babies from illness"), communicate how to adopt the protective behavior (e.g. "here is a picture of positioning"), help to reduce barriers to action ("here are some common breastfeeding problems and how to overcome them) and demonstrate action through skills development activities (e.g. observing and providing support on breastfeeding technique).

Another set of interventions draw on **Social Cognitive Theory (SCT)**.¹⁷ A counselor, facilitator or program start a process begin by learning about an individual's or family's views and experiences of specific behaviors, offer relevant information through context-adapted messages, provide opportunities for social support, instill self-efficacy, model behaviors and provide reinforcements such as goal-setting, follow-up visits and support from influential persons. The counseling approach used in "Caring for newborns and children in the community" draws substantially on SCT.

Finally, some interventions use group-based approaches drawing on **community development and socio-interactionist theory**, including Community Action Cycles, Participatory Learning and Action and Community Dialogue, all of which have the same structure.^{8,18} The intervention starts with learning from participants' own knowledge and experiences, introduces new 'external' knowledge relevant to participants' own experiences, supports them in prioritizing problems identified when these two sets of knowledge are confronted and then explore options for change, take action at an individual and community level before evaluating their progress. The emphasis is on co-creating an intervention by merging the participants' own knowledge with external knowledge, and on developing capabilities for ongoing problem-solving beyond the intervention. There are strong similarities between SCT and the ways in which participatory learning and action has been used in health promotion, though PLA seeks to build collective as well as self-efficacy.

LIST OF ABBREVIATIONS

ASHA	Accredited Social Health Activist (India)
AWW	Anganwadi Worker (India)
CHEW	Community Health Extension Worker (Nigeria)
CHW	Community Health Worker
CINAHL	Cumulative Index to Nursing and Allied Health Literature
C-IMCI	Community Integrated Management of Childhood Illness
HDA	Health Development Army (Ethiopia)
HEP	Health Extension Program (Ethiopia)
IYCF	Infant and Young Child Feeding
iCCM	Integrated Community Case Management (of childhood illness)
IMCI	Integrated Management of Childhood Illness (IMNCI includes newborn infants)
MCE	Multi-Country Evaluation (of IMCI)
NGO	Non-Governmental Organization
NHM	National Health Mission (India)
LGA	Local Government Area (Nigeria)
LHW	Lady Health Worker (Pakistan)
OR	Odds Ratio
PLA	Participatory Learning and Action
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent health
RR	Relative risk or risk ratio
SBCC	Social and Behavior Change Communication
SCT	Social Cognitive Theory
SDG	Sustainable Development Goal(s)
TBA	Traditional Birth Attendant
VHSNC	Village Health Sanitation and Nutrition Committee (India)
VHW	Village Health Worker (employed by IMCI project in Bangladesh)
VVHW	Voluntary Village Health Worker (Nigeria)

EXECUTIVE SUMMARY

BACKGROUND

Community and primary care approaches remain essential to improving child survival in the Sustainable Development Goals era.^{19,20} IMCI is a globally influential child survival program, but its community component (C-IMCI) has been the least implemented, and requires focused attention.^{21,22,23} WHO's Strategic Review of IMCI assesses the program's overall implementation and seeks to identify options for increasing the access to and the utilisation of child health services in countries with high mortality. Well-resourced and integrated community health worker programs are widely seen as essential to increasing the coverage of interventions for child survival and across the continuum of care for RMNCAH.¹¹ In 2015, WHO and UNICEF launched an integrated training course for Community Health Workers entitled *Caring for newborns and children in the community*.²⁴ The course includes three packages to train CHWs on how to conduct home visits for pregnant women and newborn infants, promote healthy growth and development for children under five, and treat or refer sick children. The 2016 WHO Strategic Review provides an opportunity to assess the potential for revising or repositioning activities included under C-IMCI to take into account epidemiological changes, additional knowledge about effective interventions and delivery systems, WHO's new training packages for CHWs, as well as the aspirations of the Global Strategy for Women's, Children's and Adolescents' Health and the Every Woman, Every Child movement.²⁵

AIM

The aim of this desk review is to identify community approaches that can strengthen the capabilities of individuals, families and communities to improve child health, complement activities recommended in WHO's new training course for CHWs, and be effectively and sustainably scaled up.

METHODS

I conducted an analytic desk review after searching Embase, PubMed and CINAHL for peer-reviewed literature on community interventions to improve behaviors and outcomes related to child survival published between 2000 and 2016 using terms from previous systematic reviews. I also consulted WHO, UNICEF and country-specific C-IMCI documents as well as reviews on community health worker programs.

I set three criteria for identifying effective and scalable community approaches. First, they had to be supported by evidence from experimental, quasi-experimental studies, or evaluations nested in large-scale programs and demonstrating improvements in relevant practices or survival (neonatal, infant, or under-five). Second, they had to align with the objectives of the Global Strategy by being equity-focused and providing a building block for continuum of care approaches in RMNCAH. Third, as a simplified indicator of scalability, they had to have supporting training materials and use community platforms commonly found in high-burden settings (e.g. women's associations or health committees). I then considered evidence from India, Nigeria and Pakistan to discuss opportunities and challenges to scale up in more depth.

FINDINGS

Learning from C-IMCI

The Multi-Country Evaluation and Analytic Review of IMCI conducted in 2003 suggest that C-IMCI was probably not scaled up extensively due to: (1) overall lack of resources for IMCI and community health worker programs; (2) a lack of clarity regarding the specific activities to be carried out under C-IMCI; (3) a lack of practical, easy-to-use training tools and job aids for frontline workers and other community-based actors (e.g. health committees).²⁶ A 2001 implementation framework from the CORE group provided critical guiding principles for C-IMCI but was deliberately non-prescriptive in order to build on countries' own experiences and contexts.²⁷ This lack of 'guidelines' from agencies that ordinarily issued so many may have inadvertently resulted in a 'demoting' of C-IMCI in relation to its other more guidance-loaded components. A positive step forward might therefore be to retain the principles of the 2000 CORE framework, but develop more practical tools to support C-IMCI, learning from country experiences and the research community. This would also be a more accurate reflection of the historical development of IMCI components overall: these often emerge out of in-country experiences, become 'repackaged' by technical experts at a global level, and are then branded as recommendations for translation back into local contexts.²⁸

Platforms and approaches

From 2000 to 2016, most intervention studies or programs sought to strengthen the capabilities of caregivers and communities to improve child health through one or more of five platforms, and using a range of theory-informed approaches, as described below.

Home visits

Frontline workers carried out home visits to offer health education to caregivers and their families through didactic teaching or SCT-informed counseling about protective behaviors. Counseling usually promoted desired preventive, care and treatment-seeking behaviors by offering a mix of context-adapted messages, support with decision-making and problem-solving. Some large programs, such as Ethiopia's Model Family program, involved training Health Extension Worker to conduct home visits to counsel families on a wide range of family health practices extending across the continuum of care for RMNCH.²⁹ Many scaled up home visit programs also involved detection and referral for illnesses in newborn infants and as part of iCCM.³⁰

There is strong evidence that counseling through home visits can improve essential newborn care practices, care-seeking for maternal and newborn health problems, and reduce neonatal mortality.^{31,32} Packages including both antenatal and postnatal home visits have led to 30-60% reductions in neonatal mortality in proof-of-principle trials (Risk Ratio [RR]: 0.55, 95% CI: 0.48-0.63), and smaller effects in larger studies embedded within government programs (RR: 0.88, 95% CI: 0.82-0.95).³³ This evidence justifies the creation and scale up of WHO's *Caring for the newborn at home* training module for CHWs, which largely focuses on home visiting. There appears to be no systematic review of the effectiveness of home visits and of different counselling modalities for child survival beyond the neonatal period, though the evidence suggests that visits might be useful to deliver a number of interventions including hygiene promotion for illness prevention, appropriate care-seeking, infant and young child feeding (IYCF), and early childhood stimulation.^{30,34}

Women's groups

Studies and programs have engaged women's groups in three main ways: didactic health education; behavior change communication drawing on SCT; Participatory Learning and Action (PLA) and other methods drawing from socio-interactionist theory.

In the first category, women's groups have served as peer-'amplifiers' to diffuse messages for behavior change (e.g. Care Groups).³⁵ We review the effects of this approach below. In the second category, groups have provided a platform for behavior change by allowing CHWs and women to discuss desired behaviors and barriers to practicing them (e.g. in the Shivargh trial).³⁶ This SCT-informed approach was very impactful in efficacy trials where it was also combined with home visits, but less effective in scale up initiatives: a large SBCC program using group-based counseling with Accredited Social Health Activists (ASHAs) and media approaches to improve maternal and newborn health in India in a population of 23 million in India did not translate into the large reduction in neonatal mortality seen in smaller efficacy studies.³⁷

The most widely tested approach to working with women's groups in the perinatal period is PLA. PLA fulfills the utilitarian functions described above (peer diffusion of information and negotiation of behaviors), and has an additional in-built element of community capacity building. A group of 15-20 women comes together monthly or fortnightly under the guidance of a local facilitator, ideally with one group per 500 population. Groups go through a four-phase cycle of meetings in which they: (1) identify problems, analyse their immediate and more distal causes, prioritise the problems for which they want to take action; (2) discuss and prioritise possible strategies to address the prioritised problems; (3) implement the strategies, individually, as a group, and with their community; (4) evaluate their progress. A meta-analysis of trials in Malawi, Bangladesh, Nepal and India found that women's groups practicing PLA led to a 20% reduction in neonatal mortality (OR: 0.80, 95% CI: 0.67-0.96) and a 23% non-significant reduction in maternal mortality (OR: 0.77, 95% CI: 0.48-1.23).¹⁵ Groups reduced neonatal mortality by over 30% in rural areas when at least a third of pregnant women attended meetings.¹⁵ They were cost-effective by WHO standards and showed had the greatest impact on mortality among the most marginalised.^{15,38,39} A recent trial found that the approach was feasible and reduced neonatal mortality when delivered by India's Accredited Social Health Activists (ASHAs).⁴⁰ This has led India's

National Health Mission to recommend scale up in ten states (see Appendix item 3). The Government of Ethiopia has also recently adapted PLA for its Health Development Army (HDA) based on experiences in Tigray, where it led to strong improvements in care-seeking for maternal and newborn health.⁴¹ The program has been recommended for nation-wide scale up.²⁴ Recent research also shows early positive results following implementation of an integrated MNCH strategy including health systems changes and participatory women's groups in northern Nigeria.⁴²

Evidence on the effectiveness of group-based strategies beyond the neonatal period is more tenuous. A common approach is the Care Group model, which has been used extensively by NGOs to improve child survival and appears to rely largely on the Health Belief Model.³⁵ A paid facilitator meets around ten volunteer women as a group every two to four weeks and shares up to three new health messages about prevention and care-seeking for mothers and children. Each group member relays the messages to around ten households with pregnant women or children under five. George et al. compared ten Care Group projects and nine matched non-Care Group projects in five countries between 1998 and 2010.⁴³ Care Group projects achieved a higher coverage of child survival interventions compared to non-Care Group projects in all countries. The mean annual percent reduction in under-five mortality was -4.80 in Care Groups project areas and -3.14 in non-Care Group project areas ($p = 0.09$). This evaluation used a before and after, non-randomised design, and the impact of Care Groups on under-five mortality was estimated using LiST. Although the approach has mostly been used by NGOs, a recent pre and post controlled study from Burundi found similar increases in knowledge, practice and coverage of child survival interventions in areas with Care Groups integrated within Ministry of Health (MoH) structures compared to areas using NGO-led Care Groups.⁴⁴ This suggests that the approach could be used to support CHWs in areas where they have high workloads, and could be integrated within government health systems. The increases of coverage of key child survival interventions in Care Group projects is impressive, but there are two reasons to be cautious about recommending global scale up: (1) evaluation designs used so far do not enable strong statements about causality; (2) the theoretical approach underpinning the model (sharing context-adapted messages) implies a linear relationship between knowledge and behavior change which has been widely. Given the extensive use of this model, a positive but cautious approach might therefore be to recommend further implementation and urgent testing with more rigorous designs.⁴⁵ Specifically, we need more information about whether what peer-counseling methods are used in Care Group projects beyond 'communicating messages', and impact data on infant or child mortality from randomized controlled trials or better-designed plausibility evaluations.

Engaging with husbands and partners, community leaders and community health providers

Studies and programs widely recommend engaging with men, community leaders and community health providers to diffuse or reinforce messages, negotiate behaviour change, and help create a supportive environment for women and their families to make healthful choices. A recent meta-analysis of fourteen studies found that involving men in individual or group-based interventions increased utilization of maternal health services, including skilled birth attendance and postnatal care, and led to a 66% reduction in the likelihood of postpartum depression (OR: 0.34, 95% CI 0.19-0.62; five studies).⁴⁶ Men have been involved either through SCT-informed counseling during home visits, or as participants during meetings organized by women's groups as part of their PLA cycles.

Several studies described the importance of engaging with religious and political leaders to gain support for maternal and child health activities. Some teams used group (community *durbars*) or individual communication to sensitise political and religious leaders to upcoming interventions³³, or asked them to be actively involved by making supportive speeches and sermons.⁴⁷ In participatory learning and action cycles, groups typically organised two community-level meetings to involve other community members and leaders in discussing maternal and child health problems, ask for their support in implementing the groups' proposed strategies, and share progress.⁴⁸

Private providers (e.g. private doctors, drug-sellers and pharmacists) have not received enough attention in the literature on ICMI. Involving private providers in orientation sessions about IMCI or offering them a full or shortened IMCI training course has been shown to improve their case detection and treatment skills.^{49,50,51} Community Dialogue has also been used to engage with men, leaders and community health providers as part of iCCM in Niger, Mozambique and Malawi for example.¹⁶ This approach has the potential to build community capabilities alongside iCCM scale up and would benefit from further implementation and evaluation. Increasing investment in iCCM through frontline workers combined with community mobilization and innovative methods to improve supervision can increase treatment and care-seeking rates for diarrhea, pneumonia and malaria, and through this could make a strong contributions to mortality reduction.^{52,53,54,55,56}

Health committees

Health committees (e.g. village health committees or health-facility committees) have been used to improve demand for and access to equitable access to services and quality care.⁵⁷ They usually involve community representatives, community health workers and facility-based providers, and often use processes to collect and monitor health data at a community level in order to enable better planning and decision-making locally and at higher levels of the health system. Experience with CHW programs suggests that health committees can be effective in supporting CHW programs and improve accountability when community participation is well-established and there is support for decentralisation planning and action.¹² Recent evidence suggests that iCCM has been scaled up more successfully in settings where it was accompanied by a comprehensive community engagement strategy with support from leadership and collaboration between CHWs and Community Health Committees.⁵⁸ In Kenya for example, joint decision-making through dialogue between community members and service providers led to improvements in facility births and improved the accountability of service providers to the communities they served.⁵⁹ In Vietnam, local maternal and newborn stakeholder groups that included primary healthcare staff and local politicians used a PLA or triple-A “like” problem-solving to improve birth outcomes, leading to increased antenatal care uptake and reduced neonatal mortality.⁶⁰ Ethiopia’s Last 10k programme, which aims to improve maternal and child health in rural areas by linking Primary Health Units and communities, reports that health committees and community-based data monitoring and decision-making are key to their work.⁶¹ This emerging evidence supports the conclusions of a systematic review of the effects of health committees, which suggested that they can improve the quality and coverage of health care.⁵⁷

Mass media

The literature suggests that mass media campaigns can lead to changes in maternal and child health behaviors, especially when new policies, community-based activities, services or commodities are being implemented and when exposure to campaigns is high.^{62,63,64} A systematic review of 111 mass media interventions for child survival found that the majority of campaigns addressed reproductive health (n=67), multiple child survival behaviors (n=44), diarrheal disease (n=15) and nutrition (n=14). Knowledge about desired behaviors and care-seeking improved after exposure to mass media interventions, but there was strong evidence of publication bias in favor of positive studies: only six out of 111 reported negative results. In Burkina Faso, the midline results of a cRCT testing the effects of a radio campaign to improve key family behaviors related to child survival found positive effects on care-seeking for diarrhea (adjusted Difference in Difference [DiD] 17.5%; 95% CI: 2.5-32.5), antibiotic treatment for fast/difficult breathing, and saving money during pregnancy (adjusted DiD, 12.8%; 95% CI, 1.4- 24.2).⁶⁵ Overall, the evidence suggests that mass media is an effective complement to, but not a substitute for, dialogue-based interventions with frontline workers. There is a need for more rigorous evaluations of mass media interventions in health promotion, including for women’s, children’s and adolescent’s health.

Combined approaches

Lessons from successful trials and large-scale programs such as Alive & Thrive suggest that working through multiple community platforms and dialogue-based approaches yields the best results.⁶³ Countries such as Malawi and Nepal have achieved considerable reductions in child and neonatal mortality over the past two decades, and both adopted a mix of community engagement strategies supported by CHWs in addition to iCCM. In Malawi, Health Service Assistants were instrumental in increasing coverage of iCCM and implemented the National Community-based Maternal and Newborn Care package through home visits and demand generation via Care Groups and Community Dialogue.^{66,67} In Nepal, Female Community Health Volunteers (FCHVs) were trained to promote birth preparedness, essential newborn care, detection and treatment for pneumonia and also worked closely with Village Development Committees and women’s groups.⁶⁸

The synergy between home visits and group-based community mobilization to improve neonatal survival has been demonstrated in several successful trials.^{36,69} The balance of evidence suggests that a community strategy combining home visits and groups is likely to be the most effective to reduce neonatal mortality. Participatory Learning and Action groups are recommended to increase the capabilities of communities to improve maternal and newborn health, and have shown good results in high mortality areas, especially when one third or more of pregnant women are in a group. Both home visits and PLA groups have been supported by WHO recommendations and the Every Newborn Action Plan.^{70,71,72}

Characteristics of successful community approaches

Overall, successful community-oriented approaches that strengthen the capacities of caregivers and communities to improve child health have three main characteristics:

1. They rely on a core of *dialogue-based activities with strong investments in frontline workers* (CHWs or NGO-supported workers), including training, supervision and context-appropriate incentives. They draw on formative research in the community, and/or use methods that elicit women's and other community members' priorities, current practices and ideas related to maternal and child problems, then engage them in problem solving about how to overcome them. The most promising approach to working with groups is participatory learning and action, which can build the capacities of women and communities as part of full PLA cycles, or as part of regular engagement with men, opinion and religious leaders by using a short cycle of dialogue and decision-making as in Community Dialogue. While some programs used mass media, the literature suggests that this was most successful as a complement to dialogue-based activities with frontline workers.
2. Successful approaches used a *combination of activities* that created multiple opportunities for engagement between frontline workers and community members, and were strategically chosen for their different strengths. For example, the Shivgarh intervention offered a combination of home visits for women and newborns and monthly community meetings to generate social support for change among mothers, fathers and other community members.³⁶
3. They *build communities' capacities to address broader social determinants of reproductive, maternal, child and adolescent health* (and thereby their capabilities), by going beyond the household level, for example by boosting men and community members' support for maternal and child health, supporting village health committees and addressing issues such as lack of transport or poor quality care in facilities.

RECOMMENDATIONS

1. Scale up home visits with caregivers (mothers, partners and family members) for pregnancy and the neonatal period (as in "Caring for the newborn at home") and for children under five (as in 'Caring for a child's healthy growth and development), using counseling models based on social cognitive theory.

Home visiting interventions are already promoted by WHO and UNICEF, and scale up needs to focus on the most underserved areas and those with a high proportion of home deliveries. In areas with high levels of institutional deliveries, the intervention needs to be complemented by quality improvement activities in facilities.

2. Scale up women's group meetings for maternal and child health, preferably monthly, preferably with one group per 500 population, privileging the most underserved rural communities, and at least 30% of concerned caregivers, e.g. pregnant women and mothers of children under five in groups.

Group meetings drawing on the Health Belief Model or Social Cognitive Theory are likely to further build individuals' and perhaps families' capabilities as during home counseling, but less likely to build community capabilities, which are more likely to be strengthened using Participatory Learning and Action cycles that empower women and catalyze community-wide action.

Two PLA cycles could be supported: the first for maternal and newborn health and the second for the healthy growth and development of older children. Combining participatory learning and action with women's groups with the home visit package 'Caring for the newborn at home' in rural areas of high-burden countries is likely to reduce neonatal mortality and build both caregivers' and communities' capabilities. This approach might be suitable in countries that currently do not have structured group-based interventions for maternal and newborn health. Emerging scale up initiatives in high-burden countries including India, Nigeria and Ethiopia should be supported. A group facilitation module for CHWs is currently being prepared with WHO to complement the home visit module linked to "Caring for the newborn at home".

It would be timely to develop and test a group facilitation module to complement WHO's 'Caring for the child's healthy growth and development' training package. The module could be discussed and designed in a working group similar to the one convened to discuss postnatal visits following the 2012 WHO/UNICEF recommendation⁷³. It could build on recent experiences with PLA to improve child health and development in India and Ethiopia, Positive Deviance, Care Groups, community dialogue and interventions tested in recent trials to improve IYCF, preventive practices and early childhood development in India and Pakistan (see also Appendix 4).^{74,75,76,77,78} There isn't an infinite number of group 'platforms' in a community; a single community cannot have a perinatal group, an IYCF group, a family planning group, a water, sanitation and hygiene group and an early childhood development group running concurrently. An integrated group module that would complement the home visit aids of 'Caring for the child's healthy growth and development" could be adapted by countries that wish to do so and increase the coverage of essential interventions for healthy growth and development.

3. Use participatory engagement methods such as Community Dialogue with community leaders and community providers as part of iCCM

Community mobilization appears to be a key factor in the scale up of iCCM. Participatory methods that enable caregivers and communities to input into and support iCCM, such as Community Dialogue, are recommended as part of iCCM scale up. There is a strong need to develop, test and disseminate such methods with private providers in particular.

4. Disseminate approaches and tools that support effective health committee functioning

In the original C-IMCI framework, health committees were envisaged as key actors to ensure better links, accountability and planning between communities and health services. Their full potential has not been fully realized, despite evidence of benefits in countries where they have received support (e.g. Kenya and Uganda). Clearly there is no one-size-fits-all approach to working with Health Committees, although characteristics of successful structures have been described.⁵⁷ There is a need to collate approaches and tools from settings where facility- and village-based committees have been used and achieved their goals, and disseminate them widely.

5. Use mass media approaches strategically

There is evidence to support the use of mass media as a complement rather than an alternative to investing in community engagement led by frontline workers.

Finally, an additional recommendation is to collate, systematize and test tools for (a) family planning (preconception and postpartum) and (b) adolescent health and nutrition home visits and group meetings to be used by frontline workers. There are numerous training packages for family planning counseling, but fewer for community health workers or peer-educators doing individual counseling or group meetings for adolescent health and nutrition. Collating these tools and integrating them with the "Caring for newborns and children" package would close the loop of CHW training tools for RMNCAH.

BACKGROUND

EVOLVING EPIDEMIOLOGY

The last two decades have witnessed substantial but unequal improvements in child survival. Child deaths fell by half between 1990 and 2015, from 12.7 million to 5.9 million, but deaths during the neonatal period have been harder to reduce and now constitute 45% of all deaths to children under five (2.7 million).⁷⁹ The time around birth is the period of greatest vulnerability: around 2.7 million infants are stillborn every year, and half of all neonatal deaths occur within 24 hours of birth.⁸⁰ Interventions to prevent or treat diarrhoea, malaria, pneumonia and vaccine-preventable diseases – all major killers of children beyond the neonatal period - have received substantial attention, but their coverage remains low and inequitable.⁸¹ A recent systematic review found that caregivers often have difficulty recognizing diarrhea, malaria and pneumonia (<50% for all three illnesses) and few seek help from community health workers (<6%).⁸² Another review focusing on newborn infants found low levels of illness recognition and care-seeking from CHWs.⁸³ Care-seeking for acute lower respiratory infection is particularly low in many settings, and a large proportion of it occurs in the private sector.⁸⁴

Strong inequalities in child mortality persist both between countries and within countries.⁸⁵ There is a need to increase the coverage of child health interventions with a focus on the neonatal period and a commitment to equity. In addition, we must acknowledge broader influences on child survival. An estimated 45% of all under-five deaths are linked to undernutrition.⁸⁶ Gender inequality and women's disempowerment lead to child deaths through a dense web of causation that hides a patriarchal spider.⁸⁷ An ecological study of 138 countries found that increases in the UNDP's Gender Inequality Index were very strongly associated with neonatal ($\beta = 53.8$; 95% CI: 41.6-64.1) and under-five mortality rates ($\beta = 68.1$; 95% CI 49.7-86.9), even after adjusting for potential confounders ($p < 0.001$).⁸⁸ Community actions to build capabilities for RMNCAH must begin by recognising and strengthening women's agency and voice.

Interventions to improve RMNCAH are closely linked, and providing them as a continuum of care could maximise benefits.¹⁴ The global community is committed to ending preventable women's and child deaths by 2035 and achieving a "grand convergence" in reproductive, maternal, newborn and child survival within a generation.⁸⁹ The third SDG and the Global Strategy for Women's, Children's and Adolescents' Health have endorsed two child-focused targets: reducing the global under-five mortality rate to 25 per 1000 and neonatal mortality to 12 per 1000 by 2030.²⁵

Community and primary care approaches remain critical to improving child survival in the SDG era. They can build the capabilities of caregivers and communities to adopt life-saving preventive, care and treatment-seeking practices and generate demand for health services.^{19,20} Strengthening the uptake and quality of care in health facilities is necessary but not sufficient to avert all child deaths: facilities tend to focus on curative care rather than prevention, and children from poor families are less likely to access them.¹¹ Community and primary care approaches alone could save an estimated 372,000 newborn infants by 2020 and contribute to reducing inequities in mortality by reaching the poorest, even as facility-based care increases.¹⁹ Community-oriented approaches also serve the Alma Ata and Ottawa Charter commitments to increasing community participation in the planning of health services.⁹⁰

AIM OF THE REVIEW

Aim: to identify the most promising community-oriented approaches for the treatment, care and prevention of illness in the sick child, with a focus on high-burden countries (under-five mortality rate >50 per 1000 live births)¹. This review is intended to inform discussions about whether C-IMCI should be modified to serve current needs.

Research question: "Which community-oriented approaches can strengthen the capabilities of individuals, families and communities to provide treatment, care and prevention of illness to the sick child, and be effectively and sustainably scaled up?"

Definitions: We have provided a glossary for terms used in this review on p.3.

We define *high-burden countries* as those with under-five mortality rates exceeding 40 per 1000. In 2015, ten of these countries had more than 100,000 child deaths per year and accounted for 60% of the world's child deaths (India, Nigeria, Pakistan, DRC, Ethiopia, Angola, Bangladesh, Kenya, Uganda and Afghanistan).⁹¹

We define *community-oriented approaches* as those that seek improve care practices in the home, boost appropriate care-seeking, engage communities to identify and undertake actions to improve child health, improve health worker communication skills, strengthen links between facilities and communities, and improve the accountability of service providers to community members. These broadly fall under the umbrella of community engagement/participation, community mobilization and health promotion/education activities.

Community engagement refers to a range of approaches along a continuum of participation. In the context of interventions to promote health, Information, Education and Communication (IEC) refers to the process of working with individuals and communities to develop communication strategies that promote positive health behaviors appropriate to their settings, mainly through context-appropriate health education. IEC strategies are usually considered to involve minimal community participation, mainly on a consultative level. Behaviour Change Communication (BCC) recognises that behaviour is not only dependent on having information and making a personal choice, but also requires a supportive environment within the immediate community (including family, peers, neighbours and community leaders) and the wider society.⁹² Community mobilization is more similar to BCC than IEC in that it recognizes the importance of the wider community and society in providing a supportive environment for positive behaviors. As such, community mobilization can be a component of BCC strategies. Community mobilization often uses participatory facilitation techniques to allow individuals and communities to decide which problems they want to address and how to address them. The input of supporting agencies in providing information and advice to guide these decisions can vary, with some letting communities drive the process and others offering more guided support. In its more radical form, community mobilization can challenge the reductionism of BCC strategies that only target key behaviors and do not address their underlying political and economic determinants. For example the MaiMwana Project, a participatory intervention with women's groups to improve maternal and newborn health in Malawi, saw women's groups ask community health workers to come and give information about newborn care, but also organize literacy classes to empower women, thereby challenging some of the more deep rooted causes of ill-health in the community.⁹³

The review examines service delivery from community health workers or other providers only insofar as it involves community engagement/community participation or treatment oriented intervention. Although our brief was to leave out the integrated case management of childhood illness (iCCM), our literature search identified several studies commenting on the importance of community mobilization for the success of iCCM, so this is discussed here. The review does not cover the literature examining the benefits of different approaches to community health worker training, supervision and remuneration, as these are extensively covered in existing systematic reviews and largely dependent on the types of community activities being supported.^{11,12,94,95,96}

We review the most promising community-based approaches in terms of:

- (1) Evidence of their efficacy for strengthening individual, family and community capabilities for the prevention, care and treatment of illness for the sick child as evidenced through reductions in child, infant or neonatal mortality rates or in care-seeking or home practices;
- (2) Enablers and barriers to sustainable scale up in three selected countries (India, Nigeria and Pakistan)

METHODS

I searched the PubMed and Embase databases for articles with abstracts that included “community-integrated” OR “community-based management of childhood illness” OR “community engagement” OR “community participation” OR “behaviour change communication” OR “home visit” OR “groups” OR “health committees” or “health days” OR “child health days” OR “family practices” OR “care practices” AND “child survival” OR “child development” OR “child mortality” OR “neonatal mortality” OR “diarrhoea” OR “pneumonia” OR “malaria”. We searched for articles published between 2000 and 2016 and used the Cochrane filters for low and middle-income countries. We included intervention studies using experimental and quasi-experimental methods, as well as systematic and non-systematic reviews. The initial search returned 2,578 abstracts, which were filtered down to 88 abstracts for relevance. I filtered these further by excluding commentaries and articles solely focusing on iCCM without any reference to community approaches.

I also reviewed WHO and UNICEF programme documents, consulted recent systematic reviews on community health worker performance and motivation and mass media interventions.

I set three criteria for identifying effective and scalable community approaches:

- They had to be supported by evidence from experimental, quasi-experimental studies, or evaluations nested in large-scale programs demonstrating improvements in relevant practices or survival (neonatal, infant, or under-five)
- They had to align with the objectives of the Global Strategy by being equity-focused and providing a building block for continuum of care approaches to RMNCAH.
- As a simplified indicator of scalability, they had to have supporting training materials and use community platforms commonly found in high-burden settings (e.g. women’s associations or health committees).

I then considered evidence from India, Nigeria and Pakistan to discuss scalability opportunities and challenges in more depth.

FINDINGS

LEARNING FROM C-IMCI

In 1995, WHO and UNICEF developed the Integrated Management of Childhood Illness (IMCI) strategy to improve child survival. In 2003, the strategy expanded to include newborn infants. IMCI has three components: 1) building health worker skills; 2) health systems strengthening; and 3) family and community practices that promote child survival, growth and development. The integrated Community Case Management (iCCM) of childhood illness translates facility-based IMCI case management guidelines for use in the community.⁹⁷ In theory, iCCM therefore has activities under all three IMCI components including health worker training, improving linkages between facilities and community mobilization to stimulate demand.⁹⁸ The third component of IMCI – Community-Integrated Management of Childhood Illness or C-IMCI - was intended to support and strengthen the first two by building the capacity of caregivers and communities to protect the health of children.

The CORE group and an inter-agency working group on IMCI including WHO and UNICEF formulated seven basic aspirational principles for C-IMCI, all of which remain relevant for WHO's 2016 Strategic Review:

- (1) It should be implemented at a district and community-level but be linked to a national plan;
- (2) It should build on existing programs and community structures rather than create new ones;
- (3) It should use participatory approaches to planning and implementation to promote ownership and sustainability;
- (4) It should seek to build partnership at all levels with clearly defined roles and responsibilities;
- (5) It should recognise the importance of both curative and preventive interventions for reducing child mortality and morbidity;
- (6) Ideally, all three components of IMCI should be implemented together, as C-IMCI is likely to work best if the two other components are in place – if this is not possible C-IMCI could be initiated and the other two components could be gradually introduced;
- (7) Phased introduction of key family health practices is acceptable.

The CORE group also proposed a framework for the implementation of C-IMCI. The framework was intended to be descriptive rather than prescriptive, and the expectation was that implementation would differ from country to country.⁹⁹ It included four main components:

CORE group framework: The four components of C-IMCI

(1) Improve partnerships between health facilities and the communities they serve

The aim of this component was to increase the use of health facilities and outreach services by creating equitable partnerships allowing for community input in health services and participation in the management of health facilities. Recommended activities included joint outreach by community and facility-based workers at a village level, collaborative oversight of health facilities by village health committees, and collaboration on health information systems to plan health service delivery and measure progress.

(2) Increase appropriate care and information from community providers

Examples from vertical disease-specific programs that it is helpful to build the skills of formal community health workers to provide counseling, care, and contribute to community mobilization, while at the same time engaging with other community providers including volunteers, traditional healers, traditional birth attendants, private practitioners, pharmacists and drug sellers.

(3) Integrate the promotion of key family practices for child health and nutrition

This third component focused on the promotion of 16 key family health practices at the household and community level.¹⁰⁰ Efforts at community and district level could be complemented by mass media campaigns. The original framework also stated that communities should develop a sense of ownership of the key practices, and share responsibility for practicing and promoting them in the long-term.

(4) Link efforts to those other sectors to address the determinants of ill health and achieve sustained improvements in health

Recognising that health is intimately linked to other sectors (e.g. livelihoods, education, water and sanitation), the final element of C-IMCI recognises this and suggests the creation of a multi-sectoral platform to build partnerships between the health and non-health sector.

Of all three arms of IMCI, C-IMCI has been the least widely implemented: by 2003 over 103 countries had integrated the first two IMCI components into their health systems, but only an estimated half of these gave additional attention to improving family and community practices.²⁶ The 2004 Multi-Country Evaluation of IMCI found that health systems factors impeded implementation and scale-up of the strategy overall.²² The scale up of C-IMCI, in particular, was impeded by a lack of practical guidance for implementation and this limited the potential of the broader strategy to have an impact on child mortality.

The 2003 analytic review of IMCI conducted in Egypt, Indonesia, Kazakhstan, Mali, Peru and Zambia found that activities related to community IMCI started later than the training of health workers in first-level health facilities, and that coverage of these activities was low or non-existent in most of the six countries.²⁶ Key informants said that there was a lack of understanding about Community IMCI “was”.²⁷ Although the 14-16 key evidence-based family health practices recommended by WHO were well accepted, there was a felt need for prioritisation and simplification of messages and actions.²⁶

When countries and donors made funds available for community interventions, these were sometimes re-branded as part of C-IMCI, but the projects were often limited in scale and not always well-coordinated with health services. There were materials to help facilitators carry out in-country planning workshops for C-IMCI, but, critically, there were no widely disseminated practical training manuals or job aids for community health workers linked to community IMCI, though PAHO and other groups had made their own.¹⁰¹ One of the framework’s architects, Peter Winch, described a clash of expectations: NGO implementers liked the flexibility of the CORE framework because they had helped develop it, and it gave them a scheme that resonated with their concerns and experiences on the ground. Participants from Ministries of Health, on the other hand, wanted a clearer definition of C-IMCI as well as concrete, budget-linked activities and tools for implementation, more akin to what was done with the health worker training component.^{26,27}

As described earlier, the 2000 C-IMCI framework did not include specific guidance on the mix of community-oriented approaches to be considered, or a planned sequence of home visits or group meetings to promote the 16 key family health practices. As a result, C-IMCI has been implemented in very different ways across countries. Of the five countries that took part in the Multi-Country Evaluation (MCE), three provided details of their C-IMCI activities (Bangladesh, Brazil and Peru).^{47, 102, 103} These are described in detail in Appendix 1. In all countries, C-IMCI started after facility-based IMCI (Brazil, Uganda), or took place in different areas to facility-based training (Peru).¹⁰⁴ In Bangladesh and Tanzania there were pre-existing C-IMCI “like” activities to improve child health and nutrition.¹⁰⁵

Encouragingly, IMCI appeared to be most effective when all three strategies were implemented together. In Bangladesh for example, increases in both the quality of facility-based care and appropriate care-seeking for illness resulted in substantial increases in the use of services.⁴⁷ In a 2012 effectiveness trial of IMCI in India, community interventions included antenatal and postnatal home visits in pregnancy as well as three-monthly meetings with women’s groups. These interventions reached high coverage, with 40-45% of mothers receiving three visits in the first week of life and 45.6% attending a group meeting, leading to substantial improvements in newborn care practices.⁴⁹

An evaluation of UNICEF's 2001-2005 Accelerated Child Survival Programme, which supported IMCI in Mali and Benin, provides further insights into C-IMCI and its synergistic relationship with the other IMCI components.¹⁰⁶ Overall, the ACSD did not improve child survival. Bryce et al. hypothesised that this might have been due to the low coverage of effective treatment interventions for malaria and pneumonia, especially the lack of community case management, and the fact that neonatal deaths and undernutrition were not addressed. In addition, she commented that unremunerated and poorly supervised CHWs were largely trained to provide health education to mothers through messages, that there were too many of these, and that several did not target key causes of mortality.¹⁰⁶

After the MCE, the four most widely used activities described in the literature as falling under C-IMCI were home visits and group meetings, orientation meetings to disseminate key IMCI messages with community leaders, religious leaders, and the Care Group model, which will be described in the next section.

The 2003 Analytic Review of IMCI, the 2004 Multi-Country Evaluation and the broader IMCI literature suggests that scale up of C-IMCI was impeded by: (1) a lack of resources channeled towards community frontline workers, their training, supervision and incentives, and a focus on health-facility based training; (2) a lack of clarity regarding the specific activities to be carried out under C-IMCI; (3) a lack of practical, easy-to-use training tools and job aids for community health workers and other community-based actors (e.g. health committees) and a focus on high-level conceptual and implementation frameworks. While this was intended to provide flexibility in implementing C-IMCI, it also contributed to unequal implementation. The principles of the 2002 CORE Framework for C-IMCI remain extremely useful to inform future programming however, as they articulate basic principles of partnership, phasing, and flexibility to local needs. A positive step forward would therefore be to retain the principles of the 2002 CORE framework, but develop more practical tools to support it, building on WHO's new 'Caring for newborns and children in the community' and learning from country experiences and the research community.

OVERVIEW OF COMMUNITY APPROACHES

From 2000 to 2016, most intervention studies or programs sought to strengthen the capabilities of caregivers and communities to improve child health through one or more of five platforms, and using a range of theory-informed approaches, as described below.

Home visits

Home visits to caregivers are the most commonly used approach for building the capabilities of caregivers and families to prevent, manage or seek treatment for newborn and child illnesses, as well as to improve healthy growth and development.¹⁰⁷ Most home visiting interventions involve counseling to promote behaviors through interpersonal communication, sometimes with additional practical skill-building activities, problem-solving and goal setting as informed by Social Cognitive Theory. Most studies of home visiting strategies carried out over the last decade have focused on the perinatal period and on IYCF, stimulation and parenting, with fewer studies testing interventions to improve recognition, care and treatment-seeking for illnesses in older children aside from the MCE studies.¹⁰⁷

The strongest evidence in support of home visits to improve child survival comes from South Asian studies focusing on improving maternal and newborn health. Packages including both antenatal and postnatal home visits have led to 30-60% reductions in neonatal mortality in proof-of-principle trials (RR: 0.55, 95% CI: 0.48-0.63), and smaller effects in larger studies embedded within government programs (RR: 0.88, 95% CI: 0.82-0.95).³³ Until recently most studies had been from South Asia, with additional quantitative pilot data from Southeast Asia.^{31,108} In the last three years however, important evidence about home visiting interventions for newborn care have emerged from Ghana, Tanzania and Uganda.^{33,109,110} In all three cases, the interventions achieved changes in essential newborn care practices. Effects on neonatal mortality were measured in two studies and were either in the right direction but too small to detect (0.92, 0.75-1.12 in Ghana) or not apparent (odds ratio [OR] 1.1, 95%CI: 0.9-1.2); the authors attributed this to substantial increases in facility-based deliveries and/or poor quality of facility-based care.^{33,109} These emergent findings suggest that while scaling up counseling through home visits could improve essential newborn care practices at scale where coverage is sufficient, in settings where facility-based deliveries are rising rapidly it may not be sufficient to reduce mortality in the absence of quality improvement strategies.

What about illnesses? Tripathi et al. (2016) meta-analysed seven trials examining the effects of home visits by CHWs on the identification of serious illness in newborn or young infants (up to 59 days of age). There was wide variation in the CHWs' ability to identify serious illness (33.3 to 90.5%), but their home visits did significantly improved care-seeking for those serious illnesses that were identified (RR=1.35; 95% CI=1.15 to 1.58, n=6 studies).¹¹¹ Six out of the seven trials were conducted with newborn infants, so generalizability for older children is limited.

What about older children? Surprisingly, there appears to be no systematic review of the effectiveness of home visits and of different counselling modalities for child survival beyond the neonatal period, though the evidence suggests that visits might be useful to deliver a number of interventions including hygiene promotion for illness prevention, appropriate care-seeking, infant and young child feeding (IYCF), and early childhood stimulation.^{30,34} Home visits were an important element of the C-IMCI strategy tested in Bangladesh: Village Health Workers reached around half of mothers with infants in their study areas, which may have contributed to the positive changes in care-seeking behaviors observed in this study.⁴⁷ A 2016 meta-analysis examining the effects of hand washing promotion for the prevention childhood diarrhoea in LMICs found community-based hand washing promotion could prevent around a quarter of diarrhoea episodes (rate ratio 0.72, 95% CI 0.62 to 0.83; eight trials, 14,726 participants); half of the interventions reviewed involved a home visit.¹¹² BRAC has successfully engaged CHWs to visit homes in order to detect, refer or treat children with acute respiratory infection.¹¹³ Finally, interventions to promote appropriate IYCF practices and stimulation for development have also made successful use of home visits in combination with other strategies.^{76,77,78}

Overall, the successes achieved with home visiting programs across a range of maternal and child health outcomes justifies the WHO's focus on this platform as a key opportunity for the activities described in 'Caring for newborns and children in the community'. There are two caveats to this. First, several of the most successful home visiting interventions for neonatal survival, growth and development also included other activities, especially group meetings, and these could be considered to support these packages. Kumar et al. combined group meetings with home visits and had the largest reduction of any community intervention to reduce neonatal mortality aside from Abhay Bang's home-based newborn care trial.^{36,114} Yousafzai et al. combined home visits with monthly women's groups meetings to achieve improvements in child development with the LHW programme in Pakistan.⁷⁸ Second, a key lesson of IMCI is that "community interventions are not a panacea for weak health systems".⁹⁸ The effect of home visits on behaviors and mortality is likely to vary considerably by context and strength of implementation. Key issues will include maintaining quality, coverage and reaching the poorest families at scale by addressing the CHW selection, role clarity, training, supervision, supplies, incentives and health systems linkages amply discussed in the literature on CHW programs.¹² In settings where access to facility-based care is high, quality improvement interventions and those focusing on linking communities to facilities will be required, in addition to household-focused activities.

Women's groups

While home visits can build the capabilities of caregivers and families to care for healthy and sick children, group-based strategies can strengthen their impact by using SCT-informed approaches but also help catalyse broader community action. Researchers and programs have worked with groups in different ways and with varying degrees of intensity. Some have used groups to disseminate messages (group communication). For example Baqui et al.'s Community Care arm had a community mobiliser who disseminated messages in a population of 18,000 by rotating across areas of 225 every four months.¹¹⁵ Others, such as the Hala trial team, did monthly group meetings as part of behaviour change communication, in order to negotiate the adoption or avoidance of specific behaviors.⁶⁹ This SCT-informed approach was very impactful is efficacy trials where it was also combined with home visits, but less effective in scale up initiatives: a large SBCC program using group-based counseling with Accredited Social Health Activists (ASHAs) and media approaches to improve maternal and newborn health in India in a population of 23 million in India did not translate into the large reduction in neonatal mortality seen in smaller efficacy studies.³⁷

The evidence suggests that low intensity groups (e.g. every 3-4 months) and those that do not include a substantial proportion of members concerned with the problems discussed (e.g. few pregnant women, or mothers of infants) fail to gain 'traction' in the community and therefore to have impact.^{15, 37, 47, 69, 115}

The most widely tested approach to working with women's groups is participatory learning and action (PLA). PLA fulfills the utilitarian functions described above (peer diffusion of information and negotiation of behaviors), and also seeks to support women's empowerment and build community capacity. A group of 15-20 women comes together monthly or

fortnightly under the guidance of a local facilitator, ideally with one group per 500 population. PLA involves a four-phase cycle of meetings in which group members: (1) identify problems, analyse their immediate and more distal causes, prioritise the problems for which they want to take action; (2) discuss and prioritise strategies to address the prioritised problems; (3) implement the strategies, individually, as a group, and with their community; (4) evaluate their progress. In the course of the cycle, PLA groups also have at least two community meetings. In the first they share their prioritised problems and strategies with the wider community, including men, community leaders and local health providers, in order to ask for their support in implementing the strategies. In the second community meeting, they share their progress and plan for the future.⁴⁸

A meta-analysis of trials in Malawi, Bangladesh, Nepal and India found that women's groups practising participatory learning and action led to a 20% reduction in neonatal mortality (OR: 0.80, 95% CI: 0.67-0.96, 7 studies, n= 119,428) and a 23% non-significant reduction in maternal mortality (OR: 0.77, 95% CI: 0.48-1.23).¹⁵ Groups reduced neonatal mortality by over 30% in rural areas when at least 30% of pregnant women attended meetings.¹⁵ Three out of the four effective trials were conducted in South Asia, where neonatal mortality was high and care-seeking low. One trial from Malawi combined participatory groups with a health facility-based quality improvement intervention, leading to a 16% reduction in perinatal mortality (OR: 0.84, 95% CI 0.72-0.97).¹¹⁶ The women's group interventions improved home care practices including early and exclusive breastfeeding, the use of clean delivery kits and delayed bathing, but had less impact on care-seeking behaviors.¹⁵ Process evaluation data from seven trials show that the groups implemented a wide of range of strategies addressing both proximal (low awareness of danger signs) and distal determinants of maternal and child health (low social support for women's health, financial insecurity, lack of transport, illiteracy).⁹³ They were cost-effective by WHO standards, inclusive, and showed the greatest impact among the most marginalised.^{38,39}

Can the intervention be scaled up in high-burden countries? A recent trial found that the approach was feasible and effective when delivered by India's Accredited Social Health Activists (ASHAs).⁴⁰ This has led India's National Health Mission to recommend scale up in ten states (see Appendix for details). The Government of Ethiopia has also recently adapted PLA for its Health Development Army (HDA) based on experiences in Tigray, where it led to strong improvements in care-seeking for maternal and newborn health.⁴¹ The program is poised for nation-wide scale up. Recent research also shows early positive results following implementation of an integrated MNCH strategy including health systems changes and participatory women's groups in northern Nigeria.⁴²

Evidence on the effectiveness of group-based strategies beyond the neonatal period is more tenuous. While there is substantial evidence for the effect of PLA during the perinatal period, much less evidence is available for this particular approach to improve the health of older children, though recent evidence from Bangladesh suggests that they can improve knowledge and practices related to child health and nutrition.¹¹⁷ There is a long history of participatory group interventions to reduce undernutrition, as summarised by Rifkin and colleagues in 2007, and many drawing on group-oriented methods such as Positive Deviance.¹¹⁸

One of the most widely implemented group intervention to improve child survival is the Care Group model.³⁰ A paid facilitator meets around ten volunteer women as a group every two to four weeks and shares one to three new health messages about prevention and care-seeking for mothers and children. Each group member relays the messages to around ten households with pregnant women or children under five. George et al. compared ten Care Group projects and nine matched non-Care Group projects in five countries between 1998 and 2010. Care Group projects achieved a higher coverage of child survival interventions compared to non-Care Group projects in all countries. The mean annual percent reduction in under-five mortality was -4.80 in Care Groups project areas and -3.14 in non-Care Group project areas ($p = 0.09$).⁴³ This evaluation used a before and after, non-randomised design, and the impact of Care Groups on under-five mortality was estimated using LiST. Most Care Group programs have been implemented as three-way partnerships between communities, governments and NGOs. Departing from this model however, a recent pre and post-test controlled study from Burundi found that areas with Care Groups integrated within Ministry of Health (MoH) structures had similar increases in knowledge, practice and coverage of child survival interventions compared to areas using an NGO-led Care Group model.⁴⁴ This suggests that the approach could be used to support CHWs in areas where they have high workloads, and can be integrated with government health systems. The increases of coverage of key child survival interventions in Care Group projects is impressive, but there are two reasons to be cautious about recommending global scale up: (1) evaluation designs used so far do not enable strong statements about causality; (2) the theoretical approach underpinning the model (sharing context-adapted messages) implies a linear relationship between knowledge and behavior change which has been widely. Given the extensive use of this model, a positive but

cautious approach might therefore be to recommend further implementation and urgent testing with more rigorous designs.⁴⁵ Specifically, we need more information about whether what peer-counseling methods are used in Care Group projects beyond ‘communicating messages’, and impact data on infant or child mortality from randomized controlled trials or better-designed plausibility evaluations

In conclusion, the evidence supports the WHO’s recommendation to scale up women’s groups using participatory learning and action to reduce maternal and neonatal deaths in rural areas of high mortality settings. This method can complement antenatal and postnatal home visits with a focus on building community capacity. The evidence also supports further review, discussion and implementation research on the effectiveness of group-based intervention for child survival beyond the neonatal period, in support of the intervention described in “Caring for children’s healthy growth and development”, including Care Groups, SCT-informed behavior change communication with groups and PLA approaches.

Engaging with husbands and partners, community leaders and community health providers

Studies and programs widely recommend engaging with men, community leaders and community health providers to diffuse or reinforce messages, negotiate behaviour change, and help create a supportive environment for women and their families to make healthful choices. A recent meta-analysis of fourteen studies found that involving men in individual or group-based interventions increased utilization of maternal health services, including skilled birth attendance and postnatal care, and led to a 66% reduction in the likelihood of postpartum depression (OR: 0.34, 95% CI 0.19-0.62; five studies).⁴⁶ Men have been involved either through SCT-informed counseling during home visits, or as participants during meetings organized by women’s groups as part of their PLA cycles.

Several studies described the importance of engaging with religious and political leaders to gain support for maternal and child health activities. Some teams used group (community *durbars*) or individual communication to sensitise political and religious leaders to upcoming interventions³³, or asked them to be actively involved by making supportive speeches and sermons.⁴⁷ In participatory learning and action cycles, groups typically organised two community-level meetings to involve other community members and leaders in discussing maternal and child health problems, ask for their support in implementing the groups’ proposed strategies, and share progress.⁴⁸

Private providers (e.g. private doctors, drug-sellers and pharmacists) have not received enough attention in the literature. Grépin examined the share of maternal and child services delivered by the private sector using 198 Demographic and Health Surveys from 70 low-income and middle-income countries collected from 1990 to 2012.¹¹⁹ 54% of treatments for diarrhea and 57% of treatments for fever or cough were accessed through the private sector. Treatment for children was more commonly accessed in the private sector than reproductive health services. These data suggest the need to engage with the private sector in relation to childhood illness. Involving private providers in orientation sessions about IMCI or offering them a full or shortened IMCI training course has been shown to improve their case detection and treatment skills.^{49,50}

Recent evaluations of iCCM programs in Burkina Faso, Malawi and Ethiopia show that the Burkina Faso programme suffered from a lack of systematic community mobilization to generate demand for services, as well as problems with training and supportive supervision.¹²⁰ Community Dialogue has also been used to engage with men, leaders and community health providers as part of iCCM in Niger, Mozambique and Malawi. This approach has the potential to build community capabilities alongside iCCM scale up and would benefit from further implementation and evaluation. Increasing investment in iCCM through frontline workers combined with community mobilization and innovative methods to improve supervision can increase treatment and care-seeking rates for diarrhea, pneumonia and malaria, and through this could make a strong contributions to mortality reduction.^{49,50,51,52}

A review of debates relating to the benefits of TBA training is beyond our remit. Briefly however, a string of systematic reviews by Sibley et al. have suggested that training could improve the knowledge, attitudes, and behaviors of TBAs, but that impacts on perinatal and maternal mortality remained to be determined through more and better research.¹²¹ Recommendations from existing systematic reviews are conflicting.^{31,122} In settings where TBAs are widely used, involving them in community mobilization activities is very likely to be beneficial, as demonstrated in at least three trials where they were took part in group discussions or PLA cycles which led to strong improvements in home delivery practices.^{66,123,124}

Health committees

Health committees (e.g. village health committees or health-facility committees) have been used to improve demand for and access to equitable access to services and quality care.⁵⁷ They usually involve community representatives, community health workers and facility-based providers, and often collect and monitor health data at a community level in order to enable better planning and decision-making locally and at higher levels of the health system. It is difficult to test the benefit of health committees as they are often considered essential to the functioning of primary health care under a commitment to Alma Ata and the Ottawa Charter and simply not in need of ‘testing’.

Experience with CHW programs suggests that health committees can be effective in supporting CHW programs and improving accountability when community participation is well-established and there is support for decentralisation planning and action.¹¹ In addition, recent evidence suggests that iCCM has been scaled up more successfully in settings where it was accompanied by a comprehensive community engagement strategy with support from leadership and collaboration between CHWs and health committees.⁵⁸ In Kenya, Kaseje et al (2010), examined the impact of joint decision-making through dialogue between community members and service providers in 12 intervention areas compared with 12 matched control areas across six districts, and found large improvements in facility births (41% in intervention sites vs. 23% in control sites, $p < 0.001$), as well as improved accountability of service providers to the communities they served.⁵⁹ In Vietnam, local maternal and newborn stakeholder groups that included primary healthcare staff and local politicians used a PLA or triple-A “like” problem-solving to improve birth outcomes, leading to increased antenatal care uptake and reduced neonatal mortality.⁶⁰ In Uganda, an initiative called CODES combined UNICEF tools to systematize priority setting, allocation of resources and problem solving with Community dialogues based on Citizen Report Cards and U-Reports to engage communities in monitoring service provision and demanding quality services. Community dialogues based on the Citizen Report Cards (CRC) brought together service users, providers and leaders. The Dialogues increased community awareness of health care services, utilization, and led to discussions on processes for improvement. The dialogues also brought together service users, providers and leaders to discuss problems and find solutions.¹²⁵ Health committees have also been widely involved in the use of social autopsies for maternal and child health. A review of the history and use of social autopsy tools by health committees provide evidence of their usefulness, especially when communities are involved in the inquiry and follow-up action.¹²⁶ The development and wide-scale adoption of agreed, standardized social autopsy tools for maternal and child health based on the Pathway to Survival and Three Delays Model could enhance efforts to reduce mortality and morbidity. Finally, Ethiopia’s Last 10k program, which aims to improve maternal and child health in rural areas by linking Primary Health Units and communities, reports that health committees and community-based data monitoring and decision-making are key to their work.⁶¹ This evidence supports the conclusions of a systematic review of the effects of health committees, which suggested that they can improve the quality and coverage of health care.⁵³

Mass media

The literature suggests that mass media campaigns can lead to changes in maternal and child health behaviors, especially when new community-based activities, services or commodities are being implemented and when exposure to campaigns is high.^{62,63,64} A systematic review of 111 mass media interventions for child survival found that the majority of campaigns addressed reproductive health ($n=67$), multiple child survival behaviors ($n=44$), diarrheal disease ($n=15$) and nutrition ($n=14$). Knowledge about desired behaviors and care-seeking improved after exposure to mass media interventions, but there was strong evidence of publication bias in favor of positive studies: only six out of 111 reported negative results.⁶² In Burkina Faso, the midline results of a cRCT testing the effects of a radio campaign to improve key family behaviors related to child survival found positive effects on care-seeking for diarrhea (adjusted Difference in Difference [DiD] 17.5%, 95% CI: 2.5-32.5), antibiotic treatment for fast/difficult breathing, and saving money during pregnancy (adjusted DiD, 12.8%, 95% CI, 1.4- 24.2).⁶⁵ Overall, the evidence suggests that mass media is an effective complement to, but not a substitute for, dialogue-based interventions with frontline workers. There is a need for more rigorously evaluations of mass media interventions in health promotion, including for women’s, children’s and adolescent’s health.

Combined approaches

Lessons from the successful trials described earlier and large-scale programs such as Alive & Thrive suggest that working through multiple community platforms and dialogue-based approaches yields the best results.⁵⁸ Countries such as Malawi and Nepal have both achieved considerable reductions in child and neonatal mortality over the past two decades; both adopted a mix of community engagement strategies supported by CHWs. In Malawi, Health Service Assistants were instrumental in increasing coverage of iCCM and implemented the National Community-based Maternal and Newborn Care package through home visits and demand generation via Care Groups and Community Dialogue.^{66,67} In Nepal, Female Community Health Volunteers (FCHVs) were trained to promote birth preparedness, essential newborn care, detection and treatment for pneumonia and also worked closely with Village Development Committees and women's groups.⁶⁸

The synergy between home visits and group-based community mobilization to improve neonatal survival has been demonstrated in several successful trials.^{26,47} The balance of evidence suggests that a community strategy combining antenatal and postnatal home visits with community or women's group meetings, either practicing participatory learning and action or other group-based participatory activities, is likely to be the most effective strategy to reduce neonatal mortality. Both home visits and women's groups practicing participatory learning and action have been supported by WHO recommendations and the Every Newborn Action Plan.⁷⁰⁻⁷²

CHARACTERISTICS OF PROMISING APPROACHES

The most successful approaches to strengthening the capabilities of caregivers and communities to improve child health had three main characteristics:

- (1) They rely on a core of *dialogue-based activities with strong investments in frontline workers* (CHWs or NGO-supported workers), including training, supervision and context-appropriate incentives. They draw on formative research in the community, and/or use methods that elicit women's and other community members' priorities, current practices related to maternal and child problems, then engage them in problem solving about how to overcome them. The most promising approach to working with groups is participatory learning and action, which can build the capacities of women and communities as part of full PLA cycles, or as part of regular engagement with men, opinion and religious leaders by using a short cycle of dialogue and decision-making as in Community Dialogue. While some programs used mass media, the literature suggests that this was most successful as a complement to dialogue-based activities with frontline workers.
- (2) Successful approaches used a *combination of activities* that created multiple opportunities for engagement between frontline workers and community members, and were strategically chosen for their different strengths. For example, the intervention tested in Shivgarh trial in Uttar Pradesh, India – which led to a 54% reduction in neonatal mortality over 16 months - used home visits, monthly community meetings, folk song meetings and engagement with TBAs and community leaders.³⁶ Similarly, the intervention tested in the Hala trial, Pakistan, used antenatal and postnatal home visits, women's group meetings, and community meetings.⁶⁹ Systematic reviews related to community-interventions for malaria, handwashing promotion for diarrhoea and pneumonia also concurred that going beyond educating through health messages and using a combination of community approaches to intensify coverage and address equity is best.^{127,112,128} Countries such as Niger and Mozambique have succeeded in crafting community strategies involving discussions at 'relais communautaire' (community meeting points), community/folk and mass media, engaging networks of traditional chiefs and groups, community-led design, implementation and monitoring of action plans.⁵⁸ The Alive and Thrive programme to improve maternal nutrition and infant and young child feeding through an integrated strategy combining intensive interpersonal communication through home visits and group meetings, community conversations with opinion leaders, mass communication and advocacy with policy-makers in Vietnam, Ethiopia and Bangladesh, now starting in India (UP and Bihar). This led to large increases in exclusive breastfeeding, dietary diversity and timely introduction of complementary feeding.¹²⁹
- (3) They *addressed broader social determinants of maternal and child health*, by going beyond the household level, for example by boosting men and community members' support for maternal and child health, engaging with community leaders and health providers (e.g. TBAs and private providers).

I recommended specific community-oriented approaches if they met all of the following criteria:

1. Supportive evidence from either experimental or quasi-experimental studies, or evaluations nested in large-scale programs demonstrating improvements in relevant practices or survival (neonatal, infant, or under-five)
2. Alignment with the objectives of the Global Strategy by being equity-focused and providing a building block for continuum of care approaches to reproductive, maternal, newborn, child and adolescent health
3. As a simplified indicator of scalability, interventions had to have supporting training materials and use community platforms commonly found in high-burden settings (e.g. women's associations or health committees).

I then considered evidence from India, Nigeria and Pakistan to discuss scalability opportunities and challenges in more depth (see Appendix Table 2). The recommendations draw on the literature review and examination of literature from these three countries.

RECOMMENDATIONS

1. Scale up home visits with caregivers (mothers, partners and family members) for pregnancy and the neonatal period (as in “Caring for the newborn at home”) and for children under five (as in ‘Caring for a child’s healthy growth and development), using counseling models based on social cognitive theory.

Home visiting interventions are already promoted by WHO and UNICEF, and scale up needs to focus on the most underserved areas and those with a high proportion of home deliveries. In areas with high levels of institutional deliveries, the intervention needs to be complemented by quality improvement activities in facilities.

2. Scale up women’s group meetings for maternal and child health, preferably monthly, preferably with one group per 500 population, privileging the most underserved rural communities, and at least 30% of concerned caregivers, e.g. pregnant women and mothers of children under five in groups.

Group meetings drawing on the Health Belief Model or Social Cognitive Theory are likely to further build individuals’ and perhaps families’ capabilities as during home counseling, but less likely to build community capabilities, which are more likely to be strengthened using Participatory Learning and Action cycles that empower women and catalyze community-wide action.

Two PLA cycles could be supported: the first for maternal and newborn health and the second for the healthy growth and development of older children. Combining participatory learning and action with women’s groups with the home visit package ‘Caring for the newborn at home’ in rural areas of high-burden countries is likely to reduce neonatal mortality and build both caregivers’ and communities’ capabilities. This approach might be suitable in countries that currently do not have structured group-based interventions for maternal and newborn health. Emerging scale up initiatives in high-burden countries including India, Nigeria and Ethiopia should be supported. A group facilitation module for CHWs is currently being prepared with WHO to complement the home visit module linked to “Caring for the newborn at home”.

It would be timely to develop and test a group facilitation module to complement WHO’s ‘Caring for the child’s healthy growth and development’ training package. The module could be discussed and designed in a working group similar to the one convened to discuss postnatal visits following the 2012 WHO/UNICEF recommendation¹³⁰. It could build on recent experiences with PLA to improve child health and development in India and Ethiopia, Positive Deviance, Care Groups, community dialogue and interventions tested in recent trials to improve IYCF, preventive practices and early childhood development in India and Pakistan (see also Appendix 4).^{131,132,133,134,135} There isn’t an infinite number of group ‘platforms’ in a community; a single community cannot have a perinatal group, an IYCF group, a family planning group, a water, sanitation and hygiene group and an early childhood development group running concurrently. An integrated group module that would complement the home visit aids of ‘Caring for the child’s healthy growth and development” could be adapted by countries that wish to do so and increase the coverage of essential interventions for healthy growth and development.

3. Use participatory engagement methods such as Community Dialogue with community leaders and community providers as part of iCCM

Community mobilization appears to be a key factor in the scale up of iCCM. Participatory methods that enable caregivers and communities to input into and support iCCM, such as Community Dialogue, are recommended as part of iCCM scale up. There is a strong need to develop, test and disseminate such methods with private providers in particular.

4. Disseminate approaches and tools that support effective health committee functioning

In the original C-IMCI framework, health committees were envisaged as key actors to ensure better links, accountability and planning between communities and health services. Their full potential has not been fully realized,

despite evidence of benefits in countries where they have received support (e.g. Kenya and Uganda). Clearly there is no one-size-fits-all approach to working with Health Committees, although characteristics of successful structures have been described.⁵⁷ There is a need to collate approaches and tools from settings where facility- and village-based committees have been used and achieved their goals, and disseminate them widely.

5. Use mass media approaches strategically

There is evidence to support the use of mass media as a complement rather than an alternative to investing in community engagement led by frontline workers.

Finally, an additional recommendation is to collate, systematize and test tools for (a) family planning (preconception and postpartum) and (b) adolescent health and nutrition home visits and group meetings to be used by frontline workers.

There are numerous training packages for family planning counseling, but fewer for community health workers or peer-educators doing individual counseling or group meetings for adolescent health and nutrition. Collating these tools and integrating them with the “Caring for newborns and children” package would close the loop of CHW training tools for RMNCAH.

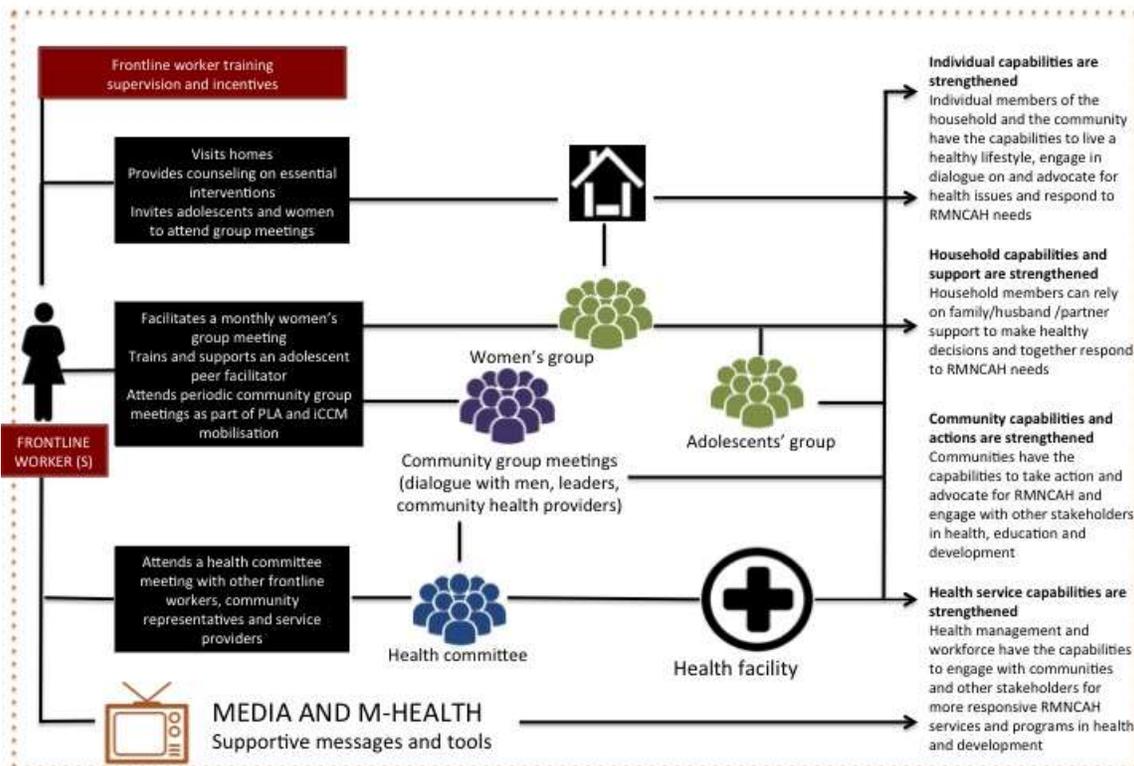
Draft framework for community actions to strengthen capabilities for RMNCAH

The draft framework below describes possible community actions to build the capabilities of individuals, families and communities to improve RMNCAH, going beyond child health, but building upon WHO’s “Caring for newborns and children in the community” for CHWs.

In this framework, one or more frontline workers are supported to:

- (1) Conduct home visits as described in “Caring for the newborn at home” and “Caring for a child’s healthy growth and development”. The current home visit guidance could be expanded to include counseling materials for family planning where appropriate. The home visit tools mainly use principles of Social Cognitive Theory and are more suited to building individuals’ and families’ capabilities.
- (2) Facilitate a monthly group meeting following principles of participatory learning and action. The PLA module for maternal and newborn health developed with WHO could be complemented by another group facilitation modules for health growth and development, as described below.
- (3) Support adolescent group meetings led by peer educators. There is a need to review peer-led individual and group-based approaches to improving adolescent health including and beyond sexual and reproductive health.¹³⁶
- (4) Attend periodic community dialogue meetings with men, community leaders and community health providers to support iCCM-related mobilization
- (5) Together with other community members, participate in a village health committee to improve linkages between communities and health providers, and accountability of providers to the community

COMMUNITY ACTIONS TO STRENGTHEN CAPABILITIES FOR RMNCAH



CONCLUDING REMARKS

“While community participation provides a foundation for change, it does not ensure that specific, life-saving behaviours will be adopted and institutionalised preferentially over any other behaviors. Communities may not have the skills for an epidemiologically relevant selection of targeted risk-enhancing behaviours and limited knowledge of suitable risk-reduction behaviors [...] in the absence of an external perspective, a community’s deeply entrenched cultural notions and beliefs may limit their ability to recognise the risk associated with their existing practices and to take corrective actions.”¹³⁷ (p.459)

In these comments, the architects of a successful community intervention to improve neonatal survival lament the fact that community interventions often either promote generic messages that do not engage with people’s realities and concerns or, on the other extreme, put the entire onus on communities to identify problems and come up with solutions themselves. To remedy this, they recommend collaboration between scientifically minded organisations and communities in a Behavior Change Management process. This process involves formative research to: (1) identify epidemiologically targeted key behaviours; identify suitable target groups for a behavioural intervention; (3) develop appropriate behaviour change ‘transactions’ for each of these groups; (4) leverage the influence of social networks to expedite behaviour change; and build mechanisms to sustain and institutionalise new behaviours. In essence, the task is to ‘glocalize’ interventions, i.e. to make standardised global recommendations work within the concerns and realities of local communities.

But who are the best ‘glocalizers’?

Let us think about how behaviour change strategies are developed in the real world, for example in a state, province or district. Would programme managers have the resources to carry out the detailed, localised research required for it? They may consult District-level health surveys and perhaps do some qualitative research, but what about TIPS and the careful packaging of messages and behaviour change transactions for each target group? In addition, most program planners are typically not working with one set of behaviours (e.g. those related to essential newborn care), but with multiple sets (e.g. those related to maternal, newborn and child health). Are they going to develop culturally appropriate behavioural transactions for each target group for each set of behaviors for each age group? Even if one prioritised behaviors, is this feasible? BCM may work well within quasi-vertical, donor-driven behaviour change programs, because the focus can be on promoting a narrow set of behaviours while leaving others to other programs. But a district or state-based programme planner may not have this luxury.

There is a second, or complementary solution, and it does draw on community participation. Advocating for participation is not the same as promoting an untargeted behavioral free for all. In PLA, Community Dialogue and other participatory approaches, there are often two levels of problem/behaviour prioritisation: the first is done at a district or State level, on the basis of epidemiological data and global recommendations for prevention, care and treatment. These feed into local group facilitation. The second prioritisation is done by local group members on the basis of perceived local relevance and the potential for change. Groups do not get it wrong: when presented with a set of maternal, newborn and infant health problems, they recognize the most prevalent ones.¹³⁸ Asking groups ‘why’ problems or deaths happen - as in social autopsy processes - allows them to explore the social and medical causes of health problems using both their own and external knowledge. Using stories with local motifs and picture cards depicting prevention, care and treatment solutions helps groups to discuss which solutions are the most acceptable to them, and how to make them work in their communities. In effect, community groups do their own formative research, their own ‘glocalization’.

Kumar et al. are right: we need a more systematic approach to designing behaviour change strategies, and this essentially involves ‘glocalization’. But where will and where should the capacity for glocalizing global recommendations come from? Will it come from NGOs, donor-led vertical behaviour change programmes, government teams, or local communities? If one takes a capability approach, moving up the ladder of community participation towards greater levels of collaboration leads to greater trust and sustainability. The values that drove the 2000 framework for C-IMCI still matter. Building communities’ capabilities to identify, understand and address local health problems still matters, because those communities with high levels of capacity are better able to pursue ongoing collective action for health.

Table 1: Community components of C-IMCI interventions

Country (reference)	Coverage	C-IMCI or C-IMNCI components	Evaluation	Findings
Bangladesh (Arifeen et al. 2009) ⁴⁷	Estimated cRCT population: 350,000 Intervention: 175,000	<ul style="list-style-type: none"> Household counseling by Community Nutrition Promoter (4.5 years exposure) Household counseling by Village Health Workers (18 months exposure) Community-case management by VHWs Reduction of harmful practices by village doctors (training and follow up, unspecified frequency) Community mobilization through mini-theatre Mosque-based sermons on care and care-seeking 	cRCT of IMCI versus control in 20 facility catchment areas (10 intervention vs 10 control clusters). Total implementation period was 5 years, with delays in the implementation of some community components.	<p>58% of caregivers of children aged 0–11 months (n=498) in intervention areas said they had been counseled on care-seeking by VHWs in the previous six months, vs 1% in control areas (n=510)</p> <p>29% of caregivers of children 0–11 months (n=498) in intervention areas said they had been counseled on care-seeking by CNPs in the previous six months, vs 7% in control areas (n=510).</p> <p>IMCI implementation led to improved health-worker skills, health system support, and family and community practices, but the yearly rate of under-five mortality (excluding deaths in first week of life) was similar in IMCI and control areas (8.6% vs 7.8%).</p>
Brazil (Amaral et al. 2005) ¹⁰³	Three groups of municipalities covering c.7.8 million population overall, with 4.2 million population in intervention areas (including c. 400,000 in high intensity IMCI areas).	As part of the Family Health Programme, each CHW visited 100-200 families a month. CHWs were present in municipalities without and without IMCI and their home visiting health messages were aligned with IMCI in 2005.	Non-randomised, controlled evaluation comparing high intensity, low intensity and no-IMCI implementation	No difference in coverage of CHWs and no data on % of homes visited. No overall impact on under-five mortality. Authors suggested that this was due to Brazil's different epidemiological profile, where only one third of infant deaths are linked to causes addressed by IMCI, and training did not address the first week of life.
India (Bhandari et al. 2012 and Mazumder et al. 2014) ⁴⁹	Study population: 1.1 million Intervention area: c.500,000	Anganwadi workers (AWW) made postnatal home visits on days 1, 3 and 7 to promote early and exclusive breastfeeding, delayed bathing, keeping the baby warm, and care-	cRCT with 18 primary health centre catchment areas (9 intervention vs 9 control)	42.6% of 6204 caregivers interviewed in the intervention areas reported receiving the three recommended visits in the first week of life and 45.6% reported attending

	<p>seeking for illness. AWW also assessed newborns for signs of illness and referred them if needed. They also visited LBW infants on days 14, 21 and 28. Accredited Social Health Activists ran women's group meetings once every three months for an incentive of Rs35.</p>	<p>a women's group meeting in the last three months. There were significant improvements in newborn care practices including early (40.7% vs 11.2%) and exclusive breastfeeding (77.6 vs 37.3), delayed bathing (84.5 vs 36.3) and nothing or gentian violet applied on cord ((84.1 vs 39.5). There was a 20% reduction in neonatal mortality among infants born at home but no effect on those born in facilities. Significant reduction in the infant mortality rate (aHR: 0.85; 95% CI: 0.77-0.94) and neonatal mortality beyond the first 24 hours of life (aHR: 0.86, 95% CI: 0.79-0.95). The study also found improvements in care-seeking from an appropriate provider for severe neonatal illness (risk ratio 1.76, 95% CI: 1.38 to 2.24), local neonatal infection (4.86, 3.80 to 6.21), as well as for diarrhea and pneumonia.</p>	
<p>Cambodia, Kenya, Malawi, Mozambique, Rwanda (George et al. 2015) ⁴³</p>	<p>10 care group and 9 non-care group projects funded by USAID in five countries some under the auspices of C-IMCI (e.g. in Malawi, Cambodia and Mozambique)</p>	<p>Formation of mothers' groups of approximately 10 Care Group volunteers who are each responsible for visiting on average 10 households closest to their home. A supervisor visits a Care Group every 2–4 weeks to teach the volunteers 1–3 new key messages to share with their neighbors. Household visits by Care Group volunteers are conducted every 2 weeks. One paid local facilitator (often called a promoter) oversee the activities of approximately 400–1000 households.</p>	<p>Retrospective evaluation using non-randomised, non-controlled baseline and endline surveys of Knowledge, Practice and Coverage (KPC) for 17 maternal and child health practices, and LiST to model effects on under five mortality</p> <p>In Care Group project areas, coverage increases for high impact interventions were more than double those in non-Care group project areas for antenatal care visits, tetanus toxoid vaccination, multiple micronutrient supplementation, complementary feeding, hand washing with soap, oral rehydration therapy, oral antibiotics for pneumonia, and malaria treatment. Overall, Care Group projects yielded significantly higher increases in coverage than non-Care Group projects for high-impact coverage indicators measured ($p = 0.0007$).</p>

<p>Peru (Huicho et al. 2005) ¹⁰²</p>	<p>Five-day community IMCI training course for community health workers emphasising delivery of basic IMCI messages. The training includes two practical sessions in facilities and two in communities.</p>	<p>Ecological study in Peru's 34 health districts</p>	<p>11 CHW per 10,000 children under five were trained in the C-IMCI course. Training of CHWs with IMCI course was not associated with mortality reduction but there was a significant association with height-for-age change.</p>
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Table 2: Opportunities and challenges for selected community approaches in India, Nigeria and Pakistan

	OPPORTUNITIES	CHALLENGES
INDIA		
Women's groups	<ul style="list-style-type: none"> • Women's groups using participatory learning and action to improve maternal and newborn health have been tested twice in rural India, including once with government ASHAs and in the context of a parallel scale up of home-based newborn care.⁴⁰ The intervention demonstrated a significant effect on neonatal mortality and essential newborn care practices when facilitated by ASHAs, and led to an increase in birth preparedness and facility among more marginalised families. • This systems intervention complements India's existing IMNCI strategy, which include ASHAs facilitating monthly group meetings. • A package building on the same approach is being developed to promote health growth and development, which could complement "Caring for the child's healthy growth and development". • The National Health Systems Resource Centre and the National Health Mission have recommended the scale up Participatory Learning and Action with women's groups to the Ministry of Health and Family Welfare for scale up in 10 states: Assam, Bihar, Jharkhand, Odisha, Madhya Pradesh, Chhattisgarh, Meghalaya, Rajasthan, Uttarakhand, Uttar Pradesh. Manuals exist to train ASHAs to conduct PLA meetings to improve maternal and newborn health. • The National Health Mission has suggested a facilitation, supervision, incentive and training structure for the intervention. This is currently being tried out in Jharkhand. 	<ul style="list-style-type: none"> • State Mission offices must agree to take up the intervention and allocate resources for this in their Programme Implementation Plan. • The ASHA's role as an agent of social change has been difficult to sustain due to increasing workload and incentive structures that favour involvement in promoting institutional deliveries (Rs 600 per delivery), helping with children's immunisations (Rs 150 per session completed) and conducting home-based newborn care (Rs 250). Studies have reported issues with ASHA training, which often involves reading through the manuals with no structured skills development process.¹² The ASHA programme, one of the largest CHW programs in the world reportedly spent 48% of funds available (Rs 5,400 out of 10,000 available) from 2005 to 2011. • A particular challenge lies in the desire to scale up maternal and child health interventions through self-help groups. Some states, notably UP, have developed and tested behaviour changes approaches loosely modelled on those tested in the Shivgarh trial. One of these has been evaluated and shown some improvements in antenatal care attendance, clean delivery practices and essential newborn care practices in areas where ASHAs facilitated women's group meetings compared to areas only exposed to media interventions, though no overall impact on neonatal mortality.⁴³ The National Rural Livelihoods Mission (NRLM) will create and support 8-9 million self-help groups (SHG) across 640,000 villages over the next decade. This will be accompanied by an investment of Rs15,000 (US\$250) per household to support community mobilization and livelihood promotion. These SHG are now being widely targeted as potential platforms to deliver health, family planning, nutrition, sanitation and agriculture-related interventions. This creates several opportunities but also presents three key dangers: (a) layering a vast range of messages or activities onto SHGs or their federating bodies may impede change through 'message overload' and lack of focus unless a phased and strategic approach is taken; (b) self-help groups may not achieve sufficient coverage of pregnant women and mothers of children under five

		<p>either in SHG meetings themselves, their Federations or through activities to boost social diffusion; (b) if access to SHGs and their savings facilities become conditional on participating in activities related to health, nutrition groups risk losing their voluntary and participatory character, and effectively disempowering women.</p>
<p>Engagement with husbands and partners, community leaders and private providers</p>	<ul style="list-style-type: none"> • Successful interventions tested in India (e.g. Shivgarh) have engaged with these actors. • Participatory women’s groups are open to all concerned community members, including men and TBAs, and evidence suggest that they attend these meetings • Engagement with private providers and TBAs was an explicit component of the IMNCI strategy tested in Bhandari and should be retained in scaling up the programme.⁴⁹ Materials used in this study could be reviewed and disseminated. 	<ul style="list-style-type: none"> • Engagement can be superficial if carried out as part of mass media or education through messages • There are currently no widely disseminated, WHO-approved published materials to conduct community dialogues or group orientation with men, community leaders, private providers in the context of iCCM.
<p>Health committees</p>	<ul style="list-style-type: none"> • Village Health Nutrition and Sanitation Committees have a wide range of functions related to community health, and operate an untied fund of Rs 10,000 per year. Strengthening VHNSCs could benefit a range of activities for women’s and children’s health across the continuum of care. 	<ul style="list-style-type: none"> • VHSNC have substantial potential as structures involving ASHAs, community leaders and members of the primary healthcare team. However studies suggest that few VHNSC receive the training and support required to function effectively and autonomously, and often have spending of their untied funds dictated at district-level, which curtails their responsiveness to local needs.¹³⁹
<p>Mass media</p>	<ul style="list-style-type: none"> • Although evaluation reports were elusive, the India Maternal and Child Health media campaign (2009) involving TV and radio apparently led to improvements in knowledge, intended behavior related to delayed bathing for newborns, the need to plan for post-partum emergencies, sleep under an ITN and put the baby to the breast within one hour. Several other TV and radio campaigns such as the Ek, Teen, Do (1-3-2) about the importance of birth spacing, and Gaanth Baandh Lo about birth preparedness have been implemented in Bihar, Orissa and Madhya Pradesh. Further evidence is required on the cost-effectiveness of these interventions against behaviors or hard health outcomes. They could be funded as a complement to more woman and child-centric activities such as home visits and participatory women’s groups, but not at their expense. 	<ul style="list-style-type: none"> • There have been very few rigorous evaluations of mass media campaigns for child survival in India; most evaluations have no counterfactuals. A 2014 systematic review found one campaign from 1991 to promote ORS, and another relating to Tuberculosis.⁶² No mass media interventions have been evaluated with adequate counterfactuals in India.

NIGERIA		
Women's groups	<ul style="list-style-type: none"> • Nigeria's 2011 Saving Newborn Lives report suggested searching for opportunities to involve women and communities in solving problems such as high workload during pregnancy and transport to facilities and a review of the C-IMCI training module to incorporate community essential newborn care was recommended in 2011.¹⁴⁰ • Community health extension workers should spend 80% of their time in the community and 20% in facilities. A recent controlled before and after pilot study in Northern Nigeria found that repositioning the role of CHEWs using the model of Ghana's Community-Based Health Planning Service (CHPS) strategy led to increases in antenatal care, facility births and consultations at health posts. CHEWs were encouraged to move from clerk/aide roles in urban facilities to rural areas in pairs, with incentives, making them based in health posts, giving them training in counseling for family planning, handling uncomplicated deliveries and make referrals and IMCI.¹⁴¹ This model shows great potential and could be expanded with activities dependent on local needs. Given the great number of tasks that CHEW may be entrusted with, Volunteer Village Health Worker might be more natural facilitators for women's groups as they also have a role on Community Development Committees and Village Health Committees, though some describe their role as 'nascent'. • In some states such as Ebonyi, participatory women's groups and TBAs have already been identified as a potential strategy to improve care practices for mothers and newborns as well as raise awareness of entitlements under the Free Maternal and Child Health Care Program.¹⁴² 	<ul style="list-style-type: none"> - Political instability in the northwest and northeast of Nigeria have affected the delivery of maternal and child health services, contributing to high mortality rates. It is unclear whether participatory women's groups would be able to meet in this environment. On the other hand, this is where the approach is likely to have the greatest impact on mortality rates, and many women in <i>purdah</i> belong to women's groups organised together for economic activities - Role clarification, remuneration structures for CHEWs and VVHWs have not been universally achieved - The coverage of the Free Maternal and Child Health Care Programme is not universal and this is likely to impeded demand for services.
Engagement with husbands and partners, community leaders and private providers	<ul style="list-style-type: none"> • Given the importance of men in supporting their partners to take decisions that protect their and children's health, involving them in community dialogue or as part of community meetings in PLA cycles could have large benefits. There is little evidence on men's involvement in maternal and child health programs in Nigeria. One study used a quasi-experimental design to evaluate an intervention to reduce the risk of unintended 	

	<p>pregnancy, HIV and STIs. Men in the intervention group were significantly more likely to report condom use at last sex with main partner (OR=4.10, 95%CI=1.81-8.68) and fewer refusals to use condom with main partner (OR=0.28, 95%CI=0.13-0.64) at three-month follow-up than those in the comparison group.¹⁴³</p> <ul style="list-style-type: none"> From 2013-5, the Strengthening Health Outcomes through the Private Sector (SHOPS) initiative trained over 350 clinic level private providers in Lagos state, 500 Officers-in-Charge of public Primary Health Care facilities, and 4,500 Proprietary Patent Medicine Vendors (PPMVs) in Abia, Benue and Nasarawa states to recommend zinc and ORS for diarrhoea treatment. Such large initiatives could be complemented at community level by community dialogues to strengthen the use of iCCM.¹⁴⁴ 	
Health committees		<ul style="list-style-type: none"> Nigeria's 2004 revised National Health Policy emphasized active community engagement in the provision of PHC services through village development committees, as supported in the 1987 Bamako Initiative, which promoted sustainable primary health care through community participation in financing, maintenance, and monitoring of services.¹⁴⁵ However the NHP failed to support strong primary health care delivery, which is noted as one of the key contributors to persistently high maternal and child mortality and morbidity (Massoud, 2008 in Sharma & Nguyen).¹⁴⁶ In 2008, Massoud reported that the relationship between village health committees and the broader health system mainly involves relaying information about disease burden upwards. His recommendations include recognizing and supporting local neighbourhood associations as vehicles for influencing and participating in the planning of health services. There is little work on VHCs in Nigeria generally.
Mass media	<p>The Nigeria Saving Newborn Lives report (2011) advocates for dissemination of maternal and newborn health-related messages through mass media and through 'community groups'.</p>	<p>There were no evaluations of mass media campaigns on any maternal and child health outcomes in Nigeria except a before and study testing the impact of a communication intervention to influence norms relating to female genital cutting.¹⁴⁷</p>

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Women's groups	<ul style="list-style-type: none"> • Trials blending home visits and community mobilization through participatory women's group meetings and community meetings have been conducted with Lady Health Workers (LHW), and their materials can be used for scale up in conjunction with the 'Caring for the newborn at home' module.^{69,148} • Further recent studies have also developed LHW training materials for health growth and development, including home visiting tools and group meeting facilitation tools, which could be used for scale up in conjunction with the 'Caring for the child's healthy growth and development'.⁷⁸ • The LHWs' supervision structure and workplan already accommodate a monthly group meeting.¹² 	<ul style="list-style-type: none"> • The LHW program still has substantial coverage issues, with an estimated 40% of eligible households still not served by a LHW, as well as reports of poor-quality training, supervision and problems with supplies.¹² • Some provinces are affected or recovering from conflict, and specific modalities of outreach services, including training TBAs to carry out health promotion, recognise danger signs during the perinatal period and refer to health facilities have been recommended.¹⁴⁹
Engagement with husbands and partners, community leaders and private providers	<ul style="list-style-type: none"> • Successful research trials that have improved maternal and newborn health in Pakistan have all involved some form of engagement with men and TBAs.^{69,78} This is strongly recommended by these studies' authors. 	
Health Committees	<ul style="list-style-type: none"> • Health systems reforms conducted in 2011 has led to high-priority preventive programs formerly managed by the federal government – such as family planning, primary healthcare (PHC), immunization, maternal/neonatal and child health, nutrition– are now managed at the provincial level. Many see this decentralization as an opportunity for locally relevant planning and better support to LHWs and Village Health Committees.^{150,151} 80% of the population uses the private sector, fee-for-service system.¹⁴⁹ LHW's engagement with Women's Health Committees appears to be improve their overall performance.^{152,153} 	
Mass media	<ul style="list-style-type: none"> • Several interventions have used proximity media (e.g. local theatre) as part of broader community engagement strategies.⁶⁹ • There have been several RMNCH mass media campaigns in Pakistan. These have been evaluated in terms of audience reach and potential effects on knowledge and behaviors, but none had counterfactuals. 	<ul style="list-style-type: none"> • An independent evaluation of the PAIMAN programme, which featured mass media and proximity media interventions appreciated their usefulness as part of an SBCC strategy, but recommended more focus on working directly with women's groups, which they perceived to be a more impactful strategy.¹⁵⁴

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2016

3, BHUBANESWAR



सत्यमेव जयते

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Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi-110011

No. 513
15 JAN 2016
Mission Directorate

D.O No. Z.15015/56/2015-NHM-I (Part)

Dated 4th January 2016

Dear Mission Director,

I am writing to you with regard to the use of Participatory Learning and Appraisal (PLA) method in community action. PLA is a method that has demonstrated positive outcomes for a range of community related interventions particularly on reducing morbidity and mortality from conditions related to maternal, newborn, and child health and nutrition. A note on PLA with a training design and strategy is attached. It is suggested that ASHA facilitators be trained in the PLA method and mentor ASHA in using the method. We request you to review the note and assess the feasibility of implementing this training for ASHA facilitators in your state. The costs and incentives can be budgeted in the PIP subject to the overall ceiling of Rs. 16,000 per ASHA.

2. Please let me know if you require any clarifications.

With regards,

Yours sincerely,


(Manoj Jhalani)

Encl: as above

Mission Director, National Health Mission, Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Meghalaya, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh

TRAINING DESIGN AND STRATEGY - TRAINING ASHA FACILITATORS FOR IMPROVED RMNCH OUTCOMES USING PARTICIPATORY LEARNING AND ACTION

1. Background

This proposal describes plans to train ASHA facilitators for improved Reproductive, Maternal, Newborn and Child Health (RMNCH) outcomes through Participatory Learning and Action.

1.1 What is Participatory Learning and Action?

The PLA approach is a capacity building process in which women's group members invite non-group members, adolescent girls, pregnant women, mothers, and men, frontline service providers to learn about, plan, carry out and evaluate activities to improve health in a participatory and sustained basis. The PLA approach directly addresses women's empowerment, an important underlying determinant of health and nutrition outcomes.

A PLA cycle has four phases. In the first phase, a facilitator supports groups in identifying RMNCH problems in their area, discuss the causes and consequences of these problems, and prioritise the ones that they want to address. In the second phase, groups identify locally feasible strategies to address their prioritised problems. In the third phase, they implement their strategies. In the fourth phase, the groups evaluate their strategies. The groups also meet with the broader community twice during the meeting cycle to share their prioritised problems, strategies, and gain support for the implementation of their strategies.

1.2 Ekjut and the evidence for PLA

Ekjut's work on empowering communities through Participatory Learning and Action meetings has been shown to reduce newborn and maternal mortality. Work conducted in Jharkhand and Odisha in 2005-2008 demonstrated a 45% reduction in newborn mortality. The most marginalised benefitted the most, with a 73% reduction in newborn mortality compared with a 33 % reduction among the less marginalised. This is the result of the approach being equity-focused, attracting the most vulnerable groups. The findings were published in *The Lancet*¹ and received endorsement by the World Health Organisation (WHO) in 2014. WHO now recommends community mobilisation through Participatory Learning and Action (PLA) as an intervention to improve maternal and newborn health.²

1. Tripathy PK, Nair N, Barnett S, et al. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *Lancet* 2010; 375: 1182-1192.

² World Health Organization. WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. Geneva: World Health Organization, 2014. http://www.who.int/maternal_child_adolescent/documents/community-mobilization-maternal-newborn/en/

The intervention was piloted in Jharkhand by NHM Jharkhand with a separate training module for ASHAs (2012-2013), with the objective of saving newborn lives. In Odisha, the approach was scaled up under the "Shakti Varta" programme to address under nutrition. In States like Bihar, West Bengal and Madhya Pradesh, PLA work has been taken up by various development agencies.

1.3 State involvement in PLA

The PLA approach was discussed with State nodal offices in 2014, and all participants expressed interest in PLA. Given that several States had not yet completed training in modules 6 and 7, there was concern about adding new content to the training at that time. However, now that several states have completed or are in the process of completing these trainings, the opportunity has arisen to introduce PLA. This will strengthen the ASHA facilitators' and ASHAs' ability to improve the shape social norms, improve the uptake of services, address inequities, and increase problem-solving skills.

2. Design

PLA involves three rounds of training of a total of 14 days, spread six months apart each, as follows:

- PLA Round 1 (5 days)
- PLA Round 2 (5 days)
- PLA Round 3 (4 days)

In PLA round 1, the facilitators will be trained in:

- Understanding issues of inequity within the community
- Learning skills to facilitate six meetings, covering the first two phases of the PLA cycle
- Acquiring competencies to prioritise RMNCH issues within their communities
- Together, understanding underlying causes of RMNCH problems, and cause and effect relationships
- Collectively identifying feasible, context-specific strategies to address prioritised RMNCH issues

In PLA round 2, the facilitators will be trained in:

- Supporting the implementation of strategies selected by groups
- Problem-solving skills
- Supporting groups to discuss specific RMNCH topics building on, and following the contents of modules 6 and 7

In PLA round 3, the facilitators will be trained in:

- Supporting groups to discuss additional RMNCH topics building on, and following the contents of modules 6 and 7, along with gender-based violence

- Supporting groups in evaluating their activities
- Identifying future thematic areas of focus for their group activities

3. Geographic focus

The intervention will focus on States that have low RMNCH indicators - 1. Assam; 2. Bihar; 3. Chhattisgarh; 4. Jharkhand; 5. Madhya Pradesh; 6. Meghalaya; 7. Odisha; 8. Rajasthan; 9. Uttarakhand; 10. Uttar Pradesh.

4. Outcomes

We expect that the intervention will lead to improved RMNCH outcomes, and specifically in maternal and newborn survival. We estimate that the intervention will **save 81,824 newborn lives across the 10 States**, assuming a baseline neonatal mortality rate of 35 per 1000 livebirths and a crude birth rate of 25.

5. Training strategy

The proposed steps of the training strategy are as follows:

1. Ekjut will train National Trainers
2. National Trainers will train State and ASHA trainers with additional support from Ekjut
3. State and ASHA trainers will train ASHA facilitators to conduct the PLA meetings
4. ASHA facilitators will provide on the job training to ASHAs while conducting meetings themselves.
5. All BCMs will be trained along with ASHA trainers for effective supervision
6. All DCMs will be given a two-day orientation on PLA

The estimated training load is described below.

States	State trainers	ASHA trainers	Block Community Mobilisers	ASHA Facilitators	State-specific training load
UP	59	2622	825	6808	7633
Bihar	16	126	534	4964	5498
MP	25	300	313	3991	4304
Rajasthan	25	640	249	2066	2315
Chhattisgarh	46	3551	292	3551	3843
Odisha	11	166	N/A*	1672	1672
Jharkhand	12	474	844	2184	3028
Assam	7	447	149	2878	3027
Meghalaya	2	65	N/A*	334	334
Uttarakhand	5	156	101	606	707
TOTAL	208	8547	3307	29054	32361

* In these states, the nodal officers at the block level will be trained, according to local requirements.

5. Supportive mechanisms

- ASHA facilitators will conduct 10 meetings in the presence of the local ASHAs. Remaining ASHAs from neighbouring areas will be invited to this, and then they themselves will conduct meetings in their own villages.
- In the next month, she will support ASHAs who observed the meetings in the previous month to conduct their own meetings.
- ASHAs who have observed meetings in other villages can conduct meetings on same topic in their respective villages in the same month.
- Over a period of two months, she will have supported all ASHAs conducting meetings in her supervision area.
- ASHA facilitators will use monthly cluster meetings as a forum to introduce and plan for PLA meetings.
- An indicator on the performance of ASHAs can be created and included in existing performance indicators.

6. Incentives

- ASHA facilitators may be given Rs1000 monthly, or Rs.100 per meeting (for 10 meetings).
 - ASHAs may be given Rs100 per PLA meeting.
 - The ANM or BCM are suggested to attend PLA meetings.
 - Verification of incentives for ASHAs and ASHA facilitators will be done by BCMs.
 - Payment will begin for facilitators and ASHAs after the first meeting after the first round of training.

Appendix: Detailed description of the Participatory Learning and Action cycle

Phase 1: Identify, discuss and prioritise problems

- The facilitator introduces RMNCH issues by showing pictures to illustrate the links between women's health and nutrition, early conception, low birth weight, childhood illnesses and poor growth and development
- Groups discuss common women's, maternal, neonatal and child health problems presented through picture cards
- Groups prioritise the problems that are most prominent in their area
- The facilitator shares information on causes and consequences for these problems through participatory methods and gives key, simple messages about the practices emphasised in the ASHA module 6 and 7 on the skills that saves lives. This is

accompanied by practical demonstrations and activities.

Phase 2: Identify and prioritise strategies

Groups discuss strategies to address prioritised problems. Strategies must be feasible in a local context. The facilitators' role is to guide groups in selecting realistic strategies and support groups in allocating responsibilities for their implementation and follow-up. This phase ends with a community meeting to share identified problems and strategies with the community.

Phase 3: Implement strategies

Groups implement their strategies and periodically review progress, with support from facilitators. Groups (and communities) take action towards addressing the priority issues and would reflect in positive change in practices, collective action and increased demand/uptake for services.

Phase 4: Evaluate progress

Groups evaluate progress and success in the implementation of their strategies. Groups and communities will be aware of their success and gaps in addressing priority issues and its impact in terms of changes in practices, improved knowledge and awareness on RMNCH issues and possible solutions, role of the collective, key stakeholders and service providers and will have a roadmap taking it forward with role clarity.

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ASHA

03/15/14

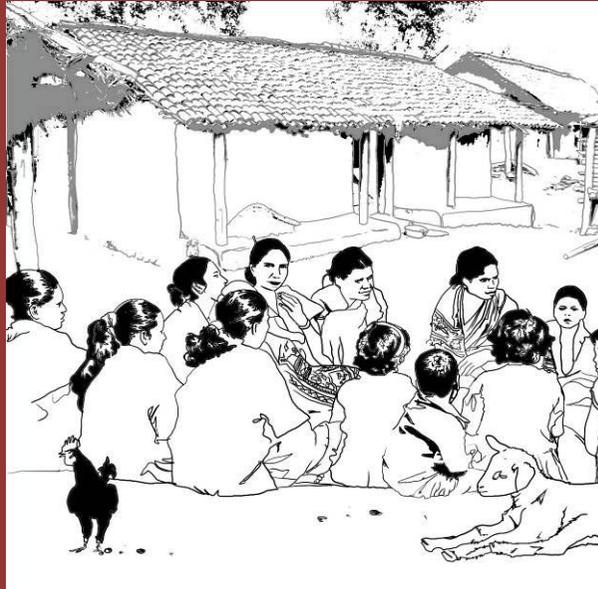
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Participatory Learning and Action

to improve children's healthy growth and development



Facilitator's Hand book

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MEETING 11: DISCUSSION & DEMONSTRATION II - INITIATION OF COMPLEMENTARY FOOD FOR CHILDREN AT 6 MONTHS, HANDWASHING, FOOD ENRICHMENTS

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MEETING 13: DISCUSSION & DEMONSTRATION IV - SAFE HANDLING OF FOOD AND WATER

MEETING 14:PREVENTION OF CHILDHOOD ILLNESSES

MEETING 15: CARE AND FEEDING DURING ILLNESS, ORS PREPARATION

MEETING 16: UNDERSTANDING THE IMPORTANCE OF STIMULATION OF CHILDREN

MEETING 17 : EARLY CHILDHOOD STIMULATION TECHNIQUES

MEETING 18: PREVENTION OF EARLY MARRIAGES AND DELAYING FIRST PREGNANCIES

MEETING 19: DISCUSSING ACCESS TO LOCALLY AVAILABLE CONTRACEPTIVES

MEETING 20: DISCUSSION ON POSSIBLE STRATEGIES FOR IMPROVING HEALTH OF WOMEN AND CHILDREN

MEETING 21: REINFORCING STRATEGIES FOR ENRICHING FOOD FOR CHILDREN

MEETING 22: REINFORCING STRATEGIES FOR IMPROVING HEALTH AND NUTRITION OF WOMEN AND CHILDREN AND PLANNING FOR COMMUNITY MEETING

MEETING 23: COMMUNITY MEETING - 2

MEETING 24: EVALUATION OF WOMEN'S GROUP ACTIVITIES BY GROUP MEMBERS

ANNEXURE-1 FORMAT FOR SOCIAL MAP

ANNEXURE-2 FORMAT FOR TRANSECT WORK

INTRODUCTION

CARING project: the Participatory Learning and Action (PLA) approach to improve growth of children under 2 in Jharkhand and Odisha

The PLA cycle integrates health and nutrition for mothers and young children which:

- Builds on evidences of proven effectiveness of PLA for health and nutrition
- Focuses on improving family and community practices to reduce malnutrition, and improve newborn and maternal health, including hygiene practices.

There has been substantial evidence that PLA through women's groups has impacted improvements in maternal and newborn health. The participatory and reflective nature of PLA and growing experience in India suggests that an integrated PLA cycle which covers a range of health, nutrition and hygienic practices is likely to have an impact on linear growth of young children. As PLA encourages the participation of men, adolescents and non-SHG members in the learning and action process, it can be a platform for communities to engage on various health issues including sanitation.

Process

PLA is different from the IEC (Information, Education and Communication) approach. While IEC tries to impart information, PLA seeks to build peoples' capacities to identify their problems, develop strategies to tackle them, build solidarity to work together as a group and community, and put plans for behaviour change into ACTION. The PLA cycle will be facilitated by trained local women in selected villages. The cycle will involve 24 facilitated meetings with women's groups focussing on maternal and child health and nutrition that will primarily target pregnant mothers and lactating mothers, mothers of children under-2 and adolescent girls. The purpose of group meetings is to increase community understanding of undernutrition and catalyze individual and community level action to address it. The meeting cycle is structured in four phases:

- (1) Assessing the health and nutrition situation; (Phase 1)
- (2) Deciding on actions to take; (Phase 2)
- (3) Taking action; (Phase 3)
- (4) Evaluating the process (Phase 4)

The emphasis will be on using stories, games and pictures to illustrate the causes and consequences of problems and facilitate group discussion, problem-solving and decision-making. Key information and simple health promoting messages will be woven into the group discussion.

The 24 meeting PLA cycle

The content of the meetings is developed but standardised so that core practices are covered through the process.

The set of problem picture cards developed will build on those already used in a formative research done in Odisha and Jharkhand. Participants will use picture cards to identify and prioritise their problems, and develop strategies through the problem solving approach for action around MNCHN. Building on this base, undernutrition which is often an unrecognised problem, can be more effectively introduced and actions promoted.

The phase 1 will include 4 meetings, while the phase 2 will have another 4 meetings at the end of which there will be a larger community meeting involving other stakeholders from the community and also the frontline health workers. The third phase will have 13 meetings followed by a similar community meeting and the last concluding meeting will be on evaluation of the previous 23 meetings.

Delivery of the CARING meetings

The PLA meetings will be delivered by trained facilitators who shall be local women covering a population of approximately 1000. The meetings will be conducted at monthly intervals over a period of 24 months. The facilitators will be trained in intervals during the PLA process so that new information can be shared, skills developed over time. The training of facilitators will be provided in four phases of 3-4 days each throughout the full PLA cycle. These trainings will be organised at the district offices. The training programmes will also provide an opportunity to collect feedback from the facilitators and to address concerns and issues coming up from the community level.

The meetings will be between 1.5 to 2 hours in length and women and men in the community, particularly pregnant and lactating women, women with children below 2 years of age and adolescent girls will decide on the venue and time of the meetings. Each meeting will be documented, attendance of participants in each meeting will be tracked to ensure continuity, and the facilitators will reach out to the most marginalized groups to encourage their participation. Data from these meetings will be compiled and progress tracked over time.

	CONTENT	METHODS
	Theatre groups perform street play on undernutrition	
	PHASE I - Identifying problems	
1	Introduction to the meeting cycle; MUAC & growth chart; Understanding social inequity; Strengths of groups	'Power walk' game
2	Understanding the causes of Undernutrition & Current practices related to pregnancy and nutrition	Life cycle using story-telling & Group discussion
3	Identifying & prioritizing problems related to maternal health + nutrition	'What is it?' & Voting game
4	Identifying & prioritizing problems related to child health + nutrition	'What is it?' & Voting game
	PHASE II - Analyzing problems and exploring solutions	
5	Understanding causes and finding solutions for the 3 prioritised problems (household level, community level and facility level)	Story-telling and 'but why?' game
6	Understanding causes and finding solutions for the 3 next prioritised problems (household level, community level and facility level)	Story-telling and 'but why?' game

7	Discussing and prioritizing possible strategies for implementing the solutions	'Bridge' game
8	Assigning responsibilities, deciding indicators and methods for measuring the progress and planning for community meeting	Format discussion
9	Community meeting 1	
	PHASE III - Taking action	
10	Discussion and Demonstration: members to bring locally available foods to discuss about food diversity; food requirements of mothers & children	Mapping of locally available foods
11	Discussion and Demonstration: annaprasana ceremony - timing of initiation of complementary feeding; enriching complementary foods; demonstration of hand washing	Complementary feeding –'annaprasana'; Hand washing
12	Discussion and Demonstration: making a nutritious powdered grain mix for children and discussing how to enrich it	Preparation of recipe
13	Discussion and Demonstration: safe handling of food & water	Role-play, demonstrations
14	Prevention of childhood illnesses (diarrhoea, malaria, ARI, worms, measles)	Game using 'Prevention picture cards'
15	Care & feeding during illness and ORS preparation	Demonstration
16	Understanding the importance of stimulation	'Climbing the ladder' game (skills to reach school)
17	Early childhood stimulation techniques -Toy-making	Toy-making
18	Prevention of early marriages and delaying first pregnancies	Role-play / Story telling
19	Discussion on contraception: discuss temporary methods that are locally available	Story and discussion, using picture cards
20	Discussion on possible strategies for improving nutrition in women & children	'Card /materials' Game
21	Reinforcing strategies about enriching foods	'Khichidi' game
22	Reinforcing strategies for improving health and nutrition in children	'Chain' game
23	Community meeting 2	
	PHASE IV - Evaluating	
24	Evaluation of WG activities by group members	

1. Introduction to the handbook

This handbook for facilitators is to help them conduct meetings with women's groups using the Participatory Learning and Action cycle. It provides guidance for the group members to identify and prioritise problems related to health, nutrition and hygiene and takes them through a series of meetings to help them find practical strategies to solve the prioritized problems.

It contains guidelines for groups for sharing their learning and seeking support for developing strategies with the larger community.

Objectives of the handbook

The objectives of the handbook are:

- To provide a set of guidelines for facilitators to conduct women's group meetings in the community
- To help facilitators understand maternal, newborn, child nutrition and sanitation related problems and facilitate its prioritisation with groups
- To help groups to decide appropriate strategies to address the prioritized problems
- To help facilitators to motivate the groups for implementation of the strategies
- To help the facilitator to engage the group members to plan and prepare for the community meetings
- To help members to evaluate their activities at the end of the intervention cycle

How to use the handbook

- This handbook will help the facilitator prepare for the meetings
- It will enable the facilitator to arrange the materials required for effective facilitation
- The handbook will help facilitators recall the training inputs and plan their meetings beforehand
- It will be beneficial for the facilitators to go through the content of the meeting in the handbook and do a mental preparation (mock drill can also be done) before actually conducting the meetings. It will also be useful to use the handbook during periodical reviews between meetings to emphasise on the focus of next meeting/s and methodologies suggested.

2. Aim of the project

The aim of the project is to enable women and the community to collectively understand, discuss, strategise and execute strategies to address priority issues related to maternal health, nutrition, water, sanitation and hygiene leading to improved maternal, newborn and child health and hygienic practices.

Objectives:

- To increase awareness about maternal and child health problems and undernutrition in women and children and ways of approaching them in the community
- To improve knowledge on maternal and child health problems and understanding of issues relating to under nutrition among women and children

- To have a better understanding of their rights related to maternal and child health, nutrition and hygiene.

3. Responsibilities of the facilitator

1. to select existing women's group for the programme
2. to activate and strengthen the selected groups
3. to form new groups if necessary
4. to conduct regular meetings with the group members
5. to encourage participation from all group members
6. to ensure that she reaches the venue before the scheduled time for the meeting
7. to help the groups identify problems related to maternal and child health, undernutrition and unsafe sanitation/hygiene
8. to help them prioritise problems
9. to help them identify possible solutions to those problems
10. to help the groups find appropriate strategies for addressing the prioritized problems
11. to help them implement the strategies
12. to help them to plan and conduct the community meetings
13. to help members to evaluate their activities at the end of the intervention cycle

4. Role of the women's group

1. to have monthly meetings
2. to collectively identify maternal and child health, undernutrition and hygiene related problems and to prioritise them
3. to identify possible solutions and appropriate strategies to address the same
4. to plan, implement and monitor these strategies in the community
5. to share information discussed in the meeting with others who do not attend
6. to participate actively in activities in the community
7. to involve the larger community in achieving the goals

AT THE START OF EACH MEETING ...

1. Informally chat with the participants and other members of the community
2. Encourage the participants to sit together in a circle
3. Welcome the participants and thank them for coming
4. Explain the purpose of the meeting
5. Encourage the members to recall the contents of the previous meeting

AT THE END OF EACH MEETING ...

1. Summarize the learning from the meeting
2. Ask the group members the evaluation questions
3. Confirm the date, time and meeting place for the next meeting
4. Inform the group about the content of the next meeting
5. Informally chat with the participants and other members of the community
6. Thank the women for attending the meeting
7. Make sure all the necessary information is entered in the register

MEETING 1: Introduction to the project, Understanding social inequity, Strengths of groups And introducing the MUAC and Growth Chart

PURPOSE OF THE MEETING:

1. To introduce participants and self
2. To introduce the project
3. To understand the need to include all sections of the society
4. To understand the importance of working as a group
5. To introduce the methods for measuring undernutrition

MATERIALS REQUIRED:

Chits specifying the characters for the game, list of questions, few sticks, pen and register, MUAC tape, Growth chart

TIME TAKEN: 1.30 Hours

METHOD: 'Power walk' and 'Stick' games

PROCESS:

1. INTRODUCTION OF PARTICIPANTS AND SELF

- Facilitator will introduce herself and anyone who is visiting from outside the village
- Facilitator will encourage all the participants to introduce themselves, while ensuring that no one gets left out

2. INTRODUCTION TO THE PROJECT

- Facilitator will start by telling the participants about the objectives of the 'CARING' project
- In subsequent meetings they will be discussing about maternal and child health, nutrition and hygiene
- The facilitator will tell them about the process of implementation of the project
 - ❖ There will be a 22+2 community meetings in the village
 - ❖ The meetings will be held once a month
 - ❖ Discussions on health, nutrition and hygiene will be done in the meetings
 - ❖ Causes of maternal and child health problems and the underlying causes of under nutrition will be discussed
 - ❖ Possible solutions to the problem will be found by the group members
 - ❖ Strategies will be decided by the group members for implementation
 - ❖ Responsibilities will be undertaken by group members for implementing strategies

- ❖ The group will self evaluate their progress on selected strategies and finalize the way forward

THE WOMEN'S GROUP PLA CYCLE

Over the next few months women in the community will learn to collectively participate in the decision-making process that affects their lives. The 22 meetings will follow the standard four phases of the Participatory Learning and Action cycle and will focus on Maternal and Child health, Nutrition and Hygiene issues that is the hallmark of the community mobilisation intervention – problem identification and prioritization, planning strategies together, implementing them and evaluating together:

- In the first phase of the cycle the members play a game to discuss which mothers do not receive entitlements related to health and nutrition, discuss reasons for this and invite mothers to join the future meetings. The group will then use picture cards to identify the problems and use a voting game to prioritize the problems that they would like to address.
- In the second phase, the group members explore causes of the prioritised problems through story telling sessions. They will also identify possible strategies to overcome these problems and undertake responsibilities for its implementation and decide on indicators for measuring the progress
- The group will then hold a community meeting to feedback to the community about what they have learnt over the last few months and to seek their support for implementing the strategies.
- In the third phase of the cycle, women will put these strategies into practice. They will also be introduced to other positive strategies on newborn care, postnatal care, routine immunization and some strategies to enhance the density and diversity of complementary foods using locally available food and practicing responsive feeding and early childhood stimulation. Group members are encouraged to follow hygienic practices to improve health and sanitation
- In the fourth phase of the cycle, women will discuss the progress of their strategies and share what they have done well and where they could do better in future, so that they can learn from the process.

THE FOUR PHASES OF THE PLA CYCLE



3. 'POWER WALK' game - developing an understanding on equity issues in the community

Poor and disadvantaged people in villages have high mortality rates and also have poor access to health services. The members need to understand why some of them experience multiple barriers and physical distance to access.

The 'power walk' game will help them to understand equity issues at the village level and motivate them to include vulnerable people and also sensitize the community and health workers towards their needs. The game will also help to identify and understand why some people get left out in a programme even with the best of intentions and be able to plan with community members and health care providers to identify them and come up with possible strategies to include them.

Method for conducting the 'Power walk' game

- Facilitator will choose any seven women volunteers from the group
- She will explain the game to them before the meeting starts
- Each of the volunteer will be given a chit with a character that she will be representing
- The volunteers will be asked to keep their role/character a secret
- To start the game the facilitator will ask them to stand in the centre of the group in a line
- **Facilitator will ask a few questions** related to availing certain services that are provided by the government; those characters who would have availed the services asked by the facilitator shall take one step forward and those who did not shall stay back.
- This process shall continue and after each question at least one participant shall stay back and the rest go one step ahead.
- The characters who take one step forward shall only be asked further questions.

(For better participation of the characters and for making the game more interactive it is advisable that the characters have rehearsed prior to the meeting. While planning for the game each character is also given directions on when to stop while playing the game)

Characters for the play (examples of 7 characters given below, other relevant characters can be included based on the respective project areas)

Character 1: Pregnant woman residing in a 'hard to reach' area

Character 2: Pregnant woman residing near Anganwadi centre / in regular contact with the AWW

Character 3: Daughter-in-law of the village leader

Character 4: Mother with children less than five years of age who is unaware of immunization schedule

Character 5: Mother, who is a daily wage labourer

Character 6: Mother who has more than 6 children

Character 7: Mother who has had no schooling

Questions to be asked by the facilitator and the responses

	Questions to be asked	Responses to the questions
1	How many of you have/had registered your pregnancy? Please take one step forward	Pregnant woman residing in 'hard-to-reach' area (Character 1) will remain standing and others will take one step forward
2	How many of you have been getting the ration from the Anganwadi centre? Please take one step forward	Mother who is a daily wage labourer (Character 5) will remain standing and others will take one step forward
3	How many of you have completed your childrens' full immunization? Please take one step forward	Mother with children under five years of age (Character 4) will remain standing and others will take one step forward
4	How many of you have received 4 ANCs and been counselled on family planning, breastfeeding and nutrition during your antenatal visit? Please take one step forward	Mother with 6 children, and Mother with no schooling (Character 6 and 7) will remain standing and others take one step forward
5	How many mothers have received medicines for de-worming for their children? Please take one step forward	Mother living near Anganwadi centre and Daughter-in-law of village leader (Characters 2 and 3) will take one step forward

Discussion questions for the *community first* and then the characters:

- Who are the people who have come to the front and why?
- Who are the people who were left behind and why?
- How can we ensure that the voices of marginalised get included in the community processes? Why is this important?
- How can we make sure that everyone in the community reaches the end line?

4. Method for demonstrating the strength of a group – the 'stick' game

Facilitator will engage the participants in a game that goes like this:

- Ask any woman from the group to come forward
- Give her one stick and ask her to break it
- She will be able to break it easily
- Then give her 2-3 sticks and again ask her to break them together
- She will be able to break this using some strength
- Now give her a bundle of sticks tied together and ask her to break the bundle
- She will not be able to break the bundle
- Now ask other group member/s to try and break the bundle



- They will not be able to break it

Facilitator will ask the participants why it is so. And after listening to their responses she will summarize that there is strength in groups. As a group they can be more effective in improving the health, nutrition and hygiene status in the community.

Discuss the benefits of working together as a group. Some examples include:

- Women make friends and support one another within a group, so they do not feel isolated and alone. They gain an informal support network which can help them make difficult decisions.
- Women learn from each other, they can discuss and learn about their rights, and they will generate more ideas than individuals alone.
- Groups can help to alleviate the effects of discrimination against women, as women become more integrated into their community. Women develop personal strengths and learn to value their role in the community, such as overcoming their fear of self-expression and participating more effectively in the community, and this improves their self-esteem.
- Working together as a group can save time, achieves more, reach a wider number of people and have a long lasting impact on a community.
- Women can learn to generate and manage resources.



CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. This way the facilitator can assess how much the participants have understood. She will encourage all the participants to speak. At the end she will take a tentative date for the next meeting and conclude the meeting and also inform them about the content of the next meeting.

FROM THE SECOND MEETING ONWARDS AT THE START OF EACH MEETING ...

REVIEW OF THE LAST MEETING:

- **Facilitator will ask all participants who were present in the last meeting to raise their hands and make a note of it**
- **Ask the participants who were present in the last meeting about what they had learnt?**
- **Facilitator will help the participants recall the activities / games and important discussions**
- **Facilitator will now encourage the participants to actively participate in this meeting**

MEETING 2: Understanding the causes of Undernutrition & Current practices related to pregnancy and nutrition

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting
2. To understand the diverse causes of undernutrition and the inter-generational aspects of undernutrition
3. To understand the importance of the first 1000 days of life
4. To understand the group's perception of prevailing behaviour and practices related to nutrition and health among mothers and children under 2 years of age

MATERIALS REQUIRED:

Flex with intergenerational undernutrition cycle, Game to understand diverse causes of undernutrition, questions on current practices, Register and pen

TIME TAKEN: 1.30 Hours

METHOD: Flex with intergenerational cycle and discussion

PROCESS: USE OF FLEX WITH PICTURES TO UNDERSTAND THE INTER-GENERATIONAL UNDERNUTRITION CYCLE

- Facilitator will show the flex with the undernutrition cycle to the participants
- Facilitator will ask the participants what they understand from the chart
- Using the observations from the participants, the facilitator will encourage a discussion on the importance of the first 1000 days of life beginning from pregnancy through the 2 years of life of the child. She will emphasize that undernutrition runs in an inter-generational cycle. Young girls who grow poorly become stunted women and are more likely to give birth to low birth weight infants. If those infants are girls, they are likely to continue the cycle by being stunted in adulthood. That adolescent pregnancy heightens the risk of low birth weight, therefore, good nutritional support is needed at all stages—infancy, childhood, adolescence, and adulthood—especially for girls and women.

'EXPLORING CAUSES' GAME:

- Facilitator will have a list of possible causes of undernutrition written down in her notebook prior to the meeting (the immediate and underlying causes: inadequate dietary intake, household food insecurity, inadequate care, diseases, unhealthy household environment, lack of health services, income related issues-poverty, unemployment, lack of capital - social, economical, political, cultural, etc)
- Facilitator will again use the intergenerational undernutrition chart
- At each stage of the cycle she will ask the participants what are the causes for undernutrition, e.g. pregnancy – insufficient food, unbalanced diet, food restrictions, inadequate care, etc
- Facilitator will write in bold letters the causes mentioned by the participants on a cardboard and ask one volunteer to hold it
- Facilitator will continue to ask and probe for each phase of the cycle and ensure that all the causes noted earlier have been discussed in detail
- Many participants will now be holding the cardboards with different causes written on them
- Facilitator will now summarize that undernutrition is because of multidimensional factors and therefore has to be addressed at different levels and at all phases to improve the health of the mothers and children
- Facilitator will initiate discussion referring to each of the causes and will tell them these can be prevented if the cycle can be broken which she will be discussing next

GROUP'S PERCEPTION ON CURRENT PRACTICES RELATED TO HEALTH AND NUTRITION AMONG WOMEN AND CHILDREN

- Facilitator once again refers to the life cycle chart and focuses on undernutrition during **pregnancy** and moving through **birth, infancy, early childhood** and **adolescence**. Through the chart the facilitator makes effort to sensitize the community to address undernutrition and anaemia much before girls reach the reproductive age.
- Facilitator then asks the group about the current practices related to health and nutrition during each stage of the life cycle [0-6 months, 6 months–5 years, adolescence, pregnancy]
- To break the cycle it is important to first identify it. Encourage the group to discuss the various practices in their village
- Ask the participants if they agree that the cycle can be 'broken'
- Facilitator will tell the group that in future meetings they will discuss together how this cycle can be 'broken'.

Facilitator can use the questions below as a guide to facilitate discussion and keep the group focused on these issues:

- What do they understand by 'undernutrition'? What do they call it?(local names)
- Are there any food restrictions during pregnancy and for lactating mothers?

- What are the food restrictions during their pregnancy? Why is it so?
- What are the food restrictions for lactating women? Why is it so?
- Do they think adolescent girls have special dietary need? If so, why?
- Why do they think undernutrition occurs in children?
- At what age can this start?
- How soon after childbirth do women generally breastfeed their newborn?
- Do they think pre-lacteals are required for children?
- Is breastfeeding enough for children up to 6 months of age?
- When do children start getting solid food in the community?
- What kinds of foods do children aged 6-9 months normally eat?
- How often are they fed?
- How do they keep the food and for how long?
- When children are ill, should they continue to breastfeed?
- What kinds of food should children eat when they are ill?
- How many children with measles have they seen and do they think this disease is serious? If yes, why do they think so?
- How many diseases do they think can be prevented in the Government's routine immunization?
- How serious is the problem of malaria in their area?
- What other diseases do children suffer from?

CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. This way the facilitator can assess how much the participants have understood. She will encourage all the participants to speak. At the end she will take a tentative date for the next meeting and conclude the meeting and also inform them about the content of the next meeting.

MEETING 3: Identifying and Prioritising problems of maternal health and nutrition

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting
2. To identify the problems related to mother's health and nutrition in their community.
3. To find out how common these problems are in their community

MATERIALS REQUIRED: Maternal health picture cards* (picture card from 1-8) picture card text*, pebbles, prioritization format, chart paper, pen, and notebook, (**picture cards with text in annexure*)

TIME TAKEN: 2 Hours

METHOD: 'What is it?' Game using picture cards and 'Voting game'

PROCESS: 1. IDENTIFYING THE PICTURE CARDS SHOWING MATERNAL NUTRITION PROBLEMS:

Facilitator will explain that she will introduce topics using a game called "What is it?"

- She will put the picture cards face down on the ground
- Any member of the group will pick up a card and pin it to the back of any volunteer member. The facilitator will ask the remaining group members/participants to carefully look at the card
- The member with the card pinned to her back tries to guess the topic written on the card while taking help from the remaining group members by asking several questions, e.g. is the problem related to child, maternal health? Is it a disease? Is it something that helps prevent a problem? The group members will try to enact the issue/problem (without speaking) that is shown on the card and allow the member to guess.
- The process is repeated until all the picture cards have been covered
- One blank card is kept to include any problem that the community thinks has not been already included



Sample Picture Card

SYMPTOMS	PREVENTION	MANAGEMENT
<ul style="list-style-type: none"> • Inadequate weight and height • Pale tongue, nails • Weakness, easily tired, giddiness, • Fainting 	<ul style="list-style-type: none"> • Improving adolescent growth • Increased food intake, take iron/folic acid tablets daily and reduce work load during pregnancy and lactation • Delay first pregnancy and increase birth intervals • Using iodized salt • Parasite control 	<ul style="list-style-type: none"> • Iron and vitamins supplements • Treatment of worms and malaria • Increased nutritious food intake

- CAUSES:**
- Growth Faltering – stunted, weak, adolescent, etc
 - Parasitic Infections (Hook worm)
 - Depletion of body stores (Frequent pregnancies < 3 years interval)
 - Under nourished & Unbalanced diet
 - Excessive bleeding during periods
 - Malarial fever
 - Iodine & micronutrient deficiencies

Description on the reverse of each picture card

2. PROCESS OF PRIORITIZING THE PROBLEMS

To help the participants identify the problem picture cards again

- Facilitator will distribute the picture amongst them
- She will allow them to look at the cards carefully
- She will allow them to ask if they have not understood the pictures
- Facilitator will explain the card if there is a doubt

Facilitator will explain that they will be playing a “voting” game:

- Facilitator will encourage all participants to take part in this exercise
- She will take each problem picture card in turn and remind the participants what the problem is (using the local name for it) and ask them to describe the symptoms. Then place the card on the ground, picture facing upwards, in the middle of the circle so that all can see them clearly
- She will put the cards in a line leaving enough space for some pebbles to be put against each card.



- After all the cards have been laid out – explain that, as a group, they are going to choose problems, that they think are common in their community and need to be discussed in the meetings
- They may want to consider how common the problem is in their community and/ or how serious it is?
- Facilitator will give each of the participants 6 pebbles.
- Asking the participants to place three pebbles against the problem card they consider to be the most important, two on the next most important and one on the third most important problem.
- Asking the women to think carefully before putting the pebbles against the cards, and that they should not be guided by others in the group
- Asking them to place the pebbles alongside the picture cards so that the picture is clearly visible to others.
- After every member has put the pebbles, asking any member to add up the pebbles against each card and write down the number on a paper next to each problem card.
- The card with the maximum number of pebbles is the first priority, and so on.
- Facilitator will inform the group about the order of their prioritized problems.
- Facilitator will choose the first 3 prioritized problems and take a consensus from the group – If some problems are interrelated then the facilitator may consider including more cards.

CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. She will encourage all the participants to speak and tell them to discuss what they have learnt with their family members and with those who could not attend the meeting. At the end she will take a tentative date for the next meeting and conclude the meeting and inform them about the content of the next meeting.

Meeting 4: Identifying and Prioritising problems of child health and nutrition

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting
2. To identify the problems related to child health and nutrition in their community.
3. To find out how common these problems are in their community

MATERIALS REQUIRED: Child health picture cards* (picture card from 9-16) picture card text*, pebbles, prioritization format, chart paper, pen, and notebook, (**picture cards with text in annexure*)

TIME TAKEN: 2 Hours

METHOD: 'What is it?' Game using picture cards and 'Voting game'

PROCESS: 1. IDENTIFYING THE PICTURE CARDS SHOWING MATERNAL NUTRITION PROBLEMS:

Facilitator will explain that she will introduce topics using a game called "What is it?"

- She will put the picture cards face down on the ground
- Any member of the group will pick up a card and pin it to the back of any volunteer member. The facilitator will ask the remaining group members/participants to carefully look at the card
- The member with the card pinned to her back tries to guess the topic written on the card while taking help from the remaining group members by asking several questions, e.g. is the problem related to child, maternal health? Is it a disease? Is it something that helps prevent a problem? The group members will try to enact the issue/problem (without speaking) that is shown on the card and allow the member to guess.
- The process is repeated until all the picture cards have been covered
- One blank card is kept to include any problem that the community thinks has not been already included



Sample Picture Card

SYMPTOMS	PREVENTION	MANAGEMENT
<ul style="list-style-type: none"> • Frequent loose stools • Fever • Vomiting • Abdominal pain • Dehydration 	<ul style="list-style-type: none"> • Hand washing with soap and water before feeding the baby and before preparing feeds • Food hygiene (storage, handling, cooking) • Thorough washing of feeding utensils regularly • Breast feeding within 60 minutes of birth to ensure intake of colostrums • Exclusive breast feeding for child up to 6 months of age • Avoid bottle feeding 	<ul style="list-style-type: none"> • Early recognition and early referral if dehydration detected • Adequate oral rehydration at an early stage – Giving ORS • Continue breast feeding during diarrhoea • The frequency of breastfeeding should be increased

CAUSES:

Diarrhoea is caused by **germs** (bacteria & viruses) that enter the body through **unclean** drinking **water**, **unclean food** and **unclean hands** through faecal-oral route

Description on the reverse of each picture card

2. PROCESS OF PRIORITIZING THE PROBLEMS

To help the participants identify the problem picture cards again

- Facilitator will distribute the picture amongst them
- She will allow them to look at the cards carefully
- She will allow them to ask if they have not understood the pictures
- Facilitator will explain the card if there is a doubt

Facilitator will explain that they will be playing a “voting” game:

- Facilitator will encourage all participants to take part in this exercise
- She will take each problem picture card in turn and remind the participants what the problem is (using the local name for it) and ask them to describe the symptoms. Then place the card on the ground, picture facing upwards, in the middle of the circle so that all can see them clearly
- She will put the cards in a line leaving enough space for some pebbles to be put against each card.
- After all the cards have been laid out – explain that, as a group, they are going to choose problems, that they think are common in their community and need to be discussed in the meetings
- They may want to consider how common the problem is in their community and/ or how serious it is?



- Facilitator will give each of the participants 6 pebbles.
- Asking the participants to place three pebbles against the problem card they consider to be the most important, two on the next most important and one on the third most important problem.
- Asking the women to think carefully before putting the pebbles against the cards, and that they should not be guided by others in the group
- Asking them to place the pebbles alongside the picture cards so that the picture is clearly visible to others.
- After every member has put the pebbles, asking any member to add up the pebbles against each card and write down the number on a paper next to each problem card.
- The card with the maximum number of pebbles is the first priority, and so on.
- Facilitator will inform the group about the order of their prioritized problems.
- Facilitator will choose the first 3 prioritized problems and take a consensus from the group – If some problems are interrelated then the facilitator may consider including more cards.

CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. She will encourage all the participants to speak and tell them to discuss what they have learnt with their family members and with those who could not attend the meeting. At the end she will take a tentative date for the next meeting and conclude the meeting and inform them about the content of the next meeting.

Meeting 5 & 6: Understanding causes and finding solutions for 3 prioritized problems

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting.
2. To understand the causes and effects for the prioritised problems related to maternal and child health in their community through a story-telling process.
3. To arrive at the root causes using the “but why?” game and arrive at solutions to deal with the problems using the “but what?” game.

MATERIALS REQUIRED: Script for story, picture cards (drawn by facilitators), pen, notebook, chart paper

TIME TAKEN: 2 hours

METHOD: Storytelling and ‘but why?’ and ‘but what?’ games

PROCESS:

UNDERSTANDING THE POSSIBLE CAUSE AND EFFECT LINKAGES TO THE PRIORITIZED PROBLEMS

Facilitator will use storytelling and picture cards to help women understand the causes and effects of the problems they have prioritized. The causes will include both the **immediate** and **underlying causes** that include both **social and medical causes**.

Stories should be simplistic and have a theme that is clearly defined and strikes a chord with the community, characterization should have the local context (learning from the current practices in and around child birth), style should include pictures that highlight the causes leading to the problem; the plot should have a dramatic ending to have an impact on the listeners.

In this meeting the facilitators will narrate a story that weaves through the immediate, underlying and structural causes of the problem.

For the story-telling the following aspects are kept in mind:

- Context/background
- Symptoms of the problem
- Causes for the problem – both immediate and underlying
- How to prevent the problem

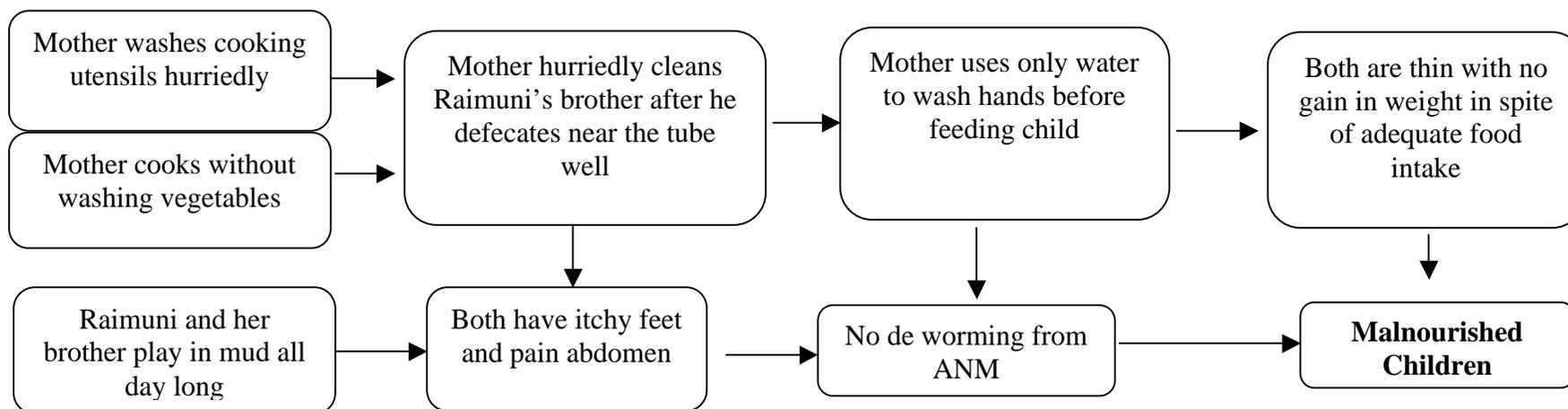
To develop a story.....

1. Choose the problem cards which has the causes written on the backside
2. On separate cards the facilitators will draw pictures of the **immediate** and **underlying** causes leading to the problem.

3. The cards are arranged in such an order that leads from the underlying to the immediate causes and ultimately to the prioritized problem.
4. The cultural practices that may lead to the problems are included in the story
5. The story is written using the text written on the back of each of the prioritized picture cards (causes, symptoms, prevention)
6. The facilitator can refine the story with help from the supervisors at the review meetings
7. Facilitator will make picture cards to represent the main points in the story, e.g. picture of a young pregnant girl, rituals being performed, etc. For narrating the story the facilitator will use hand drawn pictures of the *immediate* and *underlying* causes, and also some on harmful practices. While narrating the stories these pictures are laid on the ground as they are mentioned in the story. This helps the participants to follow the story line while focussing on the causes, effects and preventive actions and helps the participants to understand the linkages between them.
8. The protagonist is a person from the village and the underlying and socioeconomic causes of the problems are woven into the story in such a way that the listeners internalise the causes leading to the said problem.

Example: A story on worm infestation will include the following causes:

Five years old Raimuni and her 2 years old brother are looked after by their grandmother while her parents go to work in the field. Raimuni's mother quickly washes the vessels and cooks vegetables without washing them properly before she goes to work. When her baby brother passes stool her mother hurriedly cleans him near the tube well and after washing her hands with plain water she feeds her baby brother before leaving. Raimuni and her brother always played in the mud the whole day and often complained of pain in stomach and itchy feet. Raimuni's mother was worried because both the children were not putting on weight although they were eating the required amount of food and so she decides to take them to the ANM. The ANM tells Raimuni's mother that both her children are malnourished because their hands and legs are looking thin while the abdomen looks swollen and that they are underweight and that they may have worms in the stomach which may be the cause for their not gaining weight and the itchy feet are because some worms can also enter through the skin when they are bare feet in the mud. The ANM also scolds her for not routinely taking de-worming medicines from her every 6 months.



After narrating the story the facilitator will ask any group member to repeat the story with the help of the pictures laid down on the ground to remind them of the main causes leading to the problem.

PROCESS OF FINDING SOLUTIONS TO THE PROBLEM RELATED TO WORMS

Facilitator will explain that they will be playing a game called 'but why?'

- Encourage all participants to take part in this exercise
- Allow the picture cards to remain on the ground after the story-telling session
- Facilitator will ask the group to discuss what happened at the end of the story (e.g. there was a stillbirth), but why did the baby die? and so on until all the causes to the problem have been covered.

The 'but why...?' game

Q: Why did the ANM say that Raimuni and her brother were undernourished?

A: Because their hands and feet were thin while the abdomen was swollen

Q: But why were the abdomen swollen and hands and legs thin?

A: Because in spite of eating the required amount of food they were not gaining weight

Q: But why were they not gaining weight?

A: Because they complained of stomach pain and had worms in their stomach.

Q: But why did they have worms in the stomach with stomach pain?

A: Because they played bare feet in the mud all day

Q: So what are the other reasons for the children's getting worms?

A: Because their mother did not clean her hands properly with soap after cleaning Raimuni's brother after he defecated and also did not wash the vegetables properly before cooking them and the utensils were also hurriedly cleaned.

The facilitator will summarize the causes at the end of the 'but why?' game by recalling all the causes that led to the problem.

To arrive at the solutions she will now ask the participants, 'but what?' can be done to prevent the problem from happening and all the solutions are listed in their register.

To arrive at the **strategies** the facilitator will ask '**what could have been done?**' to prevent the problem from happening and note down all the responses for use later on.

CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. This way the facilitator can assess how much the participants have understood. She will encourage all the participants to speak and tell them to discuss what they have learnt with their family members and with those who could not attend the meeting.

Before concluding the meeting tell the participants that now they know about causes and solutions for the prioritized problems and they will decide on the strategies to deal with the problem in the next meeting

At the end take a tentative date for the next meeting and conclude the meeting.

MEETING 7: Prioritizing possible strategies to address the problems

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting
2. To prioritize strategies arising out of the solutions using the 'bridge game' for implementation.

MATERIALS REQUIRED: Chart with list of solutions, 2 bricks, 2 sticks, few wooden planks, format (strategies), pen and notebook)

TIME TAKEN: 1 ½ hours

METHOD: Bridge Game

PROCESS: **IDENTIFYING STRATEGIES AND PRIORITIZING THEM AFTER UNDERSTANDING THE OPPORTUNITIES AND BARRIERS FOR IMPLEMENTATION OF STRATEGIES**

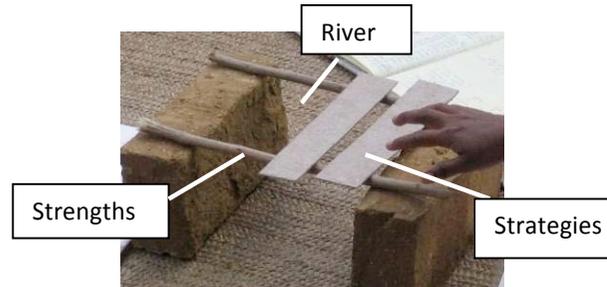
Facilitator will explain that they will play '*the bridge*' game. This is a practical and visual exercise to help participants understand the present situation "they are now in" with regard to health and nutritional problems of women and children and "where they would like to be".

- Ask the participants to imagine they are standing on one bank of the river. This represents their current situation with regard to health of women and children in their community. Place one brick on the ground.
- Place another brick a little apart that represents the other bank of the river representing the situation with regard to health of women and children in their community.
- The space in between is the river which is the barrier that is preventing them from reaching where they want to be.
- To overcome the barriers they need to build a bridge that represents the strategies that will have to be implemented.
- Place 2 long sticks across the bricks at right angles. These represent the strengths of the groups that will provide the supportive base to implement strategies.
- The shorter planks will be placed across the two sticks that will represent the strategies.

Once the bridge has been explained start from the beginning and have a discussion about each aspect, reminding them about discussions from previous meetings:

1. The first brick = where are we now? (i.e. Problems in mothers and children)
2. The second brick = where we want to be? (i.e. Healthy mother and healthy baby)
3. The river = the barriers we face

4. The two long sticks = the strengths we have as a group (e.g. active savings group, helpful village leader, sincere ASHA / AWW, unity among group members, etc)
5. The shorter planks = the strategies the group will come up with. They need to decide what these will be now ...



To identify strategies the facilitator will initiate brainstorming on the different strategies that the group thinks could help them prevent the prioritized problem by asking ‘but how?’ e.g. but how can you ensure that the newborn is given colostrums as first feed? But how can you ensure that the baby is exclusively breast fed? But how can you ensure timely initiation of complementary feeding?

- Keep prompting for as many suggestions as possible.
- For each strategy discuss the barriers they face and the strengths they have as a group and discuss whether it is a feasible strategy.
- Once the group has decided they want to implement a strategy and that it is feasible for them as a group, place a short plank on the bridge.
- Similarly all the strategies are taken up and the bridge is completed.

Through the process of listing, discussion and prioritizing, the group decides on different strategies that they want to use and they think are feasible for them to implement



CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. This way the facilitator can assess how much the participants have understood. She will encourage all the participants to speak and tell them to discuss what they have learnt with their family members and with those who could not attend the meeting.

Before concluding the meeting tell the participants that they now know the strategies and they will be implementing these strategies together for preventing the prioritized problems

At the end take a tentative date for the next meeting and conclude the meeting.

MEETING 8: Discussing responsibilities and deciding on indicators for measuring progress & preparing for the community meeting

PURPOSE OF THE MEETING:

1. To encourage women to recall the main discussion from the previous meeting
2. To undertake responsibilities for implementing the prioritized strategies and measuring progress.
3. To plan to share the learning from the previous meetings with the wider community.

MATERIALS REQUIRED: Chart with list of strategies, format (strategies implementation format), chart paper, pen and notebook

TIME TAKEN: 1 ½ hours

METHOD: Format discussion & Interactive discussion

PROCESS: **1. DISCUSSING PROCESS OF IMPLEMENTATION OF STRATEGIES AND UNDERTAKING RESPONSIBILITIES FOR THE SAME AND MEASURING ITS PROGRESS**

Facilitator will take up each strategy to be implemented and ask how the groups plan to implement them

- For each strategy discuss the following in details:
 - When do they want to start the implementation?
 - What actions / activities are necessary?
 - Who will take responsibility for its implementation?
 - Do they want / need to involve non-group members? How feasible is this? Who will take responsibility for interacting with them?
 - What should they do if they experience any problems while implementing the strategies?
- For each person assigned a role, discuss as a group how they will proceed to ensure that they have enough support and guidance.

The facilitator will keep a record using a table like the one given below and also ensure that any one group member also maintains this record.

Village	Problem prioritised	Strategy to be implemented	Person(s) responsible	Progress of Implementation	Remarks

2. HOW WILL PROGRESS BE MEASURED?

1. Discuss whether it is important to measure the progress of their work? If so, why? If not, why not?
2. Discuss how they would like to measure their progress? They could use simple indicators.

For example:

- STRATEGY – Encouraging pregnant women to take iron tablets
- INDICATORS – How many pregnant women are there in the village? How many took iron tablets?

3. Discuss who will take responsibility for measuring the impact of the strategies? They may wish to complete a table like the one below, or if there is any literate woman in the group she can take up the responsibility of maintaining the record. If no one in the group is literate they could consider having assistance from other members of the community, e.g. school girls, or consider other methods of measuring their progress.

Meeting No.	No. of newly pregnant women in village	Name of pregnant women	Consumed iron tablets	Regular ANC	Kitchen garden	No. of deliveries in the village	Used SDK	Exclusive breast feeding	Wiping and wrapping within 30 minutes	Remarks

3. DISCUSSING AND PLANNING DETAILS OF THE COMMUNITY MEETING WITH THE GROUP

- Facilitator will discuss the need for having a community meeting.
 - The need for the entire community to take responsibility for implementing the strategies.
- Facilitator will find out from the group about the following:
 - When do they want to have the community meeting? (time, date)
 - Where do they want to have it? (Place/ venue – school premises/ open area / Panchayat hall, etc.)
 - Who will they like to invite for the meeting? (Frontline government staff, village leaders, village elders, nearby villagers, teachers, etc.)
 - Who will like to take responsibility for the invitation?
 - What will be the mode of invitation? (Letter, traditional methods, etc.)

- What are the resources required? (Seating arrangements, food, water, etc.) How will they obtain these?
- What will be the method of dissemination of their learning with the community? (Story-telling, street play, role play, puppet show, picture cards, songs, etc.)
- What kind of help will they need from the facilitator? (Preparation of script, help with practicing the play, discuss about the previous meetings, etc.)
- Facilitator will encourage women to participate and take up responsibilities.
- The method of presentation should be made simple so that everyone can understand. The presentation should be in the local language.
- Facilitator will help the groups to practice for the play in advance (characters in the play, voice should be loud and clear, etc.).
- Facilitator will help the group to decide the venue and the seating arrangements (where the stage is to be set, place for the audience, etc.).

CONCLUDING THE MEETING

Facilitator will summarize all the discussions with the help of the participants. This way the facilitator can assess how much the participants have understood. She will encourage all the participants to speak and tell them to discuss what they have learnt with their family members and with those who could not attend the meeting.

Before concluding the meeting remind the participants about all the responsibilities they have undertaken to be able to implement the strategies well. At the end take a tentative date for the community meeting and conclude the meeting.

Meeting 9: COMMUNITY MEETING - I

PURPOSE OF THE MEETING:

1. To disseminate learning from all previous meetings to the wider community.
2. To present the strategies decided by the groups to the community.
3. To seek support from the community for implementing the strategies.

MATERIALS REQUIRED: Picture cards, chart with list of strategies, locally available resources for decorations, pen, register etc.

TIME TAKEN: 3 - 4 Hours

METHOD: **Street play, storytelling, picture cards discussion, puppetry, song, dance, etc.**

Some useful tips prior to holding the community meeting:

- During the community meeting the women's group members will summarize their activities over the past few months and share the prioritised problems and strategies to the larger community and key stakeholders, e.g. village headmen, government officials, health workers and others who have not attended the meetings.
- Street plays, puppetry and storytelling are some of the innovative approaches that can be used by the group members for dissemination of the prioritised problems and their underlying causes.
- Stakeholders (especially the frontline health staff) can be requested to inaugurate the function so that their role in the community can be acknowledged.
- During the preparation for this meeting the facilitators will help the members in script writing, acting, etc. and rehearsals.
- The members can use locally available resources like 'saris' as back drop, leaves for decorations, jute woven mattresses for seating the attendees, etc. The group members can voluntarily contribute money for the logistic arrangements like food, microphones, etc.

Any group member is encouraged to preside over the meeting with help from the facilitator.

PROCESS:

- The meeting can start with a welcome song followed by thanking the audience for being able to attend the meeting and briefing them about the day's proceedings.
- The meetings conducted so far should be discussed briefly to help the audiences understand the process
- Women's Group members will then present the method they have selected for disseminating the prioritized problems, barriers identified, strategies selected to overcome the problems and the local resources they have. While sharing the information the members will note the stakeholders who will be able to help with the implementation of strategies.

[Facilitator to support and encourage the members to conduct the meeting smoothly]

- Towards the end of the community meeting, the stakeholders should be asked to share their experiences. These experiences can be recorded by the facilitator and later be used as quotes. The facilitator can use the following format for keeping a note of meeting findings:

Community Meeting Format

Name of the group	Dissemination Method	Total Female Participants	Total Male Participants	Designation of the stake holders	Feedback/comments of the stake holders

There is no one way of conducting this meeting; however the following points can be useful:

- The community meeting should be held with full enthusiasm like a festival
- The members can pin up the picture cards used in the earlier meetings on a sari to attract the crowd and also to make them understand what the stories were about.
- Arrangements should be such that everyone present can listen to the discussions clearly and is able to understand.
- Ensure that everyone is comfortably seated to be able to see and hear the discussions.
- Make sure that the meeting is simple to understand and not too lengthy.
- The audience should have a good mix of adolescent children, mothers of children between 0-5 years of age, pregnant and lactating mothers. They should be encouraged to sit in the front.
- Encourage the pregnant and lactating mothers, mothers of children 0-5 years of age to share their views.
- Invite people from the audience to share their views on malnutrition with the community.
- The relevant decisions at the meeting should be noted down by any one group member.



CONCLUDING THE MEETING

Before concluding the meeting the facilitator will request any group member to thank the audience for having attended the meeting and having provided their support in being able to implement the strategies that were decided. Invite them for a group/folk dance. At the end take a tentative date for the next meeting and end the meeting.