Vitamin A in Child Health Weeks:

A toolkit for Planning, Implementing and Monitoring

Micronutrient Initiative

solutions for hidden hunger

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Purpose

This toolkit has been developed to assist district level managers to plan, implement and monitor child health weeks or similar regular twice-yearly events in order to reach the greatest number of children to improve their health and survival. The generic term District is used in these materials to refer to a sub-national level and the term District Health Management Teams to designate the responsible team at this level.

We acknowledge that other organizations have been undertaking or may undertake work that will inform and complement this toolkit. We will endeavour to keep this toolkit updated and will welcome comments and suggestions to improve a future revision.

KIT CONTENTS	SUGGESTIONS FOR USE
Developing a Guide for District Health Managers to Plan, Implement, and Monitor Vitamin A Supplementation in Child Health Weeks	This document can be used to help develop a country-specific guide for planning, implementing, and monitoring child health weeks for district health managers. To facilitate the adaptation of this document at country level, there are sections in the document where country-specific information can be added. We suggest that the term • "Child Health Week" is replaced with the appropriate name in your country that is used to describe twice yearly events that provide a package of health services to 6-59 year old children and that the term • "District" is replaced with the appropriate name for the (sub-national) administrative level in your local health system at which child health weeks are planned, implemented, managed and monitored
Orientation for Planning, Implementing and Monitoring Vitamin A in Child Health Weeks: A Facilitators' Guide	The Guide for Facilitators is a step by step guide for conducting an orientation and planning workshop at district level, and uses various tools including Power Point Presentations, job aids and sample worksheets.
CD ROM	The CD contains all the documents in non PDF format that you can edit. These files are provided to help you to adapt the documents to your specific situation.

Acknowledgment

The Micronutrient Initiative thanks the many people and partners who have contributed to the development and revision of the tool kit. They are individually acknowledged in the respective documents.

About this document

The rationale for this document

In many countries, vitamin A supplements are no longer distributed through stand-alone vertical campaigns, but as part of a more integrated approach of twice yearly expanded **outreach** services aimed at achieving the highest possible coverage of children. This integrated approach may be called Child Health Week, Child Health Day, Child Action Day, Child Survival Day, Enhanced Outreach Strategy among other names in common use.

This document uses the phrase "**CHILD HEALTH WEEKS**" as a generic name for any such integrated approach that involves a system for routinely planning, conducting, monitoring and evaluating these services every six months over the course of several years.

In many countries, the responsibility for planning and managing child health weeks is devolved to sub-national levels. The names of sub-national administrative areas vary by country. They may be known locally as wards, local government areas, districts or by some other description. In this document, we use **DISTRICT LEVEL** as a generic description of this sub-national level and assume that a **DISTRICT HEALTH MANAGEMENT TEAM** is in charge of planning, budgeting, conducting and reporting on activities.

Training materials have been already developed to train health workers and programme managers on the technical aspects of vitamin A deficiency and nutrition. However the need has been expressed for guides and training materials that emphasize the child survival value of these preventive services including vitamin A supplementation, and that guide the operational aspects of the child health weeks approach. Developing this Guide for District Health Managers is strongly recommended as a part of developing a national strategy for child health weeks. The development and use of a Guide for District Health Managers helps to establish common standards for the programme and helps to ensure a consistent approach to programme implementation across the country.

Purpose and structure of this document

A Guide for District Health Managers needs to be developed by each country and should be specific to the situation and programme in that country. The purpose of this document is to provide a **framework** that can be used, at national level, to define the content of a manual for use at district level: *A Guide for Planning, Implementing, and Monitoring Child Health Weeks for District Health Managers*.

This document lays out the sections which can be included in a district guide for planning, implementing and monitoring child health weeks at the district level. This document is NOT intended to be distributed and used as a district level guide. Each chapter lists the issues and decisions that will need to be addressed in each section as a country specific guide is developed. It lists the key content and guidelines which will need to be included in each section of such a guide.

The purpose of a country-specific *"Guide for Planning, Implementing, and Monitoring Child Health Weeks for District Health Managers"*, once completed in a country and distributed to all districts, will be to guide programme planning at the district level, and to serve as programme resource for district managers and anyone involved in planning of and training for child health weeks.

Policy support for a Guide for Planning, Implementing, and Monitoring Child Health Weeks for District Health Managers

Prior to developing this guide, a national strategy should already have been developed. The national strategy document should describe what is meant by child health weeks in the country context, and outline an approach or plan for implementing these activities in a way which is integrated with, and builds on the existing health system and services.

The national strategy should provide districts with the flexibility to add services that are relevant to local priorities, and with a list of recommended services which districts can offer if they have the capacity to do so. Services should only be added if the district has the capacity to deliver them to specified standards.

Scope

This document is meant to be the Phase I of a guide for child health weeks. It focuses on vitamin A supplementation as one of the key preventive services delivered during child health weeks. A phase II document would aim to include other interventions such as de-worming, immunization, and treated bednets as part of a minimum package of services delivered during child health weeks.

How to use this document

Use this document as a framework to help develop a *"Guide for Planning, Implementing, and Monitoring Child Health Weeks for District Health Managers"*. As a first step, replace each instance of:

- [country name] with the name of your country
- "Child Health Week" with the appropriate name in your country that is used to describe regular events that provide outreach services at least twice yearly to children and their caregivers in all communities
- "District" with the appropriate name for the (sub-national) administrative level in your local health system at which child health weeks are planned, managed and monitored
- Text in grey boxes that is specific to the situation and programme in your country.

Contents

LIST OF TABLES

LIST OF FIGURES

Acknowledgements

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List of Acronyms

CBO	Community-Based Organizations
CHD	Child Health Day
CHW	Child Health Weeks
CS	Child Survival
DHMT	District Health Management Team
EPI	Expanded Programme for Immunisation
EOS	Enhanced Outreach Strategy
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide-Treated Nets
MDG	Millennium Development Goals
RED	Reach Every District
VAC	Vitamin A Capsule
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplementation

Introduction

What are Child Health Weeks?

Child Health Weeks (CHW) are regular events organised to deliver an integrated package of preventive services known to be highly cost-effective for improving child health and survival that are run in conjunction with routine services at health facilities.

CHW aims to reach **all** children under the age of 5 years at least every six months during a limited time period (week or month). The package of essential preventive health services is defined by local circumstances and needs and usually includes VAS, deworming, insecticide-treated bednets (ITN's) or other services as deemed appropriate.

CHW share several aspects with the Reach Every District (RED) strategy[1] in the sense that they aim to provide regular outreach services, supportive supervision and on-site training, community links with service delivery, and they rely on effective monitoring and the use of data for action and better planning and management of human and financial resources.

How do child health weeks contribute to national priorities and strategies?

This section should include key highlights of a national strategy for addressing Vitamin A Deficiency (VAD) and/or Child Survival (CS) through CHW:

Prior to developing this guide, a national strategy should already have been developed. The strategy document should describe what is meant by CHW in the country context, and outline an approach or plan for implementing these activities in a way which is integrated with, and builds on, the existing health system and services.

Careful planning at the development stage will greatly increase the chances that the CHW activities will become institutionalized as a routine outreach approach.

This approach is very likely to be new or different and may need to be explained well at the beginning of the programme. Managers and service providers need to understand that this approach is planned for several years and not a one time campaign effort.

List here highlights of the country strategy such as:

- objectives
- services being offered
- activity cycle
- partners and coordination

[1] WHO/UNICEF. Global Immunization Vision and Strategy (GIVS) 2006-2015, p.33

In [*country name*] CHW were adopted by the Ministry of Health as a national strategy for Child Survival in __ [*year*].

Example: Objectives of CHW in [*country name*] are:

- To increase coverage of vitamin A supplementation of children (6-59 months) to above 90% twice a year
- To achieve a coverage of ____% for de-worming of all children age 1 year to 5 years,
- To increase the number of children reached with a vaccine (for example DPT) from __ __% to __ __%, and
- To increase community awareness of the importance of vitamin A and key family care practices.

What services are offered during child health weeks?

In this section, list the services that will be offered during CHW.

The national strategy should specify the **essential services** that are to be offered in all districts (e.g. **the essential minimum package of services**).

The national strategy should also provide districts with the flexibility to add services that are relevant to local priorities, and with a list of additional services which districts can offer if they have the capacity to do so. However, services should only be added if the district has the capacity to deliver them to specified standards.

Lessons learned

Countries with successful programmes have started with a few key services and then added components once good levels of coverage have been reached.

Offering a package of services in an integrated approach allows resources and efforts to be combined for best results.

Examples

"The Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa – Through Health System Strengthening and Implementation at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions"[2] offers some useful examples.

A ***minimum package*** of high-impact, low-cost interventions may include:

- promotion of early, exclusive and prolonged breastfeeding
- routine immunisation of mothers and children
- Vitamin A supplementation for all children age 6 to 59 months
- De-worming for all children age 1 year to 5 years

[2] African Union / WB / UNICEF, version 9, 2006.

along with others, such as the promotion of oral rehydration therapy (ORT), zinc supplementation for the treatment of diarrhoea, and the promotion of appropriate complementary feeding.

Additional region-specific interventions might include

- Promotion of distribution or re-treatment of insecticide-treated mosquito nets
- Ivermectin to treat onchocerciasis

Why are Child Health Weeks important?

Include in this section a brief presentation of country and district data to justify the need for a CHW.

Highlight a few critical points about child survival and vitamin A deficiency and current coverage of services which will get people's attention and convince them of the need for urgent action.

Keep this section as simple and as uncluttered as possible so that the main messages are easily conveyed. It might help to seek advice of media or public relations people to determine what type of presentation will be most convincing. The aim is to convince the audience that:

- Reaching children with these key services is critical for child survival
- Low vitamin A status is a concern in this community and requires action
- De-worming and other key interventions are also important for child survival, and
- While some progress has been made, increased coverage of services is needed to fully protect children.

Justification for Child Health Weeks ...

Information to be presented:

- Under five mortality rate, number of deaths per year or deaths per day. Supplementation with vitamin A is recommended in all countries where the U5MR exceeds 70 per 1,000 live births – an internationally accepted proxy indicating a high risk of deficiency among children under five.
- Data on vitamin A deficiency in country and per district using serum retinol data from surveys, if available. (Since any level of deficiency is linked with increased mortality, focus on the total % of target population below the recommended cut off[3].)
- If using clinical data of xerophthalmia, present these along with WHO cut off values. Be aware that for many outside the nutrition sector, this data is complex and not very convincing because the numbers and percentages are so small.
- Any dietary intake data which demonstrates low levels of vitamin A intake.
- Information on helminth infections and measles morbidity and mortality
- Contribution of vitamin A deficiency to all under five deaths and (perhaps) deaths associated with the major childhood killer diseases
- Potential lives saved by good coverage with vitamin A[4] and other child survival services
- Health service coverage of the country
- Other key information such as current immunization coverage and vitamin A coverage rates.
- Data on trends of coverage achieved by previous distributions of vitamin A or estimated in six month intervals.

[3] It is often better not to discuss details of different levels of deficiency (mild, moderate and severe) since this can be confusing and will likely detract from the important child survival relevance of any deficiency.

[4] Use country data such as data in appendix of Vitamin and Mineral Deficiency Global Report.

Why vitamin A supplementation?

It has long been known that vitamin A deficiency is the main cause of preventable blindness in children. We now also know that vitamin A plays an important role in strengthening the body's resistance to infection. Those children who are vitamin A deficient suffer an increased risk of death and illness, particularly from measles and diarrhoea.

A meta-analysis of several studies[5] has shown that improving the vitamin A status of deficient children aged 6-59 months by giving vitamin A supplements twice yearly dramatically increases their chances of survival by:

- Reducing all-cause mortality by 23%;
- Reducing measles mortality by 50%;
- Reducing diarrhoeal disease mortality by 33%.

Twice yearly preventive vitamin A supplementation is one of the most cost-effective health interventions for reducing infant and child mortality.

As vitamin A is stored in the liver, high-dose vitamin A supplements can be given once every four to six months to prevent vitamin A deficiency in children[6].

Why de-worming?

There is strong evidence demonstrating how worm infections damage a child's health. Worm infections are also associated with a significant loss of micronutrients. Roundworms are the most prevalent soil-transmitted helminth infection in preschool children and cause poor absorption of vitamin A, which can aggravate malnutrition and anemia rates and contribute to retarded growth. A child's physical fitness and appetite are negatively affected and his or her cognitive performance at school is compromised. The constant and life-long immune activation due to worm infections reduces the body's capacity to resist other infections[7].

Preschool children are extremely vulnerable to the micronutrient deficiencies induced by worm infections. They are in a period of intense physical and mental development and critically need the vitamins and minerals that are lost through worm infections.

Treating children of any age for worms is one of the simplest and most cost-effective interventions for improving a child's health.

CHW complement routine health services

To achieve national health goals, it is vital to achieve as near universal coverage as possible with essential interventions. While many essential clinical and preventive services are available at hospitals and health centres, they do not reach enough of the people who need them particularly children under five years of age. Each district can provide outreach services on a routine and regular basis to bring essential services closer to communities.

The CHW approach offers an additional routine service that extends services to the community, at least twice each year. CHW offer a cost-effective

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[5] Beaton GH, Martorell R. Aronson KA et al. Effectiveness of vitamin A supplementation in the control of young child morbidity and mortality in developing countries. Toronto, Canada: University of Toronto, 1993.

[6] From Distribution of vitamin A during National Immunization Days: WHO/EPI/GEN/98.06

[7] WHO/UNICEF 2004. *How to add De-worming to Vitamin A Distribution*. p.8

way for districts to provide preventive services to many more mothers and children beyond what is possible through routine health facility visits or contacts.

For example all children up to the age of five need to receive all their requisite immunizations, and to receive vitamin A capsules and de-worming tablets every 6 months. Although attendance for preventive services may be good for children under age 1 year, attendance usually decreases for older children. For this reason, many preventive services which may be necessary for children older than 1 year of age do not achieve adequate coverage.

CHW offer a regular opportunity to improve coverage.

CHW offer an opportunity to remind caregivers to come to health facilities and outreach sites for these services.

The use of CHW as a periodic routine outreach mechanism has been shown internationally to improve vitamin A coverage, increase immunizations given, and increase other preventive services such as de-worming, ITN distribution and health promotion.

Schedule for Child Health Weeks

CHW are an expanded outreach activity held every six months to enable routine health services to reach out for maximum coverage of children under age 5 with a key set of preventive services.

CHW will be conducted every year during the months of _____ and _____ [Specify the months]

If immunisation campaigns are being planned, it is important to coordinate and see if the two events can be integrated to reduce operational costs and the number of activities which impact on the work load of health workers.

Activity Cycle:

One month before the Child Health Weeks

- Make sure that adequate supplies are ordered and plans for delivery to districts and health centres is clear
- Hold meetings with those who will remind the community about the planned activities
- Conduct orientation or refresher training of service providers
- Distribute supplies

In the month of the Child Health Weeks

- Promotion activities at community level (week before and during CHW)
- Distribution of key interventions
- Supervision visits
- Completion of tally sheets
- Monitoring using spot checks and supervisory visits

One month after the Child Health Weeks

- Review meetings with teams (this is vital for planning for next time)
- Completion of summary reports at districts
- Post-event surveys conducted in survey areas, where appropriate

Second and third month after the Child Health Weeks

- Preparation at provincial and national level reports on activity
- Survey conducted in survey areas, where appropriate (see chapter 3)
- Review of survey results (if done) and analyze bottlenecks to coverage and performance
- Begin planning for activities of next distribution with attention on supply requirements

Part 1

Guide for Child Health Weeks

Chapter 1

Planning for Child Health Weeks

Once the decision has been made to implement CHW, the process of planning is a very important next step. For each district, a detailed plan and budget for activities will need to be drawn up. This step will not be required before every distribution. Once the plan is developed, the same plan can be used for subsequent distributions with revisions based on lessons learned from previous distributions, and adjustments in supplies, as needed.

It is essential to make adequate advance provision for the costs and staff time for at least two CHW each year in the district's annual plan and budget.

This will help to ensure the early communication of needs and allow for sufficient time to acquire the materials and support required. An annual plan and budget will also help to facilitate the integration of CHW activities into regular budgetary planning cycles of district and national Heath Ministries. Inclusion of CHW in district and national Health Plans and budgets will help to ensure support for future distributions.

Technical assistance and input may be needed for the initial planning process. However this is mainly a start-up expense and should not be required for future CHW. Planning for future distributions will focus on results achieved and adjusting the plan according to what has been learned.

1.1 Reviewing the population to reach

In most countries, the aim of CHW is to reach **all children age 6 to 59 months**. For each service, the number of children to reach will depend on the number of children in each target age group:

Service	Age group	Total Number of Children in this District
Vitamin A	6 to 59 months	
De-worming	12 to 59 months	
Other services including immunization	Depends on service provided and national policy	

- The aim is to reach all children with vitamin A and de-worming twice a year. However, although each country should strive to reach all children, the reality is that this is often difficult to achieve and using realistic projections of expected coverage may contribute to better planning and budgeting.

How to calculate the population to reach

Include here directions for how to calculate the number of children to reach.

The preferred method for doing this will need to be decided by the country when defining the national strategy.

There are several ways to do this and the same method should preferably be used by all districts, recognising the fact that not all districts will have reliable demographic data on which to estimate populations to reach.

The population to reach is the children who are the intended beneficiaries of VA and other child health services. In most countries this will be all children between 6 and 59 months of age.

Countries usually identify two cohorts based on the Vitamin A dose schedule:

1. Children 6-11 months who receive 100,000 IU,
2. Children 12 to 59 months of age who receive 200,000 IU.

In some programmes, participation is extended to women in the post-partum period.

Estimating the population to reach is dependant on accurate denominator data and is the basis for programme coverage estimates. Many districts have different sources of denominator data and some of these sources, such as census data, are outdated, or do not reflect real population dynamics (like emigration and immigration into the area). There are important consequences of not having reliable population data:

- Using a lower denominator will result in high coverage, but runs the risks of an inadequate supply of materials or not reaching all eligible children.
- Using a higher denominator will result in low coverage and is a source of de-motivation to staff as targets are not met.

In determining a real denominator, a number of issues can be considered

1. Review demographic data from previous supplementation activities or campaigns where high coverage has been achieved
2. Use EPI population figures which are often accurate in particular for children 6-11 mo
3. Review community birth registers if these exist
4. Systematically add or subtract a multiplier to known census data, e.g. adding 10% in an urban area according to recent population trends.

Methods to calculate population to reach

1. Using actual population data

- Ideally, the size of the population to reach would be generated from listings compiled at the local level or at the point of distribution of capsules, such as community health registers.
- Some public health programmes do enumerate the population and where available, this data can provide the most accurate foundation on which to forecast supplies, as well as to measure coverage. These figures, as for data on total population, must however be agreed-to by the relevant health authorities or an official body, in order to avoid each programme using its own data.

2. Using the total population data and applying a percentage

- In the absence of this enumeration, estimates of the target population are usually calculated by multiplying the total population by the percentage of the children falling in the different age groups.
- The proportion of children in these age groups varies due to differences in demographic patterns. Some basic estimates have been recommended for countries in Africa, as illustrated in the table below (Table 1).
- It should be emphasised that there are several ways to determine the total population, and the accuracy of estimates will depend on the quality of population data. For many countries, the total population is only determined

at the national level and then extrapolated to sub-national areas, including districts. These population figures are often based on census data, and while they are updated to account for estimated population growth, they are not collected frequently.

- This calculation only needs to be done once a year. For the subsequent years, minor updates to account for population growth and other minor adjustments can be made.

Table 1: Example of estimates of target groups based on demographic characteristics

Target population	% of total population	Number of people (examples)
Total population	100	10,000,000
Children from 0 to 59 months	20	2,000,000
Children from 6 to 11 months	2.4	240,000
Children from 12 to 59 months	16	1,600,000

1.2 Finalising the distribution strategy, and identifying and mapping the distribution points

The number of children in each target age group for CHW was calculated in the previous section. This section will focus on developing an appropriate approach for the implementation of CHW services, and the strategies to use to reach these children.

Each sub-district or health area will need

- A list of communities with an estimate of the number of children in each area, and how each area will be covered during CHW.

In this section, list the distribution strategies recommended by the national strategy.

This may include any of the following:

- use of health facilities – clinics and health centres
- use of existing community health posts
- use of existing community health workers
- reaching children who attend any pre-school facilities
- regular outreach activities, such as mobile services for immunization, already planned during the week
- use of community-based organisations (CBOs) who conduct developmental/administrative activities
- partnering with NGOs and CBOs who do outreach activities
- special outreach to communities planned for the CHW

Often distribution strategies will include a combination of fixed posts, outreach activities and even a door-to-door approach. Although effective, the door-to-door approach tends to be expensive.

The district will need to decide which combination of the recommended approaches will enable them to reach the highest coverage in the context of realistic budget and logistical limitations.

The district will need to have a map or a list of distribution sites, perhaps separated by individual health areas showing:

- where the community can be encouraged to bring children to health facilities or a central place
- where children can be reached through current community-based health posts, and regular outreach activities, and
- where additional outreach may be required

The next step is to discuss and decide how all areas will be reached during the week.

The district, or health centre teams, will then need to draw up a schedule of which sites will provide services, in which locations, on which days. This schedule is important for informing communities before the CHW, as well as for supervision and monitoring during the CHW.

Include a recommended ratio for the number of children per site (maximum).

Example – a maximum of 200-300 children per site per day for outreach activities.

In low-density areas, a minimum number of children to justify a post may need to be specified as well. This will be based both on the capacity of district staff to reach communities during the week, and realistic estimates of how far parents will travel to bring their children for services.

1.3 Planning personnel requirements

District staff will need to work with health facility staff to draw up a plan and budget to ensure that adequate staff will be available to cover all of the distribution points during the week. This is a critical part of the planning exercise, as the number and composition of staff teams is both one of the most important success factors as well as the single most important cost.

The number of staff required will depend on:

- The number of distribution points
- The number of children expected at each distribution point
- How long staff will need to be at each site (1/2 day, one day or more)

Other considerations are also:

- The number of service being offered during the CHW
- The need for specialised/mandated staff (nurses/health assistants for immunisation)
- Whether volunteers are being used
- Plans to partner with community workers and local organizations for service delivery

- The extent to which children will be reached through regularly planned services (like health facility visits[8]) and
- How many special outreach services are planned?
- Plans to reach missed children
- The number of volunteers for social mobilisation

Districts will need to determine the number of staff required, and how many sites each person or team will need to visit during the CHW.

The guide can also suggest how district staff can recruit others to join in the effort. For example, staff from other departments and government agencies, as well as from non-government organisations and community members.

In this section, the national programme will need to include some norms and standards to guide district level planning, such as:

- minimum number of staff per post, or recommended ratio of staff to number of children
- staff requirements for specific CHW services
- arrangements for volunteers helping with the distribution
- arrangements from which organizations and how many to work on social mobilisation
- MOH departments and other government staff and partners participating in Child Health Week efforts

Example – For community posts, a minimum of 2 service providers per distribution point is recommended

Districts will also need to discuss, in realistic terms, the type of support required for the distribution teams during the CHW. Since the Child Health Week is an activity to be implemented by the health system every six months for several years, the type of support requested and costs should be consistent with normal MOH standards and allowances, and every effort made to minimise extra costs.

Include here standards for acceptable or allowable costs related to personnel. For example:

- food provision or food allowances for day travel
- travel allowances and accommodation for overnight journeys
- costs of transport, or procedures for accessing transport
- communication and any other costs allowed

Some countries also provide an incentive to volunteers and to staff. This should only be done if this is standard practice for Ministry activities, and if there is capacity for government to absorb these costs in the future. When CHW are planned from the outset as a Ministry of Health activity and not a donor project, there is a greater chance that the twice yearly effort can become a routine activity absorbed by national health budgets.

[8] In the case where community members who live near health facilities are being encouraged to bring their children to the health facility for CHW services, several country programmes have found that CHW services run more efficiently when children are served separately or as part of preventive services so that the large numbers of children does not interfere with routine outpatient and sick care services.

1.4 Planning supplies

Supplies should be collected or received about a month in advance, and distributed to all health centres two weeks before CHW.

Ensuring that enough capsules are available is one of the most critical factors for success of CHW. Running out of supplies during CHW will severely reduce coverage. Once supplies have been received by the district, ensuring an adequate supply to the distribution points is fundamental.

Supplies needed for CHW will include:

- Vitamin A capsules
- De-worming medicine, and safe water, cups etc. if required
- Vaccines, syringes, needles and disposal boxes (if immunization services are included)
- Vaccine carriers and ice for outreach
- Reference and promotional materials
- Scissors or nail clippers to cut capsules (needles and blades not recommended)
- Waste basket or box for disposing of emptied capsules and other waste
- Job aids
- Tally sheets
- Reporting forms

Plus, other materials required for additional interventions

Include recommendations here on the number of items per distribution point.

Specify which items should be one per post and which should be one per staff member.

Make sure to include 5-10% extra for all supplies.

Capsule requirements will need to be calculated based on the number of children to reach.

How to calculate the number of vitamin A capsules needed?

If supply needs are estimated only at a national level, based on national statistical information, there is a risk of incorrect extrapolation to districts that may not reflect true needs. Any variability and imprecision of target population data can lead to gross errors in forecasting needed supplies.

It is necessary to develop protocols that will lead to a more systematic forecasting, and then to link these results to actual coverage data to improve the estimates over time.

There are three steps to estimating the VA supply needs for CHW, including:

1. Estimates of the population to reach
2. Estimates of anticipated coverage for two distributions per year
3. Estimates of overage for handling losses (up to 5%)

A worksheet is provided in ***annex A*** to help plan vitamin A supplies for CHW and accounting for remaining capsules. Over time, this should contribute to improve the calculations of capsules required for programme planning.

Step 1: Estimates of the population to reach

see section "How to calculate the population to reach"

Step 2: Estimates of anticipated coverage for two distributions per year

Once the target population is calculated, the next step in estimating the Vitamin A supply requirements is to determine the projected coverage for a particular area. This should be based on the most recent results of VAS distribution coverage. Projected coverage should be as realistic as possible and accurately reflect available resources and existing work plans as they are critical to calculate the number of capsules required.

Step 3: Estimates of overage for handling losses

- It is usual to increase the number of capsules by 5% to account for handling losses.

Additional considerations – packaging and types of capsules required

- It is necessary to consider the packaging of capsules. VA capsules generally come in bottles of 500. If the district requires 182,177 100,000IU capsules, they will require 365 bottles. These will then have to be further divided into smaller numbers using appropriate packaging for distribution to sites where Child Heath Weeks are implemented.
- You will also need to consider which capsules are required
  - One 100,000 IU capsules per child 6 – 11 months
  - One 200,000 IU capsule per child over age 12 months,
  - If using only 100,000 IU capsules, you will need
    - Two capsules per child over age 1 year,
    - One capsule per child 6–11 months,
- Although proper planning and forecasting should prevent this, if only 200,000 IU capsules are available, you will need
  - One capsule per child 6–59 months,
  - For children 6–11 months, only half of the capsule will be used and the rest will be discarded.

These VA capsule requirement estimates should be used for all levels of programme implementation. In doing so, these estimates ensure that sufficient supplies are provided down to each distribution point. If it is found that not all distribution points had an adequate number of capsules, the next step is to plan for providing additional support and training to these distribution points in order that the process of forecasting may be strengthened and improved.

Annex B provides an example of a summary sheet that may be used to determine whether the forecasted number of vitamin A capsules was sufficient or not to meet the needs of the target population. This district summary may be useful in refining the estimates for the population of children, while also serving to track vitamin A stocks over time.

Calculating the Number of De-worming Tablets Required

De-worming tablets need to be distributed twice a year and the target group for distribution is very similar to that for VAS. More and more countries are adding

de-worming to VA distribution following the publication of the WHO/UNICEF Guidelines[9].

The target group for de-worming is children 12 to 59 months.

> The number of tablets required will depend on the expected coverage and on the type of tablets being used. *Indicate here which type of tablet is being used.*

Examples:[10]

- For Mebendazole (500mg): one tablet per child 12–59 months
  Number of tablets required **=** (No. of children 12–59 months x expected coverage) + 5% for wastage
- For Albendazole (400 mg): 1/2 tablet per child 12–23 months, and one tablet per child 24-59 months
  Number of tablets required **=** (No. of children 12–59 months x 0.87 (see note below)) + 5%
  Tablets required = number of capsule x expected coverage

N.B. This multiplier of 0.87 is used to calculate the total number of albendazole tablets needed, since only ½ a tablet is used for children age 12–23 months.

Calculating other supply requirements

> *For other services, include here information on how to calculate requirements for those materials also.*

1.5 Planning logistics

Planning for CHW requires systematic and practical planning details for logistics:

- how supplies will be transported to the distribution sites, and conditions of storage
- transport arrangements for preparation activities before the Child Health Week
- how staff will be moved around during the distribution.

The distribution plan for supplies:

Each district team should have a Distribution Plan – It will be helpful to have a set of standards for what districts should include in the distribution plan: who is responsible for making sure supplies get to where they belong, how supplies will be received in the district, places and conditions for storage, a schedule specifying at what time supplies should be in the district and at health service points, and how they will get there.

Vitamin A capsules and de-worming tablets do not require a cold chain so they can be easily transported. However, attention should be paid to expiry dates and efforts should be taken to ensure that supplies are used in a timely manner.

Encourage district teams to explore available transport options for sending supplies to locations.

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9 WHO/UNICEF 2004. How to Add Deworming to Vitamin A Distribution.
10 *Idem*. P.16

- When dates are known well in advance, it is often possible to plan ahead and use available transport.
- One option is to send supplies back to the district or health centres with personnel who come to a central location for training or other purposes.
- Mobile teams can take supplies out with them at the time of distribution.
- Be sure to consider the quantity of supplies and materials being distributed so that there is adequate space in the vehicle being used.

A transport plan for personnel

Transport for personnel (for preparation activities beforehand, and for staff during the distribution) is one of the biggest challenges in CHW.

Transport also is one of the most expensive parts of operational budgets, especially if bed nets are included as they are bulky and heavy. Therefore, it is wise to encourage district teams to solicit vehicles and drivers from other programmes and organizations to help.

Include guidelines for what type of allowances can be paid for drivers and fuel.

If use of public transportation is encouraged, include specific guidelines for what is and is not allowed, and how and when transport costs will be paid or reimbursed.

District and health facility staff will need to work together to develop a transport plan based on the requirements defined in sections 1.3 and 1.4. When completed well in advance, the team has more time to solicit help and donations from groups working within the district.

1.6 Planning for training and supervision

At the beginning of the programme orientation sessions[11] will be needed to:

- Clarify roles and responsibilities of team leaders and supervisors
- Assist districts and health centres to plan and prepare for the upcoming distribution activities, and
- Orientate service providers about CHW and train them to give vitamin A capsules and other key services correctly.

[11] Refer to the Facilitator's Guide on Orientation for Planning CHW included in the tool kit

Orientation sessions before CHW will include the following:

Level	Main Content areas	Duration	Recommended timing
District teams	• Importance of CHW and services offered • Planning for Child Health Week • How to train service providers • Practical training on how to give Vit A • Reporting	2 days	About one month before the distribution.
Service providers	• Importance of Child Health Week and services offered • How to give capsules, and interaction with caretakers. • Skills for other Child Health services	1 day	One to two weeks before the distribution.

Supervisors	• Same content for service providers above and add:
	  • How to supervise
	  • What to observe during supervision
		Can be trained together with District teams.	Same as district teams (one month before distribution).

Orientation activities will be much more intensive in the beginning when preparing for the first one or two CHW. Once the system is established, orientation sessions may be reduced or used as an opportunity to introduce new services. If staff turn over is high, assess and give intensive training.

District staff will be responsible for training health facility staff who will then recruit and orientate community volunteers.

There are many potential sources of community volunteers, and these will vary in each district. Volunteers can be drawn from the following:

- NGOs and community-based organizations working in the district
- Church or religious groups
- Mother's groups working on nutrition and child health.

[1] UNICEF Vitamin A Adverse Events Interactive Learning and Resource CD-ROM, soon to be released.

Content for Training:

Detailed information for training of service providers is included in ***Part II:*** *Information and Skills for Service Providers*.

Include here a list of topics to be covered:

Suggested Technical Content for Training Service Providers

People administering vitamin A capsules and de-worming tablets need to know:

- The importance of vitamin A for child survival and the benefits of providing de-worming at the same time
- How to identify target age groups
- In what order to give vitamin A, de-worming tablets and other services
- Recommended doses for each age/target group
- How to recognize the type of capsules of vitamin A available for distribution (100,000IU and 200,000 IU)
- How to store and handle vitamin A and other medicines
- How to open a capsule and give vitamin A to a child
- How to give a half-dose if using only 200,000IU capsule
- The need to wipe oily hands
- How to handle a choking child if this should happen[12]
- How to give different doses of de-worming tablets correctly
- What to tell the parent/caretaker at time of distribution
- How to record distribution of vitamin A and de-worming on child health card (if available) and tally sheet (see Chapter 3)

Supervisors

- All of the above topics, plus:
- The side effects/safety, and effectiveness of vitamin A
- How to obtain and maintain supplies
- How to calculate and monitor coverage for vitamin A and de-worming based on tally sheet data (see Chapter 3)
- The purpose of supervision

Tools for training:

Include here a list of Job Aids to be used in training for CHW.

Examples of job aids are included in Part II and include:

- Information for health workers on CHW
- How to give VA capsules and messages for parents
- Fact sheets on VA and de-worming
- checklists for planning and supervision.

[12] UNICEF Vitamin A Adverse Events Interactive Learning and Resource CD-ROM, soon to be released.

Training approach:

The most effective approach for training is to use a methodology focused on practical aspects of the distribution, and one which gives trainees an opportunity to discuss and solve problems.

When learning new skills, such as how to give vitamin A capsules, practice sessions are critical. Practice sessions also allow the trainer to observe the health workers and to ensure that they grasp the content and the new skills. District teams and others who will train service providers will need to be comfortable with the information as well as the recommended training methods.

Session 6 of the Facilitator's Guide covers both the content, as well as some suggested exercises, for training.

A Plan for Training

Each district will need a plan for training all the service providers. The plan will include details such as:

1. Where and when the training will be taking place?
   - The venue can often be made available at no cost
2. Who will be trained? Number of participants?
   - 25 people per session is recommended and no more than 40.
3. Who will do the training?
4. Materials, resources and logistics required for the training
5. The costs to conduct the training.
   - This should include allowances for transport and/or food for the participants
   - Training should be part of district health staff's normal work. The only additional costs incurred should be for travel and possibly food if long distances are involved.

Since CHW are to continue as an activity twice a year, it is critical for districts to plan based on usual standard operational costs for activities, and not to see this as a special donor project.

Include recommendations for how districts are expected to organize training sessions before CHW.

Suggest who the trainers could be and what support would be appropriate.

In this section, also give some guidance on how to minimize the costs for training.

A Plan for Supervision

Supervision visits during CHW are an important part of follow up of training. Visits also are also an important source of information about the programme and how activities are going.

The District will need a plan for supervision. This will include:

- A list of names of the supervisors, the area and number of posts they will oversee

- Arrangements for meetings before the CHW
- Arrangements for transport, communications and travel expenses (if required) during the week
- Arrangement for a meeting at the end of the CHW or early the following week

Include in this section what districts are expected to organize for supervision during CHW.

List who should supervise and what they are expected to do.

Give guidance on how many sites should be visited.

Suggest what kind of support is appropriate for allowances, transport and travel expenses.

Content for training of supervisors is included in ***Part II:*** *Information for training and skills for supervisors*.

Each supervisor will need to know

- What supervision is, and why it is important
- What is needed for effective supervision
- How to supervise
- How to use supervisory checklists

1.7 Planning for social mobilisation

This section will need to focus on the communication activities the districts are expected to organize before and during the CHW. It should also address: Who should mobilise community members? Which methods of mobilisation should be used? When and how the mobilisation should be done?

The primary role of district health teams is to ensure that all communities know about the Child Health Week, the services available and why these are important and why they require support from the community.

What is the key information to provide about CHW?

Minimum information: All parents and care takers need to know

- The dates of the CHW
- That all children age 6 to 59 months should be taken with their child health card
- Where and when to go (times and locations for the nearest services)
- What services will be given
- The health benefits of the services (i.e. that this is important for the health of every child)

As communities become well aware of CHW every six months, additional behavioral-targeted messages can also be introduced.

What is the best way to inform communities?

Health staff can work with community leaders such as political leaders, headmen, religious leaders, teachers, community organizers and chairpersons from different groups to spread the word about the upcoming Child Health Week. Neighborhood health committees are also useful contacts for information dissemination.

Details about these different methods and channels are included in Part II.

Special attention will need to be given to poorer communities or to more remote communities (such as those that can only be reached by boat, in mountainous areas or those affected by heavy rains) since these often have the most vulnerable children, and may not be represented by key community leaders.

When is the best time to do promotion activities?

Meetings and discussions can be held two or three weeks before the distribution with community leaders and those who will help with social mobilisation. Timing will depend on how much time is needed for preparation and on the types of promotion activities planned.

The main community announcements about the event should be made the week before and during the week of the CHW.

What support is going to be available from the national level?

Include here an overview of the National Communications Strategy

For context, include in this section a brief overview of what the national programme is planning and doing in the area of communications and IEC, and the role of the districts in this effort. A well-perceived strategy will result in the creation of demand throughout the community for continuing the programme.

An effective strategy will need to be carefully designed, based on research and evidence of what works, and specific to the country and programme situation.

The process of developing a communication strategy will include formative research, development of key messages, selection of audience and channels, pre-testing of materials or tools and plans for dissemination, monitoring and evaluation.

This section can highlight key findings of the formative research, the key messages, main components of the communications strategies, recommended methods to inform communities living in urban, rural and most remote areas, and plans for monitoring the effort.

1.8 Overall action plan and budget

The previous sections have guided the planning process for CHW: reviewing the area and population to reach with services, how these services will be delivered, what staff, supplies and logistics are needed to support activities, and how training and social mobilisation will be done. In each section, district teams have been encouraged to look at the support and resources required and to project the costs of these activities.

In this section, the plans and cost projections in each of these areas need to be brought together as one operational plan and budget for the CHW.

Districts can be asked to summarise these activities and the budget required in a proposal or micro-plan. This section will need to introduce either proposal guidelines or the micro-planning tools which must be completed and submitted by the district. Examples of micro-planning forms can be found in the tool kit.

Completed plans at the district level will include:

- A list of communities with the number of children under 5 and the number of children in each target age group (per service provided)
- Lists of the distribution points and locations
- Staff requirements for the distribution and supervision, and transport required.
- Plan and costs for training of health centre staff and service providers
- Supplies required and costs for transporting supplies to the district, and within the district.
- Plans and costs for social mobilisation (both meetings to brief leaders as well as promotion activities before and during the CHW)
- Plans and costs for supervision activities during the distribution, and
- Plans and costs for review meetings and compiling results.

Encourage districts to explore cost sharing with other programmes and mobilizing resources from within the district. This should include line items within the district health budget which can be used to support CHW and information on how districts can access these funds.

Budgets should indicate what costs are already covered by contributions from the district health system and other resources generated within the district, and what costs may need external support.

A recent cost analysis study[13] conducted in Ethiopia to cost VAS and other interventions as part of the Expanded Outreach Strategy (EOS) Programme showed the following:

- A large proportion of the costs of the EOS are relatively independent of the number of children reached, meaning that expanding coverage adds relatively few costs and results in the overall cost per child falling
- The cost of the EOS teams, supervisors and transportation constitute 99% of the costs on distribution day. These costs are determined by the number and size of the teams, which in turn are mainly related to the services in the package. The number of children only impacts on team size if there is a significant increase.
- Population density is the other major driver of the number of teams and therefore overall costs are higher where density is lower.
- The supply costs on distribution day are the major cost that changes as the number of children changes but the supply costs are minimal
- The vitamin A component of the EOS is a highly cost-effective health intervention

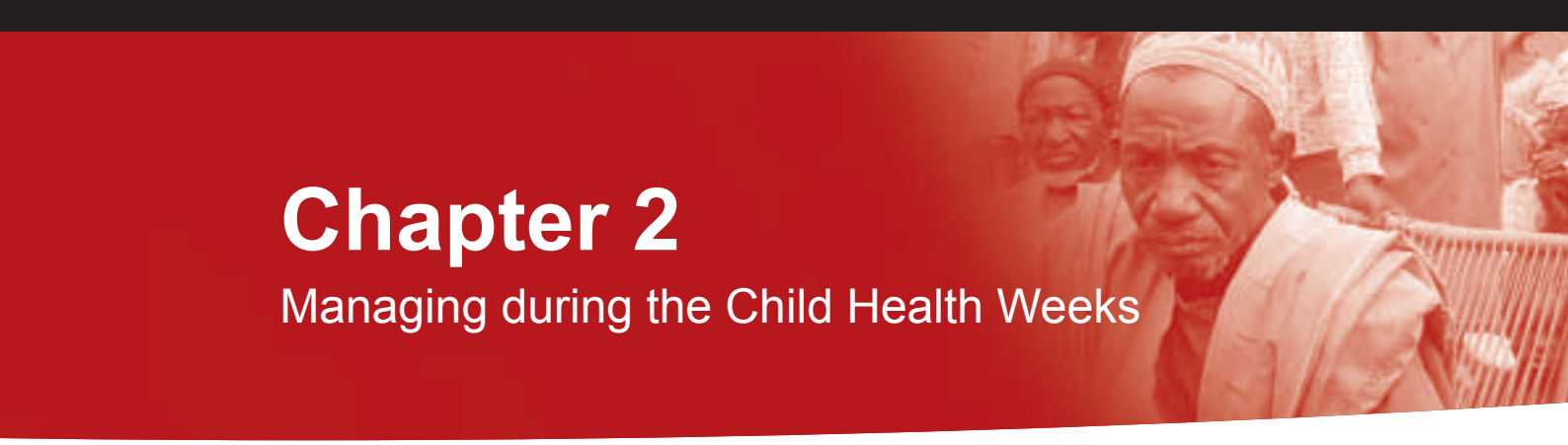
The spreadsheets developed for this study will be adapted to assist with budgeting VAS at district level.

In this section, introduce tools for micro-planning or an outline for preparing a proposal for CHW. The development of annual proposals covering two rounds should be encouraged.

Also introduce the standard framework for preparing a budget.

Indicate sources of funding within the health system budget and how districts can access these funds, as well as external potential sources of support available for Child Health Week activities.

[13] Study was conducted by Jack Fiedler, consultant SSDS, with support from the MI, WB, A2Z and UNICEF Ethiopia. Final report to be submitted in 2007.



Chapter 2

Managing during the Child Health Weeks

2.1 Key activities during implementation

As a result of the planning process, each district should have a map of the distribution areas and a schedule showing:

- Where distribution points are located
- Dates and times for services at each location
- Number of staff at each location, and
- Supervisors
- Each distribution point should have a plan on how to set up an integrated delivery post to facilitate the delivery of services (see **Annex C**)

The following activities will be going on and should be scheduled during that week:

- The Distribution: services offered at each of the distribution points and movement of staff to the different distribution points.
- Social mobilisation may need to continue during the week to remind community members to go for services.
- Meetings with team members at the end of the day, and between supervisors and district staff frequently during the week are recommended. A quick review of tally sheets and the supply situation can indicate how activities are progressing, issues identified and any corrective action taken. For example, teams can quickly compare the number of children reached to those expected and can decided what to do about it in areas where coverage is very low.
- Communication is important. Provision for cellular phone cards or phone calls between distribution teams and team leaders, and between team leaders and management can greatly assist team work in the field. This will facilitate quick follow up for any problems identified such as insufficient staff or supplies.
- Observations and exit interviews at distribution points.
- Supervision, which is discussed in the section below.
- Payment of any needed funds or monies.

2.2 Supervision

Supervision visits, using a supervisory checklist, are a very important part of the Child Health Week. Supervision before and during the week should focus on supportive supervision to solve problems and improve skills.

The job of the supervisor is to ensure quality and compliance with norms. For vitamin A distribution this means that capsules are cut correctly, the right dose is given, and essential health messages provided. Supervisors must also ensure that providers have enough capsules to cover their areas, be able to handle problems which arise, and should always recognize and reward good work done.

Supervisors will also need to pay attention to high risk areas and population groups.

The number of supervisors should be calculated based on how much time it takes to work with one team, and to move from one group to another.

Include here recommendations for how many supervisors will be needed, for example:

- In urban areas, 1 supervisor can cover 5 to 10 distribution points depending on how close posts are located;
- In rural areas, 1 supervisor can cover 3 to 5 distribution points or one supervisor for a specific area which may group a few villages.

Supervision tools

Introduce supervision tools or checklists which have been developed for supervisors to use. A ***Job Aid*** for Supervisory Visit Checklist can be found in the tool kit.

2.3 Observations and exit interviews at distribution points

If the national programme plans to have district teams conduct monitoring activities, and collect data for monitoring, a brief overview of these plans can be included in this section.

Such monitoring activities often involve observation and exit interviews at the time of distribution. This can provide important feedback on the situation at service delivery points and skills and knowledge of service providers.

A ***Job Aid*** for Exit Interviews can be found in the tool kit.

If district teams are expected to carry out observation visits and exit interviews, include in this section the following:

Instructions on what districts are expected to do

How to select sites and how many sites to visit for this purpose

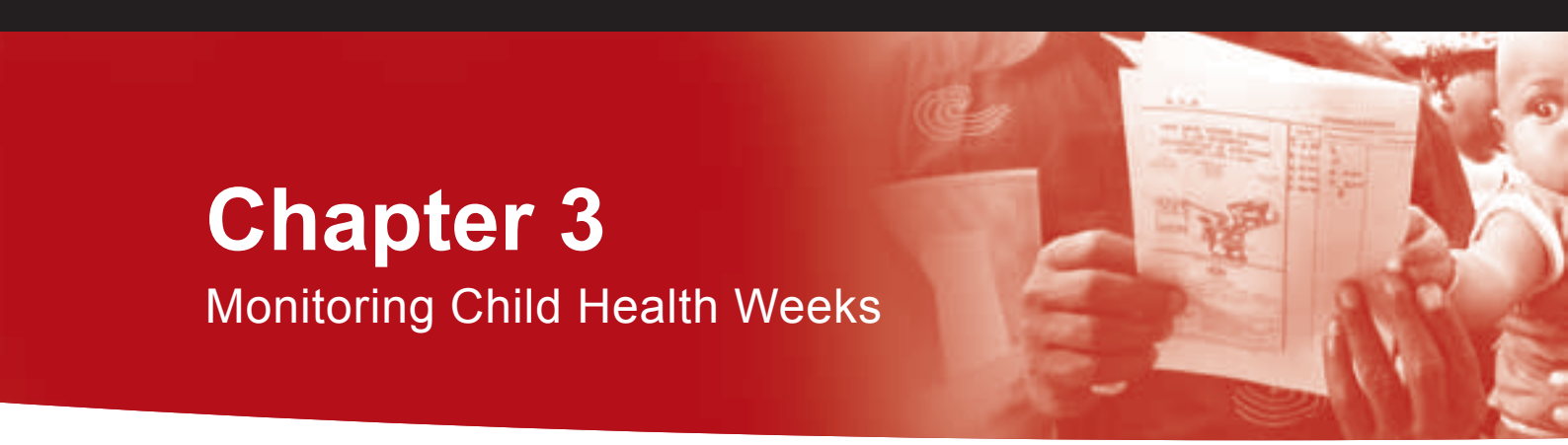
How to summarise the data collected.

2.4 Problem solving

The following table provides examples of problems that may occur at the time of distribution and actions that can be taken to address these problems. It is important to anticipate what may go wrong during CHW and have in hand a trouble shooting plan. An example of a trouble shooting plan can be found in Annex 2 in the Facilitator's Guide on Orientation for Planning CHW.

Table 2: Examples of potential problems that may occur at the time of distribution and proposed solutions.

	Problems identified during CHW	Possible responses or actions to be taken
Supplies	Supplies have not arrived by the beginning of the week	• Continue CHW • Inform your direct supervisor immediately • Contact other districts if they can provide you with some supplies for the first day or two
	Distribution points run out of VA capsules or de-worming tablets during the week, but not both	• Continue CHW • Inform your direct supervisor immediately • See if other areas can help cover the shortage until more supplies get sent • Start with what you have and inform the communities that more supplies will come
	Distribution points run out of tally sheets	• Continue CHW • Inform your direct supervisor immediately • Make copies before running out completely • Use notebooks or other sheets of paper to register the information until more tally sheets are provided
Staff	Shortfall of health workers or community volunteers	• Continue CHW • Inform your direct supervisor immediately • Extend CHW by a few days
Transport	Vehicles break down	• Continue CHW • Contact your direct supervisor immediately • Find out if arrangements can be made with other distribution points • Contact partners if could temporarily assist with their own vehicles
Attendance	Areas with low turn out	• Continue CHW • Inform your direct supervisor • Was the community well informed about the dates? Ensure that you inform the leaders and ask for their assistance • Check if there are any special events in the community • Ensure that there are no rumours in the community regarding the distribution



Chapter 3

Monitoring Child Health Weeks

Monitoring is an extremely critical component of planning and implementation. Monitoring is a continuous and systematic management process which involves collecting and then analyzing data on programme processes and results. This analysis provides programme managers with regular feedback and early indications of progress, or lack thereof, in the achievement of intended results. Monitoring will allow managers to identify problems, develop solutions and guide interventions. Monitoring should inform managers whether programme activities are being implemented in the way that they should be, at what cost and whether targets are being met. Monitoring VAS and CHW should be integrated with monitoring other district based initiatives and programmemes, like EPI and IMCI, and use similar tools as those employed for routine monitoring of health services.

Monitoring will take place at every level: national, district and each point where services are provided. This chapter will focus on the monitoring that should take place at district level.

Include here a short summary of the monitoring and evaluation framework which has been developed for CHW.

This framework should refer to the programme objectives introduced at the beginning of this guide, and explain how progress towards those objectives is going to be measured. The section will also introduce the various reporting forms so that district staff can see how district reports are important and used at higher levels.

3.1 Why monitoring child health weeks at a district level is important

- Data collection and monitoring at a district level, feeds into the national level and guides decision making about programme design and the allocation of funds. As VAS coverage is an internationally agreed upon indicator to track progress towards the 4th Millennium Development Goal (MDG) of reducing child mortality, reliable coverage data from the district level is therefore important to monitor a country's progress towards achieving MDG4.
- To determine whether the programme is going according to plan and whether objectives and targets are being met.
- To improve programme performance, effectiveness, efficiency and reduce costs
- Monitoring can identify low performing health centres and areas within a district.
- Monitoring will identify children who are consistently missed by the intervention and identify the reasons why.
- To provide feedback to those involved in implementing the programme and let them know how well they are doing.

3.2 Development of indicators to monitor child health weeks

As with most public health interventions, there are a number of components to CHW. Each of these components can be monitored and indicators can be developed to do this.

Annex D provides a table of possible indicators that can be used to monitor CHW. Many aspects of CHW will be monitored at a national level. Measuring the impact of CHW is clearly important. However, collecting information on disease patterns and mortality rates is usually not possible at district level.

At a district level, it is critical to have information about those components of CHW, such as planning, training, and supervision, that will influence whether high coverage is attained or not. These indicators do provide key information directly useful for targeting areas in need of improvement in service delivery, planning and implementation.

Table 3 proposes some indicators that can be used. When choosing indicators to monitor performance, consideration should be given to

1. Does the indicator measure what you need to know?
2. Is the data required to measure the indicator easy to collect?
3. Does the indicator measure the changes that you need to know about?
4. How often will the indicator be measured
5. Who will be responsible for measuring it?

Table 3. Indicators that can be used to monitor the provision and utilisation of services at district level

Type of information	Indicators	Frequency of measurement	Responsibility for measurement
Provision of services, including logistics			
Support for quality supervision, training, etc. Timely receipt of required supplies at each key distribution point	• # of staff and volunteers mobilized for child health week • Number supervisory visits planned actually taking place • % health care workers trained prior to child health week • % volunteers trained prior to child health week • % of health centres/ distribution points reporting adequacy of supplies for given round	• After each child health week	• District health management team with data from health centres
Utilisation of services			
Level of understanding of the importance of vitamin A	• % of mothers aware of the importance of vitamin A • % of health workers and volunteers area of the importance of vitamin A	• Annually	• Health centre staff
Coverage			
Reliable estimates of actual coverage	• % of children 6-59 months old receiving VAS within last 6 months • % of children receiving de-worming tablet in the last 6 months	• During each child health week – data from tally sheets • After each child health week – validation survey	• District health management team.

Collecting data on **coverage** is of the most important ways to monitor CHW and this chapter focuses on developing robust and practical procedures for ensuring that accurate coverage data is collected. Coverage and utilization data is critical for district programme managers to monitor the overall performance of the programme, to identify areas of low coverage and to provide inputs on supply forecasts. What follows below in this guide is an outline of some approaches which can be used, at a district level, to measure the coverage of child health week activities.

3.3 Calculating coverage of VAS

There are several indicators for monitoring coverage that can be used. These are outlined in ***Annex E***. It is neither feasible, nor appropriate, to measure all of these indicators at a district level.

As each child, aged 6 – 59 months, needs to receive a preventive dose of VA every six months, it is essential to record what coverage is achieved in each six month period, or semester. Consequently, **simple coverage**, the percentage of children who are reached during each child health day, is the most appropriate and practical indicator currently used. The main disadvantage of this indicator is that it does not measure whether all children receive a VA capsule twice a year. In countries with a high coverage each child health week, we can assume that a high percentage of children receive two capsules a year. However, in reality, in most countries, coverage varies significantly from CHW to CHW and we cannot make this assumption.

As this indicator is administratively simple to collect and relies on information collected on tally sheets, it is recommended that the VAS coverage indicator should remain as outlined in below.

The coverage indicator should reflect coverage separately for children between 6 – 11 months and children 12 – 59 months, as shown in ***Table 4***.

Table 4. Vitamin A supplementation coverage: core indicators at all levels

6 – 11 months	12 – 59 months
The number of children aged 6–11 months who received a vitamin A supplement **during each child health week** % coverage **during this period**	The number of children aged 12-59 months who received a vitamin A supplement **during the child health week held between 1st January and 30th June or between 1st July and 31st December** % coverage **during this period**

It is recognized that, in some countries, VA is not only delivered during CHW. VA may be given to a child when they visit the health services for preventive or curative services. In countries where VA is given outside CHW, coverage for the primary delivery mechanism, in terms of the number of children reached, should be reported.

For vitamin A

$$\text{Coverage (\%)} = \frac{\text{Number of children 6-59 months to receive vitamin A}}{\text{Total number of children 6-59 months}} \times 100$$

For de-worming

$$\text{Coverage (\%)} = \frac{\text{Number of children 12-59 months to receive de-worming}}{\text{Total number of children 12-59 months}} \times 100$$

Because each child needs to receive 2 preventive doses not more than 6 months apart, it is essential to record what coverage is achieved in each six month "SEMESTER" of a year:

Include here coverage or relevant indicators for other services offered during CHW.

3.4 Collection of data to measure coverage

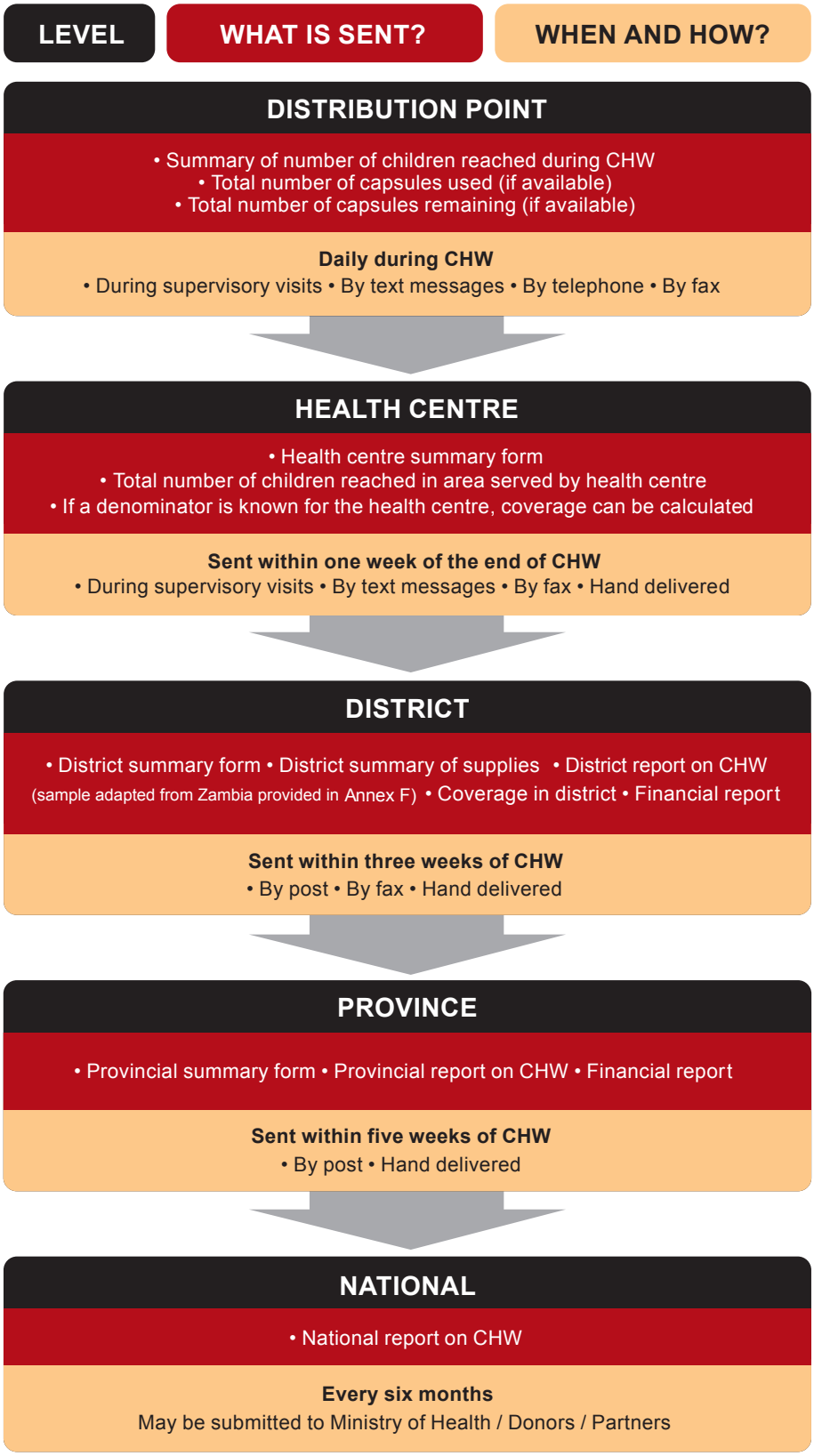
- The most straightforward way to estimate coverage during CHW is to record the number of doses given on a tally sheet and dividing by the estimate of the number of eligible children who should have received the intervention.
- These tally sheets are forms on which health workers make a mark every time they provide a child with a dose of Vitamin A or a de-worming tablet.
- The same tally sheet can be used to indicate whether vitamin A is provided to children between 6 and 11 months of age (100,000 IU doses) or children between 12 and 59 months of age (200,000 IU doses).
- These tally sheets may also be designed to record the distribution of other components of CHW, such as de-worming tablets etc.
- At the end of each distribution round, the total the number of marks recorded during the session tells you the number of doses of Vitamin A or de-worming tables which were provided to each of the two cohorts of children. This information is then used to prepare a summary report and is critical to help monitor performance.
- Tally sheets can be maintained for the supervisor to check the data quality (accuracy of reporting).
- The same tally sheets can be used to record doses of VA given during routine services. In this instance, it is important to use one tally sheet for the first semester (1st January – 30th June) and another for the second semester (1st July – 31st December.)
- The tally sheet is the first level of data collection so accurate and timely completion of tally sheets is essential
- An example of a tally sheet, adapted from Ethiopia, can be found in Annex 2, Worksheet 9 in the Facilitator's Guide. This tally does allocated space to summarise the data and monitor the number of capsules used.

3.5 Summarising and using data at district level

Data from the tally sheets should be consolidated and sent to the health centre and then to the district level. The process by which information on the tally sheets is sent to the health centres and the district level, how it is sent, whether it is summarized or not, and who summarises it, will depend on the way the child week is organized and supervised.

In order for data to be useful, ensuring that distribution points and health centres report on time is critical. The following flow chart suggests what type of information should be sent to each level and by when. At a district level, data will be consolidated to be used to improve performance and planning, and for reporting to the national level.

Figure 1. Sample Reporting Schedule



3.5.1 Summary forms

An example of a summary form is given in ***Annex G***. This form should be adapted depending on whether it is being used to summarise information at the health centre or district level.

Health centre and district summary forms should record the following information:

- Dates of
  - Reporting period
  - Completion of form
  - Form received by next level
- Name of health centre / district reporting
- Total number of distribution points / health centres
- Number of distribution points / health centres reporting
- The total number of children to reach for each target group and intervention. These numbers should already be available since they were calculated during the planning stage. Numbers should not have to be re-calculated on the summary sheet.
  - number of children age 6 to 11 months targeted to receive vitamin A
  - number of children age 12 to 59 months targeted to receive vitamin A
  - total number of children (6 to 59 months) targeted to receive vitamin A
  - number of children (12 to 59 months) to receive de-worming tablets/other interventions
- The numbers of children reached during the child health week
  - number of children age 6 to 11 months reached with vitamin A
  - number of children age 12 to 59 months reached with vitamin A
  - total number of children (6 to 59 months) reached with vitamin A
  - number of children (12 to 59 months) reached with de-worming tablets/ other interventions
- Coverage (% of children reached with vitamin A, % reached with de-worming and other services.)

Examples of additional information that should be added to the **district** summary form are given below

- % distribution sites reporting a stock out of any of the required inputs
- Total funds allocated/used to child health week
- # people used for child health week (including staff, volunteers etc)
- Summary of supplies received and used

3.5.2 Checking data

As data is received at the district level from the health centres and distribution points, four steps need to be taken to ensure that managers will be able to use the reports for corrective action.

1. Each report should be checked for **accuracy and completeness**

2. **Some individual reports should be read as a matter of priority**. A district manager may want to see individual tally sheets from health centres with previously low coverage.
3. The district level should look for **changes in indicators** that require urgent action or that show problematic trends
4. The **timeliness of reports** should also be monitored. If reports are submitted on time, a prompt response to problems is more likely. Delays in reporting by health centres/posts also delays the process of reviewing the Child Health Week results, and this can delay resource mobilisation and allocation for future distributions.
5. Look at health centres with coverage over 100%. Make sure this is not due to data being in the wrong columns, or mathematical errors. Check the summary form which is the source of these numbers. If this is not due to error, explore for a plausible explanation why the coverage was so high in the area. It may be that the population to reach was underestimated, or that children > 59 mo were supplemented, or that children from another area attended the distribution point, etc.

3.5.3 Inaccuracies in reported coverage

Estimating coverage from recorded distribution of capsules is only accurate if

1. The number of capsules distributed (the numerator) is accurate
2. The denominator is accurate.

3.5.3.1 Problems with the numerator

- Coverage estimates may be low if distribution is under-recorded
- Coverage estimates may be high if children from outside the target area, or children over the age of five, receive capsules. Although training of health care workers to carefully screen for the targeted age group the reality in the field means that it is often very difficult to exclude these children.
- Counting the number of capsules that are ‘left over’ at the end of each round of distribution may he useful as this may reflect the number of children not reached – but only if the number of capsules received actually reflects what is needed in the district.

Some common mistakes in recording the number of capsules delivered, that will affect the accuracy of the numerator, are given in the table below.

Table 5. Common mistakes in recording the numerator (modified for VA supplements)

Mistake in tallying	Possible problem that may occur	Comment
Tallying before the Vitamin A is distributed	The child may not receive Vitamin A	Give the dose first then tally using the tally sheet
Tallying at the end of a session according to number of doses actually distributed	"Wasted" capsules or doses may be counted	Tally each dose given only as they are provided to individual children
Tallying all Vitamin A provided without distinguishing by dose and age group	Will result in inaccurate coverage data	Separate tally for children between 6-11 months and children 12-59 months
Tallying all Vitamin A provided without distinguishing by age group	Children over the age of five may be included in numerator, resulting in inflated coverage figures	Include a column on the tally sheet for doses delivered to older children (although this may legitimize the practice.) Include space on the tally sheet to capture the number of capsules delivered to the health centre. The capsule count, minus the doses delivered to targeted children, would provide an estimate of children dosed outside the age range (although wasted capsules will also be counted)

3.5.3.2 Problems with the denominator

Monitoring coverage and supply is dependant on realistic denominator data. This has been discussed in Chapter One. Points to note are:

- If some segment of society (often the poorest and most vulnerable) is not recorded in the census and do not receive capsules, they may be missed entirely, since the coverage figure is not based on an accurate sample.
- It is recommended that, for children 6 – 11 months, the EPI denominator for this age group should be used.
- If other interventions are delivered in conjunction with VA, and targeting the same age group, every effort should be made to ensure that the same denominator is used when calculating coverage.

3.6 Analysis of data

Monitoring is only useful if the data collected is used to improve performance and disseminated. An analysis of the data received can include the following:

1. **Analysis of coverage.** With respect to monitoring VA supplementation and Child Health Week performance, districts can be classified into one of three categories. In the same way as the national level can identify districts with poor coverage, districts can identify health centres with poor coverage. Resources and technical assistance can therefore be directed to these areas.
   - **a. "*On track*"** when they are reporting a coverage for the child health week of at least 80%. Highlight these areas since good coverage has been achieved. These areas may offer some lessons on how best to plan and run CHW which are useful to other areas.
   - **b. "*To watch*"** when they are reporting a coverage of 50 – 79% Make sure this is not due to data or mathematical error and check the summary form which were the source of these numbers. If not due to error, find out why the coverage was so low in these areas. Did the distribution activities take place as planned? Was there a shortage of supplies? Were the communities mobilised?
   - **c. "*High alert*"** when they are reporting a coverage below 50%. Discuss what happened in these areas and why coverage was low, and what can be done next time.

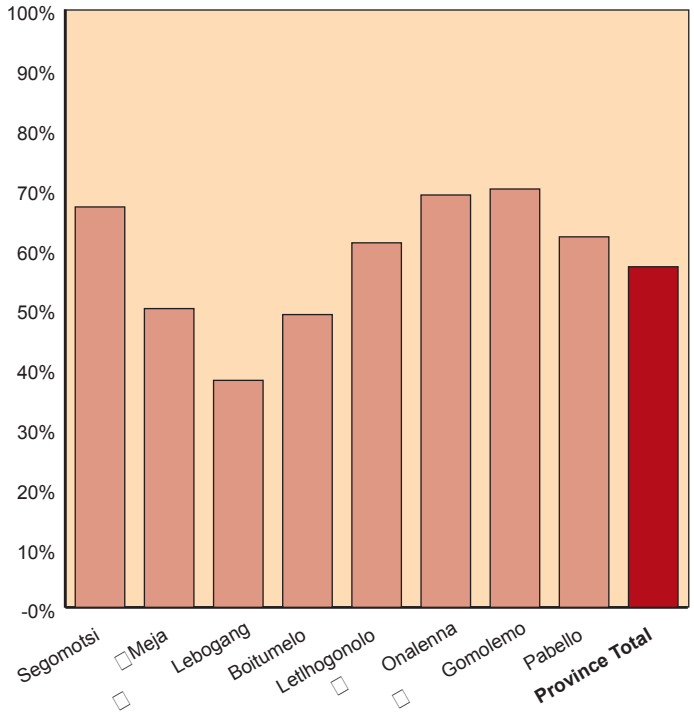
Using graphs to show coverage data

Using graphs can make it easy for stimulate discussion. Two graphs are recommended:

a) Graph of coverage (%)

You can easily compare coverage of one area to other areas and the district overall. The scale of the y axis should always be from 0 to 100% since this is the range for coverage. If there are coverage rates above 100%, keep the range from 0 to 100 (or 110) and mark those columns as 100+. This will helps to keep the right perspective and focus on which areas still have low coverage and may need attention.

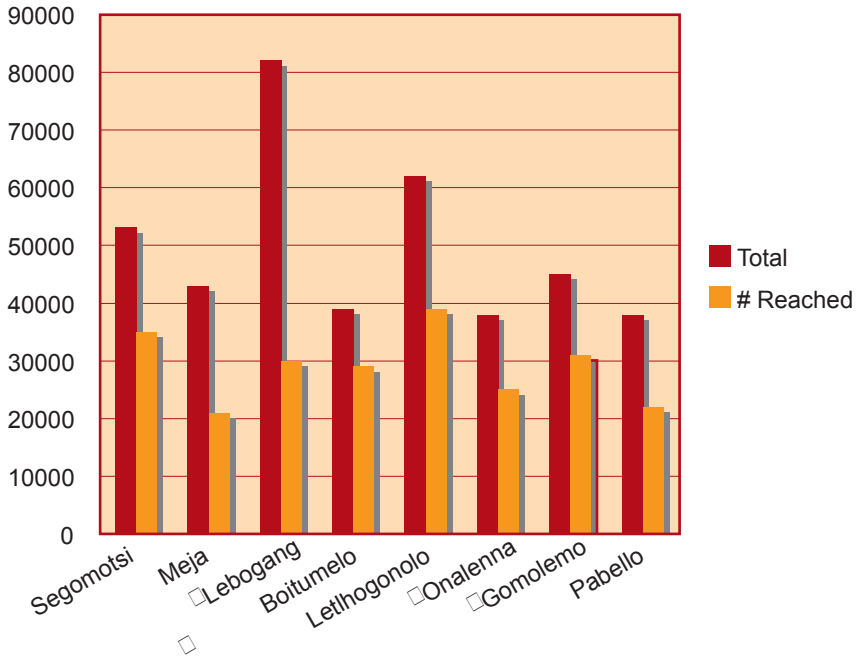
Figure 2. Coverage by Health Centre: Accelerated Vitamin A Supplementation



b) Graph of the number of children who received a capsule of VA

The scale of the y axis will be from 0 to the number of total number of children to reach in the most populous area. You can plot both the number of children in an area who received a dose of VA next to the total number of children in reach that area. Do this for each of the areas in the district.

Figure 3. Children 6 – 59 months by Division
Total number and Number reached with Vit A



At a glance this graph can easily show where most of the children are reached in your district area. This is important because a low or high coverage in an area with many children will affect your overall district coverage the most. Low coverage in areas with many children will require urgent follow up action.

2. Supervision, monitoring of child health week

a. The number of planned supervisory visits that actually took place

3. Adequacy of reports received

a. The number of health facility submitting their reports on time

b. The number of health facilities submitting accurate reports

c. The number of health facilities not submitting any reports. This can also be recorded as % of health centres submitting reports and take action if the proportion is below 100%.

4. Adequacy of supplies

a. The number of health facilities reporting a shortage of VA capsules or other child health week supplies.

3.7 Feedback

An important aspect of monitoring is the feedback to those who implement the programme. Feedback refers to the process of routinely sending analyses and reports to the peripheral levels of the monitoring system and particularly to the suppliers of data. Feedback should be prompt and should be given regardless of what the results show.

Reasons for providing feedback[14]

1. Creates a collaborative environment by acknowledging the hard work of data providers and making them aware that their data is analyzed.
2. Feedback can improve the accuracy and promptness of reports and raise the morale of health centre staff.
3. Opportunity to verify with the peripheral levels that the data received at more central levels are correct and makes the peripheral level staff accountable for the data that they provide.
4. Improves performance by showing national progress towards high coverage and allows comparison of performance between districts
5. To provide data and advocacy materials to enhance policy makers ability to make decisions regarding funding and support to CHW.

Methods for providing feedback

- Supervisory visits to health centres
- Monthly / quarterly newsletters
- Periodic meetings: A meeting of the team after each event is an appropriate opportunity to report progress to all stakeholders.
- Telephone calls or text messages
- Letters
- During routine visits by peripheral health centre staff to district offices
- ALWAYS during a meeting to plan for the next child health week.

Review meetings after the CHW can be a very valuable tool for the programme. Held at each level following the distribution week, review meetings can help to

- Speed the process of reporting and improve accuracy since data is reviewed right away,
- Motivate health workers and district staff since timely feed back is provided,
- Capture lessons learned from the experience, and
- Identify areas which did not get reached and decide what type of follow up action is needed.

[14] Taken from WHO Training for Mid-Level Immunization Managers. Module 2. Monitoring and Using data.

Distribution teams and district teams should be encouraged to schedule review meetings after the distribution week.

Include in this section recommendations for such meetings and what kind of support, such as transport, should be planned in order to help this to happen.

Content of feedback

This can include:

- Coverage achieved
- Variance from district targets
- Identification of high and low performing sub-districts / health centres
- Comparison to previous distributions / years / distribution mechanisms
- Comparison to other districts (if known)
- Details on problem areas
- Results from supervision and observation visits conducted
- Comment on promptness and reliability of reports
- Suggestions for improving delivery during the CHW and suggestions for improving data collection.

3.8 Post activity assessments

CHW may require some validation of coverage. There are several ways of doing this:

1. Post event surveys
2. Record reviews
3. Sentinel sites

These additional tools are not discussed in great detail here, as there are other resources which provide more detailed information and guidance. The point to note here is that a periodic validation of the routine reporting system to check accuracy is required. These tools may be employed for this purpose and help managers gain confidence in the reliability and accuracy of the data collected during CHW.

Post event surveys

Post event assessments can be done both to validate coverage and to identify bottlenecks, in order to strengthen the programme. Multiple methodologies exist for these assessments, depending on capacity in countries. Data needs for country level decision making and available resources, drive the objectives of these assessments, their frequency and level of stratification. These efforts are not meant to be parallel monitoring mechanisms and do not replace tally sheets or registers. As confidence is built up in data collected, both the need for validation and the methodology used will evolve.

Rapid household-based surveys, usually done at the district level, have been undertaken in a number of countries. These surveys are quite simple in design

and are carried out using a questionnaire administered to caregivers, which determine whether a child in a household has received vitamin A. The surveys should be done as close as possible to the distribution event – usually within 2 months. These can be critical in providing quick validation of coverage that may be helpful to national programme managers and donors looking for general trends in coverage and to identify where there may be problem areas.

Examples of questionnaires and methodologies that have been used in Africa and Asia can be obtained from a number of organisations:

www.micronutrient.org
www.hki.org
www.unicef.org
www.mostproject.org

Other methods of validating data

Record reviews

In district where child health cards are used, it is possible to validate coverage by reviewing these records

Sentinel sites

Sentinel sites are locations selected because they are representative of the district. The sentinel site may be a village, a health centre, or even a population group visiting the health centre (such as children attending an under five clinic). The population in a sentinel site would be surveyed periodically to assess coverage.

The advantages of sentinel sites are:

1. Surveillance is much less expensive and simpler to establish.
2. Trends in coverage over a period of time can be monitored.

However, there are a number of disadvantages, the most important being that, over time, the population in the sentinel site becomes increasingly less representative of the district as they know that they are being monitored.

3.9 Financial Reporting

A section will need to be included in the guide on financial reporting since the management of funds and timely disbursement is an important part of preventing bottle necks for the future funding for the programme.

Include here guidance on:

The budgets, line items and funding sources which can be accessed to support CHW activities.

Submission dates and deadlines for budgets, proposals and expense reports.

Financial guidelines – the standards and norms for allowances, costs and use of funding during CHW.

Recommendations can also be included for how to minimise costs and how to generate resources for these activities within the district.

Part 2

Information and Tools for Training and Social Mobilisation

Chapter 1

Training: Information and Skills for Service Providers and Supervisors

Training should focus on motivating service providers. Topics should include the benefits of and basic information on vitamin A, and the behavioral expectations for providers including correct administration of a capsule and communication skills.

1.1 Information on Vitamin A

Benefits/basic facts about vitamin A[15]

Health facts about vitamin A. Vitamin A protects children from becoming seriously ill from common illnesses; decreases the risk of children dying from diseases such as measles and diarrhoea; and prevents serious eye disease and night blindness.

Biology of vitamin A. Vitamin A is stored in the body for up to four to six months but is quickly lost when a child has an infection. Vitamin A is available in red palm oil, green leafy vegetables, papaya, mango, liver, eggs, meat. Children must eat adequate quantities of these foods regularly to get enough; if the diet is not adequate, supplementation is necessary.

Supplementation safety and side effects. There is a good safety margin for vitamin A, so that you do not need to worry excessively about the exact age of the child. Do ensure that a child is at least six months old and give the right dose for age. The side effects from vitamin A supplementation are rare but can include nausea and vomiting, which will go away with time. There are no conditions or illnesses that would prevent a child from being given vitamin A; however, children who come for supplementation for who are sick with measles or xerophthalmia should be referred to the health facility for treatment.

[15] MOST / USAID Twice-yearly Vitamin A Supplementation: A Guide for Programme Managers. p.14.

Vitamin A Dosage Schedule for Children: Prevention

Give vitamin A to all children age 6 to 59 months:

Age group	Dose to be given	Amount of vitamin A	
		If 100,000 IU capsules are used:	If 200,000 IU capsules are used:
6 months old up to 11 months	100,000 IU	All drops in 1 capsule	Half of the drops in one capsule
12 months up to 59 months old	200,000 IU	All drops in 2 capsules	All drops in one capsule

How to give vitamin A capsules to a child

- Ask the age of the child
- Ask if the child has received a vitamin A capsule in the last one month. If the answer is yes, confirm and do not administer.
- If the answer is no, ask the caretaker to hold the child, make sure the child is calm.
- Give the appropriate dose of vitamin A to the child:
  - 100,000 IU to child 6-11 months
  - 200,000 IU to child 12-59 months
- Cut open the narrow end of the capsule with scissors or a nail cutter and squeeze the drops into the child's mouth. Do not allow the child to swallow the capsule or take it home.
- Check if the child is comfortable after swallowing the drops
- Put the used capsules into a plastic bag and wipe hands to clean off oil
- Record the dose on the child health card and on the tally sheet

Provider-client communication:

Greet the mother/care taker and compliment her for coming

Remember to tell the child's parent or caretaker:

- This is vitamin A
- Vitamin A helps to make your child strong and healthy
- Note that this message will need to be refined based on recommendations from the national communication strategy
- Bring your child again for vitamin A in _____ (name of month) for another dose.

How to Record vitamin A on health cards and tally sheets/registers

This will need to include instructions for where to the mark vitamin A and de-worming doses on the child health card.

How to mark the tally sheet and common errors when filling a tally sheet.

At the base of the tally sheet, there should be space for information on the balance of capsule supplies and wastage.

Storage of vitamin A capsules

Vitamin A supplements are more stable than vaccines. However, air and sunlight will damage the vitamin. Vitamin A in the capsules should:

- Be kept out of direct sunlight
- Be kept cool
- Not be frozen

Vitamin A supplements do not need a cold chain and do not need to be stored in a refrigerator.

Vitamin A supplements, if unopened, will keep their potency, under good conditions of storage, for at least two years. However, once a bottle containing vitamin A is opened, the capsules should be used within one year[16].

Write the date on the label when you open a new bottle containing capsules so that you will know when to stop using it.

Always check the expiry date printed on the label.

Storage of 100,000IU and 200,000IU capsules (generally different colors) should be separate and clearly identified, so as not to mix up the two types of capsules.[17]

A note on Side Effects and Safety of Vitamin A Capsules (for Trainers)[18]

When training service providers, this topic is best dealt with in the sections on "How to give vitamin A". It is important for trainers to be confident about the safety about vitamin A.

When the protocol and techniques for administration are properly followed, vitamin A is safe.

The topics of contraindication and side effects can be also discussed when explaining the protocol.

- There are no contraindications for giving Vitamin A capsules to a child.[19]
- However, do not give vitamin A to a child who cannot breathe properly.
- OR if the child has already received a preventive dose within the last one month.

For side effects, the following information should be sufficient:

"Usually there are no side effects. However sometimes a child may eat less for a day, or there could be some vomiting or headache. Advise the mother/parent that this is normal, that the symptoms will pass and that no special treatment is needed." [20]

[16] WHO 1998. Distibution of Vitamin A during National Immunization days, p.14.

[17] PAHO manual "*Providing vitamin A supplements through immunization and other contacts for children 6-59 months and women up to 6 weeks postpartum: A guide for Health Workers*."

[18] Look out for the "UNICEF Vitamin A Adverse Events Interactive Learning and Resource CD-Rom" soon to be released.

[19] PAHO manual *"Providing vitamin A Supplements through immunization and other contacts for children 6-59 months and women up to 6 weeks postpartum. A guide for Health Workers*."

[20] Ibid.

1.2 Information for other services provided

Key technical information for de-worming, immunization, re-treatment of bed nets or any other service offered during CHW can be included here.

Or, if Job Aids have been defined, the guide can refer to the Job Aids.

Remember that health workers are extremely busy during outreach so only a minimum number of information and messages should be included.

What you need to know and do about malaria during CHW.
An example from Zambia:

1. What causes malaria

- Malaria is caused by a bite from an infected mosquito

2. What is done to prevent malaria

To prevent malaria there are a number of things that can be done.

These include:

- Sleeping under an insecticide treated mosquito net
- Having your mosquito net re–treated after every 12 months or after 3 washes
- Clearing your surroundings of sources of breeding sites for mosquitoes
- Every pregnant woman should take treatment to prevent malaria from the antenatal clinic.

3. The difference between a long lasting net and bundled nets

Long lasting nets (LLN) don't need to be retreated. The chemicals on the nets can still remain active even after 20 washes; they are retreated at factory level and therefore come without treatment kits. Bundled nets need re-treatment after every 12 months (1 year) or after 3 washes.

4. How is malaria treated

To treat malaria it is important that the correct protocols are followed:

- Malaria is treated using medicines that are very effective.
- Depending on the age or the weight of the child, either fansidar or coartem will be given.
- If the child has severe malaria quinine will be given.
- A child with malaria will often have a high temperature and may have vomiting and diarrhoea. Such a child will need to be given medicine to bring down the temperature and will need to be given more fluids.

From: Facilitator's manual for CHW in Zambia, Technical Section 2.8.

1.3 Key information for supervisors

What is Supervision?

- Process that involves guiding, overseeing, directing or managing what you would like to see happen during the child health week.

Why is Supervision important?

- It ensures the quality of the service provided which in turn contributes to the proper implementation of the programme:
  - Is the capsule cut correctly?
  - Is the right dosage given?
  - Is the capsule given when child calm and breaths normally?
  - Is the capsule discarded properly?
  - Are the right health messages provided?
  - Are the tally sheet and child card filled in correctly?
  - Are there enough capsules and de-worming medicines to cover the number of children in the area?

Who does the supervision?

- Supervision is usually done by someone at a higher level
  - National → Provincial → District → Health facility → Health post

What is needed for effective supervision?

- A plan
  - Map of the area to supervise and number of posts to supervise
  - A schedule
- Extra supplies (capsules, tally sheets, wipes, etc)
- Supervisory tools
  - Supervisory checklist (Job aid 4)
  - Observation checklist to identify needed improvements, gaps, and positive aspects.

How do you supervise?

- Be supportive
  - Recognize good performance
  - Build confidence
  - Be constructive
  - Do not correct health workers or volunteers in front of clients
  - Be prepared to take action

Chapter 2

Information on Social Mobilisation

2.1 What are the target groups and key messages for communication?

Include here information from the national communications strategy on key messages and target groups.

For example, for promotion of CHW in the communities, minimum information for all parents and care takers:

- the dates of CHW
- where and when to go (times and locations for the nearest services)
- what services will be given
- to take all children age 6 to 59 months, with their child health card
- the child survival or health benefits of the services (i.e. that this is important for the health of every child)

2.2 What are the best ways to promote child health weeks?

There are many ways of communicating to the community, and it is up to you to prioritize which methods work best in your community. Using more than one method will increase the chances of your message reaching the target group. The methods suggested here are only guides. You should be as innovative as possible.

There are a number of promotional methods which have been effective for spreading the word about CHW. Evaluations of Vitamin A and Polio Eradication programmes have consistently found that different approaches work best in urban and rural settings:

- In urban settings, use of radio and religious organizations (mosques, churches) and their leaders (priests, imams) were found to be effective.
- In towns and villages, use of "town criers," with microphones, meetings led by community leaders and women's organizations were most effective.
- Inter-personal communication was particularly importance in hard-to-reach and rural settings, and involvement of trusted leaders is strongly recommended.

Note that in these evaluations, the use of print materials and newspapers was not found to be effective for demand creation purposes. One report stated that neither print materials (posters, banners, billboards) nor newspapers were found to be effective although they could be useful to address specific advocacy needs[21].

[21] Waisbord, S. *Assessment of Communication Programmes In Support of Polio Eradication: Global Trends and Case Studies*, The Change Project, AED April 2004. p.6

Include recommendations in this section on the types of activities that districts can do for social mobilisation.

Have district staff focus on "How to get the word out" about CHW and make use of existing channels and networks which will not require a lot of external funding.

Below is a list of methods which have been used for community motivation.

2.2.1 Some methods which have been used:

- *Use of "town criers"*

  Many traditional communities have village announcers or "town criers". They can be used to announce the dates and locations of CHW and spread the message for parents to bring their children. Develop a simple message for announcers to share.

- *Use of Loudspeakers / Public Address System*

  Local broadcasting of messages using loudspeakers is effective and successful for advertising the Child Health Week. This can be either from fixed locations such as bus or train station, or mobile units such as cars. The messages should be clear, concise and consistent. Messages for the broadcaster should be written down to ensure consistency – as opposed to talking off the cuff.

  When speakers are mounted on a vehicle, please ensure that it moves at a slow speed so that members of the public can get the message. It is also a good idea to stop the vehicle occasionally and deliver the message before moving on.

- *Community forums and meetings*

  Community groups and networks such as NGOs, schools and the private sector can be used to alert the community about CHW. Sometimes these groups can also be called upon to provide some support (financial, personnel or material)

  In addition, a series of discussions on the upcoming Child Health Week can be held at gatherings like parent/teacher association meetings, church services, sports days, club meetings, traditional ceremonies and many other forums.

  Churches and mosques can be very helpful in getting information out to their congregation.

- *Publicity Walk*

  This may be useful to highlight Child Health Week activities and to help make communities aware of this event and stimulate participation. Pupils, teachers, police, military, local NGOs and community groups such as mother's support groups can be mobilized to hold a march on the day before the CHW begins. Advance planning is required for this activity.

- *Involvement of Schools in CHW*

  Teachers can be very helpful in promoting health activities by having school children take information home about CHW. Children should not only be used to pass information on to their parents but can also get more involved by

participating in activities like creating poems, songs or dances in support of CHW. School competitions have been used to motivate children and their teachers to participate in these events.

- *Drama performances*

  Local drama groups may be encouraged to develop short performances demonstrating the importance of participating in the CHW, and focusing on services offered. These groups can help to create awareness and motivate mothers/caretakers to take action.

  It is important to give the group a list of key messages, from which they will develop their storyline. The dramas will need to be checked for technical accuracy before being performed in public.

- *Community Radio Stations*

  An increasing number of communities have community radio stations today. These are an important ally in spreading specific messages on CHW. It is important to work closely with them. With good partnership, community radio stations may even air some or all of your messages free as their contribution to a community service. Local health personnel or community leaders could be interviewed to explain important issues about the CHW and to urge the community to participate.

Channels for sharing the message

National and local radio and television

Static and mobile PA systems

Word of mouth

Public places
- Markets
- Bus stations
- Stadiums

Special opportunities
- Antenatal consultations
- Preschool consultations
- Waiting rooms in health facilities

Networks of communicators in health

Local NGOs

Organized community groups
- Churches and Mosques
- Mutual associations
- Refund associations
- Women's associations
- Development associations
- Football clubs
- Cinema clubs
- Youth clubs
- Choir groups

Opinion leaders
- Religious authorities
- Chiefs of district
- Chiefs of villages
- Teachers
- Presidents of clubs

Key Reference Documents on Vitamin A

CD-ROM

- Learning about Micronutrient Nutrition. CD-ROM Volume 1: Vitamin A. The Micronutrient Initiative (MI), 1998
- Integrating Vitamin A with Immunization. An Information Training Package. HKI/WHO/MI.
- UNICEF Vitamin A Adverse Events Interactive Learning and Resource CD-ROM. To be released in 2007.

Manuals and Reports

- Providing vitamin A Supplements Through Immunization and Maternal and Child health Contacts for Children 6-24 months and Mothers up to 6 weeks Postpartum: A guide for Health Workers. Pan American Health Organization, 1998.
- Distribution of vitamin A during National Immunization Days: An Addendum to the Field Guide for Supplementary Activities Aimed at Achieving Polio Eradication. WHO, 1996.
- How to Add De-worming to Vitamin A Distribution. WHO/UNICEF, 2004
- Twice-Yearly Vitamin A Supplementation: A guide for programme managers. MOST, USAID Micronutrient Programme, 2001.
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5. Vitamin A and Breastfeeding, Post partum Dose

- Ross J. and Harvey P., Contribution of breastfeeding to vitamin A nutrition of infants: a simulation model. WHO Bulletin 2003 81: (2) 80-86
- IVACG. Safe Doses of Vitamin A during Pregnancy and Lactation, 1998
- Assuring adequate vitamin A to infants: Breastfeeding. Job Aid 6 in PAHO manual, 1998

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Annexes

Annex A: Worksheet for Planning Vitamin A Supplies for CHW at District Level

VITAMIN A CAPSULE		
To: National Level **From: District**	**Date:**	
Prepared by:		
Title:		
Email (if available):		
Tel: **Fax:**		
	100,000 IU (Blue) capsules	***200,000 IU (Red) capsules***
Semester 1 Forecast **Distribution Date/Month** A. Number of children to reach B. Expected coverage Semester 1 (%) C. Expected capsule needs for Semester 1 (AxB) D. Handling losses, up to 5% if required (C x 0.05) E. Sub-total Requirements Semester 1, including handling overage(C+D) F. Subtract estimated remaining stores (see calculations table below if needed) G. Total capsule needs for Semester 1 (E-F)	Month:	Month:
H. Total Number of Bottles (of 500 caps) requested (G/500 rounded up)		
Date Supplies Needed in District for Semester 1		
Semester 2 Forecast **Distribution Date/Month** I. Number of children to reach J. Expected coverage Semester 2 (%) K. Expected capsule needs for Semester 2 (I x J) L. Handling losses, up to 5% if required (K x 0.05) M. Sub-total Requirements Semester 2, including handling overage (K + L) N. Subtract estimated remaining stores (see calculations table below if needed) O. Total capsule needs for Semester 2 (M – N)	Month:	Month:
P. Total Number of Bottles (500 caps each) Requested (row O/500 rounded up)		
Date Supplies Needed in District for Semester 2		
Grand Total No. of Bottles for Semester 1 and 2 (H + P)		
***If Needed:* Method to Calculate Expected Remaining Stores**	**100,000 IU**	**200,000 IU**
Stocks received in District previous semester (A)		
Estimate of Stocks used in previous semester (coverage of children + 5% handling overage) (B)		
Estimate of Stocks remaining (A-B)		

Annex B: Example of District Summary of Vitamin A Supplies

District _____

Month _____

		6-12 Months 100,000 IU	12-59 Months 200,000 IU
A	Total Number of Children		
B	Expected Coverage		
C	Target Number of Capsules required		
D	Allocated for Distribution 'Event'		
E	Percentage Allocation/Need		
F	Number of capsules used		
G	Balance in Stock after 'Event'		

Note:

A = Total number of children in the target age group

B = Expected percentage of the target group that will be covered by VAS

C = Total number supplies required for the District, calculated as: (AxB x 10% as buffer)

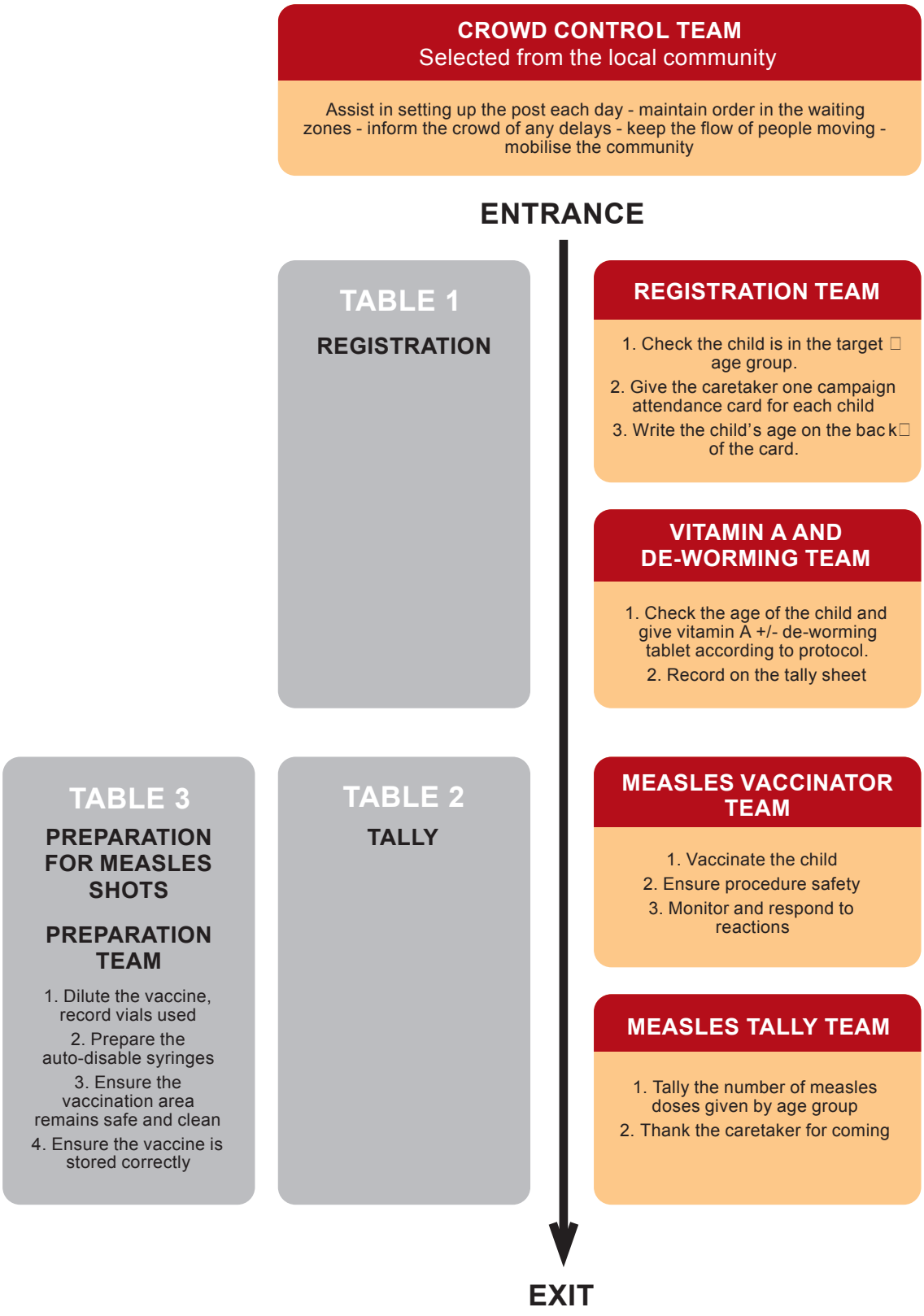
D = Total number of capsules received from centre and available for distribution per CHW

E = Adequacy of Supply = percent of supplies provided relative to demand, calculated as (D/C)

F = Total number of capsules used based on actual coverage and tally sheet data

G = Balance should be equal to D-F

Annex C: How to set up an integrated delivery post *



* From: Action against Worms, Issue no. 6, WHO 2006 and adapted from: Accelerated measles control in Zambia, Measles supplemental immunizations 2003. Control Board of Health, Zambia. WHO, UNICEF, Red Cross.

Annex D: Key Indicators of Child Health Weeks – adapted for VA supplementation

Programme area	Type of Information Needed	Illustrative indicator
Enabling environment	• Appropriate policies and guidelines in place which link CHW and VAD control to child survival	• Policy exists that defines Child Health Week parameters, including distribution mechanism likely to achieve high coverage
Provision, including logistics supply	• Support for quality supervision, training, etc. • Timely receipt of required supplies at each key distribution point; • Funding levels set and supply disbursed	• # of staff and volunteers mobilized for Child Health Week • % of districts reporting adequacy of supplies for given distribution
Utilisation	• Level of understanding of the importance of vitamin A	• % of mothers aware of the importance of vitamin A • % of health workers and volunteers aware of the importance of vitamin A
Coverage	• Reliable estimates of actual coverage	• % of children 6-59 months old receiving VAS within last 6 months [22] • % of children receiving de-worming tablet in the last 6 months
Biological Assessment	• Vitamin A status of population being targeted	• % of children 6-59 months old with serum retinol < 0.70 µmol/l
Sustainability	• Degree to which programme costs are included in MOH budget	• Vitamin A capsules are purchased using government funds • De-worming tablets are purchased using government funds • # interventions provided during the child health week
Funding	• Estimates of costs of child health week • Knowledge of source of funding	• % of communities for which budget is provided for two events • % of funding that is secured at least 3 months in advance

[22] There is currently interest in understanding whether children missed are part of a more vulnerable group that is always missed.

Annex E: Coverage Indicators

Definition	Advantages	Challenges
Full protection over five years.		
Full protection of eligible children can be defined as the number of children receiving the requisite number of doses for their age, or all nine doses by age five.	Ideally we would collect this information as it would most accurately reflect a countries progress to achieving MDG 4	• Administratively this is very complex and not feasible at the present time. It would require all children to have a child health card which would be completed and retained for five years. • Many countries do not have child health cards for all children and recording practices are often poor during CHW. • It is an additional burden on health staff to ask for child health cards and complete them. • Although retention of cards is generally good for children up to the age of one, anecdotal evidence has suggested that card retention drops off dramatically afterwards.
Full annual protection		
Percentage of children receiving 2 doses in the last 12 months, or one dose per semester in the last 12 months.	This is an appropriate and achievable indication of full protection	• Receipt of VA needs to be recorded at the child level, either on child health cards, and / or in community registers. These can be maintained at the health facility or community level. • Documentation should occur regardless of the delivery mechanism
Simple coverage		
Percentage of children who are reached during each distribution cycle or event in which VAS is provided	Indicator currently used to measure coverage. Administratively simple and relies on tally sheets. Currently the most appropriate and practical indicator.	• It does not address whether supplements are in line with international recommendations, that all children should receive one capsule every four to six months. • It could approximate for protection in countries with a relatively reliable semi-annual performance. • In reality, in most countries, coverage varies significantly from round to round.

The table above suggests that three indicators can be used to assess whether child under the age of five receive two doses of VA a year for the first five years of their life.

1. Full protection over five years
2. Full annual protection
3. Simple coverage (currently the most appropriate and practical indicator)

For most districts, measuring full protection over five years, and even full annual protection is not feasible. However, in some circumstances community registers are maintained which may allow for full annual protection to be monitored.

Measuring full protection using health facility registers and child health cards.

In order to move towards the direct measurement of two dose effective coverage, it is necessary to have some mechanism to record the receipt of VA for individuals, such as through the use of health facility registers that are used in combination with individual health cards. In many countries, there are already registers in place for EPI which help health workers keep track of immunization services provided to infants and pregnant women. In fact, there are often multiple registers at the local health facility (or community) level for different programmes, and it is important to identify how best to integrate VA monitoring into existing systems.

Districts in some countries do maintain health facility or community registers (an example of these is the register kept by community members involved in the African Programme for Onchocerciasis Control) and child health cards. Although the design and printing of the registers and cards is often done at a national level, district managers may be able to adapt them to suit their needs. Therefore some detail is provided as to how these can be adapted and used adequately capturing the information to monitor full protection.

There are some common features to registers, as they will all require detailed individual identification information to facilitate tracking (Box 1 below)

Box 1: Information to be included in health registers

- Unique identification number
- Registration date (usually the date of the first visit)
- Name of child, birth date and sex
- Name and address of mother/parent
- Dates of vaccinations and vitamin A supplements received
- Tetanus vaccination provided to pregnant women or post-partum VA (depending on country policy)

As soon as an infant is born in the community, its name can be entered in the register even before the infant has received any health services, and will be identified as an eligible child for initial vaccines, and help provide the basis for determining the number of children eligible for receiving VA capsules (once they become six months of age). An example of a health facility register is presented in ***Annex H.***

These health facility registers are only effective if they are linked with individual health cards that provide the specific details on immunisation history, vitamin A receipt and other health services provided for each infant/child. These are often referred to as 'Road to Health' cards and also include information on the growth status of children as provided from routine growth monitoring visits. Although it is recognized that such health cards are not used in all communities or countries, this information is provided here to guide those where such cards are in place, and to help provide some parameters for their development where appropriate.

Again, there are some common features of the health cards, and should at minimum ensure that all identification details can be linked to the information on the Health facility registers, including:

- Unique identification number
- Name of child, birth date and sex
- Name and address of mother
- Date when each vaccination and vitamin A supplements are received
- Appointment dates for next vaccine and vitamin A supplement
- Date when other services are provided, e.g. mebendazole, treated bed net, etc.

Where possible the Health card should be kept by the parents or other caregiver of the child, although in some settings it may be more appropriate to have health workers or community resource persons maintain the stock of Health cards. This is particularly important for the Health cards of children above 12 months of age since they will typically only come into contact with health workers and the primary health care system twice a year at the time of the distribution of Vitamin A. An example of an individual health card is provided in ***Annex I*** which includes all vaccines and scheduled doses of Vitamin A.

The card should be used when any services are provided by writing down the date for each vaccine administered, vitamin A supplement given or other service rendered. It is important to mark the next appointment date on the card and tell the mother or caregiver when and where to return for the next dose of vaccine or Vitamin A. Because these cards are going to be maintained for the first five years, it is important that they are constructed of good material that can be resistant to easy damage or degradation.

Annex F: Sample District Report on Child Health Weeks (adapted from Zambia)

Name of District		**Date of Child Health Week**	
Date of Reporting		**Report compiled by**	
District Population			

FACILITIES		
Total number of static sites		
Number of outreach sites		
Total number of sites		
HUMAN RESOURCES		
Total number of people assigned to CHW activities		
• Professional Health Workers		
• Volunteers / CDEs		
• Drivers		
Was there any orientation held prior to CHW	**YES**	**NO**
If yes – how many staff were orientated		
• Professional Health Workers		
• Volunteers / Community Development Extenders		
• Drivers		
MALARIA CONTROL		
Estimated number bed nets for re-treatment		
Number bed nets re-treated		
FINANCE		
Total Amount budgeted for CHW		
Actual Expenditure		
Variance		
LESSONS LEARNED		
CONSTRAINTS AND LIMITATIONS		
RECOMMENDATIONS		

Annex G: Sample Summary Form: Coverage during Child Health Weeks

District/Health Centre		Number health centres/distribution points	
		Number health centres/distribution points that submitted reports	
Date of CHW		Date form completed	
		Date form submitted	

Summary of Data and Coverage

	A	B	C	D	E	F	G	H	I	J	K	L
		VITAMIN A DISTRIBUTION									DE-WORMING	
	Reporting units	Number children to reach [23]			Coverage							
		6-11 mos	12-59 mos	6-59 mos	6-11 mos given VA	Coverage	12-59 given VA	Coverage	Total given VA	Coverage	12-59 mos given de-worming	%
				B + C		E/B		G/C	E +G	I/D		K/C
1												
2												
3												
4												
5												
6												
7												
8												
9												
TOTAL District / Health Centre												

[23] The number of children in each group should not have to be calculated as this was done in the planning and forecasting of supplies session

Annex H: Example of a Health Facility Register that includes both Vitamin A and Immunisations

District ..... Village .....

Name of Health Facility .....

No.	Registration date[a]	Name of infant	DOB[b]	Sex	Name of mother/ parent	Address	BCG	OPV				DTP			HepB				Measles	Vitamin A[c]									Remarks
								0	1	2	3	1	2	3	0	1	2	3		1	2	3	4	5	6	7	8	9	Completed/ died/ moved

[a] Usually date of first visit

[b] DOB: Date of birth

[c] The date should be entered for each dose received (not just an X)

Annex I: Sample Child Health Card

Name of infant		
Female or male		
Birth date of infant	Day: Month: Year:	
Name of mother		
Name of father		
Address		
Vaccines	Date given	Next appointments (date)
BCG		
DTP1		
DTP2		
DTP3		
OPV0		
OPV1		
OPV2		
OPV3		
Measles		
HepB0		
HepB1		
HepB2		
HepB3		
Vitamin A		
First dose – 6-11 months		
2nd dose – 12-18 months		
3rd dose – 18-24 months		
4th dose – 24-30 months		
5th dose – 30-36 months		
6th dose – 36-42 months		
7th dose – 42-48 months		
8th dose – 48-54 months		
9th dose – 54-60 months		
Other services (as appropriate)		
Mebendazole		
Insecticide-treated bednet		

About this guide

The purpose of this guide is to walk facilitators through the process of helping District Health Teams to plan for Child Health Weeks. The document uses the term "Child Health Weeks" as a generic name for any regular twice-weekly events which offer an integrated package of services aimed at achieving the highest possible coverage of children. Child Health Days, Child Survival Days, Enhanced Outreach Strategy are among other names in common use. In this document, we will use District Level as a generic description of a sub-national level and assume that a District Health Management Team is in charge of planning, conducting and reporting on activities.

The guide is meant to be flexible and will require a process of adaptation by each country. During the adaptation process, further input can be gathered from district facilitators or supervisors who are involved in training health workers and community volunteers. The guide is centered on motivating participants to be actively involved during orientation meetings. Most of the methods used are those which will stimulate interactive and participatory learning, and help participants to draw lessons from their experience with previous CHW or similar activities.

The guide is divided into three major parts:

- A step by step guide for conducting an orientation and planning workshop.
- Additional technical information in the form of tools, job aids and proposed handouts which may help the trainer or facilitator.
- Annexes including a sample workshop agenda and worksheets

PowerPoint presentations are included in the tool kit to assist the trainer or facilitator in delivering the content of each session.

Who are the participants?

Participants would be members of the District Health Management Team who are involved in planning and managing these activities, together with the team leaders for the distribution from all areas within the district.

Who are the facilitators?

National or province/state level staff, district managers, and key resource people (trainers) can be the facilitators for this training.

The guide is written so that it can be used either at the province/state or district level. Provincial managers with national staff can work with a group of district managers, or district managers can work with team leaders from one area.

Assumptions:

Before this guide can be used, the following conditions should be met by the program:

1) A policy decision made to use a strategy such as Child Health Weeks for vitamin A distribution as a key component for Child Survival.
2) The details of the approach should have already been defined at a national or provincial/state level with key decisions made (often stated as a strategy document). The orientation session is the opportunity to ***operationalize*** these decisions at the district level.
3) The process for micro-planning should ***have already been defined*** in the country, and the orientation session is a chance for managers to clarify the use of tables and reporting forms for the programme.

Contents

Contents

Acknowledgements

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We would like to acknowledge:

- The Government of Zambia and the National Food and Nutrition Board for permission to draw on sections of their draft *Child Health Week: Facilitator's Guide* for the Zambia National Vitamin A Programme. The introduction, and sessions one to five of this document use ideas and activities from the Zambian guide.
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List of Acronyms

CBO	Community-Based Organizations
CHW	Child Health Weeks
CHD	Child Health Days
CS	Child Survival
DHMT	District Health Management Team
EOS	Enhanced Outreach Strategy
HW	Health Worker
HEW	Health Extender Worker
IEC	Information, Education, Communication
ITN	Insecticide Treated Nets
MDG	Millennium Development Goals
VAC	Vitamin A Capsules
VAS	Vitamin A Supplementation

Introduction

Why Child Health Weeks?

Child Health Weeks (CHW) offer a unique opportunity for districts to provide preventive services to children and mothers beyond what is possible through routine health facility visits. While clinical services and many preventive services are provided at hospitals, health centres and health posts, a district can also provide outreach services to try to bring services closer to communities. The CHW offers an additional routine service that extends services, much like an expanded outreach, done twice each year.

Vitamin A is essential for both normal life and survival. Consequently, improving the vitamin A status of deficient children dramatically increases their chance of survival. Vitamin A supplementation (VAS) is therefore a key element of efforts to achieve the fourth Millennium Development Goal (MDG4), the reduction of child mortality. One driving force for the CHW is the need for children under 5 years of age to receive preventive doses of vitamin A supplements and de-worming tablets twice each year. Such a 'packaged' approach is particularly relevant for children above 12 months of age who are not typically reached by the primary health care system, save for the management of illnesses. For this reason, many preventive services offered at health facilities do not achieve adequate coverage. CHW offer an opportunity to remind caregivers to come to health facilities and outreach sites for these services. This periodic routine mechanism has been shown to improve vitamin A coverage, increase immunization coverage, and increase other preventive services such as de-worming and health promotion.

Why orientation sessions?

An orientation for district and health facility staff and community volunteers is necessary to motivate staff to reach out and increase coverage of services, and to ensure that quality services are provided. A district orientation is planned to orientate district health staff, and provide them with key reference materials to assist them during CHW activities.

The orientation session provides an opportunity for the team to determine strengths and weaknesses of previous CHW activities, and to identify actions which will address specific needs. The session is also an opportunity to provide technical updates and to distribute promotional materials, supplies and other materials needed for specific interventions.

Ideally, the district level orientation should be held **one month** before each CHW, although the planning of such events should be done for the entire year.

District level orientation workshops can take one to two days depending on available time and resources and how much previous experience teams have with the programme. For those who have been orientated before, it may take only a day, depending on what other new information is included, what issues need further consultation, and the level of turnover among workers. For the first year of the program, the workshop is likely to require two days so that there will be enough time for discussion and problem solving. With time, the orientation sessions may become shorter but until CHW become regular events, it is important to allocate enough time to these sessions. They are a critical part of the learning process because they encourage sharing of experiences and a focus on problem solving, and will improve everyone's understanding of how to strengthen the programme.

Following the orientation, district staff will be responsible for orientating health

Session 1

Opening Session and Orientation Process

Session Objectives

The objectives of this session are to:

- review, with the participants, the concept of Child Health Weeks
- introduce the objectives of the orientation and planning workshop
- give an overview of the planned sessions for this workshop

facility staff who will, in turn, recruit and orientate community volunteers.

What participants should bring to the orientation session

Participants should come to the session with:

- Population data on number of children to cover in their areas
- Information on stocks available in their area (un-used vitamin A capsules and other commodities such as de-worming tablets)
- Any activity plans and budgets prepared for this distribution

If CHW have been conducted before, participants can bring:

- Any data or reports available on what was achieved during the last distribution
- Information on what was done to promote CHW in the last distribution.
- Results of review sessions and suggestions on how to improve the next distribution.
- District managers will also want to bring plans and budgets developed for this, as well as information on the cost of the previous distribution of CHW

  If CHW have not yet been conducted in the area, experience from campaigns and other activities which included vitamin A distribution can also be used.

Materials and equipment suggested during the workshop

- Flip chart(s) and markers
- Computer with projector if PowerPoint presentations are to be used
- Stationary

Time proposed: 1 hour

STEPS

1. Introduction of participants

For the opening session, have participants introduce themselves if they have not met before. This helps set the mood for the workshop. This is also a good time to cover any necessary logistical arrangements for this workshop.

2. Opening remarks

Sometimes, it is important to have a senior manager in the district to conduct an official opening and give a short speech. This can attach importance to the orientation workshop. After the speech, you may ask the guest of honor to stay for a few minutes to listen to the objectives and expected outputs of the workshop.

3. Presentation of workshop objectives and overview

One of the facilitators will give a short presentation on the objectives of the workshop and the expected outputs. If there are no handouts, these can be written on flip chart paper for display. The presenter can also give a quick overview of the workshop agenda for the next two days (see Sample Workshop Agenda ***Annex 1***).

Proposed objectives of this orientation workshop are to:

- Review the programme status and specific needs to be addressed during the upcoming CHW
- Give updated technical information and help to prepare for orientating service providers
- Introduce promotional materials and job aids
- Finalize logistical arrangements and distribution of supplies and materials for the CHW

Sessions for this workshop

Session One:	Opening Session and Orientation Process
Session Two:	Reviewing the previous CHW
Session Three:	Planning for the next CHW
Session Four:	Logistics and Supplies for CHW
Session Five:	Social Mobilization
Session Six:	Training of Service Providers
Session Seven:	Supervision
Session Eight:	Monitoring
Session Nine:	Reporting and Feedback
Session Ten:	Financial management and Review of Action Plan and Budget

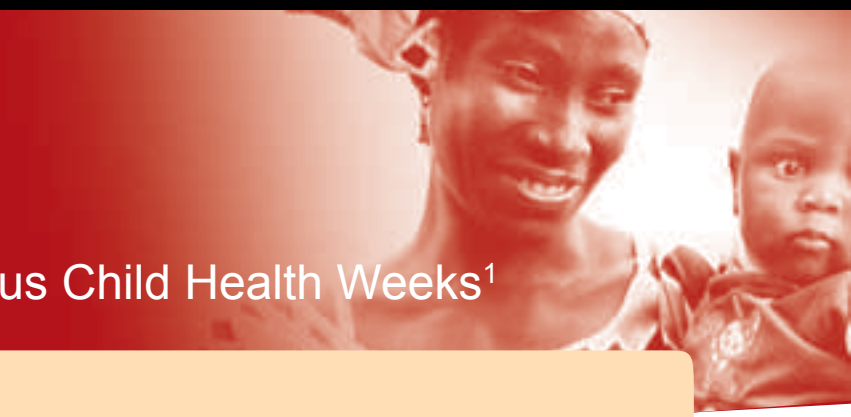
4. Presentation on Child Health Weeks

A brief presentation can be made which will cover:

- The importance of vitamin A supplementation and other services such as de-worming
- Why high coverage twice yearly is important
- The concept of CHW
- The current situation justifying the need for CHW
- The national strategy for CHW

The key ideas about CHW to present include:

- CHW offer a unique opportunity for districts to provide preventive services beyond what is possible through health facility visits.
- They enable districts to provide outreach services and brings services closer to communities.
- CHW offer an additional routine service that extends services, much like an expanded outreach, twice each year to communities.
- One driving force for CHW is the need for children under 5 years to receive vitamin A and de-worming twice a year.
- Many preventive services offered at health facilities do not achieve adequate coverage.
- CHW remind caregivers to come to facilities and outreach sites for these, and other health services.
- With multiple services offered, costs for this effort can be shared by several programmes and the effort can be an efficient use of resources and personnel.
- As a routine periodic activity twice a year, CHW have shown to:
  - Improve vitamin A coverage
  - Improve coverage of de-worming
  - Improve immunizations coverage, and
  - Increase coverage of other preventive services provided such as re-treatment



Session 2

Reviewing the Previous Child Health Weeks[1]

Session Objectives

At the end of this session participants will be able to:

- Identify which factors led to high coverage during the previous Child Health Weeks
- Identify any factors that may have led to low coverage during the Child Health Weeks
- Summarize what was learned and the important points to consider when planning for the next Child Health Weeks

of impregnated bednets.

5. Questions and answers after the presentation.

TOOLS AND AIDS:

- Sample slides for presentation on CHW
- Refer to the introduction section in the Guide for District-level Health Managers

HANDOUTS:

- Workshop agenda (a sample agenda is included as ***Annex 1***)
- An information and advocacy leaflet about CHW
- The Guide for District-level Health Managers

Proposed time: 1½ to 2 hours

This session helps participants to share their experiences of planning and implementing the previous CHW. The session will look at:

- What worked and did not work well with planning
- Experiences during activities
- Coverage achieved by each health centre and the district
- Findings of any monitoring activities carried out by the district

The main output of this session is to identify factors that inhibit or enhance success of the CHW. Recognizing these factors is a critical part of planning for the next CHW.

STEPS

1) Presentation of session objectives (listed above)

2) Presentation of results of the last Child Healt Week (or other distribution activities)

a) Request a DHMT member to report on coverage of vitamin A supplementation (children 6-59 mo) and other key interventions such as de-worming (children 12-59 mo) achieved by the district during the last round.

For each intervention, show both:

– number of children reached

– coverage in terms of % of children reached (see suggestions in Guide for District Managers, section 3.4)

Results should be presented for the whole district, as well as each health centre or area within the district. Facilitators are encouraged to review the presentation in advance to ensure information is appropriate and presented simply and clearly.

1 If CHW has not yet been conducted, review of campaigns or other distribution activities including VA can be reviewed

b) Request someone from the national or provincial office to present any national results of the last distribution. Presentations should be short, and consist of only two or three tables or slides showing coverage data and coverage of this district compared to other districts in the province/country.

c) If any formal monitoring activities have been conducted by the national level (for example, monitoring through observation/exit interviews, or coverage validation surveys), findings from these can also be presented.

3) Group work: factors increasing or limiting good coverage during the last round (30-45 minutes)

a) Tell participants that this session forms the basis for further sessions. Remind them that the details of social mobilisation will be discussed in a later session.

b) Arrange participants into 3 or 4 groups for discussion. Have one facilitator to sit down with each group.

Group Work – Discussion Questions for Small Group Facilitators

- Which sub-national areas reached over 80% coverage? Which areas reached the highest coverage during the last CHW? Look primarily at vitamin A and de-worming coverage.
- What factors made it possible to reach the high coverage?
- In the areas that did not reach 80% coverage, or in areas with the lowest coverage, what were the reasons?
- If you have information on two previous CHW:
  - Which areas have improved? What was done in the last distribution to make them improve?
  - Which areas did not improve or decreased in coverage? If so, what are the reasons?
- Include questions about other services offered during CHW.
- What lessons can be learnt from the last CHW?
- What can be done to improve the situation the next time?

Session 3

Planning for the Next Child Health Weeks

Session Objectives

At the end of this session participants will be able to:

- Confirm dates and available package of services for the next Child Health Weeks
- Review the total number of children to be reached in the district
- Propose coverage figures to reach during the next distribution

c) Ask groups to discuss what happened during the last CHW in their area, and list:
   i) main factors which resulted in high coverage in some areas
   ii) main factors which led to low coverage in other areas.

d) If needed, facilitators can use discussion questions to stimulate discussion. Sample questions are listed at the end of this chapter.

e) Encourage groups to focus on specific actions that worked well or caused problems and not just on general categories of issues.

f) Ask groups to summarize their findings, and to list the lessons learned and what type of corrective action can be taken during the next distribution.

g) Groups should then summarize their discussions on flip chart paper using a format such as the sample provided in ***Annex 2 as Worksheet #1.***

4) Plenary – Reports from discussion groups (30 minutes)

Each group will present the outcome of their group discussions; main factors for high and low coverage, and recommendations for the CHW.

At the end of the plenary session, the facilitator should summarize the main points after participants have discussed and agreed on the main positive and negative factors, and recommendations. These will be useful to start up the next session on planning.

5) Presentation: Cost of the last CHW (15 minutes)

- Have a DHMT member present a brief report on the cost of the last CHW: what the budget was, where funds and support came from, and how much was actually spent in the district on key line items during the last distribution.
- Cases where support was generated within the district, or where partnership with departments and groups was created, should be highligted.
- Participants can add examples which were mentioned in their group work.

TOOLS AND AIDS

- Sample slides for session 2
- Guide for District Managers (in particular section 3.4)
- Worksheet # 1 (annex 2)

HANDOUTS

- Brief summary of results from the last CHW
- Summary of key findings from summary report (if available)
- Worksheet # 1 to guide group work

Proposed time: 1½ to 2 hours

The last session will have generated information on what each area did during the previous CHW. This information will now be used to come up with a plan on how best to conduct the next CHW to reach higher coverage or maintain high coverage.

In this session participants will review the number of children to be reached and propose the number and coverage figures they aim to reach.

Participants will then identify activities that will help them reach these targets. This will help them to come up with an activity plan and allow time to discuss details of the plan and how it can be integrated into the overall district and health centre plans.

STEPS

1) Present session objectives

2) Presentation: The total number of children to be reached in the district (10 minutes)

a) There may not be sufficient time in the workshop to teach participants how to calculate the number of children in the target age groups. These numbers can be calculated before the workshop and presented to the group for discussion and verification.

b) All participants should be aware of how many children need to be reached in the district, and in their area.

c) Presenting the numbers will help participants understand where these numbers come from. A sample framework for presentation is included as ***Worksheet 2 in Annex 2.***

d) Refer to section 1.1 in the Guide for District Managers for details of how this is calculated.

3) Plenary (20 minutes)

- Dates for the next CHW for the district
- Agree on the health services to be provided
- Review the coverage (%) reached by the district in the last round and agree on a target for coverage for each of the interventions for the next CHW
- Discuss how the distribution will be done (options for distribution modality)
- Refer to sections 1.1 and 1.2 in the Guide for District Managers

4) Group work: Making an action plan for the next child health week (45 minutes)

a) Divide participants into small groups.

– If there are participants from several districts attending, they can each work as several district groups.

– If activities are planned only at the district level and only one plan is needed, this could be done as a plenary session or with the team working as two groups if the team is to big.

– If planning is done at the level of health centres, then divide participants into 3 groups with participants from 2 or 3 areas in each group. In this case, participants from each area will work on their own plan.

b) Ask participants to list the activities they need to plan for, to ensure they get better results for the next CHW. Emphasize to the group that it is important to focus on ***realistic*** activities. The purpose of this exercise is not to generate a wish list, but to focus on what can and should be done in next CHW.

c) Once activities are listed, have the groups fill in details for each activity using the format in ***Worksheet #3A in Annex 2***, indicating who will do this, when it must be done, how, materials needed, logistics and support required.

d) Remind participants to refer to their findings and recommendations in session 2 and to make sure that all of the constraints identified in the last CHW will be addressed this time.

e) Have some time to discuss potential problems that may occur at the time of conducting CHW such as lack of supplies, transport problems, low turn out, shortfall of health workers, etc. Use ***worksheet 3B*** to work out a trouble shooting plan.

5) Presentation of group work (30 minutes)

a) If there are 3 or 4 groups, there will be time for each of them to present plans for feedback.

Session 4

Human Resources, Logistics and Supplies for Child Health Weeks

Session Objectives

At the end of this session participants will be able to:

- Identify human resource needs and logistics support for the Child Health Weeks
- Identify all supplies or materials required to conduct Child Health Weeks
- Identify sources of support, either in form of money or in-kind contributions

b) If there are many groups (districts or health centre teams), time will be insufficient to present each plan. In this case, a facilitator or district-level person will need to sit with each group to provide feedback and guidance during the group work time.

c) If only one plan is being developed at district level, use the plenary time to consolidate the plans developed by the 2-3 teams into one district plan.

d) If typing and photocopy facilities are available, facilitators should ensure that copies of plans are made available to each participant to carry back to their stations to make it easier for them to incorporate these proposed CHW activities in their overall district or health centre plans.

TOOLS AND AIDS

- Sample slides for session 3
- Worksheets 2 & 3 in Annex 2.
- Guide for District Managers (sections 1.1, 1.2, 2.4)

HANDOUTS

- Data on total population to reach (target age groups) in district and health centres
- Worksheet # 3 for results of group work

Proposed time: 1½ hours

For successful CHW, the districts and health centres will need to ensure that there are enough staff and supplies for service delivery.

Each team or health facility will also need an outreach plan specifying the teams, dates and locations for service delivery during the week.

STEPS

1. Presentation of objectives

2. Group work on distribution plan and human resource needs (30 minutes)

a) Have participants return to the same groups used in Session 3.

b) Groups will discuss how the distribution will be carried out in their areas vis-à-vis distribution posts (health facilities and outreach sites) and what type of staff and personnel are needed to support this activity.

c) The group will:

- develop a schedule (or review their proposed schedule) for the CHW;
- identify how many staff are needed, and where additional staff can be recruited from;
- determine how staff will get from one location to the next and their needs for transport;
- estimate the cost for support of staff and how to minimize these costs.

d) Groups can use a format like ***Worksheet # 4 in annex 2*** to fill in details. Note that the section on training costs and supervision needs will be better addressed once the sessions (6 & 7) on training and supervision is done.

e) Remind the group to refer to their Action Plan in ***Worksheet # 3A***.

f) Refer to section 1.2 of the Guide for District Managers on finalizing the distribution strategy, identifying and mapping distribution points; and section 1.3 on planning personnel requirements.

3. Presentation on costs and budgets for CHW, arrangements for allowances and transport (15 minutes)

a) A person from the national level or the DHMT will give a brief presentation on standards and guidelines for staff and transport arrangements during CHW.

b) This person can also address issues raised in discussions during group work.

4. Presentation on supply requirements for child health weeks (3 slides – 15 minutes)

a) List of supplies required (Guide for District Managers, section 1.4):

(i) Vitamin A capsules

(ii) Scissors or clean nail clippers to cut capsules. Using needles, blades or pins to puncture capsules is not recommended because it can be dangerous[2].

(iii) De-worming tablets, cups and drinkable water

(iv) Vaccines, needles and disposal boxes, (if immunization services are included) vaccine carriers and ice for outreach

(v) Reference and promotional materials

(vi) Job aids

(vii) Tally sheets

(viii) Reporting forms

(ix) and other materials required for additional interventions

(x) Every distribution point will also need a bag for used capsules, and cloth or tissues for wiping hands.

(xi) Stationary (pens, pencils, erasers, notepad for referral)

(xii) Requirements for transport and fuel – it is usually easier to estimate needs once you have identified the number and location of distribution centres, their mapping, the number of teams and the duration of the distribution.

b) Use slide on how to estimate the number of vitamin A capsules required.

c) Use slide on how to estimate de-worming tablets required

d) See example of slides for session 4.

e) Use ***Worksheet # 5B*** to fill in details if time allows.

5. Plenary discussion on supplies and logistics (30 minutes)

a) With the large group, the facilitator will review Worksheet 3 – the output of Session 3 where material and supply needs were listed. If more than one worksheet 3, select one or try to have a consolidated version of worksheet 3.

b) The facilitator will list each item on flipchart paper. Refer also to Section 1.4 in the Guide for District Managers.

[2] WHO: Distribution of vitamin A during National Immunization Days. 1998 p.15

Session 5

Social Mobilization

Session Objectives

At the end of this session participants will be able to:

- Review promotional IEC materials available for Child Health Weeks
- Understand the importance of community promotion
- Have explored options for community promotion activities to support the Child Health Weeks
- Looked at promotion activities to do for the next Child Health Weeks; how and with whom

  - Level of existing stock
  - Where supplies will come from and who will provide them
  - Time frame by which supplies should be at distribution points and discuss arrangement for transporting supplies
  - How to pay for those materials and supplies which must be purchased
  - What supplies can be donated, and share ideas for getting support
  - Discuss what to do if staff runs short of vitamin A capsules or de-worming tablets during the distribution.
  - For vitamin A capsules, de-worming tablets and other medicines, review what teams should do with supplies left over
  - Estimate number of supplies required based on number (and age) of children to be reached, planned coverage and existing stocks.

TOOLS AND AIDS

- Sample slides for session 4
- Worksheets 4 & 5
- Guide for District Managers (sections 1.2, 1.3, 1.4, 1.5)

HANDOUTS

- Worksheets # 4 & 5 on human resource and supply requirements and costs
- National Guidelines on allowable expenses for staff and costs during CHW or refer to guidelines in the District Guide.

Proposed time: 1½ to 2 hours

This session looks at how to motivate parents and caretakers to bring their children to health facilities or outreach posts during CHW so they can receive key preventive health services.

STEPS

1. Presentation of objectives

2. Presentation of national IEC efforts to support child health weeks

If there are activities planned at the national level to support CHW, have someone briefly present them (3 to 4 slides only): an overview of the communications strategy, activities being done at national level to support this next CHW, and the role of the districts.

This is a good time to introduce and distribute any new IEC materials which have been developed to support CHW.

3. Presentation on promoting child health weeks in the community

This presentation will focus on the importance of informing the community about the upcoming CHW, and what districts can do for social mobilization. Information will include:

- Minimum information for all parents: dates, location, services provided, bring child health card, benefits for their children
- How to spread the word? (see examples on slides) – *note that print materials are usually not effective for demand creation*
- What timing is best? Not too long before the event and continuing during the week for some activities.
- What methods work best in different localities and situations?
- What channels work well and do not cost too much, and what channels can be used if additional resources are available?

If there are lessons that can be learned from recent surveys or monitoring activities, be sure to include these results in the presentation.

4. Group work or Plenary: Planning social mobilization activities for the next CHW (30 minutes)

This exercise can be done either as small group work (to allow more discussion) or as a plenary with the large group together. The purpose of this exercise is to review the experience with social mobilization during the last round, and to plan details for what will be done this time.

a) Have groups look at the results of group work in Sessions 2 and 3.
b) Ask them to discuss:
   – What they did for social mobilization in the last CHW that worked well?
   – What they would do differently the next CHW?
c) Have participants choose the main channels they will use to inform the community about the next CHW. Ask participants to choose 3 or 4 channels only.
d) Have participants discuss the details of these social mobilization activities:
   – What will be done through the 3 or 4 channels identified above?
   – Who will do the activities?
   – When will this be done and how long before the distribution?
   – Where and how will this be done?
   – What will be needed and how much will this cost?
   – How will they identify support from within the area for these activities?
e) Have groups summarize their discussion on flip chart paper using a format similar to ***Worksheet # 6***. If this is done as a plenary, the worksheet can be used to guide the larger group discussion.

5. Presentation of social mobilization plans (30 minutes)

If small groups are used, each group can briefly present their plans to the large group for feedback. Facilitators will need to make sure that the plans are realistic. If a plenary is used, this step is not necessary.

TOOLS AND AIDS

- Sample slides on session 5
- Worksheet # 6
- Guide for District Managers (Part 2, Section 2 on Social mobilization)

Session 6

Training Service Providers to Give VA Capsules and De-worming Tablets

Session Objectives

At the end of this session participants will have:

- Reviewed the skills which need to be focused on when training service providers to give vitamin A and de-worming tablets
- Reviewed the key content for training and have practiced with the job aids
- Discussed good approaches for teaching these skills
- Developed a plan for training of health workers and volunteers in their district

HANDOUTS

- A short 1-2 page handout on the communications strategy for the programme and recommendations for social mobilization. This handout can be prepared based on existing national IEC plan and presented by a national officer.
- Any IEC materials being distributed
- Worksheet # 6 on social mobilization activities

Proposed time: 3 hours

This session is longer than the other as it includes practical sessions.

An important part of CHW is ensuring that **quality** services are provided. This session covers the key technical information on CHW interventions, and reviews the key skills for giving vitamin A capsules to children.

Practical sessions are strongly recommended because they:

- Allow participants to practice the skills themselves and have a chance to hear common questions and issues discussed
- Give participants a chance to practice with tools and gain confidence
- Help to reinforce the importance of including practice sessions during training.

In the second half of this session, participants will discuss the training that they plan to conduct to prepare for the next CHW. Based on what will be learnt in this session, participants will plan for how this training will be done in their respective areas. This will help inform about needs and costs as mentioned earlier in session 3.

STEPS

1. Presentation of objectives

2. Give out Job Aids to participants

Briefly explain who each job aid is intended for, and how it can be used.

Job Aid 1 – Information about vitamin A deficiency

Job Aid 2 – How to give vitamin A capsules to children

Job Aid 3 – Leaflet – Example from Uganda

Job Aid 4 – Technical content for training for vitamin A distributions

Job Aid 5 – Supervisory Checklist

Job Aid 6 – Exit Interview Form

Have a copy of the national Vitamin A schedule posted on the wall.

3. Presentation: Training of service providers on vitamin A supplementation (refer to the slides)

a. The presentation should highlight brief points for training of health workers. Proposed technical content for training can be found in job aid 4

- The important focus should be on skills and technique.
- Point out the key content for training health workers.
- Basic information on vitamin A (health facts, biology, safety and side effects and schedule)
  - When discussing side effects, be sure to emphasize that side effects do happen in few cases (in approx 2 – 5% of cases). Though they are not serious, health workers must be ready to reassure parents who become worried.
  - Stress the safety margin for preventive doses of vitamin A. The minimum gap between doses should be one month. There is little or no risk if proper technique and protocols are followed.
- Slides on Technique: How to give VA capsule (refer also to job aid 2).
- Slide on Communication: it covers 3 key messages to tell parents when giving the capsule. (Messages in job aid 2)

b. Refer to Part II of the District Guide for key information for training.

4. Demonstration : How to give capsules (30 minutes)

a. The demonstration can be done by using a set of pictures or slides, by using an actual child, or through role playing. A set of pictures is provided in the tool kit.

b. Have participants follow along with job aid 2: How to give capsules. Introduce job aid 5: Checklist used by the supervisor during distribution.

c. Include the following steps in the demonstration:

- Health worker checking child card or asking the mother if the child has received vitamin A capsule (not to be confused with polio vaccine) during the last 4 weeks
- Checking the age of the child, and choosing the correct dose for age
- Cutting the capsule mid-way between the tip and the rounded part
- Giving the capsule to the child, making sure to squeeze out all the drops
- Telling the mother the 3 key messages
- Making sure the child is fine
- Disposing of the capsule correctly
- Wiping off hands to remove the oily vitamin A solution
- Filling the child card and the tally sheet

d. Demonstrate how to give halfdoses (i.e. 100,000 IU) using 200,000 IU capsules for children 6 – 11 months

- Show how to count drops
- Stress that, if there is an odd number of drops, round up
- ***Emphasize that, with half-doses, the remainder of the capsule is thrown away.***

e. End with a question and answer session.

5. Practice session (in small groups): How to give capsules (45 minutes)

a) Introduce the small group work by stressing the importance of practicing the technique during training. Emphasize that trainers are responsible for making sure that, those being trained, learn the proper technique and give the correct messages. Tell participants that this is a demonstration of an effective training exercise; when they are training, they will observe the groups and answer questions.

b) Introduce the small group work: Role play on giving a VA capsule

- Participants will form groups with 4 people in each group.
- One person will be the mother, one will be the health worker, and two will be observers.
- The health worker and the mother will play through an entire episode of a child coming to get a vitamin A capsule.
- Tell the observers not to say anything during the role play but to fill in the supervision checklist (job aid 5) and then discuss it with the health worker at the end.
- Tell the group that they are to let the mother determine the age of the child[3]. Then imagine where the child's mouth is and use a tissue to catch the drops. Other alternatives would be to use a drawing, a stuffed plastic bag or a doll for the child.
- Remind the participants to begin the session by practicing how to count drops for half doses. The number of drops counted may vary according to the weather, altitude and who is doing it.
- Tell the groups to do the role play three to four times so that everyone in the group can practice being the health worker and supervisor.

c) Hand out materials:

- vitamin A capsules, scissors, tissue paper and dolls if available
- extra copies of tally sheets and child health cards [3]
- Checklist for supervisors

d) During the group work, the facilitators will need to: observe the groups, ensure that the correct technique is being followed and to make sure that observers are filling the observation forms and provide reasonable feedback.

e) Have participants hand in the supervision checklists they completed during this exercise. One of the facilitators can compile these results to present in the next session.

6. Plenary on the practice session – How to give capsules (15 minutes)

a. As a large group, ask the participants about their experience doing this exercise. Take questions and discuss any issues which arose during the exercise. For example:

- What steps were commonly skipped?
- What parts were often done incorrectly?

[3] Alternatively, use Road to Health Cards for this, with age of the child and last dose information filled in.

– What are questions and issues that need to be clarified? One question often asked is what to do if a child vomits after receiving the drops. The correct answer will vary by country.

c. Ask participants to think about the approach used in this session. Explain that the reason this session was included was to encourage them to do similar practical exercises when they train.

d. The facilitator will end this session by talking about other practice exercises which could also be done, and approaches for practice sessions.

7. Group discussion: Planning for training for the next child health weeks (30 minutes)

a. Ask participants to think about how they will train service providers in their area before the next CHW. Emphasize that the most effective training is when the information focuses on problem solving, and when trainees have a chance to practice the skills.

b. Refer to the lessons learned in Session 2 and the plan for human resources from Session 4.

c. Tell participants to return to the same groups used during Session 3 and discuss three questions:

– How will you train the service providers in your area before the next CHW?

– What support will be needed?

– What can you do to keep costs to a minimum?

d. In the groups, participants will discuss the details of how they will do training and what is needed. Ask them to summarize their plans and discussion by filling in

Note on Side Effects and Safety of Vitamin A Capsules:

- Job Aid 5 – Supervisory Checklist
- Guide for District Managers, Part II, Section 1 on Information for training
- Worksheet # 7 – Plan for training service providers
- Tally sheets

HANDOUTS

– see job aids listed above

MATERIALS

- Have vitamin A capsules, scissors, tissues and bags for disposal. Expired capsules can be used: use both types of capsules, and have some cool and warm capsules, if possible, since these work differently.
- Have extra copies of tally sheets, child health cards, and supervisory checklists.

- Job Aid 4 – Technical content for training for vitamin A distributions

Session 7

Supervision

Session Objectives

At the end of this session participants will:

- Understand why supervision is important
- Have reviewed the tools for supervision
- Have discussed plans for supervision during Child Health Weeks

IMPORTANT

There is often the temptation to shorten this training session by taking out the practice session. For quality control, it is very important to include the practice session, and when participants go through this session, many understand why a practical approach should be used. Practice sessions are especially important where there is frequent turn-over of staff and when training volunteers to give capsules. If, for any reason, the practice session is not included, make sure that as a minimum:

– All participants practice cutting the capsules and squeezing out all the drops

– Participants practice counting drops for half doses.

Another exercise which can be used is the supervision exercise using pictures or slides which is included in the next session. This exercise shows what health workers are doing in the field now, and going through the exercise often helps to emphasize the importance of skills and why practical sessions are important during training.

[4] PAHO Providing vitamin A Supplements through immunization and other health contacts for children 6-59 months and women up to 6 weeks postpartum. A Guide for Health Workers. Job Aid 2.
[5] Ibid.

Safety of vitamin A: When training service providers, this topic is best dealt with, not as a separate topic, but included in the sections on “How to give vitamin A” and the protocol. It is important for trainers to be confident about the safety of vitamin A.

- When the protocol and techniques for administration are properly followed, vitamin A is safe.

The topics of contraindication and side effects can be also discussed when explaining the protocol.

- There are no contraindications for giving Vitamin A capsules to a child[4].
- However, do not give if the child can not breathe properly or if a child received a preventive dose within the last one month.

For side effects, the following information should be sufficient:

“Usually there are no side effects. However sometimes a child may eat less for a day, or there could be some vomiting or headache. Advise the mother/parent that this is normal, that the symptoms will pass and that no special treatment is needed[5].”

Proposed time: 1 hour

Supervision visits, using a supervisory checklist, are a very important part of the CHW. Supervision before and during the week should focus on supportive supervision to solve problems and improve skills.

Proper supervision and monitoring can also provide valuable feedback for training. In the last session, training focused on key skills for service providers. Supervision activities provide an opportunity for program managers to follow up and see which skills are being used effectively and which areas need further attention.

This session is focused on supervision at the district level. Plans for monitoring activities will be presented and discussed in the following chapter.

STEPS

1) Presentation of objectives

2) Presentation on supervision (15 min)

- Introduce this section by referring to Session 6 and the focus on skills during training.
- If information from the supervision checklists completed during the practice exercise were compiled, present these results briefly as an example of what was learned during supervision.
- Have participants look at Job Aid 5 Supervision Checklist. Briefly explain the checklist.

- Using 4-5 sample slides, present the basics on supervision and what is needed for supervision. This helps everyone develop a common understanding of why supervision is important and what is expected during supervision. Points to make include:

  What is Supervision?

  - Process that involves guiding, overseeing, directing or managing what you would like to see happen during the CHW.

  Why is Supervision Important?

  - To ensure the quality of the service provided which in turn contributes to the proper implementation of the programme:
    - Is the capsule cut correctly?
    - Is the right dosage given?
    - Is the capsule discarded properly?
    - Are oily hands wiped?
    - Is the site of supplementation appropriate (not very sunny, but enough light?
    - Is the child's head correctly positioned?
    - Are the right health messages provided?
    - Are the tally sheet and child card filled in correctly?
    - Are there enough capsules to cover the number of children in the catchment area?

  Who does the supervision?

  - Supervision is usually done by someone at a higher level
    - National → Provincial → District → Health facility → Health post

  What is needed for effective supervision?

  - A plan
    - Map of the area to supervise and number of posts to supervise
    - A schedule
  - Extra supplies (capsules, tally sheets, wipes, etc)
  - Supervisory tools
    - Supervisory checklist (Job aid 5)
    - Exit interview form to identify needed improvements, gaps, and positive aspects

  How do you supervise?

  - Be supportive
    - Recognize good performance
    - Build confidence
    - Be constructive
    - Do not correct in front of clients

- Be prepared to take action

3) Plenary: Discussion of Plans for supervision during the next distribution (20 min)

This discussion can be done in one large group, or as smaller group discussions. If small groups are used, use the same groups as in Session 3.

The facilitator will lead a discussion on:

1. How will you supervise during the next CHW?
2. Who the supervisors will be?
3. What tools will be used (schedule, checklist, extra supplies)
4. What resources are needed: transport needs and any costs incurred.

4) Practice session (in small groups): How to review tally sheets (20 minutes)

a. Explain that the purpose of this exercise is to practice reviewing the tally sheets. This is one of the roles of a supervisor during visits, and for district staff after tally sheets are collected. A quick review can inform the supervisor about how distribution activities are going.

b. Before the practice session, make about ten copies of 3 completed tally sheets. Include common mistakes such as: unclear marking, skipping marks, mistakes in adding up totals, mistakes in totalling wastage, marks in the wrong age group and how to mark the tally sheet when half doses are being used.

c. The facilitator will ask participants to return to the same groups of 4 people they used for the practice session on giving capsules.
   - Ask them to spend 10 minutes looking at and checking the sample tally sheets
   - Have them note any mistakes they see, or things to be done differently.

d. Come back as a large group and compare what groups found. The facilitator will then go over each of the 3 tally sheets and provide the correct answers.

5) Practice supervision exercise in large group using pictures or slides (if time allows)[6]

This is an effective exercise for participants to practice observing health workers during distributions. It also tends to emphasize the need for training on practical skills. This can be used in Session 6 or Session 7.

MATERIALS

- A set of 10-15 pictures (either slides on a computer or pictures posted around the room.).
- ***Worksheet # 8***

***Steps*:**

- Hand out copies of the worksheet # 8 to all participants.

[6] An exercise developed by Ruth Harvey for training in Ethiopia for the MOST Project.

Session 8

Monitoring

Session Objectives

At the end of this session participants will:

- Understand why monitoring is important
- Have reviewed the forms (tally sheets) for collecting data
- Have reviewed the tools for data collection and monitoring
- Have discussed plans for monitoring during and after the Child Health Weeks
  - Have an understanding of which indicators will be measured – by whom and when
  - Have reviewed summary forms used to collate data and the district level
- Have an understanding of how to validate coverage

- Explain to participants that you will show a set of pictures. Ask them to look at each picture and
  - Decide for themselves if this is an example of good technique or poor practice. Note: some slides show examples of both good and poor practice. On the worksheet they will circle good, poor or both.
  - Write the reason for their decision in the “Reason” column.
  - Remind them not to be too picky and find fault in every picture, but to try to find the major things being done poorly and the things being done well.
- Show the 10-15 slides allowing 2-3 minutes per slide and have participants fill in their own work sheets. There should be no discussion during this time.
- After showing the slides, ask participants to work in pairs with the person sitting next to them. Give them 10 minutes to compare and discuss their answers.
- As a large group, go through the slides one by one and share answers with the group with input from the participants.

  This method stimulates a lot of discussion and tends to highlight in, a dramatic way, the reason why practical training is important.

  This exercise is particularly effective when pictures from the country program are being used and participants realize they are seeing what is happening in the field.

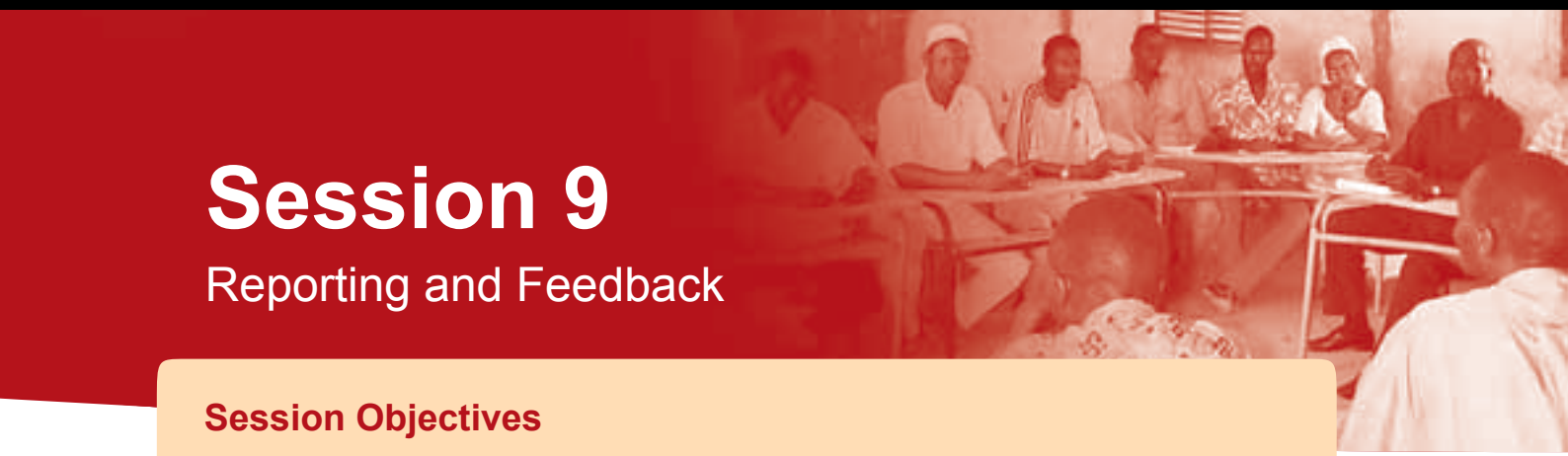
  Pictures can easily be taken using a borrowed personal digital camera, or by arranging for a photographer to take pictures during a distribution.

TOOLS AND AIDS

- Sample slides on session 7
- Guide for District Managers, Guide, and Part II: Information for supervision.
- Checklists used during training exercise
- A set of completed tally sheets with common errors to use forpractical exercise
- A set of pictures or slides showing service providers in action (for exercise with pictures)

HANDOUTS

- Job Aid 5 Supervision Checklists
- Job Aid 6 on Exit Interview
- Examples of tally sheets
- Tally sheets with common mistakes
- Worksheet # 8 (for exercise with pictures)



Session 9

Reporting and Feedback

Session Objectives

At the end of this session participants will:

- Recognize the importance of timely and accurate reporting of data
- Describe how data will be summarised and transferred to the next level
- Have reviewed summary forms
- Be able to plan for feedback sessions that actually improve planning and implementation

Proposed time: 1 hour

The level of attention that is paid to monitoring and reporting varies hugely across countries and across districts. This session is an opportunity to stress the importance of monitoring and may therefore take slightly longer than the others.

STEPS

1) Presentation of objectives – as above.

2) Presentation on Monitoring

a. Include a slide outlining "what is monitoring" and why monitoring CHW is important.

b. Brief look at indicators that can be used to monitor CHW. Although coverage is the most important indicator, districts may want to look at some process indicators as a way of improving service delivery. Remind participants of the group work in Session 2 and how much they learned by looking at coverage data.

c. Collection of data

   i. Tally sheets

   ii. Summary forms

   iii. Calculation of coverage. Show a slide on how to calculate coverage. Although there are a number of key indicators for monitoring coverage, the focus here should be on calculating simple coverage in each six months (Semester) of a year. Programmes, other than the VA program, may have other key indicators and these can be presented here.

   iv. Problems with the numerator – including a reflection on the common mistakes in the use of tally sheets.

   v. Problems with the denominator. Session Four will have prompted a discussion on how to calculate the population to reach. The points to highlight here are that:

      1. Some segments of the population may be missed altogether.

2. That if more than one intervention is being given during the CHW, every effort should be made to ensure that the same denominator is used when calculating coverage.

d. Some countries do have child health cards and some districts may be using them. If appropriate, one slide here could look at the opportunities to use information on child health cards to calculate other coverage indicators, like full annual protection.

3) Plenary

A short plenary session could look at

a. Data collection tools available in the district.
b. The usefulness of these tools and recommended changes.
c. Discussion around a child health card and how it could be used in that district.

4) Small group session

a. A short session in small groups, could propose appropriate process indicators and who should measure them.
b. Discuss what to do about children over five / children outside the catchment area who attend the child health week. Is there a district policy on how to handle them?

TOOLS AND AIDS

- Sample slides for session 8 on Monitoring.
- Guide for District Managers, Guide, Chapter III on Monitoring.
- A set of data collection tools (see sample ***Worksheet # 9***)

HANDOUTS

- A child health card
- Sample tally sheet
- Sample summary sheet

Session 10

Financial Management / Review of Action Plan and Finances for Child Health Weeks

Session Objectives

At the end of this session participants will:

- Have reviewed the overall activities for the upcoming Child Health Weeks
- Understand how to access funds and how to manage and account for these funds
- Be able to fill the required financial reporting forms

Proposed time: 1 hour

This session is an opportunity for program managers to clarify reporting requirements with participants. This is also a chance for participants to develop a sense of confidence in working with and using data and develop an understanding of why accurate and timely reporting is so important for the program. However, one really important point to note is that monitoring, with no feedback, becomes a burden to health care workers.

STEPS

1. **Presentation of objectives**

2. **Reporting as a tool to better inform planning**

   A representative from the national program can also give a brief summary of the overall monitoring and evaluation plan for CHW so participants can see how the information in reports is part of this plan.

3. **Brief presentation on Reporting and Feedback**

   a. The Facilitator will show a few slides on reporting to emphasize
      i. Why reporting is important.
      ii. What tools/report forms will be used for reporting coverage (summary forms etc.)
      iii. When reports must be submitted. A schedule can be proposed and there should be some discussion around the practicalities of deadlines. There could also be some discussion around the mode of communicating results. Can telephones be used instead of the actual forms in very rural areas?
      iv. Analysis of data. Distinguish between districts on track, to watch and high alert. Address the issue of districts reporting coverage over 100%. If possible show some actual examples of graphs from health centers / district offices.
      v. Other indicators that can be reported on.

   b. Some slides should then be shown on:
      i. Reasons for providing feedback

ii. Methods for providing feedback and

iii. Content of feedback that is most useful

c. The presentation may include a slide on post event surveys to validate coverage if the district is planning to do such survey.

4. Plenary

a. Discussion of review meetings

i. Discuss briefly with the group the importance of review meetings to look at the data and to discuss the lessons learned.

ii. Decide when the district review meeting will be held and how feedback will be given to sub-district teams and communities.

iii. Discuss opportunities for when review meetings can be held (or if they should be held at the same time as the next planning meeting), logistics and budget needs to support review meetings.

b. Feedback

i. Discuss the adequacy of feedback at the moment and how it can be improved.

ii. Provide examples of good reporting

c. Discussion around post event surveys

i. Experiences with conducting such surveys

ii. Challenges to undertaking these events.

5. Small group discussion

a. Participants should discuss the reporting schedule

b. Complete and present Worksheets 10 and 11

TOOLS AND AIDS

- Sample slides on session 9
- Guide for District Managers, sections 3.5 to 3.8
- Examples of Results shown as data tables and graphs
- Sample tally sheet summary forms with data for exercise

HANDOUTS

- Tally sheet Summary Forms (such as ***Worksheets # 10 and 11***)

Proposed time: 1 – 1½ hours

Annexes

During sessions one to eight, participants worked on plans for activities before and during the CHW. This session will allow them time to pull these plans together and review the main activities for the next few weeks.

District managers will discuss details of how activities will be financed, what funding is available and where costs can be reduced. The team can also review ideas discussed earlier for getting local contributions to help support activities.

This is also an opportunity for managers to clarify, with programme staff, details for how finances will be managed during the CHW as well as procedures for accessing and then accounting for funds. A clear understanding of the financial aspects is important so that delays in reporting do not delay funds for the next round of activities.

STEPS

At the end of the first day, district managers can take the output from all the sessions and if necessary, consolidate these plans into an overall action plan for the district. Managers can also look at the costs and needs projected by the group to see what funding is available, and what is not covered. During this session, the consolidated action plan and available and required finances can be presented to the group.

1. **Plenary: Reviewing the overall plan in preparation for child health week**
   a. The facilitator will display the action plan produced in session 2 with updates based on input from participants from each of the previous sessions.
   b. As a group, review what will need to be done in each of the weeks leading into including the distribution, and who will be responsible.
2. **Presentation: Funding for the next child health week**
   a. The District Manager will present the budget for this CHW and what can be spent for each main activity.
   b. Participants will be instructed on how to access funding, and how to account for funds. This will include:
      – when funding will be provided and from whom
      – what is allowed and what is not allowed as programme costs
      – what the proper procedures are for dispersing funds to others and accounting

Annex 1

for it

- how to report on expenditures
- when financial account forms are due

c. Any forms that need to be filled and submitted will be passed out and explained.

3. Brainstorming on ideas to cut costs or generate resources

The facilitator will help participants to brainstorm and share ideas from earlier sessions about how costs can be reduced and how to generate support for activities. This will include such ideas as:

- support from programs within the Ministry of Health
- partnering with other organizations
- local resource people for getting the message out about the week
- contributions for transport
- contributions towards training e.g. the venue

TOOLS AND AIDS

- Sample slides on session 10

HANDOUTS

- Financial guidelines for team leaders (if needed)
- Financial reporting forms to submit to district managers

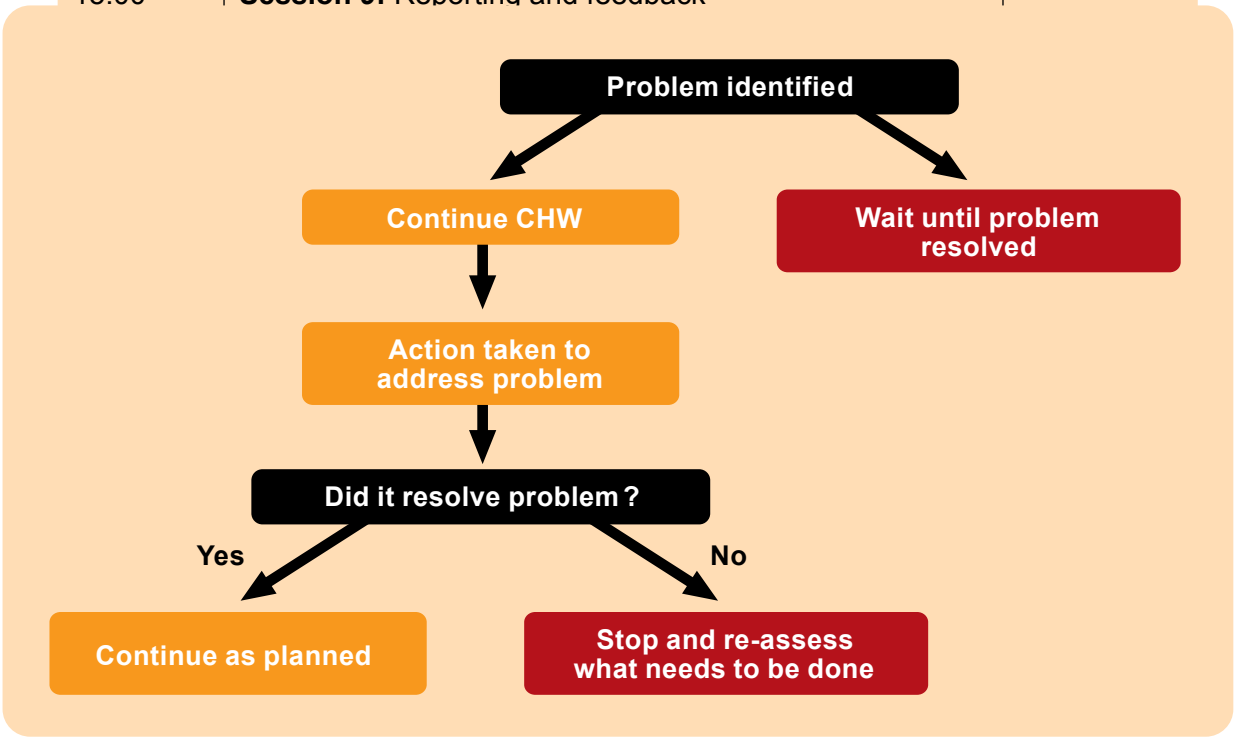
Annex 2

DAY ONE	Sample Workshop Agenda Orientation and Planning for Child Health Weeks	
09:00	**Opening Session** • Introduction of participants • Workshop objectives • Opening remarks • "Child Health Weeks, an integrated effort for Child Survival"	(60 min)
10:00	**Session 2:** Review of the Previous Child Health Weeks • Results from the district • Results from the province/national • Discussion in small groups: Looking at results	 (15 min) (15 min) (45 min)
11:15	Break	(15 min)
11:30	**Session 2** cont. • Plenary reports from group discussions • Looking at costs from the last distribution	 (30 min) (15 min)
12:00	**Session 3:** Planning for the Next Child Health Weeks • Presentation – the number of children to reach • Plenary – dates and targets for the next distribution	 (10 min) (20 min)
12:30	Lunch	(1 hr)
13:30	**Session 3:** Planning for the Next Child Health Weeks (cont.) • Group work: Making an Action plan • Plenary reports	 (45 min) (30 min)
14:45	**Session 4:** Planning for human resources, logistics and supplies • Group work: Distribution plan & human resources • Presentations: Issues for planning	 (30 min) (30 min)
15:30	Break (15min)	(15 min)
15:45	**Session 4** cont. • Plenary discussion on Supplies and Logistics	 (30 min)
16:15	**Session 5:** Social Mobilization • Presentation: messages, channels and experience • District examples: what has worked • Group work or Plenary: planning for next distribution	 (45 min) (15-30 min) (45 min)
17:30	End of day	

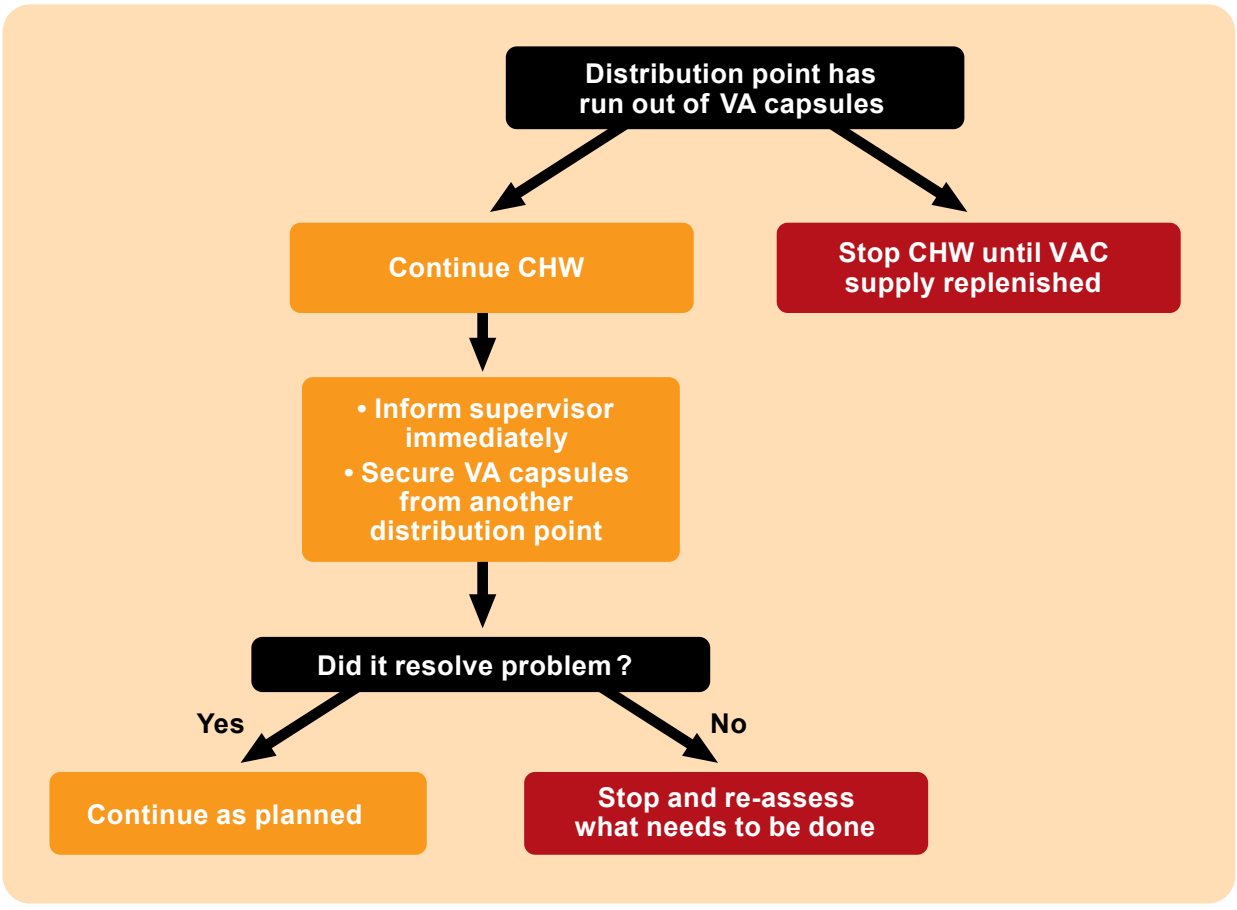
DAY TWO	Sample Workshop Agenda Orientation and Planning for Child Health Weeks	
09:00	**Session 6:** Training of service providers • Introduction of job aids • Presentation: Skills, content info for trainin • Demonstration: How to give capsules	 (15 min) (15 min) (30 min)
09:45	• Practice session: How to give capsules • Plenary	(45 min) (15 min)
10:45	Tea Break	(15 min)
11:00	**Session 6** cont. • Group work: Planning for training • Plenary: Reporting back on plans	 (30 min) (30 min)
11:45	**Session 7:** Supervision • Presentation on supervision and monitoring • Large group discussion: Plans for supervision during the next distribution	 (15 min) (15 min)
12:30	Lunch	(1hr)
13:30	**Session 7:** Supervision cont. • Practice session: How to check tally sheets • Plenary: Discussion of exercise	 (15 min) (15 min)
14:00	**Session 8:** Monitoring • Presentation on monitoring • Plenary: Discussion on available tools	 (30 min) (30 min)

Worksheet 3B: Troubleshooting Plan

15:00	**Session 9:** Reporting and feedback	



Example



Worksheet 1: Factors which increased and limited good coverage during the last Child Health Weeks

	Main Reasons for Good Coverage	How to continue this ...
1		
2		
3		
4		
5		
	Main Reasons for Low Coverage	**How this can be corrected ...**
1		
2		
3		
4		
5		
	Key Recommendations for the Next Distribution	
1		
2		
3		

Worksheet 2: Population to Reach for Child Health Week

District Population = _____

Under 5 Population = _____

	Health Centre	Children under 5yrs	Children aged 0-11 months	Children aged 12 to 59 months (De-worming)	Children aged 6 -11 months	Children 6 to 59 months (Vitamin A)
		A	B	C	D	E
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
	DISTRICT TOTAL					

Formulas

A and B can be provided from EPI programme or calculated from statistics. Numbers for A and B should be from the same source.

C = A – B

D = About ½ of B

E = C + D

These numbers will be used for estimating capsule needs, as well as for calculating coverage.

Worksheet 3A: Action Plan for Child Health Week

Activities	Dates	Who	Supplies needed	Logistics required	Support – who will help you	Additional support required
Before the distribution						
During the distribution						

After the distribution						

Worksheet 4: Human Resource Requirements and Related Costs for Child Health Weeks (Sample)

A	B	C			D		E	F	G			H	
Health Centres	Total Children 6-59mos	Number of Distribu-tion points			Staff required for special outreach effort		Training Costs	Transport cost	Supervisors			Drivers	
	Number	HF	Sch	CO	No.	Allowance	Cost	Cost	No	Allow.	Trans	No.	Allow.
District Total													

H = Distribution at Health Facilities Sch = Distribution at pre-schools CO = Community outreach distribution points

What arrangements can be made for transportation during the week?	
What arrangements can be made to borrow staff from other pro-grams and partners to help?	

Include a guide for each column. For columns costs, include a formula to guide the calculation of costs for allowance and transport.

Worksheet 5A: Micro Planning – Operational Costs – District level*

REGION / PROVINCE _____ DISTRICT _____

DATE _____

						Personnel requirement					Training of service provider								CHW Implementation								
	Name of the catchment areas	Total pop.	Pop. 6-59 months	No of distribution points	No of teams	No of health workers	No hlt ext workers	No of support staff	No of supervisors	Training and microplanning cost	Per diem coordinator & supervisor	Per diem for health workers	Per diem for support staff	Stationary	Tea break	Transport	Social mobilization	Per diem coordinator & supervisors	Per diem for health workers	Per diem for support staff	Drivers	Fuel	Soft paper	Review meeting	Total cost
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1																									
2																									
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
	TOTAL																								

A = List all the catchment areas (health centres) in the district
B = Write the total population figure for each catchment area

C = use % of the total population if no better estimates
D = Write the number of distribution points you need in each catchment area
E = Write the number of teams you need, Approx. 1 CHW team per 10 distribution points
F = One health worker per CHW team
G = Two health extension workers per CHW team

H = Four support staff per CHW team
I = One supervisor per 6 teams

K = Number of supervisors (1 per 6 teams) and coord. x 70 birr x 2 days
L = Number of health workers and HEW (3 per team) x 58 birr x 2 days
M = Number of support staff (4 x team) x 35 birr x 2 days

N = Number of participants x 5 birr
O = Number of participants x 5 birr
P = Number of CHW coordinators x 50 birr

Q = 1000 birr per district
R = Number of coordinators (2 per zone and 2 per district) and supervisors (1 per 6 teams) x 70 birr x 10 days
S = Number of health workers and HEW (3 per team) x 58 birr x 10 d
T = Number of support staff (4 per team) x 35 birr x 10 days
U = Number of coordinators and supervisors x 47 birr x 10 days

V = 100 km/day/5 litres x 4.5 birr/litre x nb of drivers x 10 days
W = Number of team x 6 birr

I US$= 8 birr

**Extracted and adapted from Ethiopian Federal Ministry of Health – UNICEF-MOST / Enhanced Outreach Strategy for Child Survival / July 2005*

Worksheet 5B: Micro Planning – supply needs – District level*

REGION / PROVINCE _____ DISTRICT _____

DATE _____

						Personnel requirement					Training of service provider							CHW In	
	Name of the catchment areas	Total pop.	Pop. 6-59 months	No of distribution points	No of teams	No of health workers	No hlt ext workers	No of support staff	No of supervisors	Training and microplanning cost	Per diem coordinator & supervisor	Per diem for health workers	Per diem for support staff	Stationery	Tea break	Transport	Social mobilisation	Per diem coordinator & supervisors	Per diem for health workers
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
13																			
14																			
15																			
	TOTAL																		

A = List all the catchment areas (health centers) in the district
B = Write the total population figure for each catchment area

C = use % of the total population if no better estimates
D = Write the number of distribution points you need in each catchment area
E = Write the number of teams you need, Approx. 1 CHW team per 10 distribution points
F = One health worker per CHW team
G = Two health extension workers per CHW team

I US$= 8 birr

H = Four support staff per CHW team
I = One supervisor per 6 teams

K = Number of supervisors (1 per 6 teams) and coord. x 70 birr x 2 days
L = Number of health workers and HEW (3 per team) x 58 birr x 2 days
M = Number of support staff (4 x team) x 35 birr x 2 days

N = Number of participants x 5 birr
O = Number of participants x 5 birr
P = Number of CHW coordinators x 50 birr

Q = 1000 birr per district
R = Nb of coordinators (2 teams) x 70 birr x 10 days
S = Number of health wor
T = Number of support sta
U = Number of coordinato

V = 100 km/day/5 litres x
W = Number of team x 6 b

**Extracted and adapted from Ethiopian Federal Ministry of Health – UNICEF-MOST / Enhanced Outreach Strategy for Child Survival / July 2005*

About vitamin A deficiency*

Every year, 11.3 million children under 5 years old die in the developing world, over six million of them directly or indirectly from malnutrition. Millions more children are malnourished. Less strong and less healthy than they should be, they have fewer opportunities to reach their full potential in life.

The problem of vitamin A deficiency (VAD) is global. It affects more than 100 million children and is responsible for as many as one out of every four child deaths in countries and communities where the problem exists. Now, there is also more evidence that VAD increases the risk of maternal death.

Vitamin A is essential for the functioning of the immune system. Giving vitamin A supplements to children who need them increases their resistance to disease, and improves their chances for survival, growth and development.

In the past, VAD has been seen merely as a cause of blindness, and in many countries vitamin A activities are still limited to blindness prevention programmes. In other countries, no action has been taken and no assessment of the problem exists.

It is now clear that elimination of VAD as a public health problem must be a principal element of child survival and maternal survival programmes where the problem exists. Eliminating VAD as a public health problem is a challenge the world must take on today.

Safety of vitamin A supplements

Concerns have been expressed in many countries about the dangers of toxicity of high-dose vitamin A supplementation. But the benefits of vitamin A supplementation far outweigh any side effects, which are transient and very rare.

Most vitamin A supplementation programmes use highdose capsules. These doses are completely safe for children when given at least a month apart. Safe lower doses have been established for pregnant women.

Reasons for action

Improving vitamin A status of deficient children increases their chances of survival:

- Death from measles can be reduced by 50 per cent
- Death from diarrhoea can be reduced by 40 per cent
- Overall mortality can be reduced by 25 per cent

Improving vitamin A status of children reduces the severity of childhood illnesses:

- Less strain on clinic and outpatient services
- Fewer hospital admissions

Improving vitamin A status also:

- Contributes to the well-being of children and families
- Prevents night blindness, xerophthalmia, corneal destruction and blindness
- May reduce birth defects
- May prevent epithelial and perhaps other types of cancer

Improving vitamin A status may reduce maternal mortality:

- Improves resistance to infection
- Helps reduce anemia

Improving vitamin A status is very cost-effective:

- Just a few cents per capsule
- Reduces health costs by lessening hospital and clinic visits
- Easily integrated into existing public health/immunization programmes

*adapted by the Micronutrient Initiative

Action need not wait for assessment

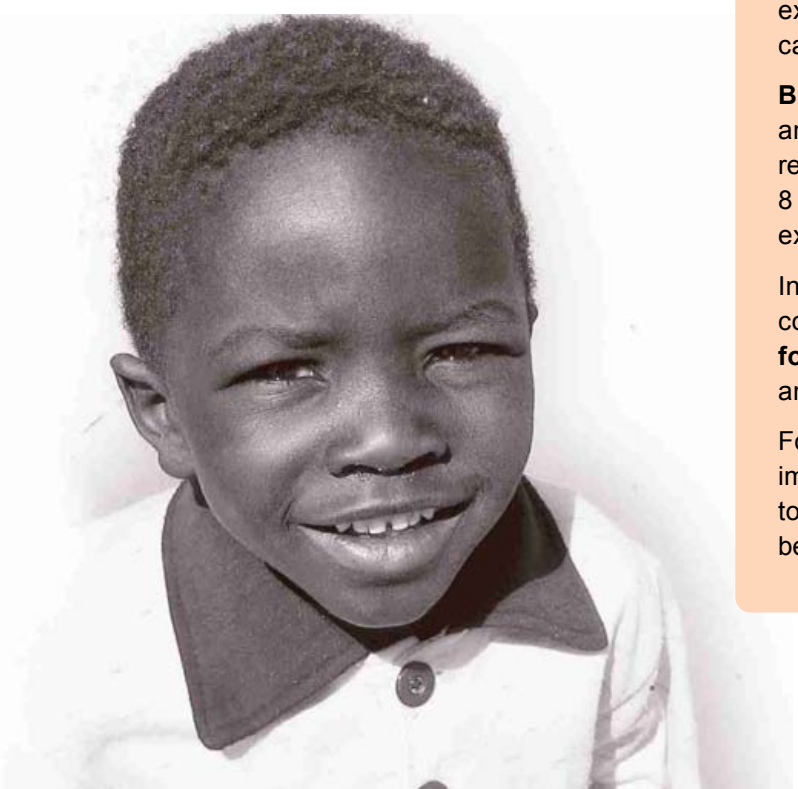
Many countries or regions may not realize that VAD is a problem, since they do not have up-to-date national-level assessments of the prevalence of VAD.

National-level assessments should take place as soon as possible in all countries that do not have such assessments. But action to eliminate VAD should not wait for the results of these surveys.

Some countries have carried out assessments using ocular indicators, such as Bitot's spots. However, these ocular signs are associated with advanced stages of VAD. Women and children may be at needlessly high risk of dying long before any eye problems are evident.

A high infant-mortality or under-five mortality rate (U5MR>70) should be taken as an indicator of a likely VAD problem, especially if it is also known that overall child malnutrition and low birthweights are prevalent and consumption of vitamin A-rich foods is low.

Governments in countries with high infant or child mortality should work with partners to put in place a programme for control of VAD, including assessment of the problem, as part of a comprehensive strategy to reduce child mortality.



Programme Activities

There are a number of ways to improve the vitamin A status of populations. Vitamin A-rich foods are not always readily accessible to people who need them. In many parts of the industrialized world, food products are fortified to ensure that populations receive adequate amounts of the vitamin. In many countries, children and adults alike take daily vitamin supplements. The following are the fastest and most cost-effective approaches to improving vitamin A status of populations.

Vitamin A supplements can end VAD as a public health problem.

Supplementation is:

- cost-effective
- safe
- sustainable
- easily implemented on a national scale
- can be carried out for many years

Supplementation using vitamin A capsules should begin at six months old in areas where children do not get enough vitamin A in their diets. Mortality reduction potential is very high, and the benefits of high-dose supplements far outweigh the very rare and transient side effects. Capsules cost just a few cents each and can be distributed through Child Health Weeks, an expanded programme on immunisation, campaigns or routine health services.

Breastfeeding support is key to reducing VAD among young children. New mothers should receive a high-dose vitamin A supplement within 8 weeks of delivery in areas where deficiency exists.

In some countries, where industrial and commercial infrastructure is adequate, **fortification of food staples** like flour, sugar and margarine can help end VAD.

Fortification can be very cost-effective. Dietary improvement, including ensuring regular access to foods that are naturally rich in vitamin A, will be part of a long-term-strategy in many countries.

How to give vitamin A capsules to children

- Ask the age of the child.
- Ask if the child has received vitamin A capsule in the last one month. If the answer is yes, confirm and do not administer. If no, continue.
- Ask the caretaker to hold the child, make sure the child is calm.
- Give the appropriate dose of vitamin A to the child:
  - 100,000 IU to child 6 -11 months.
  - 200,000 IU to child 12-59 months.
- Cut open the narrow end of the capsule with scissors or a nail cutter and squeeze the drops into the child's mouth.
- Check if the child is comfortable after swallowing the drops.
- Put all used capsules into a plastic bag and wipe hands to clean off oil.
- Record the dose on the child health card and on the tally sheet.

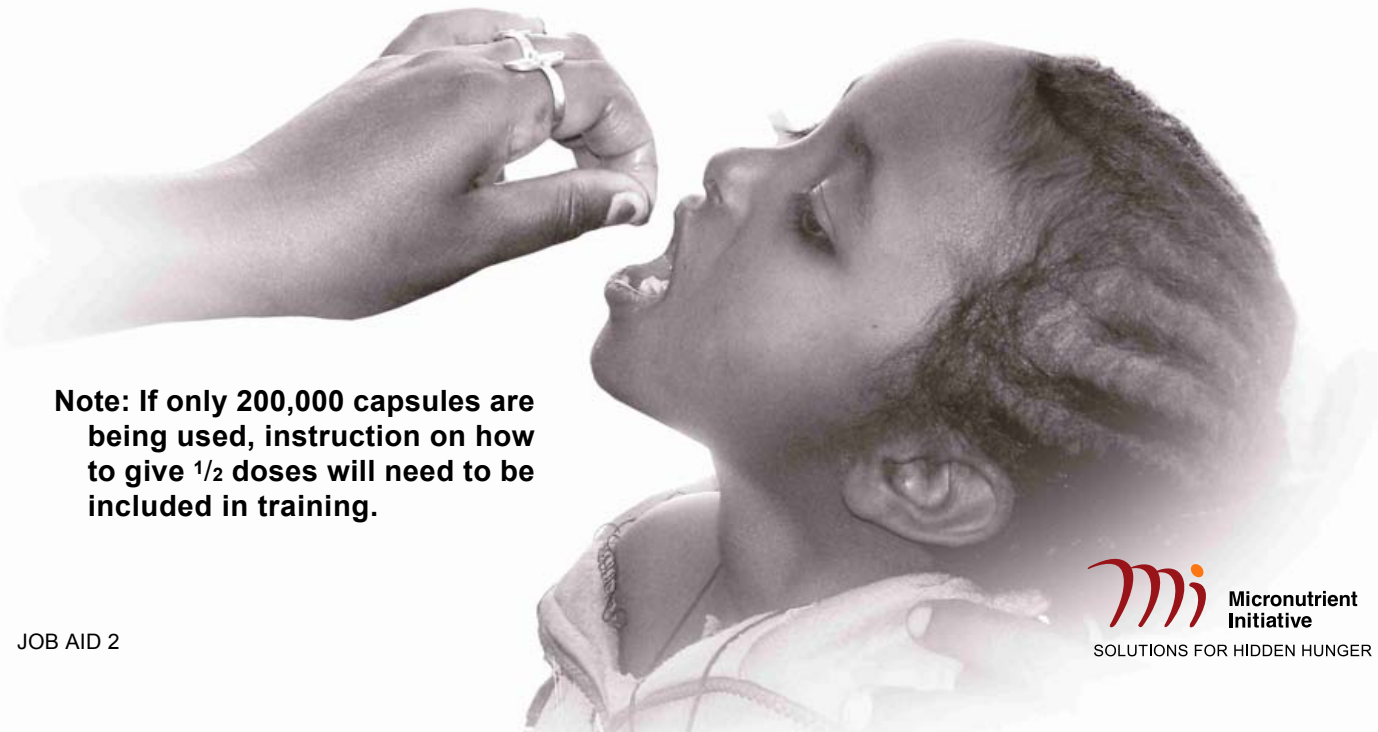
Remember to tell the child's parent or caretaker:

- This is vitamin A .....
- Vitamin A helps to keep your child strong and healthy .....
- Bring your child again for another dose of vitamin A in _____ (name of month).

VITAMIN A SUPPLEMENTATION DURING CHILD HEALTH DAYS
PREVENTIVE PROTOCOL FOR CHILDREN

Age	Dose	Frequency
Children: 6 months up to 11 months	100,000 IU (1 capsule of 100,000 IU)	Once
Children: 12 months up to 5 years	200,000 IU (2 capsules of 100,000 IU)	Every 4 to 6 months

* Do not give if child has already received a dose within last one month.
* Do not give vitamin A capsule to any woman of reproductive age during outreach.



Note: If only 200,000 capsules are being used, instruction on how to give 1/2 doses will need to be included in training.

Micronutrient Initiative
SOLUTIONS FOR HIDDEN HUNGER

Bi-annual Child Health Days

Ministry of Health, Uganda

Promotion of Key Family Care Practices

Child Health Days offer a good opportunity to promote optimal feeding and family care practices. Here is a selection of family care messages you could use:

Family care messages:

- Vitamin A fights diseases and protects lives. Take your child to the nearest health facility or outreach during Child Days until he is five years old.
- Children need vitamin A and de-worming every 6 months.
- Take children as scheduled to complete a full course of immunization (BCG, DPTHebB-Hip, OPV and Measles).
- Exclusively breastfeed your child until she is 6 months old. Do not give anything else, not even water.
- Wash hands with clean water and soap after using the latrine, before preparing food, before and after eating. Washing hands with water and soap kills germs. This will protect you and your family against disease.
- Ensure that all children under 5 years old and pregnant women sleep under insecticide treated nets (ITNs).This will protect them from mosquito bites which spread malaria.
- Ensure that every pregnant woman gets adequate antenatal care, this includes receiving the recommended doses of tetanus toxoid vaccination and IPT.
- Vitamin A protects the mother and baby against diseases. All mothers who give birth should get vitamin A. Ensure women get vitamin A and a check-up as soon as possible after a home delivery, (within first 8 weeks.)

Information for Health Workers

The Ministry of Health in April 2004 launched the strategy of bi-annual Child Health Days as accelerated action for child survival, growth and development. Child Health Days are conducted through the existing routine and outreach health services and will be conducted during May and November every year.

The minimum set of services during Child Health Days includes:

- Vitamin A supplements for all children age 6 months to 5 years
- De-worming for all children 1-5 years
- Routine and catch up immunization with special emphasis on measles for children under 1 and TT for pregnant women
- Promotion of selected family care practices, eg exclusive breastfeeding up to 6 months, home and personal hygiene, and sleeping under ITNs

Child Health Days are an acceleration of routine activities. Utilize therefore as much as possible the routine system for social mobilization and service delivery.

Encourage mothers or caregivers to come to the clinic or outreach post with Child Health Cards. These cards, if well filled in, give the information needed e.g. on vaccination status of the child. Fill in the services you give during Child Health Days on the Child Health Card and on TT cards.

All children between 1 and 5 years old are supposed to receive deworming tablets during Child Health Days.

While HMIS forms are being updated to include Child Health Day activities in the future, for now you still have to use tally sheets to record the number of children who receive Vitamin A and Deworming tablets. For vaccination please use the HMIS forms as usual. Child Health Day tally sheets are to be submitted along with the HMIS forms for November to the health facility. Compilation and reporting should follow the HMIS system.

Vitamin A Supplementation for Children: Prevention

Give vitamin A to all children aged 6 to 59 months:

Age Group	Dose	Amount of Vitamin A	
		100 000 IU capsules	**200 000 IU capsules**
6 months up to 1 year	100 000 IU	All of the drops in one capsule	Half of the drops in one capsule
1 year up to 5 years	200 000 IU	All of the drops in two capsules	All of the drops in one capsule

How to give vitamin A capsules to children:

- Ask the age of the child.
- Ask if the child has received vitamin A capsule in the last one month. If the answer is yes, confirm and do not administer. If no, continue.
- Ask the caretaker to hold the child, make sure the child is calm.
- Give the appropriate dose of vitamin A to the child:
  - 100,000 IU to child 6 -11 months.
  - 200,000 IU to child 12-59 months.
- Cut open the narrow end of the capsule with scissors or a nail cutter and squeeze the drops into the child's mouth.
- Check if the child is comfortable after swallowing the drops.
- Put all used capsules into a plastic bag and wipe hands to clean off oil.
- Record the dose on the child health card and on the tally sheet.

REMEMBER TO TELL THE CHILD'S PARENT OR CARETAKER:

- This is vitamin A
- Vitamin A helps to keep your child strong and healthy
- Bring your child again for another dose of vitamin A in _____ (name of month).

De-worming

De-worm all children between 1 and 5 years during Child Health Days according to the schedule:

Age	Albendazole (400mg)	Mebendazole (100mg)
1-2 years	1 tablet	200 mg = 2 tablets
2 -14 years	1 tablet	500 mg = 5 tablets

Albendazole can be chewed without water.
If Mebendazole is used, provide clean drinking water for children.

Immunization Schedule:

Child Health Day is not a campaign, but accelerated routine activity. Only children that are due for immunization, or that have missed their vaccination as per the schedule, should receive the needed immunizations. Check the immunization status of all children on the Child Health Card, and record any given during Child Health Days.

At birth	BCG*	+	Polio 0**
At 6 weeks	DPT-1/HepB+Hib1	+	Polio 1
At 10 weeks	DPT-2/HepB+Hib2	+	Polio 2
At 14 weeks	DPT-3/HepB+Hib3	+	Polio 3
At 9 months	Measles***		

* Give OPV-0 at birth or to an infant less than or equal to 14 days if not received previously.
** Do not give BCG to children who are HIV/AIDs symptomatic.
*** Give measles immunization to a child between 6 and 9 months if exposed to a measles case. Repeat the immunization at 9 months

Technical content for training for vitamin A distributions

People administering vitamin A need to know:

- The importance of vitamin A for child survival
- How to identify target groups for vitamin A and de-worming
- What order to give vitamin A, de-worming tablets and other services
- Recommended doses for each age / target group
- How to recognize the type of capsules of vitamin A available for distribution (100,000IU and 200, 000IU)
- How to store and handle vitamin A
- How to open a capsule and give vitamin A to a child
- How to give a half-dose to children aged 6-11 months if using only 200,000IU capsules
- What to tell the parent/caretaker at that time
- How to record vitamin A on child health card and tally sheet

Supervisors need to know:

- All of the above plus:
- The side effects/safety, and effectiveness of vitamin A
- How to obtain and maintain supplies
- How to calculate and monitor vitamin A coverage
- The purpose of supervision

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SOLUTIONS FOR HIDDEN HUNGER

Supervisory Checklist

Supervisory visit checklist during a vitamin A distribution:

Are there enough stocks of vitamin A capsules?

At the distribution, are there:

- Scissors to open the capsules
- Wipes or towels to clean oil off hands
- A plastic bag or box to throw away used capsules
- Tally sheets/reporting sheets
- A protocol for supplementation
- Are capsules stored away from direct sunlight?
- Is site organized for children to get vitamin A before any injections, so that the child will not be crying?

In practice:

- Does the provider check the age of the child?
- Does the provider give correct dose for age?
- Does the provider open, administer and dispose the capsule correctly?
- Are hands clean and free of oil?
- Does the provider make sure the child is calm before giving the vitamin A?
- Does the provider check to see that the child swallows the drops and is alright?
- Does the provider record the dose on the tally sheet afterwards?
- Does provide give parent messages about receiving vitamin A?
- Does the provider tell the parent when to bring the child again for the next dose of vitamin A?

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Exit Interview Form*

Ask open questions rather than questions that can be answered with yes and no as this provides a more reliable test of her knowledge. For example, ask “What did your child just receive from this worker?” rather than “Did your child receive vitamin A?”

a. Ask her if she knows when she should return. Correct answers are in six months, every six months, or in August for example.
b. Ask her what age children are supposed to come for this dose. The correct answer is all children between the ages of six months and five years.
c. Ask her what some of the benefits of the vitamin A capsule are. There are many correct answers. Interviewers should agree on acceptable ones, and should list those given for future use in communication campaigns.
d. Ask her if she intends to return for the next dose.
e. Ask how she thought the provider behaved toward her. Another approach, although it cannot be analyzed quantitatively, is to ask “What did you like best about the distribution, and what did you like least about the distribution?”
f. Ask if she knew that vitamin A was going to be given today.
g. If yes, ask her where she heard this information. Check the sources she mentions for information about the vitamin A capsule. These will be very useful for the communication strategy.
h. Note the date, site and number of interview.

Sample Exit Interview Form

Date .....
Site .....
Provider .....
Interview no. .....

ACTION	YES	NO
a. Can state that her child received vitamin A		
b. Can state correctly when to return		
c. Can state correctly who is eligible (6 months to five years)		
d. Can state benefit/s of vitamin A List: protects child, prevents blindness, makes child grow stronger, etc.		
e. Caregiver says health worker was polite/welcomed her		
f. Caregiver says she will or will not return for the next dose		
g. Caregiver says she did or did not know that vitamin A capsule would be distributed today		
h. If yes, caregiver says where she heard about vitamin A capsule distribution. Check all answers mentioned: Health worker Religious leader Local leader Leaflet/poster/sign/banner Neighbour/friend/relative Radio Other (list)		

* Adapted from MOST, the USAID Micronutrient Program

Micronutrient Initiative

Orientation & Planning

Vitamin A supplementation in Child Health Weeks

www.micronutrient.org

Solutions for hidden hunger

Session 1: Opening Session & Process

The purpose of this session is:

- to introduce the concept of Child Health Weeks
- introduce objectives the orientation workshop
- to review the agenda and sessions for this meeting

Orientation & Planning for Child Health Weeks

Workshop Objectives:

- Review program status and specific needs to be addressed during upcoming Child Health Week
- Give updated technical information and prepare for training of service providers
- Introduce job aids, and
- Finalize plans and logistical arrangements for supplies and materials for the upcoming round

Orientation & Planning for Child Health Week

Sessions

1. Opening Session and Process
2. Reviewing the Previous Child Health Week
3. Planning for the next Child Health Week
4. Planning Human Resources, Logistics and Supplies
5. Social Mobilization
6. Training Service Providers
7. Supervision
8. Monitoring
9. Reporting and Review
10. Review of Action Plan and Finances

Micronutrient Initiative

Accelerating Vitamin A Supplementation

Session 1

www.micronutrient.org

Solutions for hidden hunger

Why Vitamin A Supplementation?

- Vitamin A: for more than just eyes
- Strong link: Vitamin A and Child Survival

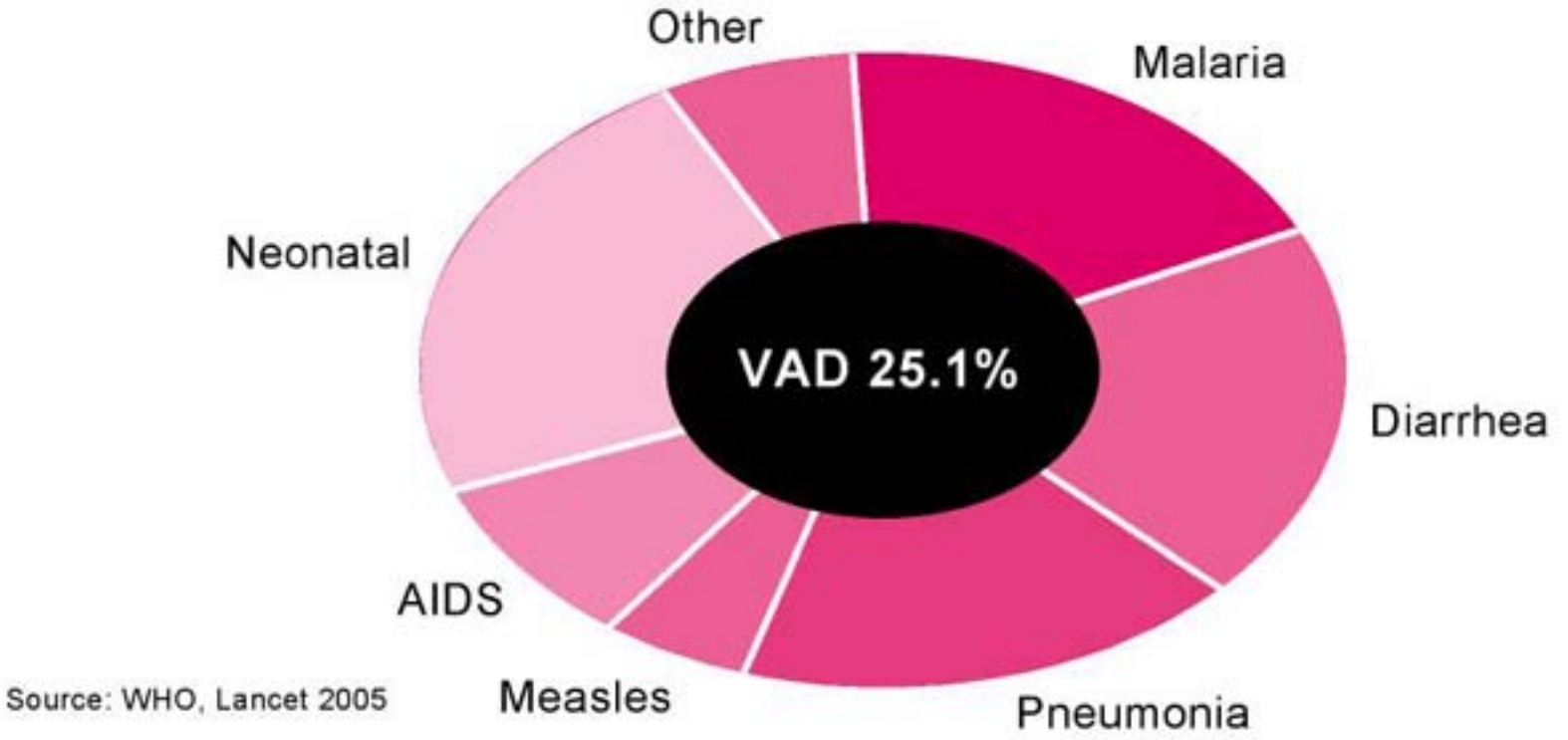
Large amount of research since 1990s….

Reason to Act

Improving vitamin A status of deficient children increases their chances of survival

- Death from measles can be reduced by 50 percent
- Death from diarrhea can be reduced by 40 percent
- Overall mortality can be reduced by 25 percent

Estimated Contribution of VAD to Child Mortality in Sub-Saharan Africa



Source: WHO, Lancet 2005

Why Every 6 Months?

- Body cannot make vitamin A
- Vitamin A is stored in the liver
- Illness quickly uses up vitamin A
- Effect of capsule on vitamin A stores only lasts for 4-6 months

to protect a child….

A Vitamin A capsule is needed

every 6 months

to have an impact on mortality in a population….

At least 70% of children

need to be reached with Vitamin A

every 6 months

What is the best way to reach children?

Accelerated Vitamin A & Integrated Outreach

Child Health Week, Child Health Day,
Child Action Day, Vitamin A Week

What is it?

- Regular events organised to deliver an integrated package of preventive services:
- Achieve high coverage & reduce inequities
- National or sub-national in scope
- Conducted twice/yr (usually 6 mo apart) & time-limited (week, month)
- Focus on children 6 to 59 months
- Supported with communications campaign
- Carried out by health workers and volunteers

Services offered…

- Vitamin A supplementation
- De-worming
- Catch-up immunizations
- Re-treatment of bed nets
- Promotion of health practices

successful programs start with a few and then add

Opportunities

- Reaches beyond health facility
- Emphasis on preventive services
- Easy to reach children >1 year old
- Timing works for vit A and de-worming
- Reminds parents to bring children for services
- Costs can be shared by several programs

Benefits

- High vitamin A coverage
- Increases coverage other services
- Links health services and the community
- Focused, effective use of resources

Successful Post-NIDs Strategy

in:

- Zambia since 1999
- Philippines since 1993
- Uganda, Ghana, Tanzania

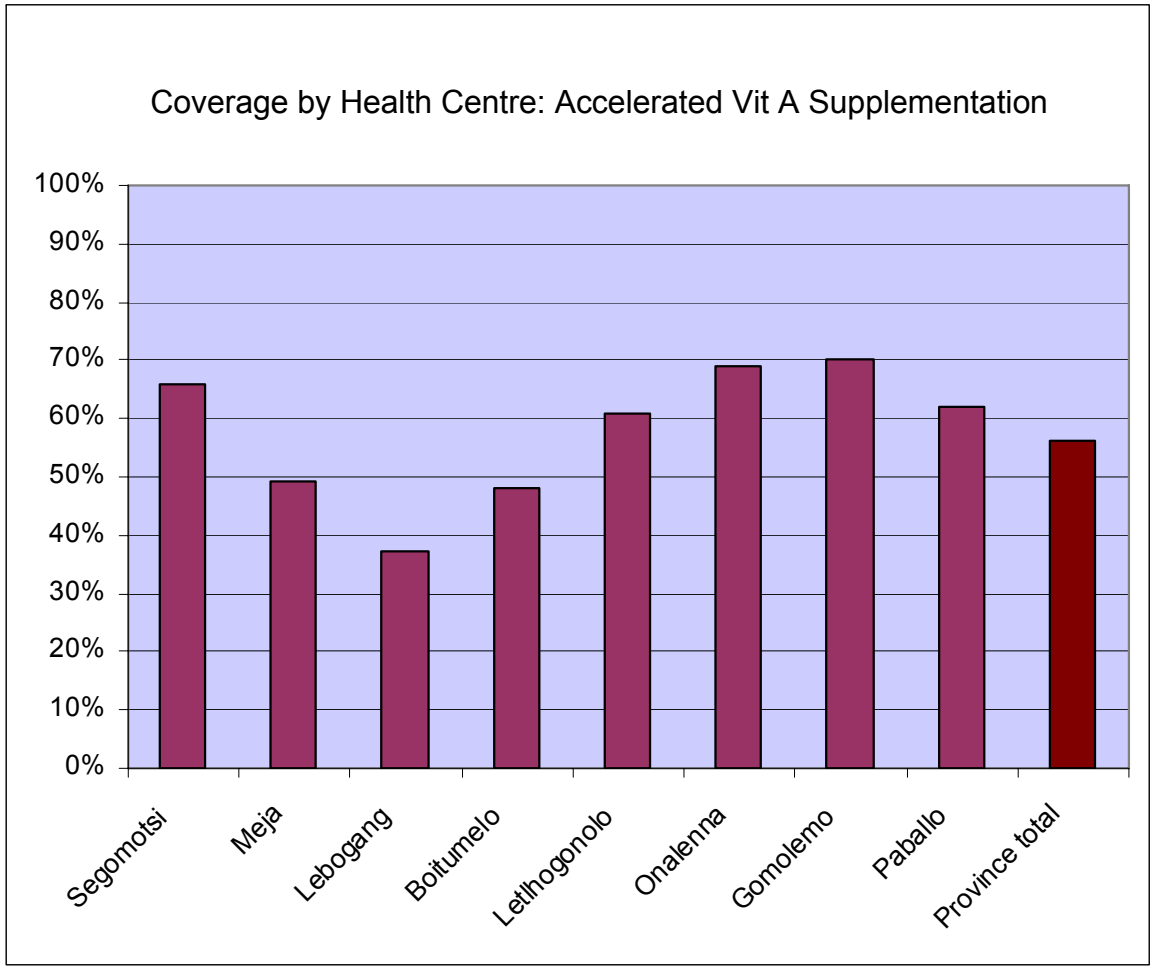
Countries able to reach and sustain
80% vitamin A coverage twice a year

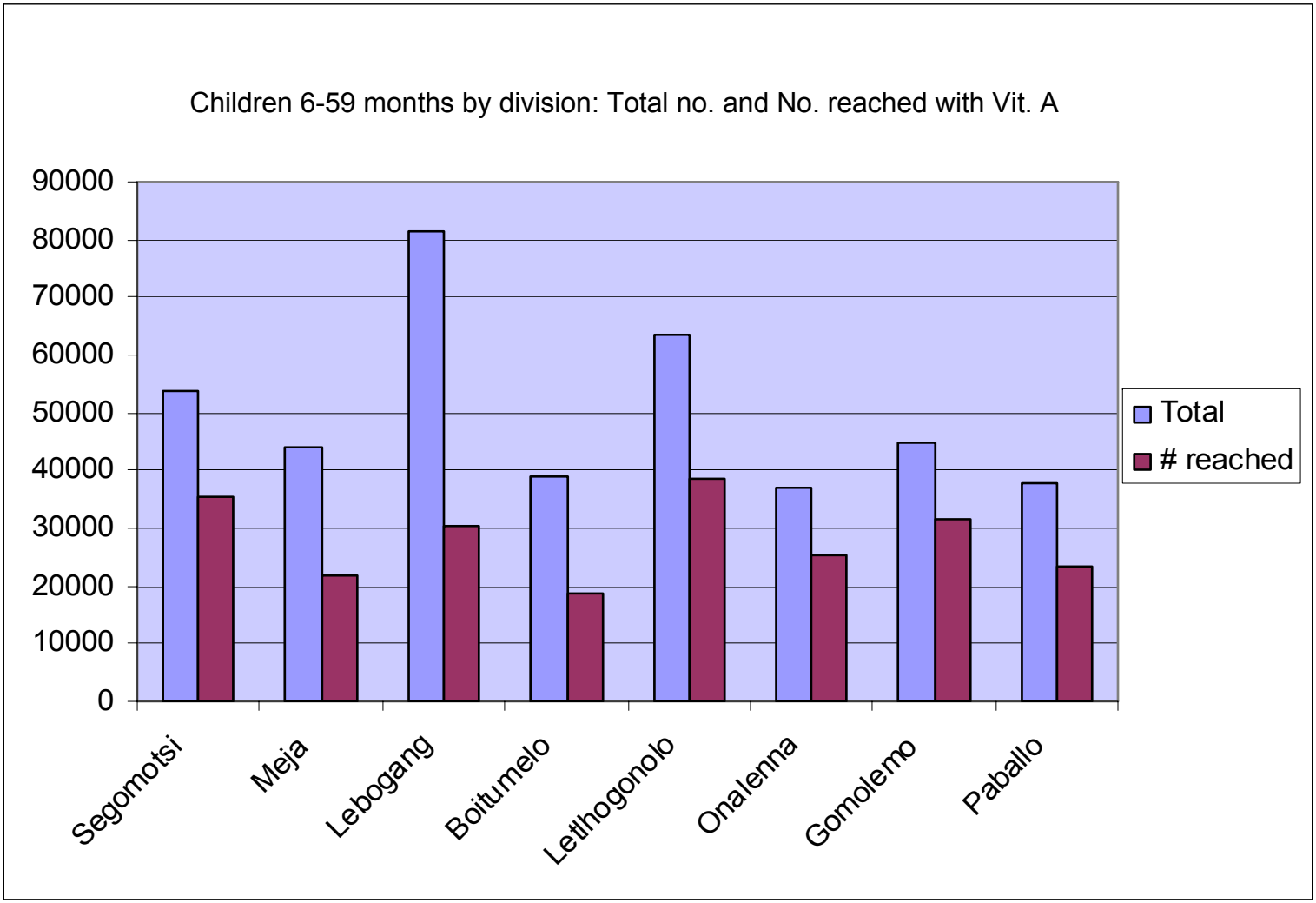
Session 2: Review of the Previous Vitamin A Distribution

The purpose of this session:

- Identify what factors resulted in higher coverage in the last Child Health Weeks
- Identify what factors led to lower coverage
- Summarize lessons learned and the important points to consider when planning for the next Child Health Weeks

Examples on How to Present Coverage




Children 6-59 months by division: Total no. and No. reached with Vit. A
90000
80000
70000
60000
50000
40000
30000
20000
10000
0
Segomotsi
Meja
Lebogang
Boitumelo
Letlhogonolo
Onalenna
Gomolemo
Paballo
Total
reached

Worksheet 1: Factors Which Increased & Limited Good Coverage During the Last Round of CHW

	Main Reasons for Good Coverage	How to continue this….
1		
2		
3		
	Main Reasons for Low Coverage	**How this can be corrected…..**
1		
2		

	Key Recommendations for the Next Round
1	
2	
3	
4	
5	
6	

Worksheet 2:
Population to Reach for Child Health Week Services

DISTRICT POPULATION = ……..

Under 5 population = ……..

	Health Centre	Children under 5yrs	Children age 0-11 months	Children age 12 - 59 months (De-worming)	Children age 6 -11 months	Children 6 to 59 months (Vitamin A)
		A	B	C	D	E
1.						
2.						
3.						
4.						
	DISTRICT TOTAL					

Session 3: Action Plans & Setting Targets for the next Child Health Weeks

At the end of this session participants will have:

- Proposed coverage figures to reach during the next Child Health Weeks
- Come up with an action plan that will improve performance and coverage of various components of the Child Health Weeks

Worksheet 2: Action Plan for CHW

Target Population for Vitamin A _____

Coverage Achieved _____ Date of Next Distribution _____

Activities	Dates	Who	List the Type of supplies needed	Logistics required	Support – who will help you	Additional support required
Before the distribution						
During the distribution						
After the distribution						

Session 4 - Planning for Human Resources, Logistics & Supplies

At the end of this session, participants will be able to:

- Identify human resource needs and logistics support
- Identify all supplies or materials required to conduct a Child Health Week
- Identify sources of support either in form of money, material or in-kind contributions
- Work out better/effective ways to collect and distribute supplies or materials from the district to all points where activities will be implemented.

What do You Need to Know to Make Your Plans?

- Population
- Expected coverage
- Duration of distribution
- Number & locations of distribution points
- Package of services
- No. of teams and no. of people per team
- No. of supervisors
- Mapping

Planning for Logistics & Supplies

Supplies needed:

- Vitamin A capsules
- Scissors, disposal bag, wipes
- De-worming tablets and supplies
- Tally sheets
- Job aids, schedule
- Supplies for other services
- Stationery

Estimating Supply Requirements…

Estimated no. capsules needed for population

Estimated no. de-worming medicines for pop.

Other supplies for distribution points/teams

From where?

timely

Consider transport required….

Number Vitamin A Capsules

Children to reach: 6-11 mo 100,000IU

12-59 mo 200,000I

(No. children to reach x Expected coverage) x 1 capsule + 5% (handling losses)

- Example: 500 children 6-11 mo and

1000 children 12-59 mo;

Expected coverage 80%

- [(500 x 80%) x 1 capsule 100,000IU] + 5%

= 420 capsules 100,000IU

- [(1000 x 80%) x 1 capsule 200,000IU] + 5%

= 840 capsules 200,000IU

De-worming Tablets

Target age group: 12-59 months

Dosage: 1 tablet (500 mg)

(Number in target group x expected coverage x 1 tablet) + 5% for handling losses

Other Supplies

What you will need per post, per health worker?

Session 5: Social Mobilization

At the end of this session participants will:

- Have reviewed promotion and IEC materials available for Child Health Weeks
- Understand the importance of community promotion
- Have explored options for community promotion activities to support CH Week
- Looked at promotion activities for the next round: what, how and with whom.

Minimum information for all parents:

- ✓ The dates of Child Health Week
- ✓ Where and when to go (time and locations)
- ✓ What services will be given
- ✓ To take all children age 6 to 59 months
- ✓ Child Survival or health benefits of the services (i.e. that this is important for the health of every child)

How to Spread the Word….

- Use of Loudspeakers / Public Address System
- Use of “town criers” or traditional announcers
- Community forums and meetings
- Announcements from Churches and Mosques
- Publicity Walk
- Involvement of Schools
- Drama performances
- Promotional Materials
- Community Radio Stations
- Commercial stations

How to Spread the Word…what works

- Use of Loudspeakers /Public Address System
- Use of “town criers” or traditional announcers
- Community forums and meetings
- Announcements from Churches and Mosques
- Publicity Walk
- Involvement of Schools
- Drama performances
- Community Radio Stations
- Commercial stations

Not expensive

How to Spread the Word…what works

- Use of Loudspeakers /Public Address System
- Use of "town criers" or traditional announcers
- Community forums and meetings
- Announcements from Churches and Mosques
- Publicity Walk
- Involvement of Schools
- Drama performances
- Community Radio Stations
- Commercial stations

Not expensive

More expensive

How to Spread the Word…

Findings from Evaluations from Vitamin A and Polio eradication programs world-wide and in Africa:

- ✓ In urban areas, radio and announcements from churches/mosques work best
- ✓ In rural areas, “town criers”, miking and traditional and community leaders work best
- ✓ Hard-to-reach areas require special strategy
- ✓ Posters and print materials not very effective

Session 6: Training Service Providers

By end of session, the participants will:

- Have reviewed skills which need to be focused on when training service providers to give vitamin A
- Understand the key content for training and practiced with job aids
- Have discussed and practiced good approaches for teaching these skills
- Have developed a plan for training health workers in your area before the next CHW

Job Aids

1. Info leaflet on Child Health Weeks (HWs)
2. How to give vitamin A, Vit A schedule (HWs)
3. Fact sheets on vitamin A and CS (Trainers)
4. Supervision checklists (Coordinators, Supervisors)

Training Service Providers……

A Focus on Skills

Training Service Providers……
A Focus on Skills

Basic info on vitamin A for health workers

Skills

- Technique – how to give capsules
- What to tell parent when giving capsules

Training Service Providers……

Basic information on Vit A

- Health Facts
  - ✓ Protects child, decreases risk dying, helps fight infections, child survival
- Biology
  - ✓ Stored 4-6 months, lost quickly fighting infections
  - ✓ Why supplementation needed (not getting enough in diet)
- Safety and side effects
  - ✓ Safety margin, what to do if side effects
- Schedule

Training Service Providers……

Side effects…..

- Usually there are no side effects
- However, sometimes a child may eat less for a day, or there could be some vomiting or headache
- Advise the mother/parent this is normal, that symptoms will pass and no specific treatment is necessary

Minimum gap – 1 month

Training Service Providers……

Skills: Technique - How to give capsules

- Giving correct age for dose
- Cutting capsule, giving it correctly
- Giving ½ dose if needed
- Marking card and tally sheet
- Disposing capsule, hands clean

Job Aid 2

Training Service Providers……

Skills: What to say

- Tells this is vitamin A
- Vitamin A helps fight illness, good for health/growth
- Another dose needed in 6 months

Training Service Providers……

How to Give

- Demonstration
- Practice

Do demonstration here..

Training Service Providers……

- How to Give Vitamin A — Job Aid 2
- Practice - - Role Play — (4 people)
  - ✓ One person be mother
  - ✓ One person be health worker
  - ✓ Two people be supervisors — Job Aid 5
- Act out, the supervisors observe, fill sheet, give feedback. Change, and do again.

Training Service Providers……

Group Discussion:

1. What did you learn from morning session?
2. For Vit A Week, How will you train workers in your area?
   - ✓ who, how long, how many batches
   - ✓ what activities in training sessions

Session 7: Supervision

The purpose of this session:

- Understand why supervision is important
- Have reviewed the tools for supervision
- Have discussed plans for supervision during Child Health Weeks

What is Supervision?

- Process that involves guiding, overseeing, directing or managing what you would like to see happen during the child health week.

Why is Supervision Important?

- It ensures the quality of the service provided which in turn contributes to the proper implementation of the program:
  - ✓ Is the capsule cut correctly?
  - ✓ Is the right dosage given?
  - ✓ Is the capsule discarded properly?
  - ✓ Are the right health messages provided?
  - ✓ Are the tally sheet and child card filled correctly?
  - ✓ Is there enough capsules to cover the no. of children in the catchment area?

Who Does the Supervision?

- Supervision is usually done by someone at a higher level
  - ✓ National → Provincial → District → Health facility → Health post

What is Needed for Effective Supervision?

- A plan
  - ✓ Map of the area to supervise and number of posts to supervise
  - ✓ A schedule
- Extra supplies (capsules, tally sheets, wipes, etc)
- Supervisory tools
  - ✓ Supervisory checklist (job aid 5)
  - ✓ Observation checklist to identify needed improvements, gaps, and positive aspects (see example)

How do you Supervise?

- Be supportive
  - ✓ Recognize good performance
  - ✓ Build confidence
  - ✓ Be constructive
  - ✓ Do not correct in front of clients
- Be prepared to take action

Session 8: Monitoring Child Health Weeks

What is monitoring?

- A critical component of planning and implementing child health days
- Continuous and systematic collection and analysis of data
- Takes place at national, district and health centre level

BUT

- Should NOT be a vertical effort
- Should be integrated with
  - existing health system monitoring (especially if there is a district health management information system
  - Monitoring of other programmes – such as Reaching Every District and EPI

Why is monitoring important

- Information from the district level feeds into national level – guides decision making and allocation of funds
- Determines whether you are meeting your objectives, and targets
  - Will identify low coverage areas
  - Will identify children who are missed – and WHY
- Improves programme performance, effectiveness and efficiency
- Provides feedback to service providers

What can be measured – and how

- Coverage
- Those aspects of the programme that will affect coverage at a district level – **planning, supervision, training, supplies**
- How – indicators. **Consider**
  - Does the indicator measure what you want to know?
  - Is the data required for the indicators easy to collect / available
  - Does the indicator measure the changes that you need to know about
  - How often will you measure the indicator
  - Who will measure the indicator

Some examples of indicators to monitor performance of Child Health Weeks

Aspect of CHW	Indicator	Frequency	WHO?
Provision – including logistics	# staff and volunteers mobilized # staff / volunteers trained # health centres receiving supplies on time # supervisory visits planned that actually take place	After each child health week	District health management team
	# districts reporting adequacy of supplies for child health week # health centres reporting on time		
Utilisation	% mothers aware of the importance of VA	Annually	Health centre staff
	% health care workers and volunteers aware of importance of de-worming		
Coverage	% children 6 – 59 months receiving VA in last six months	During each child health week	Health centre staff and volunteers
	% children receiving de-worming in last six months	After each child health week	Field workers

Coverage

6 – 11 months	12 – 59 months
The number of children aged 6 – 11 months who receive a capsules of VA during each child health week **% coverage during this period**	The number of children aged 12 – 59 months who receive a capsule during each child health week. **% coverage during this period**

Tally sheets

- First level of data collection, provides numerator data **SO ACCURACY AND TIMELINESS ABSOLUTELY CRTICIAL**
- Same tally sheet can be used to record VA / de-worming and other interventions
- Keep tally sheets as may need to verify / check data
- Distributors should be trained in how to complete tally sheets – and summarize information

Mistakes that will affect numerator

Mistake	Problem	Comment
Tally before VA given	Child may not receive VA	**Give the dose THEN tally**
Tally at the end of the session according to capsules distributed	Wasted capsules will be counted	**Tally after each dose given**
Tallying without separating by age group	Inaccurate data	Have separate sections on form for children 6 – 11 and 12 – 59
Tallying without considering children over five and children outside denominator area	Numerator, and therefore coverage will be high Not giving VA to these children is, in reality very hard	•Include a column for children > 5 •Include a space for the number of capsule delivered to distribution point. If forecasting good – this number, minus the doses to children < five = children over five.

Problems with the denominator

Note that:

- Some children will be missed in a census and missed during a child health week
- For children 6 – 11 months – use EPI denominator
- If other interventions are included in the child health week – use same denominator when calculating coverage

Session 9: Reporting and Feedback

In session 8 we looked at

- Why monitoring is important
- What should be monitored
- How data for monitoring is collected

Collecting data has no value if

- It is inaccurate
- No one sees it
- It is sent to the district level too late to take action

Reporting accurate data ON TIME is critical

At the end of the session participants will:

- Recognise the importance of timely and accurate reporting of data
- Describe how data will be summarised and transferred to the next level
- Know how to review summary forms
- Be able to plan for feedback sessions that actually improve planning and implementation

Reporting

Level	What is collected	What is sent to next level	How	When
Distribution point	Tally sheets	Summary of number of children reached Number capsules used	During supervisory visits Telephone Fax Text message	Daily during child health week
Health centre	Summary forms from each distribution point	Health centre summary form	During supervisory visits Telephone Fax	Within one week
District	Summary froms from health centre	District summary form District report on supplies Coverage Financial report	Post Fax Hand delivered	Within three weeks of child health day
Province	Summary from districts Coverage	Provincial summary form Financial report	Hand delivered	Within five weeks of CHW
National	Summary forms	National report	May be submitted to donors / MoH / Partners	Every six months

Summary forms

- Collate data from distribution points / health centres
- Include information on
  - Identification
    - Name of reporting unit
    - Name of person completing form
    - When form filled in
    - Number of distribution points / health centres
- Numbers of children to reach (from planning session)
- Numbers of children reached
- Coverage
- Additional information
    - Number of health centres with stock outs
    - Funds allocated / used
    - Summary of supplies received and used.

Checking data

- Check report for completeness
- Read some as a matter of priority
- Look for big changes from previous child health week – in number of children
- Check timeliness of report
- Check areas with very high or very low coverage – there may be mistakes

Analysis of coverage

- On track – areas with coverage > 80%
  - **In planning sessions – highlight these area.**
  - **What are they doing right?**
- To watch – areas with coverage 50 – 79%
  - **What were the problems?**
- High alert – areas with coverage below 50%
  - **Identify problems**
  - **Do they need extra resources / support?**

Analysis of other aspects of child health week

- Supervision and monitoring
  - **The number of planned supervisory visits that actually took place**
- Adequacy of report
  - **The number of health centres / distribution points that submitted reports on time**
  - **The number of health facilities NOT submitting any reports**
- Adequacy of supplies
  - **The number of facilities reporting a shortage of supplies**

Feedback

Is it important?

- Creates a collaborative environment by acknowledging the hard work of data providers and making them aware that their data is analyzed.
- Feedback can improve the accuracy and promptness of reports and raise the morale of health center staff.
- Opportunity to verify with the peripheral levels that the data received at more central levels are correct and makes the peripheral level staff accountable for the data that they provide.
- Improves performance by showing national progress towards high coverage and allows comparison of performance between districts
- To provide data and advocacy materials to enhance policy makers ability to make decisions regarding funding and support to Child Health Weeks.

How to provide feedback

- Supervisory visits to health centers
- Monthly / quarterly newsletters
- Periodic meetings. A meeting of the team after each event is an appropriate opportunity to report progress to all stakeholders – PLAN FOR THIS MEETING IN YOUR PLANNING SESSION
- Telephone calls or text messages
- Letters
- During routine visits by peripheral health center staff to district offices.
- **ALWAYS** during a meeting to plan for the next child health week.

Contents of feedback

- Coverage achieved
- Variance from district targets
- Identification of high and low performing sub-districts / health centers
- Comparison to previous distributions / years / distribution mechanisms
- Comparison to other districts (if known)
- Details on problem areas
- Results from supervision and observation visits conducted
- Comment on promptness and reliability of reports
- Suggestions for improving delivery during the Child Health Week and suggestions for improving data collection.

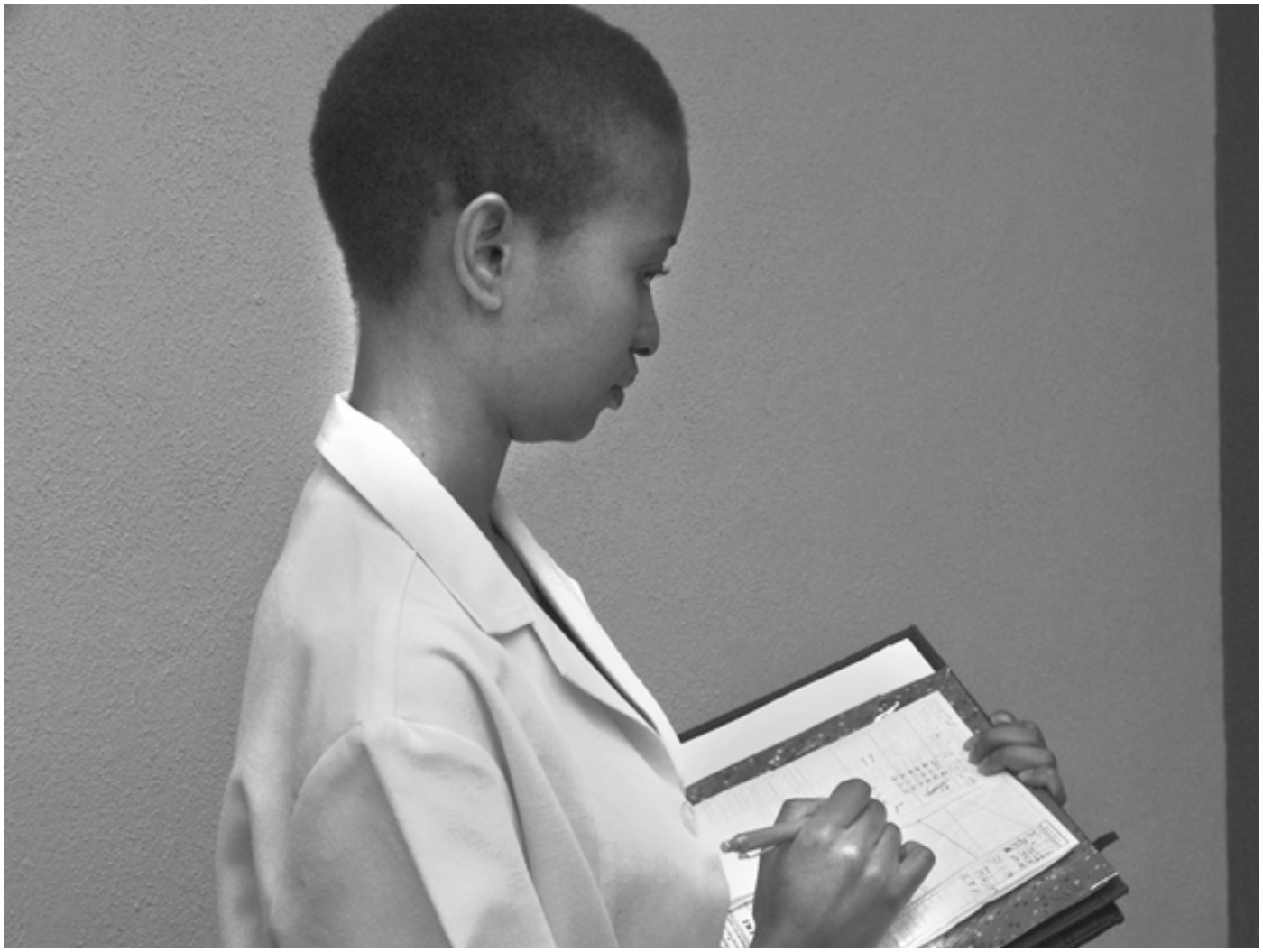
Micronutrient Initiative

Vitamin A Distribution

Demonstration

www.micronutrient.org

Solutions for hidden hunger

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