

# Working with Individuals, Families and Communities to Improve Maternal and Newborn Health



## A Toolkit for Implementation

### Module 1:

An Overview of Implementation at National, Province and District Levels



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Contents: Module 1: An overview of implementation at national, province and district levels; Module 2: Facilitator's guide to the orientation workshop on the IFC framework; Module 3: Participatory community assessment in maternal and newborn health; Module 4: Training guide for facilitators of the participatory community assessment in maternal and newborn health; Module 5: Finalizing, monitoring and evaluating the IFC action plan.

ISBN 978-92-4-150852-0

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**Cataloguing-in-Publication (CIP) data.** CIP data are available at <http://apps.who.int/iris>.

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Graphic design and Print: Imprimerie Villière - 74160 Beaumont - France

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## ACRONYMS

<b>IFC</b>	Individuals, Families and Communities (In reference to the World Health Organization's framework for Working with Individuals, Families and Communities to Improve Maternal and Newborn Health)
<b>MMR</b>	Maternal mortality ratio
<b>MNH</b>	Maternal and newborn health
<b>MoH</b>	Ministry of Health
<b>NGO</b>	Non-governmental organization
<b>PAHO</b>	Pan American Health Organization
<b>PCA</b>	Participatory community assessment
<b>UN</b>	United Nations
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

### Tell us what you think!

All comments on this document are welcome. Please let us know if you find the content useful, your experience in using this guide, if there is any information missing, if there is anything else you would add to this guide. Please send all comments to the Department of Maternal, Newborn, Child and Adolescent Health (MCA), World Health Organization (WHO), Geneva, to [mncah@who.int](mailto:mncah@who.int).





## THE STORY OF THE TOOLKIT

In 2003, The World Health Organization (WHO) published a concept and strategy paper entitled *Working with individuals, families and communities to improve maternal and newborn health*,<sup>1</sup> herein referred to as the “IFC framework”.

The IFC framework was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries.

Soon after its publication, countries began to ask how to implement the Framework and how to operationalize the key themes of empowerment and community participation. This is where the story of the five modules included in this document, *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, begins.

The work of all five modules was done under the technical supervision of Anayda Portela, WHO/Department of Maternal, Newborn, Child and Adolescent Health (WHO/MCA) in Geneva. The modules related to the participatory community assessment (PCA) were developed under the guidance of Anayda Portela, Carlo Santarelli of Enfants du Monde and Vicky Camacho, then the Regional Advisor on Maternal Health to the Pan American Health Organization (PAHO). Each module has a series of authors, reviewers and country experiences.

We have attempted to mention all the teams and moments involved below. Some individual names may not be cited, however we wish to convey our gratitude to every person and country team who has contributed, and regret any contributions which may have been overlooked or not specifically mentioned.

The first work on the PCA and the corresponding *Guide to train facilitators* began in 2005. In response to country requests in Latin America, Vicky Camacho proposed an adaptation of earlier MotherCare work and of the Strategic Approach developed by WHO/Department of Reproductive Health and Research. Veronica Kaune, a consultant from Bolivia, developed the first guide for PCA, which was reviewed by an expert group including Fernando Amado, Angela Bayer, Lola Castro, Colleen B. Conroy, Julio Córdova, Luís Gutiérrez, Martha Mejía, Rafael Obregón, and Marcos Paz.

A meeting was held in El Salvador in September 2005 to review the PCA with representatives from Bolivia, El Salvador, Honduras, and Paraguay. After the first pilot experiences in El Salvador and Paraguay, the PCA was modified to simplify the process and reporting to ensure that a country could integrate it into its ongoing planning processes.

Kathryn Church, a consultant supported by funding from Enfants du Monde and PAHO, then went to El Salvador to support the national IFC committee in a next country experience. The MIFC committee included representatives of the Ministerio de Salud Pública y Asistencia Social (MSPAS), Concertación Educativa de El Salvador (CEES), Fundación Maquilishuat (FUMA), CREDHO, and PAHO EL Salvador. The PCA was conducted in Izalco and Nahuizalco with support from local facilitators, the health units and the SIBASI of Sonsonate.

<sup>1</sup> Please see [http://www.who.int/maternal\\_child\\_adolescent/documents/who\\_fch\\_rhr\\_0311/en/](http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/)



Special mention is made of the work in El Salvador who was a pioneer in leading the IFC implementation in the Americas Region, and the PCA was subsequently reformulated on the basis of these experiences.

The El Salvador team included: Jeannette Alvarado, Tatiana Arqueros de Chávez, Carlos Enríquez Canizalez, Luís Manuel Cardoza, Virgilio de Jesús Chile Pinto, Hilda Cisneros, Morena Contreras, Jorge Cruz González, William Escamilla, Jessica Escobar, Elsa Marina Gavarrete, Melgan González de Díaz, Edgar Hernández, María Celia Hernández, Pedro Gonzalo Hernández, José David López, José Eduardo Josa, Carmen Medina, Emma Lilian Membreño de Cruz, Ana Dinora Mena Castro, Ana Ligia Molina, Sonia Nolasco, Xiomara Margarita de Orellana, Ever Fabricio Recinos, Guillermo Sánchez Flores, Lluni Santos de Aguilar, Luís and Valencia. Maritza Romero of PAHO was instrumental in supporting the process.

Kathryn Church was subsequently hired by WHO Geneva to work with Anayda Portela to simplify the PCA based on the El Salvador experience; thereafter what are now Modules 1, 3 and 4 were produced.

Carlo Santarelli of Enfants du Monde also provided important input into this work. Subsequent experiences led to further refinement of these Modules: 1) in Moldova and Albania with the support of WHO Europe and Isabelle Cazottes as a consultant, and 2) in Burkina Faso with the support of the Ministry of Health (Ministère de la Santé), Enfants du Monde and UNFPA.

Isabelle Cazottes was then hired by WHO Europe to work with WHO Geneva (Anayda Portela and Cathy Wolfheim) to develop an Orientation Workshop for the IFC framework and implementation, which served as the basis for what is now Module 2.

The workshop was based on training guides developed for the introduction of the IFC framework and implementation process used in regional workshops in Africa, Europe, Eastern Mediterranean, the Americas and Southeast Asia (workshops organized by the WHO Regional Offices of Africa, America, Europe, Eastern Mediterranean, South East Asia and Western Pacific). Module 2 was subsequently finalized by Janet Perkins, consultant to WHO, Anayda Portela, and Ramin Kaweh. A version was tested by the Enfants du Monde team with the local IFC committee in Petit-Goâve, Haiti.

Module 5 was begun by the health team at Enfants du Monde including Cecilia Capello, Janet Perkins and Charlotte Fyon, working with Anayda Portela of WHO. Carlo Santarelli and Alfredo Fort, Area Manager for the Americas Region, WHO Department of Reproductive Health and Research at the time, provided inputs. Different sections of the module were subsequently reviewed by the regional coordinators of Enfants du Monde, the national MIFC committee in El Salvador, Ruben Grajeda of PAHO, Aigul Kuttumuratova of WHO/EURO, Raúl Mercer and Isabelle Cazottes. The module was finalized by Janet Perkins as a consultant to WHO Geneva.

Janet Perkins, as a consultant to WHO Geneva, did a final technical review and edit to harmonize all five modules. Jura Editorial copyedited Modules 1, 3 and 5. Yeon Woo Lee, an intern with WHO/MCA, updated the references to ensure compliance with the WHO style guide. Pooja Pradeep, an intern with WHO/MCA, reviewed all the modules after the editor changes were incorporated. Amélie Eggertswyler, intern with Enfants du Monde, and Hanna Bontogon, intern with WHO/MCA, reviewed the layout of Module 1. Francesca Cereghetti, also intern with Enfants du Monde, reviewed the layout of Modules 1 and 5, and Saskia van Barthold, intern with Enfants du Monde, reviewed the layout of Modules 2, 3 and 4.





The toolkit, in different stages of development and in various degrees, has been used in the following countries: Albania, Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People's Democratic Republic, Paraguay and the Republic of Moldova. We have learned from each of these experiences and have tried to incorporate the learning throughout the toolkit's development.

Such a document can only be useful if it is adapted to each context, and we have intended for it to be a living document – that improves with each use and each reflection. Thus this story will continue.

Financial support for the development of the modules over the years has been received from Enfants du Monde, WHO, PAHO, WHO/EURO, the EC/ACP/WHO Partnership and the Norwegian Agency for Development Cooperation.





## INTRODUCTION TO MODULE 1

This document is the first module of a series entitled *Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation*, designed to support the implementation of the World Health Organization (WHO) framework “*Working with individuals, families and communities (IFC) to improve maternal and newborn health*”,<sup>2</sup> herein referred to as the “IFC framework.”

The IFC framework, originally elaborated in 2003, was developed in response to the observation that a robust and systematic health promotion component was largely absent from most maternal and newborn health (MNH) strategies in countries. Grounded on the foundational principles of health promotion as outlined in the Ottawa Charter,<sup>3</sup> the framework and the interventions it proposes were formulated based on an examination of evidence and successful experiences in working with individuals, families and communities to improve MNH.

This evidence was updated in 2015 and we refer the reader to the publication *WHO recommendations on health promotion interventions for maternal and newborn health*, available at [http://who.int/maternal\\_child\\_adolescent/documents/health-promotion-interventions/en/](http://who.int/maternal_child_adolescent/documents/health-promotion-interventions/en/).

To date, the IFC framework has been implemented in a number of countries spanning the six world WHO regions, including: Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Haiti, Kazakhstan, Lao People’s Democratic Republic and the Republic of Moldova. The aim of the toolkit is to support public health programmes in launching a process to work with and empower individuals, families and communities to improve MNH.

<sup>2</sup> See the following strategic document: *Working with individuals, families and communities to improve maternal and newborn health*, WHO, 2010.

<sup>3</sup> See WHO, 1986.



The implementation toolkit contains five modules, as described in the following table:

Module	Description
<b>Module 1: An Overview of Implementation at National, Province and District Levels</b>	<b>An introduction to the process of initiating implementation of the IFC framework at national, province and district levels.</b>
Module 2: Facilitators' Guide to the Orientation Workshop on the IFC Framework	A resource guide for conducting a workshop to orient national, province and district actors to the key concepts, processes and interventions of the IFC framework.
Module 3: Participatory Community Assessment in Maternal and Newborn Health (PCA)	An overview on conducting the PCA, a participatory tool designed to support district-level actors to assess the MNH situation and needs and to identify priority interventions for IFC implementation.
Module 4: Training Guide for Facilitators of the Participatory Community Assessment (PCA) in Maternal and Newborn Health	A guide to support training of facilitators to conduct the PCA.
Module 5: Finalizing, Monitoring and Evaluating the IFC Action Plan	A guide to support the finalization of the IFC action plan based on the PCA, including suggestions for monitoring and evaluation.

This first module of the toolkit, *“An overview of implementation at national, province and district levels”*, provides guidance on initiating implementation of the IFC framework in a country. The module contains a brief overview of the IFC framework and its objectives, and then presents steps that will facilitate implementation at the national, province and district levels.<sup>4</sup>

The process presented is intended to be used the first time that the framework is introduced in a country or province. Certain aspects will be adapted once a country has experience in participatory processes and in integrating the IFC framework into the broader MNH strategy.

### Who should use this module?

Although the focus of implementation efforts is at the district level, the IFC framework is designed to be integrated as a health promotion prong of a broader MNH strategy. As such, operationalization of the framework is facilitated by the actions and the leadership of actors at the national and province levels. This module is designed with programme managers and MNH actors at national, province and district levels in mind to assist them in launching an effective IFC strategy.

<sup>4</sup>The definitions of national, province and district are presented in section 2.1.



## Adapting the process

The process outlined in this guide is a suggested one and is intended to be approached with flexibility. Participating actors are encouraged to review its contents and then adapt the process within each country to suit the national and local context.

Although the proposed steps will help to ensure the successful implementation of the IFC framework, each country must take into account its ongoing strategies and initiatives, and coordinate efforts.

## Structure of the module

- Section 1** presents an overview of the IFC framework and its role within an MNH strategy.
- Section 2** outlines a process of IFC implementation at the national and province levels.
- Section 3** describes a process of IFC implementation at the district level.



# 1. OVERVIEW OF THE IFC FRAMEWORK

## 1.1 PRINCIPLES OF THE IFC STRATEGIC FRAMEWORK

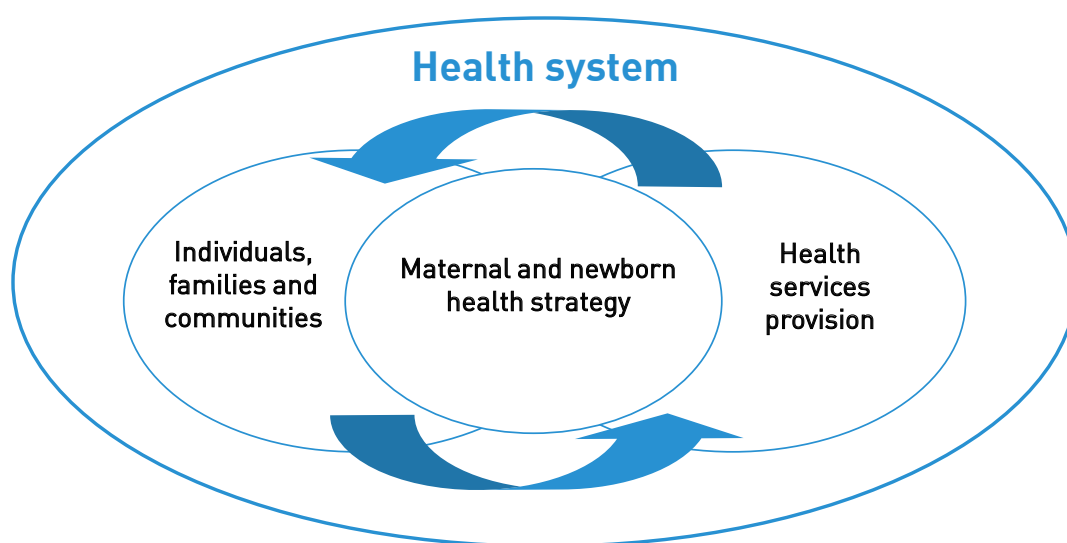
Based on the principles of health promotion as outlined in the Ottawa Charter (1986), the WHO IFC framework emphasizes working with individuals, families and communities as a critical link in ensuring the recommended continuum of care throughout pregnancy, childbirth and after birth for women and newborns. The continuum of care is optimized when it extends from the woman, the household and the community to the health provider and health services, and includes access to a skilled attendant at birth. The continuum of care also requires access to the appropriate services when obstetric and neonatal complications arise, which is one of the most critical health care delivery determinants for the survival of mothers and newborns. However, the availability of services alone will not improve MNH where there is no possibility for women, men, families and communities to make and act on health-promoting decisions.

The IFC framework emphasizes the positive and active role that individuals and groups can play to improve health, as well as the wide array of influences on health, including social, cultural and economic determinants. Within this perspective, individuals, families and communities are an essential component of the health system (see Fig. 1.1).<sup>5</sup>

### Box 1.1: Aims of the IFC framework:

1. To contribute to the empowerment of individuals, families and communities to improve maternal and newborn health.
2. To increase access to and utilization of quality health services, particularly those provided by skilled birth attendants.

**Fig. 1.1: Individuals, families and communities within the health system**



<sup>5</sup> In accordance with the WHO Framework for Health System Performance Assessment (1999), individuals, families and communities in their decisions and actions for health and their expectations of health services are important actors and resources of health systems.





The IFC framework is designed to be integrated as a health promotion component of the national MNH strategy. It aims to complement its other pillars, including health services strengthening and policy development. The IFC framework, like health promotion, is anchored within a **rights-based approach** to health. A rights-based approach recognizes that effective and sustainable development occurs only when people participate in designing the policies, programmes and strategies that are meant to benefit them. The involvement of the community in setting priorities and designing, implementing and evaluating programmes and actions relevant to health is not only a right – it also leads to more effectively meeting the community's needs. This participation is also key to empowerment (see more below), which is essential for individuals to claim their rights. At the heart of a rights-based approach is addressing unjust power relations, rooting out inequity, including gender inequity, and empowering individuals to participate in and control the resources fundamental to their well-being.

Increasingly, the international community is recognizing that preventable maternal mortality and morbidity is not only a matter of development, but first and foremost a matter of human rights. As such, creating the conditions in which women can experience pregnancy and childbirth safely is not charity but is fundamental to assuring their basic human rights. Governments are under obligation to respect, protect and fulfil these rights to which women have legitimate claim. The following seven human rights principles have been identified as fundamental to addressing preventable maternal morbidity and mortality: accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination.<sup>6</sup>

The IFC framework aims to directly impact the principles of participation and empowerment, while indirectly impacting the other principles throughout the implementation process.

**Empowerment** within the IFC framework is recognized as an end in itself as well as a process to help achieve increased access to and utilization of health services. **Empowerment can be understood as the process of increasing capacity of individuals or groups to make choices and to transform these choices into desired actions or outcomes.**<sup>7</sup> This occurs at both the individual and the collective levels as women, families and communities become aware of their rights and needs related to MNH and take action to address them.

One way to contribute to the empowerment of individuals, families and communities is to enlist their participation throughout the health programming cycle, beginning at planning and continuing through the implementation of interventions, monitoring and evaluation. The participatory community assessment (PCA) is a suggested tool that can be used to initiate empowerment processes by engaging community members at the outset of planning at the district level (see Modules 3 and 4). Module 5 provides insight on maintaining participation throughout the subsequent stages of IFC planning, monitoring and evaluation.

All those embarking on a process to work with individuals, families and communities to improve MNH are advised to read the IFC framework strategic document and become familiar with its principles and recommended interventions. The document can be accessed at : [http://www.who.int/maternal\\_child\\_adolescent/documents/who\\_fch\\_rhr\\_0311/en/index.html](http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/index.html)

<sup>6</sup> See See Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights, 2010.

<sup>7</sup> See Alsop and Bertelsen, 2006.

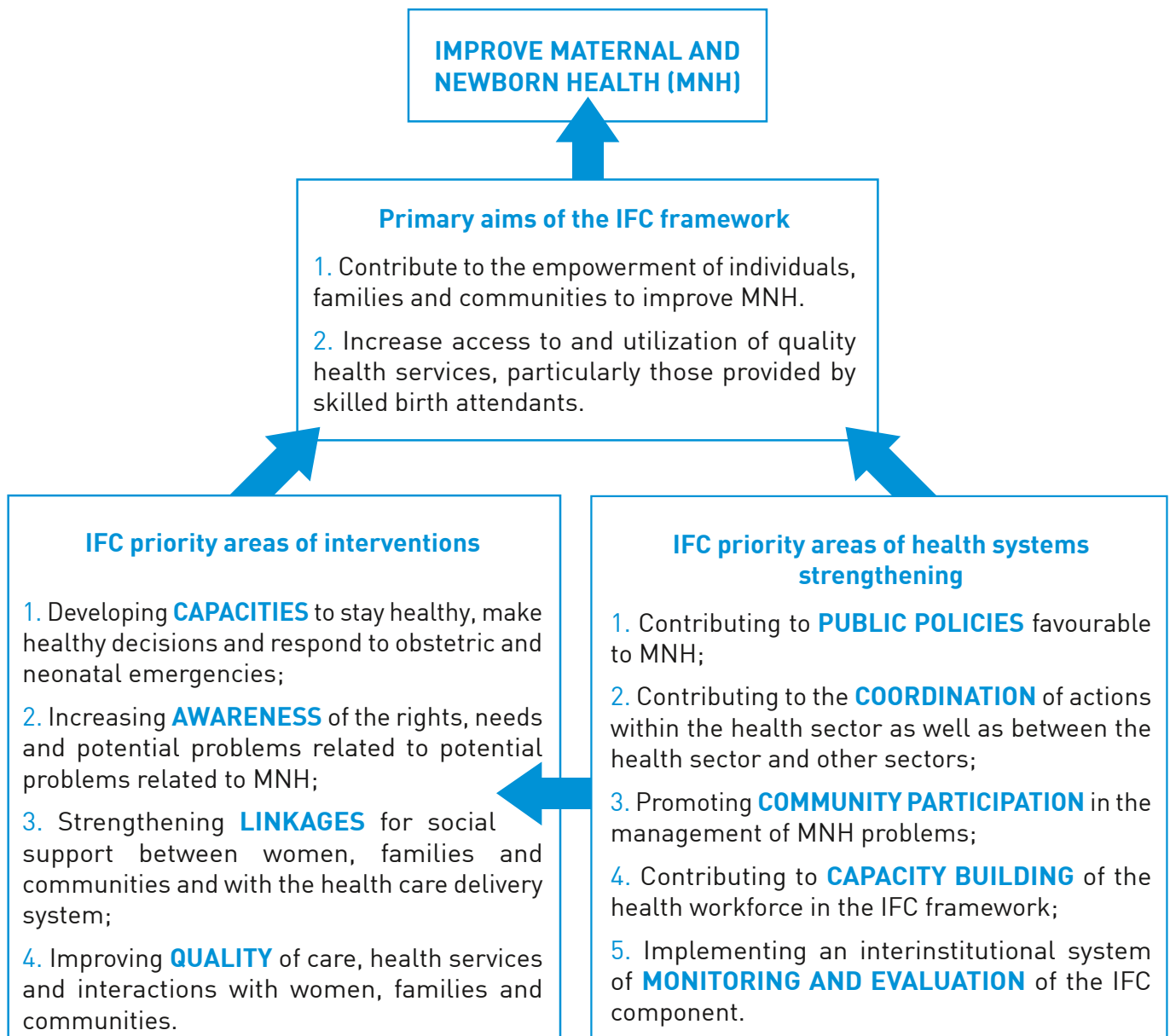


## 1.2 IFC FRAMEWORK PRIORITY AREAS OF ACTION

The IFC framework aims to empower at the community level, and thus the focus of actions within the framework is at the district level. However, experience has shown that simultaneous efforts to strengthen the health system optimize the effectiveness of the district level interventions. These efforts pave the way for scaling up the IFC framework and foster sustainability of the processes and results. Therefore, within the framework **four priority areas of**

**intervention** and **five priority areas of health systems strengthening** have been identified. This combination of actions works synergistically to contribute to change in the primary aims of the framework, which are ultimately to improve MNH, and contribute to the broader goals of the survive, thrive and transform agenda as outlined in the *Global strategy for women’s, children’s and adolescents’ health (2016-2030)*<sup>8</sup> (see Fig. 1.2).

Fig. 1.2: IFC framework objectives and priority areas



<sup>8</sup> Available from: <http://www.who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf?ua=1>



## 1.3 IFC PRIORITY AREAS OF INTERVENTION

The main areas for action at the district level are grouped into **four IFC priority areas of intervention** (see Fig. 1.3). The priority areas of intervention provide a context for thinking about and exploring the different domains in which action will ideally be taken – capacities, awareness, linkages and quality. The interventions were identified in 2003 based on a review of the literature and country programmes experiences

and through discussions in an expert meeting. These interventions are discussed in more detail in the IFC framework strategic document. In addition, the evidence base for these interventions and for the participatory approach embraced in this Toolkit has recently been updated by WHO. (Please see WHO recommendations on health promotion interventions for maternal and newborn health 2015.<sup>9</sup>)

**Fig. 1.3: Interventions in the four IFC priority areas of interventions**

Priority areas of intervention	Developing <b>CAPACITIES</b> to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	Increasing <b>AWARENESS</b> of the rights, needs and potential problems related to maternal, newborn health	Strengthening <b>LINKAGES</b> for social support between women, families and communities, and with the healthcare delivery system	Improving <b>QUALITY</b> of care, health services and interactions with women, families and communities
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Self-care/care in the household*</li> <li>• Care-seeking behaviour*</li> <li>• Birth preparedness and complication readiness</li> </ul>	<ul style="list-style-type: none"> <li>• Male involvement and family support</li> <li>• Promotion of human, sexual, and reproductive rights<sup>†</sup></li> <li>• Community participation in maternal death surveillance and response<sup>‡</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Partnership with traditional birth attendants</li> <li>• Maternity waiting homes<sup>‡</sup></li> <li>• Community-organized transport schemes<sup>§</sup></li> <li>• Community mobilization through participatory learning and action cycle with women's groups</li> </ul>	<ul style="list-style-type: none"> <li>• Community participation in quality-improvement processes</li> <li>• Companion of choice at childbirth</li> <li>• Providing culturally appropriate skilled maternity care</li> <li>• Interpersonal competence of healthcare providers*</li> </ul>

\*Health education and counselling were not specifically reviewed in the 2015 systematic review; however, these interventions are recommended and supported by other WHO documents.

<sup>†</sup>Evidence regarding these interventions is limited, which led to a research recommendation in the 2015 publication; however, these interventions are recommended as a matter of principle while awaiting further data.

<sup>‡</sup>Recommended to be established close to a health facility where essential childbirth care and/or care for obstetric and newborn complications is provided for populations living in remote areas or with limited access to services.

<sup>§</sup>Recommended to be implemented with caution in settings where other sources of transport are less sustainable and not reliable. However, measures should be taken to ensure the sustainability, efficacy and reliability of these schemes while seeking long-term solutions to transport.

Within the IFC framework, developing **capacities** refers to the reinforcement of competencies oriented towards self-care and care of women during and after pregnancy and newborns in the home. These include healthy lifestyle, care-seeking behaviour and responding to obstetric and neonatal complications. This area of intervention arises from the assumption that women, families and communities have capacities related to MNH and that appropriate

interventions can strengthen these capacities and develop those that may be lacking.

Greater **awareness** means that all stakeholders recognize that safe motherhood, safe birth and access to quality care are human rights. Governments have a legal obligation to assure that these rights are respected, protected and fulfilled. In addition, a broad array of other actors in the home and the community can participate

<sup>9</sup> Available from: [http://www.who.int/maternal\\_child\\_adolescent/documents/health-promotion-interventions/en/](http://www.who.int/maternal_child_adolescent/documents/health-promotion-interventions/en/)



in assisting women and families in exercising these rights. Increasing awareness is a first step in building the capacities of women to demand their rights and in building the capacity of government and other actors in fulfilling their obligations.

Moreover, when community members are aware of the causes of maternal and newborn mortality and morbidity, they understand that these are often preventable. Increased awareness of the health needs and potential problems of pregnant women, mothers and newborns permits individuals, families and communities to become involved in actions to address these needs and problems. It is also the right of community members to have access to key MNH information.

Strengthening **linkages** among social networks can result in greater social support among women, men, families and communities. It also promotes the relationship between such social networks and the health service delivery system. These social and health networks enhance community capacity to participate in the resolution of problems and increase access to MNH services.

Finally, the **quality** of care provided by health services influences the decisions of community members to seek these services. Involving the community in defining and monitoring services can contribute to reorienting services so that they are culturally appropriate and respond to local needs. Creating a warm and welcoming environment for women and families by allowing a companion of choice at childbirth and developing the capacities of health service providers to interact with women and families can also influence community perceptions of health services. Note that within the IFC framework, improving quality is addressed from the perceptions of women and the community in order to increase demand for skilled care. It is assumed that other quality issues will be addressed through other components of the MNH strategy.

The interventions implemented may include education (health education through alliance with the education sector), community action for health, partnerships, institutional strengthening and local advocacy. The complex nature of MNH, and of empowering individuals, families and communities at the local level, requires an **integrated** approach, with interventions from each of the four priority areas, and an **intersectoral** approach, in particular with education, transport, sanitation and income-generating programmes.

MNH programme managers and IFC partners are encouraged to implement at least one intervention from each priority area to promote a synergistic effect and to assure that each area is taken into account. This will maximize the health promotion effort at the local level.



## 1.4 IFC PRIORITY AREAS OF HEALTH SYSTEMS STRENGTHENING

In order for the IFC component to be effectively integrated into the health system and ensure an environment conducive to local implementation, it is equally important for programmes to consider and plan efforts within five IFC priority areas of health systems strengthening. Strengthening the health system within these areas will also contribute directly to the primary aims of the IFC framework. Moreover, action in these areas will serve to reinforce the broader health system, pave the way for scaling up and foster sustainability of the IFC initiative.

Contributing to **public policies** favourable to MNH involves efforts to integrate the IFC component or some of its elements into public policies designed for MNH. These efforts effectively ensure that health promotion is an integrated component of the MNH strategy. Ideally it will not only be included in policy, but financial resources will also be secured to implement it.

Contributing to the **coordination** of actions within the health sector, as well as between the health sector and other sectors, refers to efforts to assure that the IFC component is implemented as an integrated component of the MNH programme. These efforts will largely be facilitated through building and strengthening IFC committees at the national, province and district levels (see sections 2.4 and 3.4).

Promoting **community participation** in the management of MNH problems within the IFC framework not only includes giving community members a voice throughout implementation, but also institutionalizing community participation within the health system. This may include establishing mechanisms and processes for the participation of community actors in MNH programmes or building the capacity of the health services to collaborate actively with community members and to use participatory planning processes, such as the PCA.

Contributing to **capacity building** of the health workforce is critical in order to assure the presence and availability of actors proficient in implementation and management of the IFC component. Capacity building will often take the form of training actors at the district, province and national levels.

Implementing an inter-institutional system of **monitoring and evaluation** will allow for measuring and assessing the processes and results of the IFC component. The findings can inform decision-making, advocate for further support and pave the way for scaling up. IFC monitoring and evaluation will ideally be integrated in the existing monitoring and evaluation system for MNH. It will often be advisable for programme managers to take explicit steps to integrate IFC monitoring and evaluation into the existing system and strengthen the system overall. It is also important that IFC monitoring and evaluation allow for the participation of community and institutional actors. Module 5 of this toolkit provides more details on IFC monitoring and evaluation.

While we suggest that action be taken in each of the four priority areas of intervention, explicit action may not be necessary in each priority area of health systems strengthening. Programme managers and IFC partners are advised to consider each of the areas of health systems strengthening in order to identify where specific measures would be beneficial for reinforcing the system. Regardless of where programme managers decide to focus their efforts within these areas, we strongly encourage partners to assess these areas on a recurring basis in order to identify when action is needed.



## 1.5 HOW IFC FITS INTO THE BROADER MNH STRATEGY

The IFC framework is an important component of the broader national or sub-national MNH strategy. It is not intended to be implemented as an isolated set of interventions, but is complementary to a range of other critical MNH areas of work including:

- (a) achieving political commitment
- (b) promoting a favourable policy environment
- (c) ensuring adequate financing
- (d) strengthening health care services
- (e) empowering individuals, families and communities
- (f) strengthening monitoring and evaluation for decision-making

The identified interventions that are conducted outside of a broader MNH strategy will be less likely to achieve the stated objectives. This would also be true for an exclusive focus on improving health services without the IFC efforts. Improved care in the home and an increase in the demand for services require an effective, high quality and sustainable response from the health sector to respond to the newly created demand. Ideally, efforts in all areas of a comprehensive MNH strategy will be undertaken simultaneously to maximize the impact on MNH.





## 2. NATIONAL AND PROVINCIAL SUPPORT TO IFC IMPLEMENTATION

### 2.1 THE IFC “IMPLEMENTATION FRAMEWORK”

Although the focus of IFC activities is at the district level, the first steps of IFC implementation will occur at the national level when possible. District actions, then, can be supported by and integrated into national and provincial MNH strategies and actions. Fig. 2.1 illustrates the IFC implementation framework, outlining the five phases of the process occurring at the district level, as well as the support activities designed to be undertaken at province and national levels.

Before discussing in detail the activities outlined in Fig. 2.1, it is important to point out that the framework contains a process for IFC implementation that is to be used the first time the framework is integrated into a national, provincial or district MNH strategy. As will be discussed in more detail below, **we suggest undertaking IFC implementation in one or two districts initially.** Experience with IFC implementation and with other participatory processes has exhibited that the initial implementation in a country will have its challenges and can be resource-intensive, but that the process becomes easier with experience.<sup>10</sup> Careful monitoring and documentation of lessons learnt can facilitate fine-tuning of the process and subsequent scaling up of the framework (see sections 3 and 4 of Module 5).

The district (defined in the next section) is the focus of IFC activities as it is the most fully-organized unit of local government that is small enough for health staff to observe and understand important problems and developments. As such, working at this level offers important opportunities for action to improve the health of women and newborns. Benefits of working at the district level include the availability of

intersectoral mechanisms, a network of health facilities with at least a district hospital, the presence of non-governmental organizations (NGOs), and other informal mechanisms that enable registering maternal deaths.<sup>11</sup>

It is also important that the national team have a national vision of IFC implementation from the outset. This means ensuring scale-up mechanisms that support institutionalization and expansion are integrated into the design from the beginning. As the component is scaled up to cover new areas, the initial model may need to be modified to make implementation achievable. Careful evaluation of the priority areas of health systems strengthening and planning actions in these areas will facilitate sustainability and scaling-up. Some considerations and some possible strategies for scaling up the IFC framework are discussed further in sections 2.6, 2.15 and 2.16.

Countries need to consider how far they want to decentralize and what are the most efficient ways to organize the work at different administrative levels. For example, it may not be feasible, or advisable given the resources required, for all districts in a province to conduct their own PCA. Instead the results of the PCA from a neighbouring district can be discussed and used to inform planning of interventions (see section 2.16 of this module and Module 3; section 1.5).

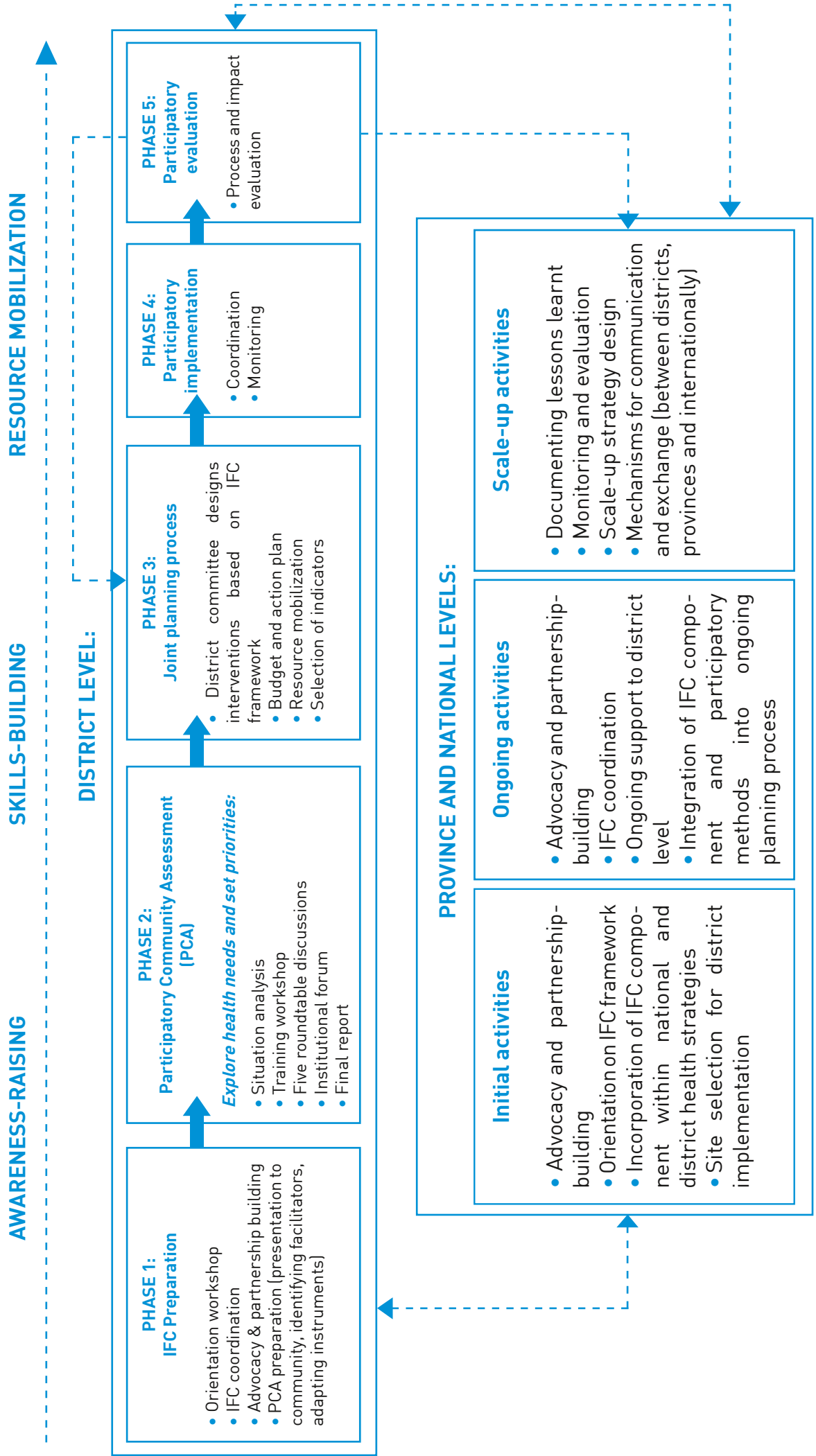
The activities for IFC implementation at the national and province levels described in this section are also outlined in the chart found in Annex 2.

<sup>10</sup> See MSPAS, 2006 and Ottolenghi et al., 2007.

<sup>11</sup> See Tarimo, 1996.



Fig. 2.1: IFC implementation framework<sup>12</sup>



<sup>12</sup> Note: This image depicts the process of an initial implementation experience of IFC in a district. For subsequent districts in a selected province, a modified process may be desired (see section 2.15).



## 2.2 WHAT DO WE MEAN BY NATIONAL, PROVINCE AND DISTRICT LEVELS?

Countries have differing political and organizational boundaries, and they organize their health system and structures following various models. Health policy decision-making occurs at different levels of the health system depending on the context, including the level of decentralization and management policies. The structure and terminology of IFC framework implementation described throughout this toolkit will need to be adapted to the specific situation of each particular country. The processes and structures described in this document are based on the following assumptions and terminology:

- The national level** includes actors from the national Ministry of Health (MoH) as well as partners from other national government agencies, national NGOs, universities, WHO and other United Nations organizations, and other international agencies. We assume that the MoH determines national health strategies and policies that will be adapted and implemented at the other levels of the system. This includes the decision to incorporate an IFC component into the national MNH strategy and policies. In large nation states, however, the MoH may have little involvement in IFC activities, and most responsibility will be assumed by a state, sub-national or regional body that has an important and independent role.
- The province level** corresponds to a sub-national geographical region, state, or governorate with a functioning provincial health authority. The provincial health authority oversees and supports the functioning of the district health authorities.
- The district level** (WHO, 1988) corresponds to a local political authority within a province, usually with a town or small city as its administrative centre. It is generally politically administered by an elected district authority (such as a mayor or local governor), while health services are organized by a district health authority, under the supervision of the provincial and/or national health authority. When considering the ideal “level” for IFC implementation, the population of the district would be between 50,000 and 100,000 in order to facilitate local accountability and ownership of the interventions and to capture true local community experiences in the assessment process. If the district populations in a province are considerably larger than this, those responsible for implementing the IFC component may choose to use the next lowest administrative level (such as a ward or sub-district) as the focus for IFC implementation. If the populations are considerably smaller than 50,000, there may not be sufficient management capacity to effectively organize and implement the IFC component.

When determining coordination and management mechanisms for implementation of the IFC framework, the responsible programme managers and partners will need to carefully consider where and by whom decisions are made. The teams must also take into account the requirements for scaling-up the IFC component, and the implications for action at different levels.



## 2.3 ORIENTATION TO THE IFC FRAMEWORK AT THE NATIONAL LEVEL

It is important to orient key stakeholders at the national level to the IFC framework and its interventions before embarking on the process. A short workshop (2 to 3 days) involving relevant programme managers from the MoH, other relevant ministries (e.g. education), as well as NGOs working in MNH is important to introduce the key concepts of the IFC framework and the different steps of implementation. This meeting will help orient those involved at the national level to the IFC framework and their potential roles in implementation. Module 2 of this toolkit contains an orientation package to help conduct this workshop.

As already mentioned, the IFC framework is designed to be integrated into a broader national or sub-national MNH strategy. Options for integration include the following depending on the status of the country's MNH strategy:

- 1. If the national or sub-national MoH is developing or revising an MNH strategy:** Programme managers and decision-makers can be oriented to the IFC framework, which may subsequently be used to support the development of the health promotion and community component of the overall MNH strategy. This gives those working on the IFC component a clear mandate to proceed with implementation.
- 2. If the MoH is in an interim period of MNH strategy development:** An orientation workshop on the IFC framework (see Module 2) can be organized by the MoH or other key actors and policy-makers working within MNH with support from WHO. If the decision-makers feel it is important to proceed with IFC implementation before the development of a new national MNH strategy, they can plan and coordinate how the IFC component will fit with other MNH components, policies and interventions.

## 2.4 NATIONAL AND PROVINCE IFC COORDINATION

After an initial national orientation, the national actors involved are encouraged to plan out a process of IFC coordination. Ideally, the MoH will take a lead role in IFC implementation in order to ensure integration into both the broader MNH strategy as well as other standard health planning processes, in partnership with other organizations and actors working in MNH. Focusing on the IFC priority areas of health systems strengthening at this level will foster the integrated implementation of the IFC component within the MNH strategy.

To ensure a synergistic effect, we suggest that actions at the community level be undertaken in conjunction with both policy and health services actions that are part of the broader national MNH strategy. Moreover, as one of the primary aims of the framework is to increase access to

and utilization of health services, it is necessary to assure that the created demand can be met effectively by the health system. Efforts directed at the health services are ideally implemented simultaneously through other components of the MNH strategy. A common programme of work with all the partners involved is the best way to move the IFC component forward at the national level.

In order to coordinate the IFC component and develop a common workplan at the national level, it is advisable to form/reactivate/strengthen a **National Coordination Committee**. Sample terms of reference for this committee are provided in Annex 1. This committee would ideally be a subcommittee of an existing national MNH committee. A **Province Coordination Committee** may also be



formed, or the existing province MNH committee strengthened. It is generally important to assign **national and province coordinators** who are responsible for leading the IFC component and coordinating between different actors. It may be necessary to reassign or hire new staff for this role.

When identifying staff to compose teams responsible for managing the IFC component at different levels, it is important to prioritize the inclusion of both women and men. This will contribute to the integration of gender perspectives throughout the management of the IFC implementation processes. It is important that the gender composition of the committees allow for gender perspectives to be integrated at all levels of management and decision-making within the IFC component.

This will also contribute to the broader goal of achieving gender equity.

## 2.5 ADVOCACY AND PARTNERSHIP BUILDING

In order for implementation of the IFC framework to proceed, it will usually be necessary to advocate within the MoH, as well as with other key MNH and IFC actors, on the importance of and rationale for implementing the IFC component. Advocacy may need to be undertaken by programme managers within the MoH, or by NGOs who wish to work with the MoH on the IFC component. It is typically important to gain the commitment of top-level decision-makers for the IFC framework to be successfully integrated and implemented.

In the process of IFC committee formation, it is advisable to build partnerships with other stakeholders working to improve the health of communities. Many countries have national and provincial committees for MNH, and it is important to assure the appropriate representatives and skills to integrate IFC work within these committees. It is also advisable to

Coordination of IFC work includes:

- development of a common workplan between different partners;
- management of national and provincial budgets and human resources;
- selection of intervention sites for IFC
- support to district committees;
- documentation of lessons learnt;
- monitoring and evaluation;
- the development of a scale-up strategy.

These activities are discussed in more detail below.

strengthen partnerships with other sectors or organizations, for example the education sector, or NGOs working in social development at the community level.

Advocacy activities may include:

- individual visits to key partners to introduce the IFC framework and to try and gain their commitment to the process, for example by securing their involvement in an IFC committee;
- organizing workshops on MNH and the IFC component; and
- organizing meetings with the attendance of international experts on health promotion and the IFC framework.



All those planning to implement the IFC framework will want to consider both the importance and implications of working with partners. Working with other organizations and institutions is one of the fundamental principles of the IFC framework and is expected to contribute to successful outcomes from IFC implementation. However,

the individual groups must be aware that collaborative working can be time-consuming and require more energy than individually managed projects. Some of the key lessons learnt from working with partners on IFC implementation are described in Box 2.1.

### **Box 2.1: Lessons learnt from IFC partnerships in countries**

These lessons have been documented from experiences in implementing the IFC framework in Bangladesh, Burkina Faso, Colombia, El Salvador, Guatemala, Kazakhstan, Lao People's Democratic Republic and the Republic of Moldova.

- Workplans need to take into account the time and effort that collaborative processes and coordination require. This includes processes for obtaining partner consensus in developing, reviewing, and finalizing different documents (terms of reference, instruments, etc.). The IFC workplan will be more easily endorsed by different partners when they are part of the overall MNH workplan.
- Financing the IFC component is an issue of concern. National level decision-makers' commitment is key to ensure that budgets are allocated for the IFC component.
- Enlisting the support of decision-makers at all levels is a long process and is ideally triggered through continuous advocacy and involvement during the PCA process.
- As different partner agencies and groups consider who should represent them in the programme, other demands and activities should be considered. Some duties may need to be reassigned to assure that the person designated has the time and motivation to actively participate and assume his/her responsibilities.
- Commitment and consistent participation is required from the key actors. Otherwise progress is curtailed and decisions cannot be made as each session requires time to bring new participants up to date. It is thus useful to provide prior detailed information on the process and what kind of involvement it entails.
- Most actors, including international agencies, government agencies, NGOs and community groups, are more comfortable working on individually developed projects, with very punctual collaboration, rather than developing a common programme of different actors.
- In countries where the IFC framework was initiated by local NGOs, these organizations faced obstacles in approaching the government services for collaboration, particularly to obtain national authorization of provincial and district level involvement.
- In some countries, government ministries and community-based NGOs may not have experience in working together. It may take time for each actor to learn how to dialogue and to work as a coordinating body with other actors.
- Different actors bring varying strengths to the process and often each contributes to diverse and complementary domains of knowledge. It takes time for each to value the possible contributions of the other and also to develop a common working language and vision. Larger and more visible organizations often tend to feel justified in asserting the importance of their involvement and views which affect the group dynamic.
- Processes and mechanisms also need to be in place to assure on-going communication between the international organizations and their joint communication with the national organizations. Often each international organization has had more contact with one particular national actor, and there can be a tendency to establish bilateral communication. It is important for the international organizations to support the group in working together, being aware of the different power relations between local partners.
- An IFC committee (or subgroup of the MNH committee) is a key element for coordinating the implementation of the IFC plan interventions. It is ideally institutionalized and its role (described in detail in the terms of reference in Annex 1) needs to be emphasized from the beginning of the process.





## 2.6 INCREMENTAL IMPLEMENTATION OF THE IFC COMPONENT

It is advisable to implement the IFC framework incrementally, starting in one province to gain experience and gather lessons learnt, and then scale up to other provinces and regions.

This type of “validation” process has several advantages; notably it allows for:

- examination of the feasibility and acceptability of incorporating the IFC component into national health initiatives;
- evaluation of the process and its impact on basic health and social development indicators within a broader MNH strategy;
- adaptation of generic processes and instruments to a national or local context;
- development of collaborative partnerships between the health sector and other sectors, as well as between governmental and non-governmental organizations;
- planning for long-term national scale-up based on lessons learnt;
- building the skills and capacities of national ministries of health and other key stakeholders to implement the IFC framework and promote the empowerment of individuals, families and communities; and
- development of regional, national and local communication networks for sharing of lessons learnt and the developing collaborative strategies.

## 2.7 INVENTORY OF ONGOING INITIATIVES RELATED TO IFC WORK

Before selecting sites for initiating IFC implementation, it may be helpful to conduct a brief inventory of on-going initiatives related to IFC work at the national level. As discussed in the PCA guide (see Module 3), one step in the situation analysis at the district level is an inventory of programmes and projects. The same forms can also be used by the national committee to collect information on other MNH initiatives focusing on health promotion activities. The national coordinators can ask each

partner organization within the national MNH committee to provide information on different programmes with interventions related to the IFC component. The group may then decide to select an intervention site where advances have already been made to promote MNH by working with individuals, families and communities. Knowing what exists and building on experience is a major principle of implementation at each level.

## 2.8 SITE SELECTION FOR INITIATING IFC IMPLEMENTATION

As mentioned above, when initiating implementation of the IFC framework in a country, it is advisable to begin in one province only and preferably in one or two districts within this province. Box 2.2 outlines some suggested criteria for selecting appropriate sites for an initial experience with the framework in a province or country. Once a country has an initial

experience with IFC implementation and lessons learnt about the process, sites for expansion can be selected based on other criteria (see section 2.16). Site selection is ideally conducted jointly by national, province and district levels, and may also be in response to local requests for assistance.



As discussed, in order to assure a relevant first experience in IFC implementation, it is suggested that the initial district selected for implementation have a population size of 50,000 to 100,000 people. It is also recommended that the IFC component be initially implemented in areas that already have functioning MNH services. This is because an important aim is

to increase utilization of skilled care, and also because it is advisable to focus initially on those areas with a limited set of needs to gain experience in IFC implementation. Later, when skills are cemented, the methodology can be adapted to other types of areas with differing needs.

### Box 2.2: Selection criteria for initial IFC implementation site(s)

- Intervention area is accessible to stakeholders from both national and province levels.
- District administrative area of 50,000 to 100,000 inhabitants.
- Need for improvement of MNH (high maternal and perinatal/neonatal mortality, high morbidity).
- High proportion of socially excluded population.
- Local and intersectoral political will.
- Available essential and emergency MNH services for pregnancy, childbirth and after birth (or referral facilities).
- Presence of community organizations.

## 2.9 ADAPTATION OF THE PROCESS AND METHODOLOGY

Before proceeding with IFC implementation and before conducting a PCA in a district, it is important to consider adaptation of the IFC process. This guide assumes a three-tiered health infrastructure, with the IFC framework applied at national, province and district health system levels. Some countries may have different health planning systems, and naturally adaptations to the process will be made accordingly. It may also be important to adapt the process to allow for its integration into existing plans and strategies, and thus prevent duplication of efforts. For example, if participatory planning or assessment processes are already ongoing in other health domains, can MNH be added to it?

The instruments contained in the PCA guide are also designed to be adapted to the district context. Before introducing the PCA instruments at the district level, the national, province and district committee members are advised to conduct an initial review to ensure use of local terminology and that relevant themes are explored. There will be other moments to review and revise the instruments once the process is under way (see Module 3; section 3.3 and Module 4). An example of IFC adaptation from the Republic of Moldova is described in Box 2.3. Tools used for finalizing an action plan for the IFC component and for monitoring and evaluation will need to be adapted and appropriate to the context. Sample tools are provided in Module 5. However, ideally programme managers will be able to directly



integrate the IFC component into the broader MNH monitoring and evaluation system and/or use tools that are already accepted and utilized

in-county. When possible, these tools will be adapted and agreed upon at the national level before district level implementation.

### Box 2.3: Adaptation of the IFC framework and PCA instruments in Moldova

The Republic of Moldova is a small country in Eastern Europe with a population of about 3.5 million. Although Moldova's maternal mortality ratio (MMR) has declined over the past decade, it has the highest maternal mortality in Europe, with the most recent MMR of 21 per 100,000 live births. The national MoH had recognized the importance of increasing community involvement in health efforts and decided to adopt the IFC framework as a core part of its MNH strategy in 2005. Working in partnership with the local WHO office and the United Nations Children's Fund (UNICEF), the Ministry decided to adapt the IFC framework. Firstly, this involved deciding to work only at two administrative levels (national and "rayon") rather than three. Also, they decided to include infant and child health, as well as MNH. This resulted in selected child health interventions being added to the four areas of the IFC framework (capacities, awareness, linkages and quality). The PCA instruments were also adapted, not only to add some questions on child health, but also to make the assessment specific to the local context in Moldova.

## 2.10 ONGOING SUPPORT TO THE DISTRICT LEVEL

Throughout all phases of IFC implementation, the district team will benefit from having technical support from the national and province levels. The province level may also receive ongoing support from the national level. This support may include the identification of one or two **expert facilitators** to support the PCA. It may also include technical support during the orientation workshop and the joint planning process, as well as during implementation, monitoring and

evaluation of the IFC component. The role of the expert facilitators in the PCA is discussed in depth in Module 3 (see Module 3, section 1.8 and Annex 1). It may be advisable to reassign staff or contract new staff with expertise in community health, community participation and empowerment strategies to help coordinate the efforts at the national level and province level. Again, it is important to include both women and men when identifying staff to fill these roles.



## 2.11 PLANNING INTERVENTIONS AT NATIONAL AND PROVINCE LEVELS

The assessment processes undertaken in districts will generate a series of proposed actions to resolve the problems identified. Some of these actions will be specific to the district level. Others actions, however, will ideally be undertaken at the provincial or national levels, or will be local actions requiring action and support from these levels. Working in partnership with the district or multiple districts, the national and provincial authorities will draw up a coordinated plan of action to ensure improvements are

achievable locally. Activities such as changes to national curricula, mass media campaigns or development of health education materials may be coordinated centrally. Results from the PCA can be used for advocacy to mobilize resources for these national activities.

Box 2.4 illustrates some national and provincial actions that were identified from initial PCAs in El Salvador and Moldova.

### Box 2.4: Examples of national or provincial actions identified in Moldova and El Salvador

- Develop and implement laws and policies restricting availability and use of alcohol.
- Increase the social support allowance for mothers and children.
- Develop a system of continuous medical education for doctors.
- Review salary scales of health care providers.
- Include health issues within the national school curriculum.
- Advocate with the government to demand the right to free health care.
- Develop a mass media campaign on prenatal care, emphasising risks, skilled attendance and breastfeeding.
- Develop a mass media campaign on domestic violence for young people.
- Improve the national water quality monitoring system.
- Develop networks between organizations working on gender and male involvement.
- Evaluate the technical capacity of staff trained in the health centres.
- Improve the interpersonal and counselling skills of health care providers.
- Develop support materials for communication interventions.
- Develop orientation and training guidelines for Village Health Committees and community-level actors.
- Support the implementation of the district IFC action plan.
- Integrate communication activities in outreach clinics guidelines.



## 2.12 MECHANISMS FOR COMMUNICATION AND EXCHANGE

The national and province committees will generally be responsible for creating and sustaining adequate communication mechanisms, both among different partners at each level, and among the national, province and district levels. Since the IFC framework is being

implemented in several different countries, international exchange of experiences may also be helpful. WHO can provide support in making links with other countries and programmes that are implementing the IFC framework.

## 2.13 MONITORING AND EVALUATION AT NATIONAL AND PROVINCE LEVELS

Monitoring and evaluation will be needed at the district level, the province level and the national level (see section 3.8 of this module and Module 5). Monitoring and evaluation are essential for assuring accountability and transparency throughout the IFC implementation process and for making adjustments and improvements. A system for monitoring and evaluation is generally developed during the planning of IFC interventions. Ideally this system is integrated into the monitoring and evaluation framework of the broader MNH strategy so as to avoid creating parallel systems.

At the national and province levels, monitoring and evaluation will typically be focused on the priority areas of health systems strengthening.

It is also important to monitor who is involved (which partners), who makes decisions, and how the district level is supported and empowered. The national level will ideally keep their district partners informed about how the IFC component is progressing at the national level, and specifically about how local activities are contributing to changes nationally. They can also provide information on how different districts are progressing.

More information on the role of the national and province levels in monitoring and evaluation can be found in sections 2.7 and 3.1 of Module 5.

## 2.14 DOCUMENTING LESSONS LEARNT

Documenting lessons learnt and sharing experiences facilitates successful scale-up of the IFC framework to other districts or provinces after an initial experience in IFC implementation (see Module 5, section 4). Lessons learnt can be gathered to make modifications both to the process being applied, as well as specific instruments and tools being used. In both Moldova and El Salvador, for example, the national and district committees documented the fact that not enough effort was made to involve non-health

sector actors in the district IFC committees. This was particularly problematic in Moldova, where the district IFC committee was almost entirely composed of doctors and nurses. Both countries learnt that a significant investment of time is required to build alliances at both national and district levels in order to achieve multi-sectoral collaboration. Some of the other lessons learnt from partnership-building in various countries are listed above in Box 2.1.



## 2.15 “VERTICAL” SCALING-UP: INSTITUTIONALIZATION OF THE IFC FRAMEWORK AND PARTICIPATORY METHODS

Introduction of the IFC framework in a country will ideally occur within a broader vision of scaling-up. There are several forms of scaling-up, but for our purposes we will be primarily concerned with “vertical” and “horizontal” scale-up. Vertical scale-up involves the institutionalization of an IFC component through policy, regulatory, budgetary, or other health system changes – in other words, the complex process of embedding the process in the institutional structure of a health system.

Once the IFC framework has been implemented and evaluated in the initial implementation district(s), the approach and the participatory planning methods that accompany it may be integrated into ongoing health planning processes. This ensures that the IFC framework is integrated into the broader MNH strategy, and that the IFC component is not delivered as a stand-alone vertical programme. In this way community involvement in identifying problems, setting priorities, and designing solutions can become standard procedures in health planning and thereby contribute to the promotion of rights.

At the national and provincial levels, this could be achieved in several ways, for example by:

- incorporating participatory assessments and planning processes into national or provincial health policies and guidelines;
- conducting yearly or biennial national or provincial quality audits which use the results of district-level PCAs; and
- reviewing health promotion strategies across a range of technical areas (for example MNH, reproductive health, child health, hygiene and sanitation, HIV, tuberculosis, malaria) and designing integrated assessment and planning processes.

Efforts toward vertical scale-up of the IFC component can typically be organized within the priority areas of health systems strengthening. Strategies to integrate the IFC component at the district level are discussed in section 3.9.

## 2.16 “HORIZONTAL” SCALING-UP THE IFC FRAMEWORK TO OTHER DISTRICTS AND PROVINCES

From the outset, it is also important to plan for “horizontal” scaling-up, referring to the geographic expansion of the IFC component to new provinces and districts. The process of IFC implementation that has been outlined in this section, and which is described in detail for the district level in the following section, is designed to be used the first time the component is introduced in a country or province. As noted above, the first implementation of the IFC framework and the first PCA will be an intensive process that requires the teams involved to learn new participatory and collaborative methods for health programming.

During the implementation process in this first site, the national, province and district teams will have ideally documented lessons learnt in order to make adaptations to the process for other districts and provinces. The national and province teams can then determine an appropriate approach for scaling-up.

Actors involved in planning IFC interventions in these districts will need to agree on alternative planning mechanisms that maintain principles of participation and collaboration. Some options are presented here.





## 1. Review of original PCA results in other districts of the same province

Communities within the same province that have a similar socio-cultural, economic and political context as the original PCA site may be able to rely on those results. A process can be developed to examine the results of the original PCA in the new community.

Preparatory steps for IFC implementation would still be relevant, including advocacy and partnership building, sensitization of community groups, and formation of a district committee (see section 3). The district committee could then organize a process to review the PCA results with different stakeholders and community groups to determine whether the prioritized problems and actions identified are pertinent for their area and make necessary adjustments to fit their local context.

We suggest that these committees organize a dissemination meeting with community groups to present and discuss the results. They may also want to conduct face-to-face meetings with district authorities to enlist their collaboration and involvement. Organizing a new institutional forum is advisable to review the original findings and discuss the similarities and differences between the new district and the PCA district. If the group feels there are many differences, the district committee can decide to investigate further, either through individual interviews with different stakeholders, or by organizing a separate series of roundtable discussions. If the institutional forum does not feel there are many differences with the PCA district, they may proceed with the joint planning and implementation processes (discussed below).

When using an alternative method to the PCA, IFC coordinators will want to carefully ensure that the process allows for the participation of community members and for the integration of gender perspectives.

## 2. Extending to areas with different needs in the same province

In communities that demonstrate marked differences from the initial IFC implementation site (for example, different ethnic groups, religious groups, migrant populations), it may be advisable to conduct a new PCA. Ideally, each province will benefit from at least one full PCA. It may be worthwhile, however, to conduct multiple PCAs within one province where the situation and needs differ. Programme managers will want to consider these decisions carefully, particularly in light of the human and financial resources required to conduct a complete PCA.

In addition, section 2.8 listed criteria for selecting a district for the first application of the IFC framework and the PCA in a country or province. Some areas may not meet these criteria and adaptations in the process may be required. For example, when extending to an area without functioning or with ineffective MNH services, the PCA will need to be integrated into broader quality improvement initiatives within the health services. Or when extending to areas with no political or institutional commitment to MNH, further actions will be needed prior to undertaking the PCA to advocate for change.

## 3. Replicate the PCA in other provinces

As discussed, it will generally be advantageous to conduct one full PCA in each province. The province committees should review the need to conduct multiple PCAs within the province where situation and needs differ.

Time and resources will need to be allocated to oversee the IFC component as it is scaled up, and programme managers and their political leaders must be committed to an approach that ensures participatory processes become the standard in health planning.



### 3. OVERVIEW OF THE IFC FRAMEWORK AT THE DISTRICT LEVEL

Fig. 2.1 in section 2.1 above outlines the various phases of IFC implementation at the district level:

1. Preparation
2. The Participatory Community Assessment (PCA)
3. Joint planning process
4. Participatory implementation
5. Participatory evaluation

As discussed earlier, this process has been designed for the initial experience implementing the IFC framework within a district or province. The PCA, in particular, may not need to be replicated in every district of every province (see section 2.16).

#### 3.1 COMMUNITY PARTICIPATION IN HEALTH PLANNING

Community action for health is one of the key strategies of the IFC framework. The framework defines a community as a “pertinent group of people, sharing common needs and problems.” Within one geographic “community” such as a district, there exist smaller communities that share common identities, for example based on ethnic, religious, geographic, or work-based identities. As stated in the IFC framework, it is important to remember that a community is not always one homogenous entity with shared values and norms, and its inhabitants will not automatically have a willingness to work together to solve problems within that community. Since IFC’s focus is at the district level with populations of up to 100,000 people, this point becomes even more important to bear in mind.

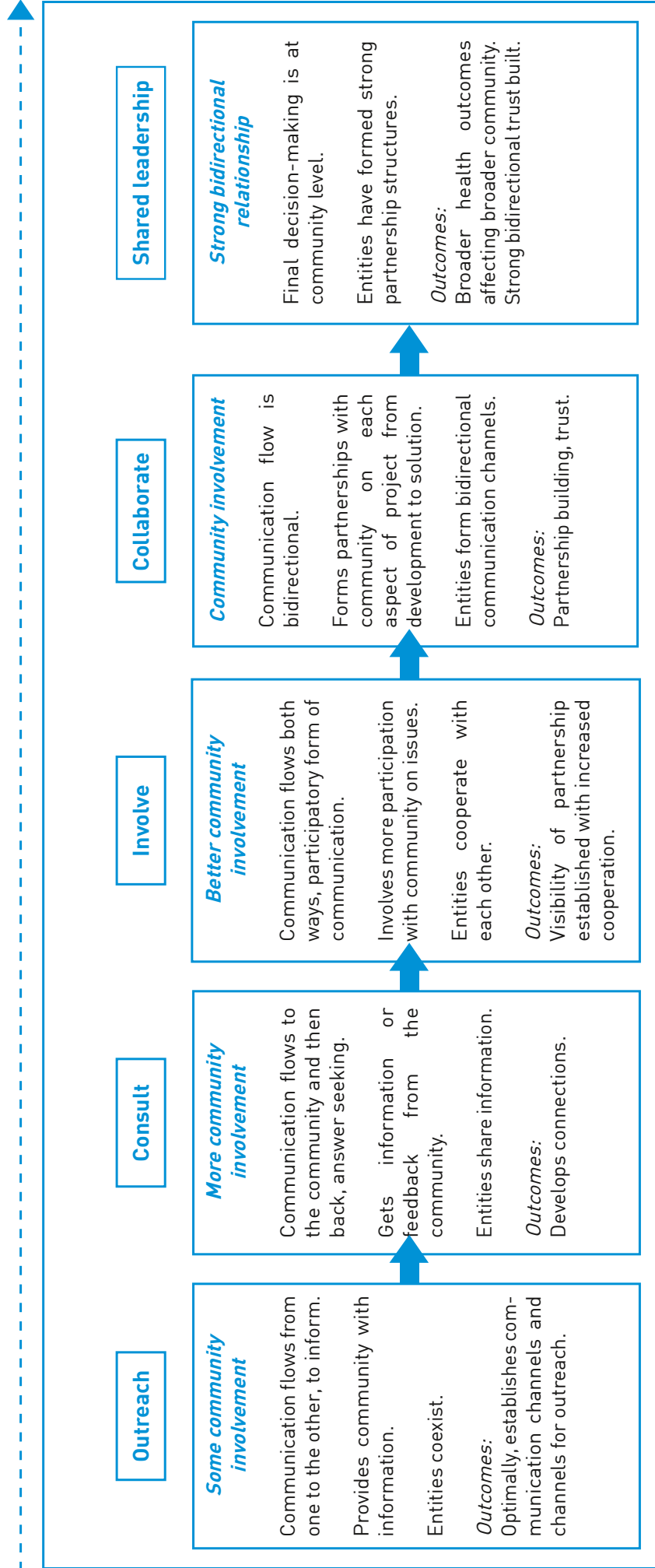
The IFC approach outlined in this document, beginning with a process such as the PCA, is an attempt to help generate collective action among key “community” actors who have a stake and a role in MNH. Enabling this collective action always sounds easier to achieve than it is in reality, and requires effort and dedication from

IFC coordinators and programme managers. It will also depend on the historical, political and social context of the country or region, since experience with community engagement is greater in some areas than others.

Fig. 3.1 illustrates a spectrum of community participation, whereby community members are increasingly involved in health-related actions in their community. The IFC framework aims to reach the “involve” or “collaborate” level of collective action, as described in the figure, since much emphasis is placed on building a relationship between the services and the community. To ensure institutionalization, health service planning ultimately must be led by the health services. Nonetheless if a programme goal is to contribute to the promotion of rights and empower communities, then processes must ensure that community participation is not limited to a consultative or advisory role, but that joint planning and decisions can be made with key actors including community representatives.

Fig. 3.1: A spectrum of community participation in health planning<sup>13</sup>

**INCREASING LEVELS OF COMMUNITY PARTICIPATION**



<sup>13</sup>Modified from the International Association for Public Participation, 2004.



## 3.2 ORIENTATION TO THE IFC FRAMEWORK AT THE DISTRICT LEVEL

As with the national level, it is important to orient local health services and other community groups to the IFC framework before launching into any kind of assessment process. This also provides the opportunity for local actors to review the IFC framework and to determine if any adaptations are needed. Once the initial IFC implementation site has been identified and agreed upon by national, province and district stakeholders, the orientation workshop can be replicated at the district level. Provincial programme managers may attend either the national or district workshops, or both. Although a district IFC committee may not have been formed yet (see below) it is still important to

identify a range of different local actors who have a stake in MNH and IFC processes.

If others become involved in the IFC implementation process after the orientation, those who attended are advised to spend time with their colleagues to explain the aims and objectives of the component, the principles and strategies of the IFC framework, and its interventions to improve MNH. Since health promotion and empowerment may be new concepts and may propose a different modality of work and relations, this orientation is important for newcomers. It may also be necessary to repeat the orientation workshops at a later date.

## 3.3 ADVOCACY AND PARTNERSHIP-BUILDING AT THE DISTRICT LEVEL

Advocacy and partnership-building are just as important, if not more important, at the district level than at the national level.

In some geographical areas, district health services have extensive experience involving communities in health planning, and may already have pre-existing health committees that include different actors and community leaders and representatives. However, they may need to strengthen efforts including reinforcing

inter-sectoral action, or developing relationships with district government authorities, NGOs or the education sector.

In other areas, district health services may have very limited experience in working with others beyond the health sector. Although they may appreciate the value of the IFC component, they may not fully understand the implications of inter-sectoral collaboration and community involvement that the IFC framework promotes.

## 3.4 DISTRICT IFC COORDINATION COMMITTEE

It is advisable to form a District IFC Committee to oversee the implementation of the IFC component. Many district health systems will already have an existing MNH committee, and efforts to strengthen the IFC component of the strategy may be integrated into on-going work. It will usually be necessary, however, to review the composition of any existing MNH committee to ensure participation of relevant partners and community stakeholders.

Within the district committee it is advised to involve stakeholders from various sectors, including health and education, as well as district authorities and community groups. It may be necessary to actively seek out representatives of marginalized groups: those who are “invisible” or discriminated against and whose voices are typically absent from on-going community or political decision-making. These groups may not be immediately identified by



community leaders who may not necessarily represent their needs. It is critical to ensure that groups who experience social exclusion have an opportunity to be involved in the process to express their voice, needs and solutions. This may involve representation on the district committee or ensuring involvement at other stages of the IFC process. It is also important to ensure participation from those working in urban, peri-urban and rural zones. Ensuring this participation is critical to the promotion of rights and equity.

When initiating IFC work at the district level, we suggest first forming a smaller subcommittee of an existing MNH committee to ensure there is sufficient focus on the process and participation from relevant stakeholders. This subcommittee can be expanded during the PCA or during the planning stage after the PCA to include other interested or relevant groups, and/or can be fully integrated into the existing MNH committee.

Sample terms of reference for the district committee, together with the listing of different groups who may be represented on it, is provided in Annex 1. We suggest that the committee remain small (maximum 10 people), at least in the initial phases of IFC implementation, to facilitate efficient coordination within the process. Again, when considering the composition of the district committee it is important to include equal numbers of women and men in order to maintain a gender perspective throughout all phases of IFC implementation and decision-making.

## Committee Chair(s)

The district committee, in consultation with province and national partners, can determine how to organize itself. Two options are:

1. The district health centre director or the head of MNH services (if different) may chair the district IFC committee.
2. The district committee may choose to elect two co-chairs, one representing the health sector, and the other representing non-health sector or community groups.

Once a committee has been formed, and members have been oriented to the IFC framework (either through the orientation workshop or by colleagues), it will be useful for the group to review the terms of reference and modify them according to their needs. They may also choose to select ground-rules for participation on the committee (e.g. if someone does not show up at more than two consecutive meetings, then action must be taken to renew their involvement or find a replacement). If the representation of various sectors and agencies on the committee are initially limited, for example only two non-health sector members, then the group can decide how to expand the membership and increase its representation. They can also determine a strategy for increasing the number of women who participate if there is a gender imbalance when initially organizing the IFC committee.



### 3.5 THE LOCAL IFC COORDINATOR

The local coordinator is the person responsible for implementation of the IFC framework at the district level, including the preparation and organization of the PCA, the joint planning process, implementation of activities, and monitoring and evaluation. In some cases the coordinator may be on or even chair the health district committee. It often will be advisable, however, to identify (and possibly hire) a separate individual for this role.

Since the PCA is an intensive phase of the IFC process, the committee may decide to assign or employ a person to work exclusively on the PCA, after which the committee may choose to continue IFC implementation without this support. The district may need support in identifying an appropriate person. Sometimes it may be necessary for the national or province level to identify persons with the required level of experience and skills. If the national or province level plans to assign or recruit personnel to support the IFC process it is important to note some potential challenges:

- those recruited from outside the implementation district may not be inclined to relocate to more rural and remote areas and may prefer to have a post in the capital or regional capital with occasional travel to the district;
- those who live outside the district and who commute may not be able to spend sufficient time working with the IFC committee and other community groups; and
- those who come from outside the district may not have a full understanding of the local community dynamics or knowledge of the diverse community actors and may take time to develop the relationships and confidence with the different actors.

External coordinators, however, may have extensive previous experience of community-based projects, qualitative research skills and valuable participatory management skills. Committees must therefore weigh the value of employing a coordinator who lives in the implementation site over the benefits of having a more qualified person who comes to the area for extended periods. Sample terms of reference for the local coordinator are in Annex 1.





### 3.6 CONDUCTING THE PCA

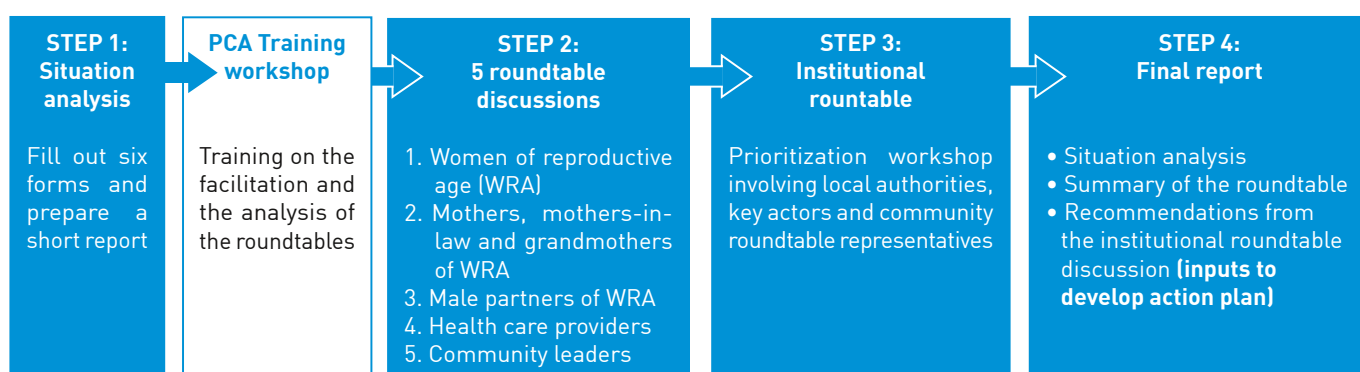
The PCA is a tool that the district health services can use to assess the MNH situation and needs in a participatory manner, through collaboration within the health sector and with other sectors (such as education and transport), with district authorities, NGOs, religious organizations, and other community groups. Using the results of the PCA, partners can then plan actions together to help create an enabling environment for care of the mother and newborn in the home and in the community and to increase access to quality MNH services. The PCA process is described in detail in Module 3 of this toolkit.

The PCA helps to initiate a process of empowerment among women, their partners, families and communities. Empowerment is strengthened as they participate actively in assessing their problems and needs in MNH, as well as in identifying potential actions and district resources that can be leveraged to address these problems and needs. This meaningful participation in developing the interventions

designed for their benefit is a right of women, men, families and communities. The PCA can also be instrumental in reorienting health services in their relations and interactions with non-health actors, including the community, thus contributing to the realization of rights through the institutionalization of participatory processes. The PCA is not intended to be a research tool, but rather a participatory process in which different actors become sensitized to the importance of collaborating with each other, of listening to each other, and of jointly planning interventions and solving problems together. By helping people and groups better understand their situation and participate in finding solutions, the PCA becomes an important first step in a health promotion process that empowers them to make choices and transform those choices into actions to improve their health and quality of life.

Fig. 3.2 lists the steps involved in conducting the PCA.

Fig. 3.2: PCA process







As can be seen in the image, the final report from the assessment process includes data collected in the situation analysis, the findings from the roundtable discussions, and a draft intervention plan developed during the institutional forum.

Since the PCA aims to assess the situation of a large and diverse geographical region, those planning the roundtables must ensure that the participants represent the interests of the whole population, in particular the poorest and most vulnerable. It is important to conduct the PCA in such a way as to promote equity. This is discussed in more detail in Module 3.

The PCA ideally will be integrated into ongoing processes. The health services network, together

with the community social network, can conduct regular assessments to provide information and feedback to health programme managers on changing MNH needs, and to conduct informed health planning processes.

The output of the PCA will be a final report (to be completed by the district committee) that will form the principle input into the joint planning process. We strongly recommend sharing the results of the assessment with members of the community as this provides a platform to discuss priority problems and advocate further for the need for joint action on MNH. It is also important for maintaining accountability and transparency.

### 3.7 THE JOINT PLANNING PROCESS

After completing the PCA the IFC committee ideally elaborates a 5-year action plan for IFC interventions. A 5-year action plan will generally allow for interventions to be fully implemented and results measured. This plan typically involves:

- a PCA (or PCA review) at the beginning;
- a baseline study (possibly);
- quarterly meetings of the district IFC committee;
- an annual meeting of all local partners;
- a mid-term review;
- a final evaluation.

The process should also have built-in feedback mechanisms to hear community voices and monitor progress and processes.

Once the final report of the PCA has been written, reviewed (by district, province and national committees), revised and finalized, the

district committee and local coordinator will be responsible for organizing a process to develop the detailed action plan for IFC interventions.

The institutional forum during the PCA, composed of different local stakeholders, will produce a priority list of problems and a draft list of interventions aiming to address these problems. Using this draft action plan, the local coordinator and district committee, with the support of province and national levels, develops the detailed action plan. This action plan will facilitate implementation, monitoring and evaluation of IFC interventions.

The IFC plan will preferably be directly incorporated into the MNH workplan. We suggest constructing an action plan consisting of a logical framework (logframe) and a detailed activities plan. The logframe is used to identify goals, objectives, expected outputs of interventions, as well as the different indicators to measure progress. This is a central tool for monitoring and evaluation. The activities plan, in contrast, provides the details for each activity, including responsible actors, resources required and a time frame. Determining these details in



advance will facilitate implementation. When using local tools, IFC coordinators will need to verify that all necessary elements are in place.

A clear action plan facilitates implementation of interventions and is essential to assuring accountability. This process is described in detail in Module 5 and sample planning frameworks (a logframe and an activities plan) are provided in Annexes 1 and 2 of that module. It is important

for the district committee to be comfortable with and understand the planning frameworks selected. It will be important to identify overall intervention goals, as well as intermediary results, and to visualize the chain of results needed to achieve the objectives. The planning frameworks are flexible tools to be modified to respond to changes in the situation and the context of the district.

### 3.8 PARTICIPATORY IMPLEMENTATION, MONITORING AND EVALUATION

Participation is emphasized throughout implementation of activities, as it is throughout all phases of the IFC framework. The district committee continues to oversee the interventions and discusses the results and progress on a continuous basis with a broader group of community stakeholders. Throughout the implementation process, it is advised that the group conduct on-going monitoring to determine progress and make necessary adjustments to selected interventions.

Although monitoring of activities will be conducted throughout the process, we suggest conducting an evaluation after a pre-determined period of time to measure the results of the interventions and their impact on selected health indicators. Results from the evaluation can be fed back into the planning processes and inform strategic decision-making (see Module 5, section 3).

### 3.9 INSTITUTIONALIZING THE IFC FRAMEWORK AND PARTICIPATORY METHODS INTO ONGOING PROGRAMMING AT THE DISTRICT LEVEL

It is important to emphasize again that the IFC framework is designed to be integrated into MNH and on-going planning processes after this first experience (see section 2.16).

At the district level, this institutionalization can involve:

- developing policies to ensure community involvement in annual service progress reviews;
- expanding the scope of the district IFC committee to ensure oversight and review of all local health activities (i.e. moving beyond MNH into a wider range of health promotion activities);

- integrating a PCA or similar participatory needs assessment and planning methodology into the MNH programming cycle, to be conducted at 3-5 year intervals;

- integrating a PCA into broader health planning cycles.

Expanding the scope of the IFC framework and the PCA to include other areas of health may serve as an important step to allow the community to participate in setting and determining their own health priorities. This also implies that the methodology and instruments of the PCA be reformulated to identify and investigate priority health needs.



### 3.10 SUMMARY OF STEPS FOR IFC IMPLEMENTATION

In conclusion, the steps of implementing the IFC framework in a country can be summarized as follows:

- presentation of the IFC framework to national and district authorities;
- formation or strengthening of a national IFC sub-group of the national MNH committee;
- inventory of IFC experiences in the country;
- strengthening or formation of an IFC sub-group within each district health committee;
- orientation workshop of the IFC component for the district health committee;
- training on how to conduct a PCA;
- PCA (or PCA review) conducted in each district by the district group, supported by national and provincial levels;
- participatory planning;
- baseline evaluation;
- activity implementation (overseen by the local committee with support from the national committee), including ongoing monitoring;
- evaluation, lessons learnt, dissemination of results at the national and local levels;
- vertical and horizontal scale-up.



**Table 3.1: Summary of activities before, during and after the PCA**

	<b>National and province levels</b>	<b>District level</b>
<b>Before the PCA</b>	<ul style="list-style-type: none"> <li>• Define the terms of reference of the coordination committees (see Module 1, Annex 1).</li> <li>• Identify the “strategic partners” and “stakeholders” for the IFC component at national level.</li> <li>• Develop a plan for implementation of the IFC framework at national and province levels, and identify the required resources (human and financial).</li> <li>• Identify one or two expert facilitators at national or province level.</li> <li>• Conduct a national inventory of experiences in IFC-related work.</li> <li>• Identify the initial IFC intervention district, in coordination with province and district level actors, according to the specified criteria (see Module 1).</li> <li>• Identify the key moments of interaction between the district, province and national levels. At province level, identify a representative to participate in the district and national committees.</li> <li>• At national level, review the PCA instruments for a first adaptation to the national context.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and revise the terms of reference of the district committee (see Module 1, Annex 1).</li> <li>• With the support of the province and national committees, develop an initial plan for the implementation of the IFC framework at the district level, and identify resources (human and financial) that are required.</li> <li>• Present the IFC framework to local actors in the community and identify the “strategic partners” and the “stakeholders” for the district committee (or broaden the existing district MNH committee).</li> <li>• Select the IFC committee chair(s).</li> <li>• Identify a local IFC coordinator.</li> <li>• Identify local facilitators for the PCA.</li> </ul>
<b>During the PCA</b>	<ul style="list-style-type: none"> <li>• Support the district level in the different stages of the PCA.</li> <li>• Find pertinent information for the situation analysis (national statistics, research in the area, programme/project reports in the area).</li> <li>• With the district level, organize a training workshop for the PCA and participate in the training. Organize follow-up, according to needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct the situation analysis:                         <ul style="list-style-type: none"> <li>○ Collect data and pertinent reports;</li> <li>○ Organize meetings for filling in and/or reviewing data collection forms;</li> <li>○ Write up the draft report.</li> </ul> </li> <li>• With the national/province level, organize a training workshop for the PCA and participate in the training.</li> <li>• Review the roundtable discussion guide, taking into account the results of the situation analysis (with support from the national and province committees).</li> </ul>



	<b>National and province levels</b>	<b>District Level</b>
<b>During the PCA</b>	<ul style="list-style-type: none"> <li>• Participate in pertinent meetings during the PCA (situation analysis, roundtable discussions, analysis meetings, institutional forum).</li> <li>• Review and comment on the PCA reports.</li> </ul>	<ul style="list-style-type: none"> <li>• Organize the roundtable discussions, including identification of participants, logistics and facilitation.</li> <li>• Carry out the five individual roundtable discussions, including meetings for analysis, and writing up reports.</li> <li>• Write up the summary report of the five roundtables.</li> <li>• Organize and conduct the institutional forum, including compiling the report with information collected.</li> <li>• Write up the final report.</li> </ul>
<b>After the PCA</b>	<ul style="list-style-type: none"> <li>• Present results of the PCA, including the draft action plan, to national and province MNH committees and other strategic partners.</li> <li>• Organize a workshop for documentation of lessons learnt from the PCA, jointly with the district level, including the revision of PCA instruments.</li> <li>• Support the district level in the joint planning process to develop a detailed action plan.</li> <li>• Review and adapt tools for monitoring and evaluating the IFC component.</li> <li>• Support the district level in evaluating the results of IFC interventions and coordinate and disseminate these results.</li> <li>• Organize a workshop for documentation of lessons learnt from IFC implementation, jointly with the district level.</li> <li>• At national level, develop a process for scaling-up IFC implementation to other districts and provinces.</li> </ul>	<ul style="list-style-type: none"> <li>• Present the results of the PCA to the district MNH/IFC committee(s) and other strategic partners and community actors.</li> <li>• Organize a workshop for documentation of lessons learnt from the PCA, jointly with the national level, including the revision of PCA instruments.</li> <li>• Organize, jointly with the province level, a process to develop a detailed action plan based on the draft plan.</li> <li>• Manage the implementation and regular monitoring of IFC activities.</li> <li>• Evaluate the initial implementation of the IFC component.</li> <li>• Disseminate results from monitoring and evaluation.</li> <li>• Organize a workshop for documentation of lessons learnt from IFC implementation, jointly with the national level.</li> <li>• Support the scaling-up of the IFC framework to other districts within the province.</li> </ul>



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# ANNEXES

## **Annex 1: Terms of reference**

- A) National and Province Coordination Committees**
- B) District IFC Committee**
- C) Local coordinator**

## **Annex 2: IFC implementation timeline**



## ANNEX 1 : TERMS OF REFERENCE

The following pages include the terms of reference for the groups and individuals who

will implement the IFC framework at national, province and district levels.

### A. IFC NATIONAL AND PROVINCE COORDINATION COMMITTEES

*Note: Generally the IFC National and Province Committees will be integrated into pre-existing national and province MNH committees, or they may be a subcommittee of them. If separate IFC committees are formed, one of the representatives may be selected to represent the IFC component in the MNH committees.*

*This section focuses on the National Committee. It will be necessary to review the roles of the National Committee and Province Committees and assign responsibilities to each. Some roles and responsibilities will overlap at national and province levels. Normally the province committee will be smaller than the national committee (maximum of five people).*

#### **Objective of the national coordination committee:**

Supervise, provide technical support to and coordinate the development and implementation of the “national plan” for the IFC component within the national MNH strategy.

#### **Scope of work:**

1. Identify partners for implementation of the IFC component (including other sectors and relevant programmes within the MoH itself, NGOs, universities and other relevant groups).
2. Represent the IFC component at the national level, within other national, regional and international initiatives.
3. Advocate the importance of this health promotion component for MNH strategies within the MoH and with other sectors and

groups and assure its integration into and coordination with broader strategies.

4. Coordinate the development of the national IFC plan, including planning of interventions; management and administration of financial, technical and human resources of the interventions; and assuring adequate financing for each phase of its operationalization.
5. Develop a system for monitoring and evaluating the IFC component at the national level.
6. Identify the necessary experts and support at various administrative and technical levels (national, province and district) for implementation of the national IFC plan.
7. Provide technical assistance throughout the implementation of the national IFC plan at all levels of the health system (province, district authority, community).
8. Develop coordination mechanisms and maintain communication with all strategic partners (at district, province and national levels) and with district committees during the different phases of development and implementation of the national plan.
9. Review and analyse existing strategies, programmes, and activities that work with women, their families and the community to improve MNH at national level.
10. Document and organize the experiences and lessons learnt in the area of IFC for scale-up at national level.



### **Members of the national coordination committee:**

The national IFC coordination committee involves the participation of representatives of organizations that work on MNH issues at the community level, including representatives of:

- MoH (one or two decision-makers in the MNH or Health Promotion programmes);
- WHO (national offices);
- other governmental agencies (education, water/sanitation, youth, etc.);
- NGOs (national or international);
- women's groups;
- universities;
- national champions in MNH or health promotion;
- representatives of the province and district IFC committees.

### **Skills and knowledge required within the committee:**

- knowledge of current MNH activities, social sciences and health education;
- familiarity with quantitative and qualitative research methods;
- experience in educational processes at community level;
- experience in community health (links between communities and services; community participation in health care improvement);
- knowledge of participatory mechanisms at the community level;
- must include or have relationships with political decision-makers, or include representatives who have the ability to influence key decision-makers.

### **Coordination:**

This team will select a coordinator and a secretary for a specified period of time. The committee should be limited to 10-12 members to allow the group to work effectively. It may be useful to consider forming subcommittees to carry out specific actions. The large group could meet two to three times a year to provide suggestions and oversight.



## B. DISTRICT IFC COMMITTEE

*Note: It is recommended to form a subcommittee of the existing district MNH committee (where one is present) of five to ten persons for the coordination of IFC activities.*

### Objective of the District IFC Committee:

Coordinate the implementation of the IFC strategic framework at district level.

### Scope of work:

1. Identify partners for the local implementation of the IFC framework (including other relevant sectors and programmes within the MoH, NGOs, and other pertinent groups at the district level).
2. Coordinate the different phases of the IFC implementation framework, including the PCA, development of the district plan, identification of interventions, implementation of activities, monitoring and evaluation and documentation of lessons learnt.
3. Identify participants for the roundtable discussions.
4. Maintain communication and develop mechanisms for effective coordination with all strategic partners during the implementation interventions, including district, province and national stakeholders.
5. Assist in the identification of experts and support required at various administrative and technical levels in the local area for the implementation of the IFC framework.
6. Participate in the joint planning process, specifically the planning of activities for implementation, and the identification of indicators for monitoring and evaluation of the IFC component.
7. Review and comment on proposals developed for funding IFC activities before submission.
8. Assure the integration of participatory mechanisms within routine health service planning processes.
9. Review and analyse existing strategies, programmes and activities at the district level that work with women, their families and the community for the improvement of MNH.



### Members of the District Coordination Committee:

The Committee should comprise a maximum of ten people, and may include:

- MoH (including representatives from the district health centre);
- health service providers with experience in MNH at the district level (for example, doctors, nurses, health promoters or midwives);
- NGOs working in MNH in the area;
- representatives of community groups, local health committees and women's groups;
- local political representatives;
- the education sector;
- other selected relevant professionals in the local area;
- religious leaders.

### Skills and knowledge required within the committee:

- knowledge of current activities in MNH and in health education;
- experience in educational processes at community level;
- experience in community health (links between the communities and services; community participation in the improvement of quality of health care);

- knowledge of participatory mechanisms at the community level;
- skills in negotiation and facilitation;
- ability to represent the voice of women, families and communities;
- must include or have relationships with local political decision-makers, or with people who have the ability to influence key decision-makers.

### Duration of service:

Each committee member will ideally be able to commit to at least two years of service on the IFC committee, after which time they may choose to rotate off and new members may be elected.

### Committee chair(s):

The district committee may be chaired by the district health services director or the head of MNH services. It may also be appropriate for the committee to elect a "community co-chair", a representative of a community group who is not part of the health sector. The committee will also need to appoint or elect a local IFC coordinator responsible for work related to the IFC component (see next page).

This committee will also elect a secretary for a specified period of time. One or two people from this district committee may be identified to represent it on the national and/or province committees (usually the chair or co-chairs).



## C. LOCAL IFC COORDINATOR

*Note: The local IFC coordinator will work closely with the chair(s) of the district committee. In some cases they may be the same person. It is usually helpful, however, to select an IFC coordinator who will be responsible for the organization and implementation of the IFC action plan.*

### Profile of the Coordinator:

- has lived or worked in the selected implementation site for a period of at least three years and knows the area well;
- has experience implementing interventions and projects at community level, especially in MNH, and has knowledge of current activities;
- has knowledge of qualitative and quantitative research methods;
- has contact with and knows the local health providers and decision-makers;
- is recognized as a leader at district level;
- has knowledge of participatory mechanisms;
- has knowledge of educational communication in health;
- has negotiation, facilitation and group management skills.

### Scope of work:

1. Organize meetings of the District IFC Committee together with the committee chair(s).
2. Support and report on progress at meetings of the National Coordination Committee.
3. Support the District IFC committee in the identification of partners for implementation of IFC interventions.
4. Maintain communication and develop mechanisms for effective coordination with all the strategic partners during the different phases of development and implementation of the different activities.
5. Support the identification of facilitators at the district level.
6. Coordinate all stages of the PCA:
  - a. Support to the PCA team in the situation analysis;
  - b. Support the review of the PCA instruments;
  - c. Present the IFC framework and PCA to relevant persons at the district level;
  - d. Coordinate the identification of the participants for the roundtable discussions;
  - e. Organize the roundtable discussions;
  - f. Facilitate the roundtable discussions, along with other facilitators;
  - g. Process and analyse the information generated by the roundtable discussions;
  - h. Prepare the PCA reports;
  - i. Document and evaluate the PCA experience, including lessons learnt and presentation of findings to the community, health care providers and decision-makers.
7. Be a part of the design team for intervention strategies at district level and support for developing a system of monitoring and evaluating the IFC component.
8. Be a resource for the scale-up of the IFC framework to other areas after the initial phase.






## ANNEX 2: IFC IMPLEMENTATION TIMELINE



IFC Implementation Continues

ACTIVITIES	YEAR 1												YEAR 2												YEAR 3											
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
<b>NATIONAL AND PROVINCIAL LEVELS</b>																																				
National IFC orientation workshop (preparation and workshop)																																				
Formation of national committee, identification of national and/or province IFC coordinator(s) and ongoing coordination work																																				
Advocacy and partnership building																																				
Resource mobilization																																				
Inventory of national experiences in IFC-related MNH work																																				
Development of a project proposal for IFC initial implementation																																				
Selection of the initial intervention zone(s)																																				
Identification of expert facilitators																																				
Review and adaptation of the IFC methodology and instruments																																				
Ongoing support to local implementation of IFC, including PCA																																				
Documentation and discussion of lessons learned from IFC implementation																																				
Post-PCA adaptation of methodology																																				
Extension of IFC to other districts and local areas																																				
<b>DISTRICT LEVEL</b>																																				
Formation of district IFC committee, selection of local coordinator(s), and ongoing committee work																																				
Advocacy and partnership-building																																				
Local orientation to IFC (preparation and workshop)																																				
Identification of the PCA team and PCA coordinator																																				
Situation analysis (data collection plus local review)																																				
Local revision of PCA instruments																																				
PCA training workshop (including practice roundtable)																																				
Individual roundtables (5)																																				
Summary report from the roundtables																																				
Institutional forum																																				
PCA final report																																				
Presentation and dissemination of PCA report																																				
Documentation of lessons learned from IFC and the PCA																																				
Development of detailed IFC activity plan (including indicators)																																				
Resource mobilization for local activities																																				
Baseline evaluation																																				
Project implementation																																				
Ongoing monitoring and evaluation																																				

 Key implementation time
  Ongoing activities





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ISBN 978 92 4 150852 0



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