State Ministry of Health

The CAPA Handbook

A "How-To" Guide for Implementing Catchment Area Planning and Action, a Community-Based Approach to Child Survival

BASICS II / Nigeria

USAID

Abstract: This manual provides step-by-step guidelines as a "how-to" for implementing the CAPA approach, and was developed for use by State Ministries of Health, program managers, technical staff, and donor agencies involved in community-oriented approaches for child survival activities. Basic Support for Institutionalizing Child Survival/Nigeria (BASICS II/N), in collaboration with Nigeria's federal and state governments, conceptualized and designed a community-based approach (CBA) called Catchment Area Planning and Action (CAPA) to empower community members to take an active role in improving the health of their children in areas of immunization, nutrition, and malaria. CAPA's approach places the locus of health program development at the community level with the intent of creating community ownership, promoting public and private sector partnerships, and stimulating demand. The approach is flexible enough for adoption by other development ministries and partners in Nigeria or by other developing countries, and its adaptation and its use in other sectors and contexts are encouraged.

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BASICS II

U.S. Agency for International Development
Bureau for Global Health
Office of Health and Nutrition
Washington, DC
Website: www.usaid.gov/pop_health/

Basic Support for Institutionalizing Child Survival Project
Partnership for Child Health Care (PCHC), Inc.
1600 Wilson Blvd., Suite 300
Arlington, VA 22209
Tel: (703) 312-6800 / Fax: (703) 312-6900
Website: www.basics.org

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This publication is dedicated to the memory of Andy N. Agle,
BASICS II/Nigeria Country Director

BASICS II / Nigeria

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ACKNOWLEDGMENTS

BASICS II acknowledges the following individuals for their contributions to the production of this publication:

Technical Writers
Ene Obi
Sam Orisasona

Technical Reviewers
Olawunmi Ashiru
George Greer
Bob Lennox

Edited by
Andrew Agle
Adewale Maja-Pearce
Ene Obi
Mireille Cronin Mather

The following individuals made valuable contributions:

BASICS II HQ/Arlington
Dan Kraushaar – Project Director

Sereigne Diene, Ciro Franco, George Greer, Vicky Johnson, Bob Lennox, John Lewis, Amy Martin, Mireille Cronin Mather, Andrea May, Beth Plowman, Tina Sanghvi, Eleonore Seumo, Ian Sliney, Robert Steinglass, and Fred White,

BASICS II/Nigeria
Andrew N. Agle – Country Director

Hezekiah Adesina, Mosum Adewusi, Nathaniel Adim, Abiodun Akinpelumi, Francis T. Aminu, Olawunmi Ashiru, Olu Ayodele, Garba Babale, Salamatu Bako, Maria Elejire, Grace Essien, Uche Eze, Carl Hasselblad, Ayo Iroko, Leila Madueke, Ken Obialor, Kunle Obisesan, Wunmi Obisesan, Chukwuyem Okoh, Rosemary Okoli, Awuese Oku, Funmi Olukeye, Ijeoma Onyeagba, Sam Orisasona, Greg Osubor, Fatimah Sada, Abimbola Sowande, Mini Soyoola, and Tony Ukwelenwa.

USAID / Nigeria
Dawn Liberi – Country Director

Garba Abdu, Liane Adams, Felix Awantang, Lynn Gorton, and Tom Hobgood.

Nigerian Government Agencies and Communities
Abia State Ministry of Health, Nigeria
Kano State Ministry of Health, Nigeria
Lagos State Ministry of Health, Nigeria
Nigeria Primary Health Care Development Agency
All CAPA communities in Nigeria

ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
CA	Catchment Area
CAPA	Catchment Area Planning and Action
CBA	Community-based approach
CBO	Community-based organization
CBC	Communication for behavior change
CHP	Community Health Promoter
DPH/DC	Director of Primary Health Care/Disease Control
HMIS	Health Management Information System
KAP	Knowledge, Attitude, and Practices
LGA	Local Government Area
MCH	Maternal and child health
NDHS	National Demographic and Health Survey
NGO	Non-governmental organization
NPI	National Programme on Immunization
ITN	Insecticide-treated net
IPT	Intermittent Presumptive Treatment
PHC	Primary Health Care Centre
PH/DC	Public Health and Disease Control
PMV	Patent Medicine Vendor
SMOH	State Ministry of Health
TBA	Traditional Birth Attendant

PREFACE

The United Nations Children's Fund (UNICEF) report *State of the World's Children 2003* ranked Nigeria 14th worst in the world for child mortality, with 110 infant and 183 under-five deaths per 1,000 live births. Malaria, diarrhoea, measles, and pneumonia accounted for 70% of those deaths, and more than 60% of the total suffered underlying malnutrition.

FACTS ON CHILD HEALTH IN NIGERIA

- Global rank in child mortality: **14th worst**
- Infant mortality: **110 per 1,000 live births**
- Under-5 mortality: **183 per 1,000 live births**
- % of deaths caused by malaria, diarrhoea, measles, and pneumonia (preventable diseases): **70%**
- % of deaths with underlying malnutrition: **60%**

Maternal morbidity and mortality in Nigeria, where 45,000 mothers die in childbirth per year, is exceeded only by India and Ethiopia. In the parts of northern Nigeria, the maternal mortality rate was estimated to be more than 2,400 per 100,000 live births.

Large-scale attempts to improve child survival in Nigeria have generally been government or donor efforts focused on vaccine-preventable diseases, diarrhea, malaria, and acute respiratory infections. Globally, such initiatives have also strived to improve health systems to enhance their abilities to provide appropriate services. Many of these country programs enjoyed considerable initial success, but the gains were eventually eroded by institutional apathy and/or loss of external support.

Experience has shown that the impact of programs to improve maternal and child health is greater when the community plays an active role in planning the interventions and participating in the implementation process. Basic Support for Institutionalizing Child Survival/Nigeria (BASICS II/N), in collaboration with Nigeria's Federal and State governments, conceptualized and designed a community-based approach (CBA) called **Catchment Area Planning and Action** (CAPA) to empower community members to take an active role in improving the health of their children. CAPA's approach places the locus of health program development at the community level with the intent of creating community ownership, promoting public and private sector partnerships, and stimulating demand.

CATCHMENT AREA PLANNING AND ACTION (CAPA):
A community-based approach to empower communities to take an active role in improving the health of their children.

A **catchment area** is the geographic area served by a particular Primary Health Center (PHC) and consists of a geographically proximate community of people with common concerns and needs. The community's size and shape is defined by shared interests, the presence of essential services and institutions, and the need to

CATCHMENT AREA:
The geographic area served by a particular Primary Health Center (PHC) consisting of geographically proximate community of people with common concerns and needs.

interact with one another. This association of people, their formal and informal health care institutions, and their society forms the basis of a catchment area.

By government design, the geographic size of a PHC catchment area is generally small enough for people to cross on foot in the course of normal business, but large enough to gain strength from associations and structures that extend beyond local settlements. In drawing the catchment area map, (an essential step for CAPA as described later), hospital cards of patients determined the boundaries. Each catchment area map delineates one CAPA community from the next.

The PHC constitutes the nucleus of the catchment area, but private health facilities, individual providers of health services (such as traditional birth attendants, or TBAs), patent medicine dealers, PHC staff, and traditional healers all serve as sources of advice, knowledge, and help to the mother/caregiver. Often overlooked are the non-medical organizations and leaders that wield considerable influence within the community. These include women's clubs, religious groups, professional and trade organizations and associations (such as taxi drivers' unions), market women, and schools. These are important resources at the community level that CAPA identifies, mobilizes, and trains to provide voluntary community services for improved maternal and child health.

SOURCES OF CHILD HEALTH CARE IN A CATCHMENT AREA:

- Primary Health Center*
- Traditional Birth Attendants
- Patent Medicine Dealers
- Traditional Healers
- Women's Clubs
- Religious Groups
- Professional/trade organizations
- Schools

Establishing CAPA as the coordinating unit of community health is perhaps the single most important activity that occurs at the community or catchment area level. The process consists of a series of steps and/or meetings that build community awareness of child survival problems and interventions, establishes community ownership of the process, gives the community a voice with which to advocate for services and resources, and sets up a system by which the community can identify and implement appropriate interventions, monitor progress and identify and resolve) problems.

CAPA:

- Builds community awareness of child survival problems and interventions
- Establishes community ownership of the process
- Gives the community a voice with which to advocate for services and resources
- Sets up a system by which the community can implement interventions, monitor progress and identify and resolve problems

This manual is intended to provide step-by-step guidelines as a "how-to" for implementing the CAPA approach, and was developed for use by State Ministries of Health, program managers, technical staff, and donor agencies involved in community-oriented approaches for child survival activities. However, the approach is flexible enough for adoption by other development ministries and partners in Nigeria or by other developing countries, and its adaptation and its use in other sectors and contexts are encouraged.

1. INTRODUCTION

CAPA has been implemented in three of Nigeria's six geo-political zones (Abia State in the southeast, Kano State in the northwest, and Lagos State in the southwest) involving 20 Local Government Areas (LGAs) —2 in Abia, 9 in Kano, and 9 in Lagos, to improve demand and quality of child survival services for nearly 7 million of Nigeria's 120 million people.

The goal for CAPA is "to promote increased use of proven child health interventions at the household, community, and health facility levels" to reduce childhood morbidity and mortality. Its interventions were centered around three technical focus areas: immunization, nutrition, and management and prevention of malaria.

WHAT IS CAPA?

CAPA is a **partnership between the Primary Health Care Centre and the representatives of the people that it serves**. It forges an enduring collaboration between communities and health care providers, a beneficial atmosphere for working together to improve health services, and a force for increasing demand for services and jointly monitoring them (see Figure 1).

CATCHMENT AREA PLANNING AND ACTION (CAPA):
A community-based approach to empower communities to take an active role in improving the health of their children.

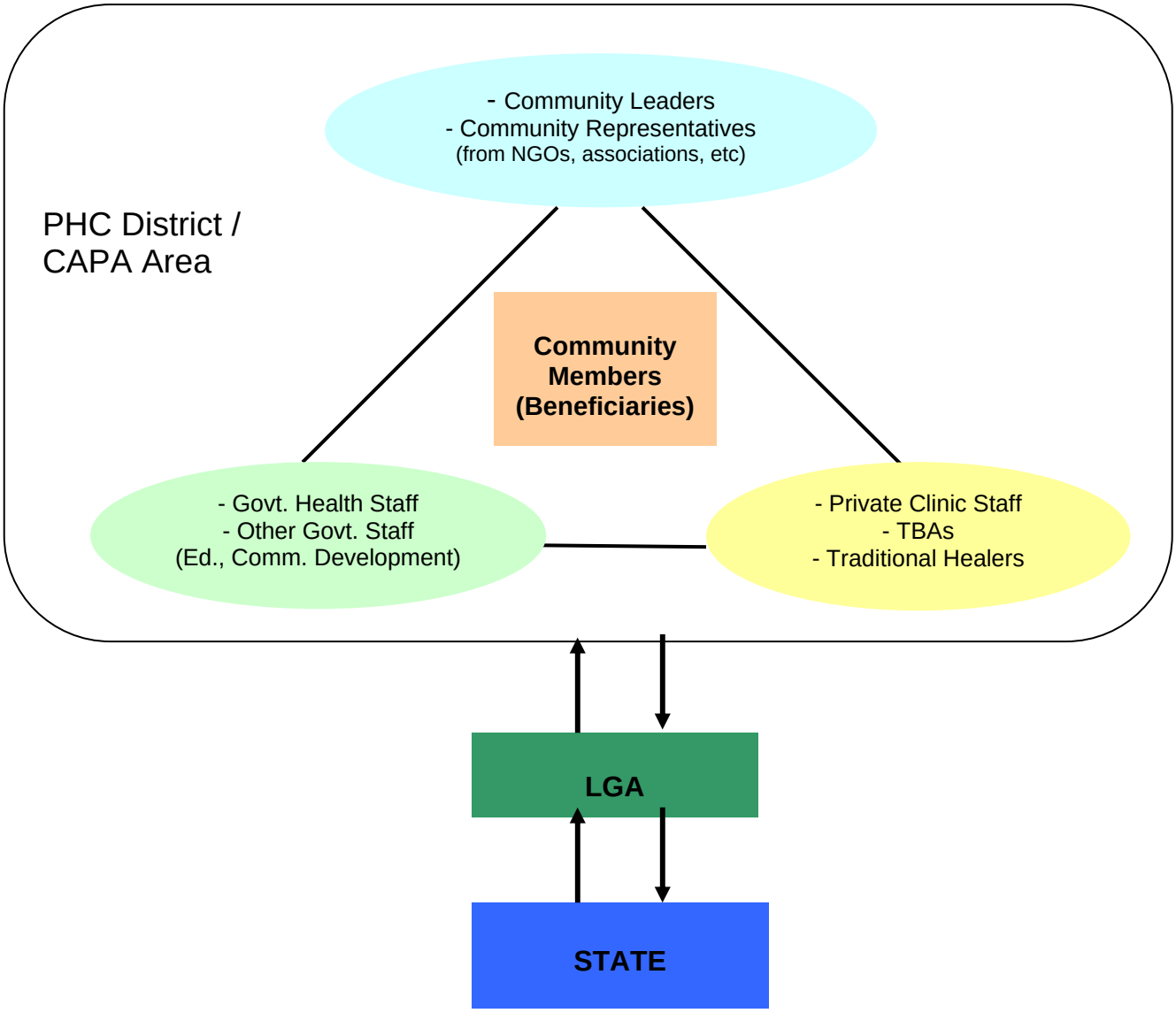
The approach allows participating communities to **identify their own human and other resources**, build alliances between groups and agencies, set goals, and train parents and volunteers to improve their children's health.

Implementation of CAPA **strengthens existing systems** by providing technical training—including quality of service for the three technical interventions—to the health staff at State, Local Government Area (LGA), and health facility levels. Facilitators trained at the State and LGA levels coordinate a program of training that then cascades to the community level. An essential role of the State and Local governments is to provide support supervision in all technical interventions for health workers, particularly at the facility level (see Table 1).

Community mobilization conducted by CAPA Committee members strives to **create demand for services**. The meeting point for the training and mobilization efforts is the health facility. CAPA relies heavily on strong community partnerships in which investments are made in **educating the general public** on key child health issues, community-based planning, orientation of community-based health providers, strengthening of health delivery and referral services, and development of a volunteer community health promoter system.

Although the program is focused on child survival objectives, it is a platform that can promote other important initiatives, such as HIV/AIDS prevention, maternal health, and sanitation. The following diagram illustrates the partnership elements of the CAPA approach.

Figure 1. CAPA Partners



Starting in 2001, BASICS II, in collaboration with the Federal MOH, the State MOH in Abia, Kano, and Lagos states, the National Program on Immunization (NPI), and the National Primary Health Care Development Agency (NPHCDA), began the CAPA initiative to develop partnerships between the members of the community and the public/private sector health providers located within the catchment areas of the government primary health care units. Table 1 describes activities conducted at the national, State, LGA, and community levels to establish CAPA in project areas.

Table 1: Activities at the national, State, LGA, and community levels to establish CAPA

Levels/ Components	Activities/Strategies			
	Capacity building; technical issues; advocacy and ownership	**Capacity Building for CAPA and CHPs**	**CAPA Process and CHP Training**	
NATIONAL	- Advocacy for community-based approach; - Ownership by Federal MOH and other government agencies - Technical training on CS issues: immunization, nutrition, and malaria			
STATE **(Multi-Sectoral Team)**	- Advocacy for community-based approach; ownership by State MOH and other government agencies - Technical training on CS issues: immunization, nutrition and malaria	National-level facilitators from government and partner organizations led TOT on CAPA for State facilitators, included immunization, followed by nutrition and malaria.		
		National-level facilitators from government and partner organizations led TOT on CHP for State facilitators, included immunization, nutrition, and malaria		
LGA **(Multi-Sectoral Team)**	- Advocacy for community-based approach; ownership by LGA - Technical training on CS issues: immunization, nutrition, and malaria	State facilitators led TOT on CAPA for LGA facilitators, included immunization, followed by nutrition and malaria		
		State facilitators led TOT on CHP for LGA facilitators, included immunization, nutrition, and malaria		
COMMUNITY			Pre-CAPA Meeting	
			CAPA Process Workshop	
			Post-CAPA Meeting	Training of CHPs
			Monthly meeting; supervision & monitoring of CAPA and CHP activities	Follow-up activities to CHP training (e.g. CHP assessment)

Keys to Success in CAPA:		
- Partnership formation	- Increased demand for services	- Increased access
- Working together/collaboration	- Community ownership of services	- Continuous monitoring

CAPA has now been introduced in **155 catchment areas** in the 20 focus LGAs **reaching over 7 million people**, of whom 1.45 million are children under five years of age. Several indicators, including breastfeeding rates, vitamin A intake, and insecticide-treated materials use, have increased in the areas where CAPA is being implemented.

All three participating states have adopted the CAPA approach and, while not yet an official government program, the NPHCDA has been encouraged to consider extending the program nationally to Nigeria's 120 million inhabitants.

2. SITUATION ANALYSIS

Although there are many similarities among Nigerian communities and their child survival problems, there are significant differences in resources available to address the problems and in the way the problems are perceived by members and leaders of those communities.

As a first step, CAPA **organizes local people to conduct a community-specific analysis to identify the problems and the available resources**. The resulting information helps the community focus attention on a few priority actions and provides a factual basis for advocating for resources to address them. Adequate baseline knowledge is essential when embarking on a project. Therefore, good background information is crucial for successful implementation. It enables the team to assess children's health needs before designing intervention strategies.

OBJECTIVE:

To gather background information on child health needs, size and characteristics of target populations, project feasibility, community structures, and readiness of communities to participate in child health care initiatives. Information on the geographic dimensions of each LGA, health needs, the number of health facilities and their status, the number of health facility personnel, the population, and the baseline is obtained for immunization, nutrition, and malaria coverage.

TASKS:

- Identify the target population and the population in need of child health interventions and services.
- Define the nature and extent of disease prevalence by reviewing available data (national, State, and local including Health Management Information System (HMIS) data, NDHS, health facility records, previous surveys, and consultant and project progress reports. Other sources of data include health facilities, local government, the Ministry of Health, communities, the World Health Organization, UNICEF, and other relevant government ministries.)
- Conduct survey, if necessary:
    - Identify the essential data needed to fully understand the situation.
    - Determine how to obtain the data (e.g. surveys, visits, and town meetings).
    - Collect data or conduct surveys, if necessary.
    - Analyze data.
    - Interpret data to identify gaps and specific needs.
- Define the catchment area and conduct a community inventory to ascertain the number and capabilities of health providers (public and private).

- Assess the quality of health care service and other support structures (private and public) on the ground.
- Assess the feasibility of the interventions.
- Determine the interest of communities, as well as federal, state, and local governments, and the likelihood of their acceptance of the intervention strategy. In most cases information is gathered by conducting informal interviews in the target areas.
- Develop presentation that illustrates need for proposed interventions for use in building community awareness and advocating for services and resources.

PARTICIPANTS:

- Project personnel
- Government staff: State/Local/Population Commission
- Community members
- Consultants

DURATION: 2 to 3 months

OUTCOMES:

- Information needed to support program planning and decisions and clear set of child survival actions needed to improve child health.
- Creation of presentation materials to be used by project partners at the State and LGA levels and by community leaders to advocate for community mobilization efforts.

3. MULTI-SECTORAL ADVOCACY

Advocacy for the program is an implementation requirement that continues through the intervention period. In the initial steps, it is an opportunity for the community **to show government and community leaders that they are serious about child survival** and that they **have a clear vision about what is needed to succeed**.

Simply stated, the information from the situation analysis of proposed interventions and the CAPA approach are used to get official backing and buy-in for the interventions. Of course buy-in and support from the Federal level is important for scaling up CAPA and integrating it with other initiatives; support at the State level is an operational necessity.

OBJECTIVE:

To obtain political and operational support for CAPA at the State Ministry of Health (SMOH) level.

TASKS:

- Establish a formal dialogue with State Director of Primary Health Care/Disease Control (DPHC/DC) to discuss the project and arrange to meet with the Honorable Commissioner for Health and Permanent Secretary. In each case, the DPHC/DC should become the point person to secure the Commissioner's approval for the project.
- With the DPHC, brief the Commissioner for Health and Permanent Secretary about the state of child survival, the donor's mandate, and the value of CAPA using information from the situation analysis.
- Hold a State PHC meeting to detail the community-based approach to strengthening child survival program intervention.
- Introduce the concept of strengthening child survival in focal States/LGAs:
    - Review previous approaches and introduce the concept of the community-based approach to child survival called the "Catchment Area Planning and Action (CAPA)."
    - Decide on steps to take and the resources required.
    - Discuss/agree on technical intervention areas to be addressed (e.g. routine immunization, nutrition, malaria)
    - Discuss pilot sites, target population, and state geographic coverage.
    - Discuss the need to involve partners from other sectors (e.g. Education, Agriculture, Women and Youth Development, Information) and form a Multi-Sectoral Group.
    - Set dates for meeting with the Multi-Sectoral Group.

- Sponsor a Multi-Sectoral Group meeting of high-level officials (e.g. Commissioners, directors of parastatals, private sector providers) to:
    - Present project to and discuss project with the Multi-Sectoral Group.
    - Agree on roles and responsibilities of all partners and sign a Memorandum of Understanding, if desired.
    - Agree on objectives and indicators.
    - Establish a time frame for action.

PARTICIPANTS:

- Honourable State Commissioner for Health
- Permanent Secretary MOH
- Director, Primary Health Care/Disease Control
- State Maternal and Child Health (MCH) Consultant and other consultants
- Donor Representatives: Director, Program Manager, and State Team Leader
- Key functionaries of all the relevant sectors, including professional bodies and the private sector

DURATION: Initially 2 to 3 months, but should continue indefinitely

OUTCOMES:

- Common understanding of donor's mandate in strengthening child survival in focal States/LGAs.
- Agreement on the value of available baseline data or survey reports to support CAPA.
- Clear understanding of the CAPA approach to child survival and its strengths.
- Agreement on the strategy for State resource mobilization.
- Stage set for team building at the State level.
- Agreement on interventions and implementation strategies.
- Signed Memorandum of Understanding, if needed.
- Agreement on the need for multi-sectoral participation and the strategy for mobilization.
- Appointment of permanent representatives by ministers and other Multi-Sectoral Group leaders.
- Guaranteed political support.

4. TEAM BUILDING AND PLANNING

Like any community-based effort, CAPA is best implemented through **collaborative efforts of all stakeholders**. Program success depends on the joint actions and commitment of multi-sectoral groups at the State level as well as within the LGA. Consistent participation of providers, government representatives, and community members in strategic planning efforts, education and enlightenment, and in monitoring of initiatives should be pursued as multi-sectoral team efforts.

For the purpose of this handbook, the State and local team building and planning are reviewed separately, but in reality, **most of the activities are implemented simultaneously and are inter-coordinated**. Experience showed that activities could be implemented in an integrated manner, provided that all resources were available.

STATE TEAM BUILDING AND PLANNING

Apart from the lead ministry, which is the State Ministry of Health (SMOH), several additional ministries and government agencies are encouraged to provide representatives to the Multi-Sectoral Group. These include the Ministries of: Information; Women's Affairs and Youth Development; Education; and Agricultural and Rural Development. Also included are the National Orientation Agency and the Agriculture Development Project, as well as selected State and local non-government organizations (NGOs), and the project staff of the donor agency. This is referred to as the State Team.

Each ministry designates representatives to serve as **permanent contacts and liaison between the Health Ministry and their respective ministries**. The Director of PHC/DC should write a letter to each parent ministry requesting that the representative be released to serve on the State Team as needed.

OBJECTIVE:

To develop commitment and build capacity of State staff to implement and support CAPA.

TASKS:

- SMOH contacts heads of the multi-sectoral organizations and agencies to nominate permanent members of the State Team.
- SMOH and all multi-sectoral ministries, parastatals and agencies identify and nominate members of the State Team.
- SMOH convenes the first State Team Meeting to discuss project implementation in detail.

- A one-day State Team meeting is held to have a common understanding of:
    - CAPA approach
    - The structure, objectives, and function of CAPA
    - Proposed technical interventions
    - Project objectives and indicators
    - Donor-mandated strategic (SO) and intermediate results (IR) objectives
    - Discuss data gathering and reporting system
    - Partners' roles and responsibilities
    - Detailed information on follow- up activities

PARTICIPANTS:

- Representative(s) of Ministry of Health
- Representative(s) of Ministry of Women's Affairs and Youth Development
- Representative(s) of Ministry of Agriculture and Rural Development
- Representative(s) of Ministry of Education
- Representative(s) of Ministry of Information
- Representative(s) of Local Government Civil Service Commission
- Representative(s) of selected local/State non-governmental organizations
- Representative(s) of State media: (print and electronic)

DURATION: One-day

OUTCOMES:

- Joint understanding of the community-based approach to strengthening child health.
- Agreement on implementation steps and schedule.
- Agreement on project objectives, indicators, data gathering mechanism, and reporting system.
- Commitment to the approach by all partners.
- A list of key participants including proposed master trainers for cascade training.
- A list of qualified trainers and facilitators.

1. DEVELOPMENT OF WORK PLAN

The State Team (comprising members of staff from the Ministry of Health, other multi-sectoral ministries, and program staff of donor agency and consultant when necessary) develops a work plan called a **control panel** (see sample Control Panel in Annex). The donor agency provides guidance on what needs to be done based on approved project timeline.

The **control panel** is a detailed implementation work plan describing all technical and CAPA interventions, communications for behaviour change (CBC) materials, monitoring and evaluation procedures. The control panel is systematically updated as work progresses. It can be used as reference material for process documentation. The control panel describes the activity to be performed detailing "who, where, and when" for the various activities and providing expected results and measurable indicators.

OBJECTIVE:

- To create a blueprint for implementation that is agreed to by all parties but is sufficiently flexible to make adjustments that accommodate individual community situations

TASKS:

- List all activities needed for implementation of CAPA at state and LGA level.
- Identify the dates, venues and personnel needed for each activity.

PARTICIPANTS: State Team

DURATION: Initial half day to full day meeting, follow up as needed for 2 – 3 months

OUTCOMES

- A working plan (Control Panel) for implementation that contains specific information about individual responsibilities and specific actions.
- A schedule and timeframe for monitoring progress and identifying problems in resources and/or performance.

2. DEVELOP OR ADAPT TRAINING/CBC MATERIALS AND IDENTIFY TRAINERS/FACILITATORS

NOTE: The concept development of training modules, information-education-communication (IEC)/CBC materials is a state-level intervention. However the pre-testing and validation is at the LGA/community level.

** Detailed exercises on developing and adapting technical training modules and IEC/CBC materials and the contents of existing technical materials can be found in the Annex.

OBJECTIVE:

- To develop a coordinated set of training materials and public education messages on child health that reinforce the SMOH program and are consistent with the specific priorities and cultural norms of the community.

- To develop a cadre of community members and health providers capable of coordinating the CAPA effort and advocating for logistical support and human resources at the state and federal levels.

TASKS:

- Identify members from the State Technical Team who have the capability to develop/adapt technical training modules and IEC/CBC materials for each intervention area (immunization, nutrition, malaria etc.).
- Review the existing training modules, IEC/CBC materials, and make recommendations to the State on the next line of action to adapt or develop new materials, and integrate the training modules and IEC/CBC materials.
- Establish desired outcomes in all technical focus areas (immunization, nutrition, and malaria), particularly in relation to what health workers and community members need to know and do.
- Gather existing materials on each selected intervention and review for accuracy and relevance.
- Conduct focus group discussion among the target audience for the IEC/CBC materials to identify knowledge gaps and inconsistent messages.
- Design the graphics and develop key messages.
- Pre-test messages and draft materials.
- Correct/amend materials based on results of pre-testing.

- Produce approved materials for use during program intervention ensuring all intervention areas (immunization, nutrition, malaria, etc) are represented by the technical team.
- Each technical team develops or adapts the module for each technical focus area.
- Materials advocated to the LGA authorities for adoption and use.

PARTICIPANTS:

- State Director PHC/DC
- LGA MOH (Selected)
- State MOH Staff: Head of project intervention units: Immunization, Nutrition, Malaria, Health Educator, Monitoring and Evaluation
- Multi-sectoral Ministries representatives (2–3 from each other ministries)
- State/LGA IEC/CBC person (if different from the Health Educator)
- Donor Technical Staff: Program Officers for Immunization, Malaria, Nutrition, Community Development, IEC/CBC, and Logistics
- Consultant (if necessary)

OUTCOMES:

- Technical training modules completed and tested.
- IEC/CBC materials finalized for printing.
- Identify master trainers to train trainers.
- Trainers and facilitators identified by all partners.
- Individuals selected to conduct advocacy at the LGA level.

LGA ADVOCACY, TEAM BUILDING AND PLANNING

NOTE: The introduction and advocacy for CAPA at the LGA level was carried out by members of the State Team.

1. ADVOCACY AND TEAM BUILDING

OBJECTIVES:

- To secure total political support and program implementation from LGA leadership

TASKS:

- LGA advocacy and team building:
  - Enlist the support of the PHC Coordinator as the formal contact for CAPA.
  - Brief Chairman and key functionaries of the LGA on all issues discussed at the State level.
  - Meet Health Department Staff.
  - Conduct LGA Multi-Sectoral Group Meeting.

PARTICIPANTS:

- CAPA State Team facilitators
- LGA Chairman
- L:GA Executive Secretary
- LGA Head of Personnel
- LGA Head of Department and MOH Focal Point personnel
- LGA Education, Information, Women's Affairs personnel

DURATION: One day with follow up over 2 to 3 month period

OUTCOMES:

- LGA Multi-Sectoral Group members fully understand CAPA.
- Implementation steps reviewed and agreed to.

2. DEVELOPMENT OF WORK PLAN, FACILITY ASSESSMENT AND CBO INVENTORY

OBJECTIVES:

- To complete key tasks necessary for implementation of CAPA, including:
  - Develop LGA workplan (Control Panel)
  - Conduct a health facility assessment
  - Conduct CBO inventory
- TASKS:Develop LGA work plan and detailed implementation plan (the "control panel")**.** The control panel will identify the participants, timelines, and logistics for completion of activities listed below.

- Conduct Health facility assessment to assess staff capabilities and facility resources:
  - Secure LGA MOH support and technical input as well as logistics help for assessing facilities and staff.
  - Design/adapt and test assessment instrument.
  - Train the assessors.
  - Conduct the assessment at the PHC level in each LGA (this can be done simultaneously by selected health facility staff).
  - Hold Multi-Sectoral Group Meeting to discuss the result of the assessment and implications for program implementation.
  - Develop plan for filling essential gaps in facilities (water, construction), staff training, health care delivery resources (e.g. cold chain, record keeping forms, vaccines).

- Conduct an inventory of community-based organizations and resources in order to identify community opinion leaders, ward political leaders, community-based organizations (religious, occupational, age-grade, market, youth, women, etc.), patent medicine vendors (PMVs), private health care providers, TBAs, traditional healers, and local NGOs needed to form the critical mobilization mass for child health at the community level.
  - Hold stakeholders meeting at the State level with the LGA MOH to plan for the LGA CBO inventory assessment.
  - Identify local resources that can be leveraged.
  - Design/adapt and test an instrument to be used in the assessment.
  - Train the assessors.
  - Conduct the assessment.
  - Hold stakeholders meeting to discuss the results of the assessment and implications for program implementation. This meeting occasionally reveals viable existing CBOs, working groups, local NGOs and companies whose resources can be tapped for child health.

NOTE: While the CBO inventory might benefit from participation of health facility staff, it should not be turned over to them as one of their duties. To do so can compromise objectivity and introduce bias into the selection process.

PARTICIPANTS:

For convenience, the 3 activities above are considered together. Participants for each may vary somewhat but in general the meetings should have:

- Facilitator(s) from CAPA State Team
- CAPA LGA Team, including
  - Ward political leaders
  - Local institutions (primary/secondary/tertiary)
  - Private health facilities
  - CBO leaders by type and location
  - Patent medicine vendors (PMVs) and their associations
  - Parent Teacher Associations (PTAs)
  - Road transport employers and employees
  - Ethnic groups/traditional leaders
  - Farmers' clubs
  - Local NGOs
  - Investment companies/agencies/corporations

This exercise may need the assistance of external assessors like mature community school students and teachers to be supervised by Local Government Community Development Officers and Health Staff. Usually the Local Government Community Department has a list of CBOs and their contact person(s) and addresses.

DURATION:

For convenience, the 3 activities above are considered together. These can be done overlapping in time and should take between 2 – 3 months to complete.

OUTCOMES:

- LGA workplan developed.
- Individual and departmental commitments established.
- Partner roles, responsibilities, and working relationships defined.
- Results from health facility assessments and CBO inventory completed and available for final planning

3. MAP CATCHMENT AREAS WITH STATE AND LGA TEAMS

OBJECTIVE:

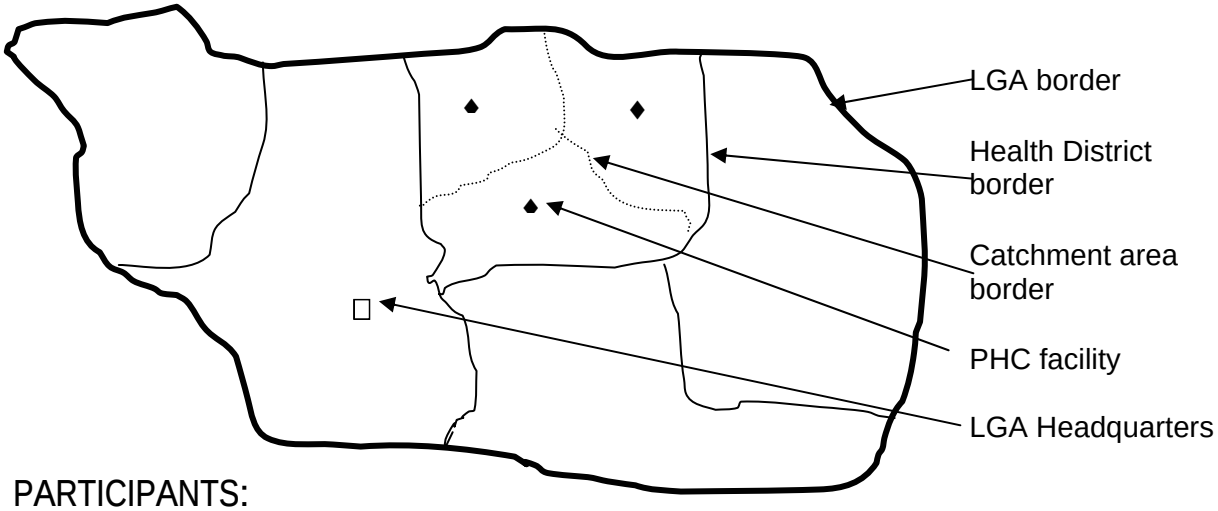
To map all catchment areas within the LGA to provide all implementers with a geographic reference to guide implementation and monitoring.

TASKS:

- Secure the political commitment and involvement of different ministries in this technical exercise during state and LGA team building activities.
- Undertake initial consultation on the mapping with the Chairman/Executive Secretary and Ward Councillors. Their leadership roles and commitment must be well defined in this instance.
- Where the State and LGA cannot provide base maps needed by the project and acceptable to all partners, base maps should be produced.
- Partners planned with relevant Local Government Area departments to draw the catchment area maps.
- Identify a qualified cartographer to work with a local guide.
- Seek permission and assistance from traditional rulers, community leaders, and key responsible people.
- Create maps showing major landmarks (PHC, schools, private health facilities, markets, religious institutions, and road networks) of the LGA or the catchment area (see example in Figure 2).

NOTE: This exercise is a sensitive socio-cultural and political issue and must be performed with caution. It must be acceptable to the people, or else it may be rejected during the CAPA training.

Figure 2: Map Showing Typical Catchment Area within an LGA



PARTICIPANTS:

- Members of the State Team and LGA Team including:
  - Representative(s) of LGA Department of Health (number to be determined by the LGA Department of Health)
  - Medical Officer of Health (PHC Coordinator)
  - Chief Nursing Officer
  - Technical Officers in Immunization, Nutrition, Malaria, and Monitoring & Evaluation
  - Representative(s) of Women's Affairs and Youth Development (2–3)
  - Representative(s) of Ministry of Agriculture and Rural Development (2–3)
  - Representative(s) Ministry of Education (2–3)
  - Representative(s) Ministry of Information (2–3)
  - Representative(s) Local Government Civil Service Commission (Governor's Office)
  - Representative(s) of selected Local non-governmental organizations (2–3)

DURATION:

The exercise typically requires 2 to 2 1/2 months to complete depending on the size of the LGA and the number of catchment areas; can take up to 4 months to complete.

OUTCOME:

- LGA and catchment area maps showing major landmarks completed.

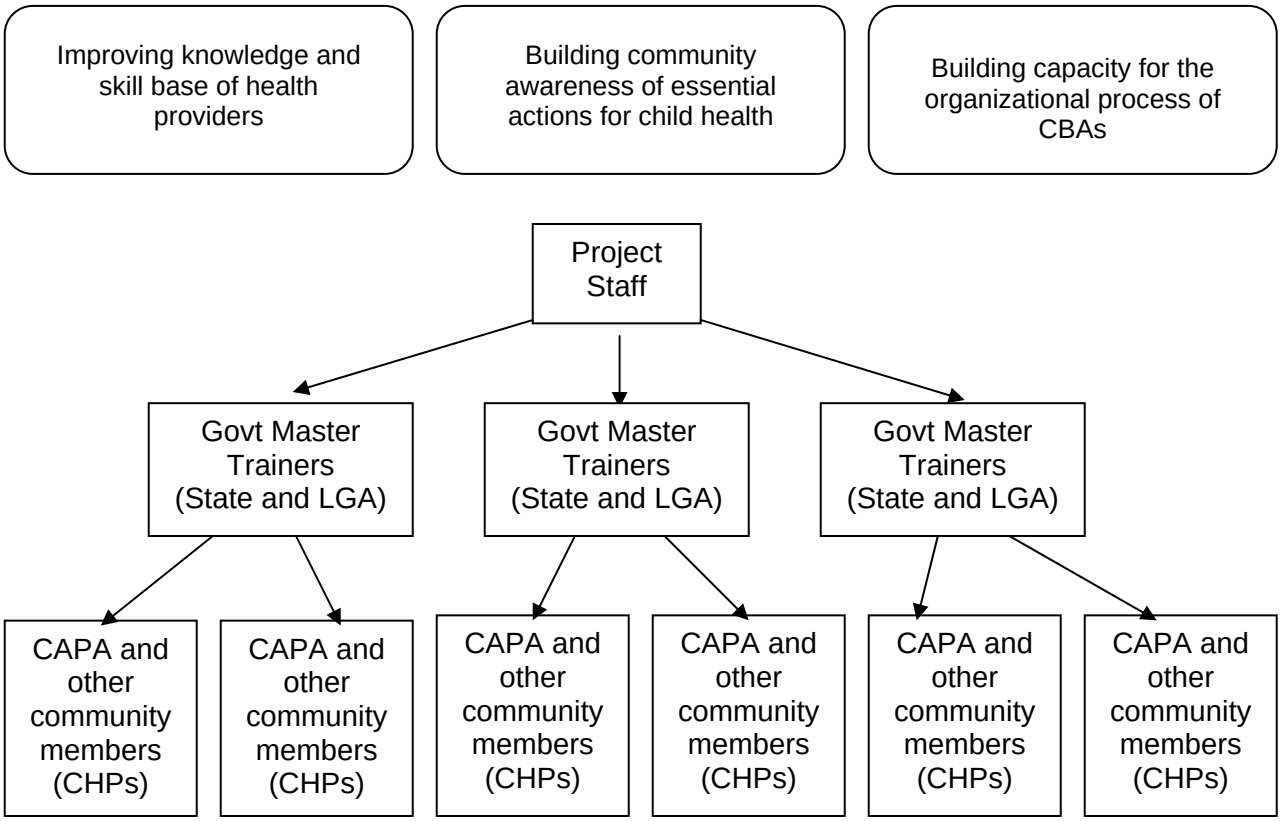
5. TRAINING AND COORDINATION

Nigeria has an exceptional sense of community and a tradition of volunteerism. However, implementation of CAPA depends upon community members learning (and unlearning) many things that are crucial to improving child survival, some of which are technical and some organizational.

To prepare community members for their **new roles as promoters, advocates, planners and monitors** in the most expedient manner, CAPA adopted a **cascade training approach** that rapidly transfers responsibility from project staff to government master trainers and to community members (see Figure 3).

Some training efforts are directed at **improving the knowledge and skill base** of public and private sector health providers, some at **building community awareness of essential actions** to preserve child health, and some at **building capacity for the organizational process** necessary to make community-based approaches succeed.

Figure 3. Cascade Training Approach



STATE-LEVEL TRAINING

The State level is the primary focus for quality control, advocacy, providing services and resources to support CAPA, and receiving referrals. The State should provide master trainers to initiate and coordinate the training at the LGA and catchment area (community) levels. As such, it is essential that State-level participants be well informed about child survival interventions, be thoroughly grounded in the CAPA approach, and be fully committed to community/health sector partnerships.

There are **three general categories of training** for SMOH personnel in which project staff (with the help of consultants) train groups of Master Trainers:

- Training of trainers (TOT) to **improve technical team skills and knowledge** about key child survival issues and interventions (Immunization, Nutrition, Malaria).
- TOT to **prepare state facilitators as coordinators of CAPA**.
- TOT for **facilitating the training and performance of Community Health Promoters (CHPs)** in mobilization and home visits.

1. TOT TO IMPROVE STATE FACILITATORS' TECHNICAL SKILLS AND KNOWLEDGE

OBJECTIVE:

To build the capacity of the State technical and facilitation teams to coordinate training and monitoring of CAPA at the LGA and community levels and to guide health provider partnership formulation.

TASKS:

- Review the knowledge and practices of the State Technical Teams (observations and pre-testing as required).
- Update trainee knowledge of key child survival interventions:
  - Immunization essentials, including routine immunization (DPT, measles, polio)
  - Nutrition essentials (vitamin A, exclusive breastfeeding, complementary feeding, feeding the sick child)
  - Malaria prevention and control (insecticide-treated bednets (ITNs), early diagnosis and treatment, intermittent presumptive treatment (IPT) for pregnant mothers)

PARTICIPANTS:

- State Primary Health Care Officers
- Immunization Officer
- Nutrition Officer
- Malaria Officer
- Monitoring & Evaluation Officer

DURATION:

To be determined by the National facilitators (immunization technical modules are very extensive and training could last for several days. Nutrition and malaria are less complicated and can be done morequickly.

OUTCOMES:

- Improved technical knowledge and capabilities of State primary health care officials about child health issues for immunization, nutrition, and malaria.
- Improved acceptance of the community participation as a viable approach to improving child survival.
- Strengthened capability of government facilities to accept referrals and support community-based health initiatives.

2. TOT TO PREPARE STATE FACILITATORS TO BE COORDINATORS OF CAPA

OBJECTIVE:

To prepare state facilitators to lead TOTs at the LGA level for Technical and CAPA Training.

TASKS:

- Provide training on the technical issues and on training communities for CAPA.
- Provide training on the use of the integrated of CAPA modules.

- Provide training on the implementation steps.
- Conduct orientation on facilitation and teaching skills.
- Define roles and responsibilities of partners (community, public sector, and private sector).
- Establish individual commitment.
- Assign State facilitators to LGAs.

PARTICIPANTS:

- State Immunization Officer
- State Nutrition Officer
- State Malaria Officer
- State Monitoring & Evaluation Officer
- 3-4 Representatives of Multi-Sectoral Group

NOTE: Only one health topic is presented during the first technical training (e.g. immunization), but multiple health topics can be combined in an integrated manner depending on the resources that are available. This should be part of the TOT training.

DURATION:

2 days for one technical topic (e.g. immunization) and CAPA implementation

OUTCOMES:

- Quality capacity building.
- Improved facilitation skills.
- Implementation steps reviewed.
- CAPA Training plan completed.
- Improved motivation and commitment of participants.
- Improved resource mobilization by all partners.
- Timetable for training at LGA level adopted.
- Facilitators allocated to coordinate/supervise specific LGAs for CAPA training

3. TOT TO PREPARE STATE FACILITATORS TO TRAIN LGA FACILITATORS ON THE CONTENT AND MECHANICS OF COMMUNITY HEALTH PROMOTER (CHP) TRAINING

> **NOTE:** TOTs for CHP training at the State and LGA levels should not be conducted until after completion of the formation and training of all CAPAs within an LGA

OBJECTIVE:

To prepare State facilitators to lead TOTs at the LGA level for CHP training.

TASKS

- Master trainers train participants to improve communication skills.
- Promote understanding of the roles and responsibilities of CHPs.
- Develop and adopt a timetable for LGA trainings.
- Assign trainers to LGAs.

PARTICIPANTS:

Trainers were drawn from those that facilitated the CAPA training at the LGA level.

DURATION:

2-3 days for one technical topic (e.g. immunization) and CAPA implementation

OUTCOMES:

- Improved facilitation skills.
- Implementation steps reviewed.
- CHP training plan completed.
- Improved motivation and commitment.
- Improved resource mobilization by all partners.
- Timetable for training LGA trainers for CHPs adopted.
- Facilitators selected to coordinate/supervise specific LGA training of trainers for CHPs.

LOCAL GOVERNMENT AREA (LGA) TRAINING

The LGA is the level at which CAPA becomes operational. State-level technical staff and facilitators have the responsibility to train LGA health staff, private sector providers, and multisectoral partners in **the second level of the cascade training program**.

LGA personnel become the major interface between the State government and the community members within the catchment area of the government PHC. The main objectives of the LGA training are **to strengthen the technical capabilities of health providers** in the areas of child survival, **to identify potential groups and resources within the LGA** that can participate in community based health care delivery, and **to establish a community structure for implementing CAPA**.

There are three categories of LGA-level training:

- TOT on technical intervention (immunization, nutrition, malaria, etc.)
- TOT for facilitating CAPA
- TOT for facilitating CHPs

NOTE: The TOT on immunization is introduced as a separate training because of its volume and complexity and is followed by nutrition and malaria. Experience suggests that community perceptions and LGA/State priorities should determine how the technical modules should be integrated. The length of training and time available for technical staff will assist in shaping the training schedule.

1. TOT TO IMPROVE LGA FACILITATORS' SKILLS IN TECHNICAL INTERVENTIONS

OBJECTIVE:

To create a critical mass of trainers/facilitators at the LGA level through capacity building in all technical modules.

TASKS:

- Arrange schedules and logistics for training: location, venue, invitation, transport, meal schedule, registration, supplies (pen, jotter, eraser, file jackets, and other materials).
- Strengthen facilitation skills.
- Implement specific tasks as defined by the modular sessions but in an integrated format.

PARTICIPANTS:

- As chosen by the State partners and donors
- As chosen by the LGA and partners

DURATION:

To be determined by the State facilitators (immunization technical modules are very extensive, and training could last 5 days, while nutrition/malaria training could take 2 to 3 days).

OUTCOMES:

- A cadre of trainers and facilitators with improved facilitation skills capable of directing technical training at the LGA level.
- A workplan of activity schedule and timetable for conducting technical training.
- Improved motivation and commitment on the LGA level.

2. TOT TO PREPARE LGA FACILITATORS TO BE COORDINATORS OF CAPA

OBJECTIVE:

To create a critical mass of trainers/facilitators at the LGA level to facilitate CAPA training at the PHC/community level through capacity building in CAPA modules.

NOTE: Only one health topic (immunization) is presented during the first technical training, and this is combined with the preparation for CAPA training. Technical training other health topics, nutrition and malaria, is conducted at a later time and with no additional CAPA training

TASKS:

- Prepare LGA facilitators for CAPA training.
- Promote understanding of the CAPA approach.
- Promote understanding of the CAPA implementation process and steps.
- Develop facilitation and teaching skills.
- Develop a timetable for LGA/CAPA training.

PARTICIPANTS:

- LGA Community Development Officer
- LGA National Programme on Immunization (NPI) Manager
- LGA Health Educators
- LGA Nutrition Officer
- LGA Monitoring & Evaluation Officer
- LGA Environmental Health Officer
- LGA Principal CHO
- Representatives from Multi-Sectoral Departments

NOTE: Not every person trained as a facilitator will facilitate at the same time. Depending on the number of PHC catchment areas in the LGA and available resources, facilitators can be spread to cover as many PHC catchment areas as possible for simultaneous training. However, no more than five facilitators are needed at any one training session. Many LGA facilitators can be trained at the same time to expand CAPA training rapidly to other Local Governments Areas.

Not every trained facilitator becomes a trainer because there may be some who lack adequate communication skills. These individuals should either be given different responsibilities or not used for training. A lot of harm can be done when the wrong message is communicated in a technical program, or even at the community level.

DURATION: 2 to 3 days in-house for all CAPA modules

OUTCOMES:

- A cadre of trainers and facilitators with improved facilitation skills capable of directing CAPA training at the community-level.
- A workplan of activity schedule and timetable for conducting CAPA established.
- Improved motivation and commitment of participants.

3. TOT TO PREPARE LGA FACILITATORS TO TRAIN CHPS

NOTE: TOTs for several or all LGAs in the State can be undertaken simultaneously.

OBJECTIVE:

To create a critical mass of trainers/facilitators at the LGA level to train CHPs in technical and interpersonal communication skills.

TASKS:

- Master trainers from the State-level TOTs train LGA participants on technical and interpersonal communication training skills.
- Promote understanding of the roles and responsibilities of CHPs.
- Develop and adopt a timetable for training CHPs at the community level.
- Designate training teams.

PARTICIPANTS:

- LGA Community Development Officer
- LGA NPI Manager
- LGA Health Educators
- LGA Nutrition Officer
- LGA Monitoring & Evaluation Officer
- LGA Environmental Health Officer
- LGA Principal Community Health Officer
- Representatives of Multi-Sectoral Departments

DURATION: 2 to 3 days

OUTCOME:

Sufficient number of LGA trainers capable of conducting CHP training.

CATCHMENT AREA LEVEL TRAINING AND COORDINATION

To review, a PHC catchment area is the geographic area served by a particular Primary Health Care Centre. A community is a group of geographically proximate people with common concerns and needs. The community possesses optimal size and shape defined by shared interests, the presence of essential services and institutions, and the need to interact with one another. This association of people and their society forms the basis of a catchment area.

A PHC **catchment area** is the geographic area served by a particular Primary Health Care Centre.

A **community** is a group of geographically proximate people with common concerns and needs.

The association of people and their society forms the basis of a **catchment area.**

The PHC is the nucleus of the catchment area, which also includes private health facilities and individual providers of health services such as traditional birth attendants, patent medicine dealers, PHC staff, and traditional healers, all of whom serve as sources of advice, knowledge, and help to the mother/caregiver. Often also overlooked are the non-medical organizations and leaders that exist within the community. Women's clubs, religious groups, professional and trade organizations associations such as taxi drivers' unions, market women, and schools are important resources at the community level. They participate actively in organizing people for action, providing volunteers, advocating for medical supplies, and occupying leadership positions. **Establishing CAPA as the coordinating unit of community health is perhaps the single most important activity that occurs at the community or catchment area level.** The process consists of a series of steps and/or meetings that build community awareness of child survival problems and interventions, establishes community ownership of the process, gives the community a voice with which to advocate for services and resources, and sets up a system by which the community can identify and implement appropriate interventions, monitor progress and identify and resolve problems.

CAPA:

- Builds community awareness of child survival problems and interventions
- Establishes community ownership of the process
- Gives the community a voice with which to advocate for services and resources
- Sets up a system by which the community can implement appropriate interventions, monitor progress and identify and resolve problems

1. CAPA

1.A PRE-CAPA MEETING:

The Pre-CAPA Meeting is **the initial introduction of the community members to the concept of CAPA and how it empowers the community to take charge of the health of their children**. As a preliminary effort, the meeting is short, run by members of the State Team and designed to include as many community members as possible.

OBJECTIVES:

- To sensitize traditional rulers and community and opinion leaders about the benefits of community-based associations in providing health services for children and about the roles and responsibilities of participants in implementing CAPA.
- To prepare the community for the CAPA Meeting, which formally sets up the process.

TASKS:

- Assemble a community-level meeting that is interactive and encourages discussion and participation, and ensure a large and representative group from the community.
- Explain purpose of visit: Child Survival and community participation.
- Introduce the participants to each other and the concept of CAPA.
- Extract from the group community perceptions of child heath problems that CAPA can address.
- Elicit community perceptions of why problems have not been well addressed in the past.
- Create awareness about CAPA as a tool for grassroots community participation in child survival and development programs.
- Sensitize the community about the need to address child survival problems through a process of formal meetings, open discussions, information sharing, education, and communication.
- Prompt community to choose reputable individuals to be the core CAPA representatives.
- Set venue, agenda, and time for the CAPA Meeting with the selected CAPA representatives.

**** See Annex for an example of a Pre-CAPA Meeting agenda.**

Samples of topics and questions for discussion in a Pre-CAPA Meeting:

- What is the role of the health worker in a community-based approach to child health like CAPA?
- What is the role of MOH and SMOH in the survival of children at the LGA and catchment area levels?
- What are childhood diseases?
- Which childhood diseases are preventable?
- What is the role of the government in preventing childhood diseases?
- What is the role of the community in the survival of their children?
- How can a community influence child health?

PARTICIPANTS: (should be 60–70 individuals)

- Traditional ruler and community and opinion leaders
- Large number of community people
- LGA Officials
- PHC workers
- Multi-sectoral facilitators
- Donor Representatives

DURATION: A 2- to 3-hour meeting, held in one day

OUTCOMES:

- Formal entry point into the community established.
- Traditional rulers and community opinion leaders and people sensitized.
- Commitment established to hold the next formal meeting.
- Sensitized participants or community representatives for the next formal meeting.
- Each identified CBO committed to send at least two representatives to the CAPA Meeting.
- Community members understand the need for participation in health care delivery systems, in particular for child health.
- Community understands the community-based approach to health care, CAPA, and its benefits.
- Community-level stakeholders understand CAPA and the need for developing a multi-sectoral team.

In short, the outcome of the exercise is to stress that **the health of the community's children is a shared responsibility** and **CAPA is a mechanism for allowing parents and other community members to influence the outcome**.

1.B CAPA MEETING:

The CAPA Meeting **builds awareness of specific needs of children and of the interventions** that have been found to be most effective in achieving and maintaining good child health. The meeting also is the opportunity for the community **to select leaders and assign duties** and **to establish a plan of action** for CAPA in their own community.

OBJECTIVES:

- Sensitize community representatives on CAPA.
- CAPA prepares plans and implements activities to improve child health and survival in their communities

MATERIALS: CAPA training modules.

TASKS:

- Introduce participants to each other and to the facilitators and to formally register them as CAPA members.
- Set the level of expectations for all participants and define roles and responsibilities.
- Select leaders and committees to facilitate the operation of CAPA.
- Present strategies for community based interventions to reduce the impact of childhood illnesses.
- Develop a work plan with the help of facilitators that outlines specific community actions to combat selected childhood illnesses.
- Set an agenda and schedule for Post- CAPA Meeting and for CAPA Committee Monthly Meetings.
- Arrange for representation of the CAPA Committee at the CAPA Committee Coordinating Forum, which is a joint meeting of representatives from all catchment areas within the LGA.

**** See Annex for an example of a CAPA Training agenda.**

PARTICIPANTS: (30–35 individuals)

Representatives are selected in the Pre-CAPA Meeting or later by the community as the CAPA representatives. The following should be encouraged to be included:

- PHC Health workers (Officer in-Charge of PHC)
- Representative of CBOs, Ward political leaders and Councillors
- Traditional ruler and community and opinion leaders
- LGA officials
- Donor and sponsor representatives

DURATION: 3 days

OUTCOMES:

- Sensitized CAPA representatives on strategies for community involvement in attacking key child health issues.
- Work plan or "control panel" presenting specific actions to combat selected childhood illnesses developed (See Annex for a sample control panel).
- Commitment to start implementation of child survival activities.
- Commitment to hold regular meetings to support the public health facility.
- Commitment to mobilize community resources for child survival in their communities.
- Commitment for community ownership of CAPA.
- Commitment to attend educational sessions to learn more about child survival, and child health and child survival interventions

1.C POST-CAPA MEETING

OBJECTIVE:

The Post-CAPA Meeting is the inaugural meeting after the CAPA Committee training designed **to formally adopt the work plan and establish working norms for the CAPA Committee**. This is the first meeting after the formation of the CAPA Committee.

TASKS:

- Prepare and reproduce the work plan for distribution.
- Prepare an agenda for considering the work plan, modifying it if required and accepting it for implementation.
- Agree on future meeting dates and operational procedures.
- Share information on health clinic and community-based health operations within both the private and public health sectors.
- Review information on public perceptions of services and of CAPA.

PARTICIPANTS: CAPA Committee members

DURATION: 1 day

OUTCOMES:

- CAPA Committee members re-examine the work plan and discuss the next steps.
- A monthly meeting is agreed upon and targets are set.
- An appointed Secretary takes the minutes of every meeting.
- Full implementation of the work plan commences after this meeting.

1.D OTHER CAPA-RELATED MEETINGS

CAPA Committees have additional opportunities to work together and with other CAPAs. These meetings are excellent opportunities to share technical information about child health, review progress on work plans, and to develop advocacy messages and messages to effectively distribute child health messages to parents and other community members.

CAPA COMMITTEE MONTHLY MEETING

The CAPA Committee meets at a regular venue each month and notes of the meeting are taken and shared as needed with partners. The meeting provides an opportunity **to discuss progress and review/revise the work plan**. Members also **report back to their neighbors** on the meeting. Facilitators who guided the CAPA formative meetings should attend CAPA Committee Monthly Meeting to monitor progress on the CAPA work plan.

CAPA has key responsibilities for the CHPs, and it is at the Monthly Meeting that appropriate **volunteers to be trained as CHPs are identified**. The CAPA Committee is also responsible for supervision of the CHPs, and the Monthly Meetings provide an opportunity **to hear from the CHPs and provide feedback** on their work. All CHPs should attend the CAPA Committee Monthly Meetings.

CAPA Committee Monthly Meeting Activities:

- Discuss progress and review workplan
- Identify volunteers to be trained as CHPs
- Exchange feedback with CHPs
- Plan for introduction of child health topics
- Discuss and resolve problems
- Get brief from the health facility
- Other issues as necessary

Another key activity, with guidance from the State and LGA Teams, is **planning for the introduction of other child health topics**. (BASICS began with immunization and later presented nutrition and malaria interventions.)

The CAPA Committee members pay frequent visits to the health facility in compliance with the work plan in order to see how attendance has improved, and also to check if the staff requires any assistance. The effect of CAPA Committee activities (community health education, campaigns, talks at different levels) is a health facility full of mothers/ caregivers and children. There are instances where the CAPA Committee members had to task themselves to extending the physical space of the immunization halls of the health facility because of a lack of sitting space for mother and their children. **When there is a particular problem, it is discussed at the monthly meeting and decisions are taken to tackle it**.

It is mandatory for the officer-in-charge of the health facility, who is equally a member of the CAPA Committee to attend the meeting **to brief on what is going on at the health facility**.

The CAPA Committee can still call an emergency meeting if there is a situation that needs urgent attention. Otherwise, all other issues are tabled at the CAPA Committee Monthly Meeting.

CAPA COORDINATING COMMITTEE MEETING

The executives—the Chairperson and Secretary—of all CAPA Committees within the LGA come together to form **a CAPA Coordinating Committee**. Meetings of the CAPA Coordinating Committee are an opportunity for sharing monitoring information and anecdotal experiences of all CAPA Committees.

CAPA Coordinating Committee Meeting Activities:

- Share monitoring information
- Share experiences, success stories
- Discuss objectives of work plans
- Propose solutions to common problems
- Present monthly situation report

This forum provides an opportunity for representatives to share the experiences on activities carried out in their work plan and the contributions they have made to their respective communities. Common solutions are often proposed that address general problems.

Friendships across communities and occasional healthy competition are also promoted. Every CAPA Committee represented is required to give **a monthly situation report** at the meeting. Success stories are an encouragement to members; problems are listened to and jointly resolved.

An Executive Committee is elected from among the members of the CAPA Coordinating Committee to guide the meetings and to help the Coordinating Committee reach consensus on next steps.

2. COMMUNITY HEALTH PROMOTER (CHP) TRAINING

Community Health Promoters are CAPA's outreach effort into the community. Nominated and selected by the CAPA Committee, the **Community Health Promoters (CHP) enter homes and promote best practices in child survival** for the community. A Community Health Promoter is a literate volunteer with a natural interest in promoting child health and who is ready to offer assistance to the community as a counsellor, adviser, and motivator.

COMMUNITY HEALTH PROMOTER:

A literate volunteer with a natural interest in promoting child health and who is ready to offer assistance to the community as a counsellor, adviser, and motivator.

To assist the CHPS in this effort, each CHP is given and trained to use a **Home Health Care Booklet,**a **Caretaker Fever Booklet** and a set of **Counseling Cards**. These contain essential information about child survival including danger signs of serious illness, nutrition essentials and growth monitoring information, effective use of ITNs, and treatment of fevers. CHPs are able to read and write, are well known to members of the community, and are available for volunteer work.

OBJECTIVE:

To create a cadre of volunteers to convey key household messages about protecting the health of children, seeking care in a timely way, and making wise choices when seeking assistance for their children.

TASKS:

- Request CAPA committees to submit list of volunteers for CHP training:
  - With the help of the CAPA Committee, assemble volunteers who will become Community Health Promoters for the first catchment area.
  - Give a brief orientation on what it means to be a volunteer and encourage questions.
  - The CAPA Committee sets a date and venue for first and subsequent trainings (only about 30 persons can be trained at any one time).

- CAPA facilitators train the CHPs in their catchment areas using the CHP Training Module, and equip them with CBC materials.

**** See Annex for an example of a CHP Training agenda.**

PARTICIPANTS: Groups of trainees (not to exceed 30)

DURATION: 2 days

OUTCOME:

A cadre of Community Health Promoters with knowledge of child survival problems and interventions.

6. SUPERVISION, MONITORING, AND EVALUATION

CAPA's approach to supervision, monitoring, and evaluation places major responsibility upon the community and the implementers rather than creates a separate top-level oversight unit at the State level. **Supervision of CHPs is generally carried out at the CAPA Committee Monthly Meetings**, which should be attended by all CHPs.

The **indicators** selected for monitoring and evaluation are **objective measures of outputs** such as number of children immunized, of children receiving correct doses of medicine, of the number of children under five sleeping under ITNs, and of mothers exclusively breastfeeding their children. **Community participation in the monitoring and evaluation process is essential** since it provides a source of immediate feedback to the implementers and the beneficiaries. It can also serve as a powerful advocacy tool when the community is seeking additional resources.

OBJECTIVES:

- To use community participation to create a simple plan with basic objective indicators that will allow community members to monitor the progress of their own program and identify steps to improve performance.

TASKS:

- Identify project indicators and measurable outcomes:
  - Review objectives and situation analysis to provide guidelines for measuring progress in improving child survival at the community level.
  - Identify key child survival indicators and measurable outcomes that are consistent with the objectives and address outcomes rather than inputs.
- Establish a baseline of essential information to serve as a benchmark for measuring progress. This should include a preliminary assessment of the State and LGA HMIS. This is done in collaboration with the monitoring and evaluation officers at each level.
- Work with the State and Local Government Area Teams to identify existing sources of data (e.g. immunization cards, vitamin A distribution program records, bednet sales) that can be used in tracking indicators.
- Identify the shortfall in information required to monitor progress and develop surveys and/or observations to collect needed information, such as:
  - Exit interviews and or "mystery client" visits of PHC or patent medicine shops to determine quality of service and advice.
  - Cluster surveys to establish ITN use patterns or IPT compliance.

- Knowledge, Attitude, and Practices (KAP) surveys to assess progress of public information efforts.
- Integrated surveys (these are labour intensive and require outside help but tend to be the most reliable evaluative tool).

■ Establish mechanisms and schedules for reviewing routinely collected information.

■ Establish a schedule (implementation plan) for routine review and discussion of monitoring and evaluation data by the community and by LGA/State representatives. The schedule should monitor and review each aspect of CAPA (technical, administrative, logistical, and informational).

■ Hold reviews of data at least at six-month intervals to discuss progress toward child survival indicators and to make adjustments to the plan based upon the perceived progress. These meetings should involve CAPA Committees, private and public sector health service providers, LGA health authorities, and State representatives when possible.

■ Identify the mechanisms for supervising the CHPs:

- Regular meetings with CHPs to discuss coverage, impact, problems, client referrals, defaulters, feedback, and recommendations.
- Measures for reducing CHP attrition through community motivation.
- Provisions for CHP expansion/training.

■ Provide feedback to CHPs on their individual and group performances using information from monitoring and evaluation activities. Feedback should be positive and seek to shape behaviour through positive examples of successes, so as not to discourage the volunteers.

PARTICIPANTS: CAPA-Committee

DURATION: Continuous

OUTCOMES:

■ A set of indicators that can document simple changes in critical behaviours (eg, breastfeeding, ITN use, immunizations completed)

■ An instrument for approaching community members with specific questions and observations to measure progress and a time table for implementation.

■ A framework for analyzing monitoring data with a plan of action to implement changes when indicated

SUMMARY

The community-based approach called CAPA creates new working and personal relationships among community representatives, private sector providers, and public health providers. BASICS II/Nigeria worked to bring these three components together in the PHC catchment area to catalyze community members in the catchment area to think about child health issues, set goals and objectives for child survival, plan interventions, and take action to improve local practices/services, and assess their own activities. The heart of the process is a three-day catchment area planning meeting where representatives from local structures and organizations/associations join with private and public health providers to plan and take action.

CAPA, unlike many other community-based interventions, had been soundly based in and dependent on participation by the public health system. Its acceptance by the Federal, State, and LGA authorities is imperative before moving to the community level. This support offers several advantages.

First, strong support and participation by the MOH staff at different levels allows the program to expand using existing infrastructure. The cascade training approach used by the program builds capacity that enables health workers to more appropriately deal with key issues in child survival. These individuals also become a resource for cascading the program to the community level. National facilitators assist with training State-level facilitators, who in turn facilitated training of LGA-level trainers. State and LGA facilitators provide technical training for the Officers in Charge and health workers at the PHC and lead the community training for CAPA and CHPs. Using the existing resources not only allows for rapid cascading of the program, but also keeps costs down.

A second advantage is that with firm grounding of the program within the health system, the CHPs have been widely accepted by the PHCs as part of the system. This also extends beyond the PHC level to higher levels and has facilitated scale up of the program.

A third advantage is that with a strong foundation throughout the health system the program more likely will be sustainable.

At the community level, CAPA creates community understanding and ownership of child-health issues leading to local decision-making and cooperation. CAPA is designed to empower all partners to achieve sustainable change through action at the community/catchment area level.

The program trained State and LGA CAPA facilitators in 20 LGAs. State and LGAs CAPA facilitators trained a total of about 4,600 CAPA members in 155 catchment areas. The CAPA training/meetings are participatory learning processes for both participants and facilitators. The objective of the training modules is to facilitate a step-by-step approach by which communities and governments plan and sustain child survival activities related to childhood immunizations, nutrition, and malaria prevention and treatment.

In addition to the CAPA members, approximately 6,000 CHPs were trained in the same 155 catchment areas, also using participatory approaches that emphasized interpersonal communication skills.

Some of the early accomplishments of CAPA include:

- Improved attendance at health facilities in the 20 LGAs in the three project states.
- Community mobilization on child health issues has become a continuous process, as health education by CAPA committee members and the community health promoters at the community level have become routine.
- CAPA Committees have helped created better harmony between health workers and the communities they serve.
- Community members are taking responsibility for their children's health.
- The States and the LGAs have become more aware of their responsibilities to the people, knowing that the demand was generated by the community.
- Community members have become involved in monitoring attendance at the clinic and in resolving health problems at the community level and in mobilizing communities to receive health services.
- Improvements have been recorded in breastfeeding, vitamin A consumption, bednet use, and in other indicators in CAPA communities.

ANNEX

1. AN EXAMPLE OF CAPA COMMITTEE WORK PLAN OR "CONTROL PANEL"

PROBLEM	SOLUTION	ACTIVITIES	RESPONSIBLE PERSONS	TIME FRAME	RESOURCES
No vaccine in the clinic	Advocacy visit to the PHC coordinator and the LGA chairperson	- Organize a community meeting to review vaccine situation - Agree to conduct advocacy visit - Fix a tentative date - Appoint one person to follow up with the LGA to secure a date - Plan and discuss on points to discuss - Select representatives - Conduct advocacy visit - Report back to the CAPA committee	Chairperson/Secretary (CAPA Committee) Chairperson/Secretary Secretary Secretary Chairperson/Secretary Chairperson/Secretary Selected representatives and community leaders		Space Transportation Transportation
Staff do not come regularly	Meeting with health worker	- At CAPA committee meeting, discuss the problem - Fix a date to hold a meeting with the staff - Confirm date with the staff - Hold the meeting and allow staff to present their problems - Discuss and find solution to health worker's problems - Monitor to see changes - Review situation at the MPC	Chairperson/Secretary Secretary Chairperson/ Secretary/CAPA Committee CAPA Committee /health workers CAPA Committee /Secretary		Space
Clinic too far from the village	Establish new outreach centres	- Organize meeting to review status of service delivery - Discuss on the establishment of new outreach centres and the number - Identify possible locations - Identify number of health workers needed - Prepare the identified locations - Request the LGA for inspection - Develop timetable for visits - Commissioning - Commence immunization activities	Chairperson/Secretary CAPA Committee CAPA Committee CAPA Committee /health workers Selected representatives Secretary CAPA Committee /health workers CAPA Committee /health workers		Furniture, etc. Transportation Logistics

Clinic is on the other side of the river	Organization of outreach centres Collaborate with boat drivers' association	- Organize meeting to review the unavailability of immunization - Discuss probable methods of transportation - Select appropriate method - Collaborate with identified transportation association in the community - Plan with the transport associations to assist in the movement of staff and vaccine - Inform LGA of the transportation arrangement - Commence immunization activities	Chairperson/Secretary CAPA Committee CAPA Committee Selected reps CAPA Committee /health workers (representatives) Secretary CAPA Committee /health workers		Transportation
Husband will not allow wives to take the baby to the clinic	Organize village meeting to educate members	- Hold CAPA Committee meeting to discuss problems and plan to meet the PHC coordinator - Meet the PHC coordinator, organize a date for the community health education - Inform the community head about the program - Arrange with the community head/CBO leaders to mobilize the community - Organize community health talk - Conduct community health talk - Monitor attendance at clinic to watch for changes - Review the situation at the CAPA committee meeting	Chairperson/Secretary Secretary Secretary CAPA Committee /health workers (representatives) CAPA committee Secretary LGA and PHC health workers CAPA Committee		Space Cash/kind for running around and venue Space

2. DEVELOPMENT/ADAPTATION OF TECHNICAL TRAINING MATERIALS

OBJECTIVE:

To develop technical training materials for State, LGA Health Facility service providers, and CAPA Committees.

> **NOTE:** The concept development of technical training materials is a State-level intervention. However the pre-testing and validation is at the LGA/community level.

TASKS:

- Constitute the State Technical team for all intervention areas (immunization, nutrition, malaria, etc.)
- Each team reviews the existing training modules and makes recommendation to the State on the next line of action to adapt or develop new materials.
- Establish desired outcomes in all the technical focus areas (immunization, nutrition, malaria, etc.) in relation to what health workers and community members need to know and do.
- Each team develops or adapts the module for each technical focus area.
- Prepare State facilitators and supervisors on the technical modules.
- Prepare Local Government Area facilitators and supervisors on the modules.
- Conduct technical training using the technical modules for health service providers.

PARTICIPANTS AT THE STATE MEETING:

- State Director PHC/DC
- LGA MOH Representatives
- State MOH Staff: Head of project intervention units: Immunization, Nutrition, Malaria, Health Educator, Monitoring & Evaluation
- Multi-sectoral Ministries representatives (2–3 from each ministry)
- State/LGA IEC person (if different from the Health Educator)
- Donor technical staff: Program Officers for Immunization, Malaria, Nutrition, Community Development, IEC & Logistics
- Consultant (if necessary)

NOTE: From the participants listed above, technical teams should be constituted for each project intervention, and each State Technical Team should consist of:

- State MOH Head of project intervention unit to act as the technical focus person/leader backstopped by the State Director PHC/DC
- Selected LGA MOH staff (1–2)
- Selected LGA technical focus person (LGA NPI, Nutrition, or Malaria officer (1–2)
- Donor Technical Program Officer for each technical focus area
- Other State and donor agency representatives: NPHCDA, NPI, UNICEF, WHO, DFID
- Rep of Multi-sectoral Ministries; Education, Information, Agriculture, etc.

Each technical team is given a generic mandate outlining what to do, the documentation of process, the quality of desired outcome, a time frame, and the reporting format. The outcome and products of all technical/non-technical teams should be shared with the State and partners at a meeting with all government agencies for approval.

The procedure for developing training materials is very technical and includes the following steps:

- Review available materials (mini-research).
- Identify gaps and/or current issues.
- If modules are to be developed, identify and assign tasks according to partners' specialty areas.
- Fill gaps or update with current issues.
- Conduct pre-testing: perception, interpretation, reactions, exactness of content, picture, layout, etc.
- Input corrections.
- Conduct validation/accuracy testing: perception, interpretation, reactions, exactness of content, picture, layout, etc.
- Complete costing, contracting, printing, and distribution plan.
- Follow up on use and supply demands.

DURATION:

It will take about 3–6 months to complete all new materials. However, implementation does not need to wait until all materials are ready, as they can be phased in according to training needs. Where the existing materials can be adapted and reproduced, preparatory time is drastically reduced, if funds are made available in a timely manner.

OUTCOMES:

- Established desired outcomes in all the technical focus areas (immunization, nutrition, malaria, etc.) in relation to what health workers and community members need to know and do, which is facilitated by the training materials.
- Technical training modules for state/LGA level training are available.
- Strategy implemented to institute a functional system that meets the demands of the indicators selected, balances demand with supply, and ensures quality services (see below).

NOTE: The desired outcomes vary from the supply side of the health system to the demand side of community members as shown in the example below for immunization.

The desired outcomes for the health system ***(supply***) side are:

- Sufficient skilled manpower
- Reliable vaccine distribution systems providing potent vaccines in sufficient quantities
- Safe injection practices and safe disposal of used material
- Accurate recording, reporting, and monitoring of immunization activities for decision-making
- A functioning self-assessment and supportive supervision system

The desired outcomes for the community ***(demand)*** side are:

- Understanding of the need for, and efficacy of, immunization to protect their children from death and disability
- Cooperative action to make immunization services accessible to mothers/caregivers
- Access to and availability of services
- A sufficient number of knowledgeable members of the community, such as CAPA committees and trained community health promoters
- Community effectively mobilized for immunization to enhance extensive coverage
- Baby tracking to ensure full compliance with immunization schedule
- Good reporting and monitoring of immunization charts at the facility level
- Good working relationship with health workers at the health facility, local government, and community levels
- Appropriate reaction when vaccine is in short supply, in coordination with other CAPA committees in the LGA or state

3. EXISTING TECHNICAL TRAINING MODULES FOR ADOPTION / ADAPTATION

BASICS II/Nigeria, working with the National Programme on Immunization (NPI), the Federal Ministry of Health, and other stakeholders, developed modules and training guides for immunization, Essential Nutrition Actions, management and control of malaria, CAPA Training, and CHP Training. Many of these materials have been adapted for use nationally. The modules are available for use by any interested groups working in these areas and can be adapted for use in other countries.

NPI: Basic Guide for Routine Immunization Service Providers:

The content of the **five** immunization training modules are as follows:

- Section 1: National Programme on Immunization target diseases, vaccines, and their administration
  - Tuberculosis and BCG vaccine
  - Diphtheria
  - Pertussis or whooping cough
  - Tetanus (including maternal and neonatal tetanus)
  - Poliomyelitis and OPV
  - Measles and measles vaccine
  - Yellow fever and yellow fever vaccine
  - Hepatitis B and hepatitis B vaccine
  - Cerebrospinal meningitis and CSM vaccine
  - Contraindications to immunization
  - Summary

- Section 2: The cold chain
  - About module 2
  - What is cold chain?
  - What cold chain equipment is used in health facilities?
  - What cold chain monitoring equipment is used in health facilities?
  - How to monitor and adjust the temperature
  - Opened multi-dose vial policy
  - The shake test to determine whether a particular vaccine has been frozen
  - How to maintain cold chain equipment
  - Summary

- Section 3: Providing immunization services
  - Preparation for immunization sessions in a fixed health facility
  - Assessing the client (screening)
  - Using the immunization register and client's card
  - Preparing vaccines for use during a session

- Ensuring safe injections
- Reconstitution of vaccine
- Vaccine administration
- After immunization
- Disposing of syringes and needles
- Organizing outreach immunizations sessions
- Summary of administrative guidelines
- After immunization sessions

■ Section 4: Communication with clients/parents

- About this module
- Communication in general
- Addressing the concerns of clients/parents first
- Communicating essential messages about immunization
- Communicating with groups
- Involving the community in planning immunization services
- Mothers' concerns about immunization

■ Section 5: Monitoring immunization coverage, dropout, and quality of service

- About this module
- Monitoring coverage and dropout
    - Recording immunization
    - Reporting coverage monthly
    - Using immunization coverage/dropout monitoring charts
    - Interpreting coverage data
    - Identifying problems and their causes
    - Taking action to increase coverage and reduce dropout
- Monitoring service and management quality
    - Set standards
    - Self-assessment of selected indicators
    - Take action to improve quality of service
    - Supportive supervision

Essential Nutrition Actions (ENA): A Trainer's Module for Health Workers:

The content of the ENA training module contain **seven** sessions as follows:

■ Maternal and child nutrition in Nigeria
■ Health services component of ENA
■ Infant Feeding Plan
■ Counselling on breastfeeding positions and attachments
■ Management of breastfeeding difficulties and their solutions
■ Communication and community mobilization to improve nutrition

- How to counsel mothers/caregivers using the Home Health Booklet

A Training Manual for the Management & Control of Malaria for Primary Health Care Workers:

The content of the malaria training modules contains **five** sessions as follows:

- Assessment of knowledge and quality of practice
- Definition and Epidemiology of malaria
- Assessment and Management of malaria
- Malaria in pregnancy
- Prevention of malaria
- Appendix: Case Studies

Catchment Area Planning and Action: Module 1: Immunization:

The content of the CAPA Module for Routine Immunization contains **thirteen** sessions as follows:

- Know your community
- Why involve different persons
- The state of our children's health
- What do we want for the health of our children?
- Take the participants through the immunization schedule, explaining the need for each vaccine
- Set immunization objectives
- Number of children in the family and its effect on the community
- Reasons why very few children in the community are immunized
- Identify solutions to the problem
- Plan activities
- Develop a workplan
- Plan how to start
- Plan assessment of the implementation of Catchment Area Planning and Action

Catchment Area Planning and Action: Module 2: Nutrition & Malaria:

The content of the CAPA Module for Nutrition & Malaria contains **ten** sessions as follows:

- How are we doing with immunization?
- Malaria prevention and treatment
- Key practices of infant feeding and child feeding
- Setting child health objectives

- The health of our children and its effect on the community
- Reasons why many children in the community are not healthy
- Identify solutions to the problem
- Developing a workplan
- Starting the workplan
- Implementing the workplan

Training Module for Community Health Promoters:

The content of the Training Module for Community Health Promoters contains **eleven** sessions as follows:

- Catchment Area Planning and Action: The need for Community Health Promoters (CHP)
- Importance of immunization and the immunization schedule
- Key practices of successful breastfeeding and complimentary feeding
- Importance of vitamin A
- HIV/AIDS and the prevention of mother-to-child-transmission through infant feeding and safe injection practices
- Home Management of the sick child: Malaria
- How to counsel mothers/caregivers using the Counselling Cards, the Fever Booklet, and the Home Health booklet
- Practice on the use of Counselling Cards, the Fever Booklet, and the Home Health booklet
- Field practice and discussion
- Conducting community group education for child survival
- How to start counselling mothers/caregivers

4. DEVELOPING IEC / CBC MATERIALS

IEC/CBC material development involves identifying audiences for ideal child health behaviours using effective communication principles in order to identify and address needs and design interventions that will help move the audience to the desired change. IEC/CBC is a cross-cutting area that takes into consideration appropriate key messages designed for technical interventions in the CAPA project.

A technical meeting with partners, including state representatives and target ministries, is conducted to develop CBC-designed messages. Some technical staff should have experience in this area. Also required are the services of a technically skilled computer graphic artist

OBJECTIVE:

To develop integrated "Communication for Behaviour Change" materials (IEC/CBC) for use by health workers and community health promoters.

TASKS:

- Develop IEC/CBC materials.
- Focus group discussion.
- Develop logo.
- Design and develop key messages.
- Pre-test messages and materials.
- Produce and distribute materials.
- Create additional IEC/CBC interventions.

The above tasks are described in detail below:

- Focus group discussion: Work with the State Team to conduct focus group discussions to assess the message needs and level of understanding in selected target communities. It is expected that the discussion will provide information on the following:
    - Level of awareness of childhood diseases
    - Appropriate language
    - Cultural beliefs and barriers to address in the messages
    - Attitudes about child health interventions

  The results of the discussion will equip staff with adequate knowledge to be considered during the development of key messages. This is to ensure that the messages are not

rejected. This involves a field trip because the discussion is at household level in the community.

- Develop a child health logo: A child health logo is a symbol of child survival. Experience shows that communities feel connected when they see the healthy child logo. Work with the team to develop the logo of a healthy, happy child, such as the one on the right.

  The end product is a child health logo that is used throughout the project sites as a common symbol that is recognized as connected with CAPA.

- Develop key messages and design materials: Work with the team to develop key messages. Take into consideration the results of the focus group discussion. Care must be taken not to convey negative messages. Information should be given on what the audience needs to know. Messages must have specific objectives and be:

  - Appropriate, relevant, and clear
  - Interesting, appealing, and attractive
  - Simple and easy-to-understand
  - Conveyed in a language that is easily understood
  - Sensitive to the cultural beliefs of the community (e.g., use local pictures)

  Assemble IEC/CBC materials already developed by the partners, if any (there usually will be some on different interventions). IEC/CBC materials include posters, flyers, the Home Health Booklet, stickers, counselling cards, radio spots, newspaper articles, videos, scripts, and graphics. Adapt suitable materials or develop new ones.

  Materials are developed with the participation of the IEC/CBC team and the technical program staff in order to ensure that adequate, appropriate, and correct information is given on the varying child health issues. A draft is brought to the next meeting of the team.

- Pre-test messages and materials: Pre-test all draft material in selected target communities. Hold another meeting to fine-tune the material. It is important to pre-test material because it provides an opportunity to make corrections based on the feelings of the target audience.

  Selected target audience can be used in another focus group discussion or interview. Patience is required to carefully listen to participants' impressions. Pre-testing may lead to revising or even changing the entire picture or content of messages.

  All partners should agree upon materials before printing, distribution, and dissemination.

- Produce and distribute materials: The number of IEC/CBC materials is contingent on the number of PHCs and CAPA Committees that will be using them. Materials are distributed as implementation progresses to accompany each technical intervention.

- Create additional communication for behaviour change interventions: Through the print and electronic media, the message is disseminated even beyond the borders of the target community through media intervention.

  Organize sensitization meetings and workshops with media executives and journalists in order to let them know the facts about child health. It is necessary to ensure that journalists are well informed about issues involved in child health or any intervention to make them stakeholders. Involve them from the planning stage so that they can advise on the role of the media in child health.

  Conduct a media survey analysis in order to look at the coverage of child health at the beginning in order to obtain a baseline. Repeat the survey annually and share the analysis with the media executives or journalists at meetings.

PARTICIPANTS:

- State MOH head of project intervention unit to act as the technical focus person/leader backstopped by the State Director PHC/DC
- Selected LGA MOH (1–2)
- Selected LGA Health Educators/IEC Officers
- State MOH Information/Documentation Officers
- Selected LGA technical focus person (LGA NPI, Nutrition, or Malaria persons (1–2))
- Donor Technical Program Officer for each technical focus area
- Other State and donor agency representatives: NPHCDA, NPI, UNICEF, WHO, etc.
- Representatives of multi-sectoral Ministries: Education, Information, Agriculture, etc.

DURATION:

If tasks are identified and shared according to specialty areas of partners, it will take about 3 to 6 months to produce all materials. However implementation does not need to wait until all materials are ready, as they can be phased in according to training needs. Where projects can adapt and reproduce the existing materials, preparatory time is drastically reduced, if funds are made available in a timely manner. Donors should be able to provide information on the printers and template used to design the original IEC/CBC materials.

5. FACILITATION SKILLS: SAMPLE OF CONTENTS FOR TRAINING

POINTS/CONTENTS FOR DISCUSSION

Discuss the following and agree on what to include to make facilitation attractive.

1. Meaning of facilitation
2. Principles and methodology of facilitation
3. The role of a facilitator
4. Characteristics of a good facilitator
5. Facilitation by persuasion
6. Co-facilitation
    - ✓ Definition
    - ✓ Advantages
    - ✓ Disadvantages
7. Team presentation by co-facilitators
8. Individual presentation
9. How to summarize

OUTCOME:

Participants share their experiences and sharpen their facilitation skills in readiness for any given program.

6. SAMPLE AGENDA FOR PRE-CAPA MEETING IN THE COMMUNITY

Moderator: (Name moderator)

1. Opening prayer
2. Self introduction – by each person present
3. Opening remarks
   - Why we are here today (objective of the meeting)
4. The community–based approach and CAPA
5. Why we are all involved – community, LGA, state, partner
6. Introduction of Technical Focus Areas
   - Immunization
   - Nutrition
   - Malaria
7. Questions and answers
8. Nomination/selection of CAPA committee (about 30 persons)
   - Criteria – gender balance/equity
   - Youth representative
9. Duration of meeting is CAPA – 3 days
   - Date: Venue
10. Any other business (AOB)
11. Pro-tem committee/responsibilities – selection
12. Closing

7. TYPICAL CAPA TRAINING AGENDA (3 DAYS):

Day One

TIME	ACTIVITY	BY WHOM
9:00 a.m. 9:15 am.	Opening prayer Self introduction by the participants	
9:15 a.m. 9:30 a.m.	Welcome remarks Workshop ground rules Appoint moderator and reporter for the day	
9:30 a.m. 9:45 a.m.	Objective of the workshop and methodology Facilitation skills	
11.00 a.m.	Tea break	
11.15 a.m.	Break into three groups to work on Sessions 2 and 3	
11:20 a.m.	**Demonstration 1:** **Session 1**: Know your community Discussion on subject and presentation	
12:20 noon	**Session 2**: Why involve different persons?	
1:20 p.m.	**Session 3**: The state of our children's health	
1:20 p.m.	Plenary – Group presentation and discussion	.
2:20 p.m.	Lunch	
3:00 p.m.	**Session 4:** What do we want for the health of our children? (Back to the group)	
4:00 p.m.	**Plenary:** Group presentation and discussions Appoint a moderator and reporter for the next day End	

Day Two

TIME	ACTIVITY	BY WHOM
9:00 a.m.	Review previous day's activities	
9:15 a.m. 10:15 a.m.	Demonstration of **Session 5**: Take participants through immunization schedule, explaining need for each antigen - Discussion Group assignment to work on Sessions 6, 7, and 8	
10:15 a.m. –	**Session 6**: Set immunization objectives	
12:15 p.m.	**Session 7**: Number of children immunized in the family and its effect in the community	
12:15 p.m.	**Session 8**: The reasons why very few children are immunized in the community	
1.15 p.m.	**Plenary**: Group presentation and discussion	
2:15 p.m.	Lunch	
3:00 p.m.	**Session 9**: Identify solutions to the problems – large group	
4:00 p.m.	Appoint moderator and reporter for the next day Closing	Moderator

Day Three

TIME	ACTIVITY	BY WHOM
9:00 a.m.	Review previous day's activities	Day 2 reporter
9:15 a.m.	**Session 10**: Plan activities	A facilitator
10:15 a.m.	**Session 11**: Develop work plan	A facilitator
11:15 a.m.	**Session 12**: Plan how to start	A facilitator
12:15 p.m.	**Session 13**: Plan assessment of the implementation of CAPA	A facilitator
1:15 p.m.	Lunch	
2:00 p.m.	Workshop review	A facilitator
2:20 p.m. 2:40 p.m.	Planning for next steps Closing	Moderator

8. SAMPLE CHP TRAINING AGENDA

DAY ONE: Moderator: _____

TIME	**ACTIVITY**	**RESP. PERSON**
9.00 – 9.10 a.m.	Arrival and registration	
9.10 – 9.20 a.m.	Opening prayers, self introduction, appointment off reporters,	
9.20 – 9.25 a.m.	Welcome address	
9.25 – 9.30 a.m.	Donor's remarks	
9.30 – 10.00 a.m.	Objectives of the workshop and ground rules	
10.00 – 11.00 a.m.	Facilitation of **Session 1**: CAPA and the need for community health promoters	
11.00 – 11.30 a.m.	BREAK	
11.30– 12.30 p.m.	Facilitation of **Session 2**: Importance of immunization and the immunization schedule	
12.30 – 1.30 p.m.	Facilitation of **Session 3**: Key practices	
12.30 – 1.30 p.m.	LUNCH	
1.30 – 2.30 p.m.	Facilitation of **Session 4**: Malaria	
2.30 – 4.00 p.m.	Facilitation of **Session 5**: How to counsel	

DAY TWO: Moderator: _____

TIME	ACTIVITY	RESP. PERSON
9.00 – 9.10 a.m.	Registration	
9.10 – 9.30 a.m.	Opening prayers and recap of previous day's activities Appointment of reporters	
9.30 –10.30 a.m.	Facilitation of **Session 6**	
10.30 – 11 a.m.	BREAK	
11.00 – 2.30 p.m.	Facilitation of **Session 8**: Group education	
12.30 –1.30 p.m.	Facilitation of **Session 9**:	
1.30 - 2.30 p.m.	LUNCH BREAK	
2.30 - 3.30 p.m.	Preparation for field work (**Session 7**)	
3.30 – 4. 00 p.m.	Closure and facilitators meeting	

DAY THREE: Moderator: _____

TIME	ACTIVITY	RESP. PERSON
9.00 – 9.10am	Registration	
9.10 – 9.30a.m.	Opening prayers and recap of previous day's activities Appointment of reporters	
9.10 –12.Noon	Field work	
12.00 – 1.00pm	Discussion on the field work	
1.00 –2.00pm	LUNCH BREAK	
2.00 – 2.30pm	Workshop evaluation	
2.30 – 3.00pm	General information and facilitators' meeting End	

■