Community-based programmes are strengthened when there is access to facility-based care. A health worker prepares a solution of oral rehydration salts, Eritrea.

National strategies must give priority attention to the removal of obstacles to effective scaling up and implementation at different levels of the health systems (see Chapter 4 for further details on measures to address bottle-necks in health-service delivery). Well known bottlenecks include irregular immunization sessions, negative experiences with the health system, distance to health centres and lack of information. At the family and community level, effective coverage of primary-health-care services is often impeded by lack of basic affordable supplies, low demand and other fundamental challenges, such as mosquito nets not being treated with insecticide.25

Both the short-term, disease-specific initiatives – increasingly supported by new international donor partners – and longer-term, health-sector development programmes are likely to continue to coexist. Sufficient human and financial resources must be invested in both sets of initiatives to produce sustainable gains for child health. Donor-driven, disease-specific partnerships should consider adapting their approaches into multisectoral frameworks that align with national health priorities, with equitable benefits for the whole national health system.24

The ultimate responsibility for ensuring children’s rights to health and nutrition lies with national governments in partnerships with civil society. Governments have an important role in developing and implementing policies to lower the barriers to primary health care, in improving the quality and efficiency of service providers and in increasing public accountability. At the same time, health policies must be accountable to the communities and districts they serve. Governments and health systems must be closely attuned to the needs and interests of the population. Developing effective, child-focused health policies and building strong institutions between communities and health systems is critical; in most countries, increases in health expenditures will need to be accompanied by substantial improvements in the policy environment to achieve significant progress towards the health-related Millennium Development Goals.28

Finding the appropriate mix of solutions for enhanced health and nutrition outcomes

Each developing country has a unique mix of opportunities for, and constraints on, the development of its health system, owing to differing levels of economic progress, environmental and institutional circumstances, political situation and current health-system capacity. As a result, there is no universally applicable method of fostering improvement. Some may find that their greatest challenge lies not in scaling up community-based approaches to essential health-care packages nationwide, but in strengthening and expanding service delivery through facility-based programmes, decentralizing health services, and addressing non-communicable diseases and conditions, such as diabetes and obesity.26

For low-income countries, particularly those where large proportions of the population are poor, interventions that address malnutrition lie within the health system. In limited-resource settings, primary health care is the most cost-effective approach to health promotion and community mobilization for such as activities as distribution of insecticide-treated mosquito nets and conducting immunization campaigns.

The challenge was to deliver an effective community-based child survival programme to rural communities with poor physical and environmental health infrastructure, and verify that the community programme contributed to mortality reduction.

Approach: The Chokwe Ministry of Health and World Relief partnership project in operation during 1999–2003 used the ‘Care Group’ approach to implement a child survival programme that aimed to address three elements of Community Integrated Management of Childhood Illness (C-IMCI):

• Improved partnerships between the health system and the community.
• Increased accessible care for community-based providers.
• Promotion of essential household practices for child health.

The Care Group approach trains community educators through group interaction. One volunteer Women’s Health Educator provides peer-to-peer health education to 15 surrounding households, and 10 Women Health Educators form a Care Group that meets once a month with a paid supervisor. During monthly Care Group meetings, a health field staff member or a Women’s Health Educator supervisor presents health messages about child survival and women’s health. The Care Group members then practise training with each other, sharing the information presented. Before the next Care Group meeting, each volunteer is responsible for visiting the households under her jurisdiction to relay the messages she has just learned.

The child survival programme was designed to be comprehensive, integrating breastfeeding, complementary feeding, use of oral rehydration therapy and insecticide-treated mosquito nets. The programme strengthened referral to local health facilities and case management of common illnesses at the facilities.

Partnerships with UNICEF and the International Committee of the Red Cross facilitated the provision of free insecticide-treated nets, vaccines and vitamin A supplements. Close cooperation with village health committees and local pastors provided support for the volunteers in carrying out health promotion and community mobilization for such as activities as distribution of insecticide-treated mosquito nets and conducting immunization campaigns.

Results: The project also implemented a community-based vital registration and health information system through the 2,300 community volunteers who collected data on births, deaths and childhood illnesses every month. These data were aggregated during the monthly meetings and then sent to health posts operated by community providers, or sorcerists, who were trained by the district Ministry of Health. The collated information was sent back to local village health committees, health centres and the Ministry of Health.

Data from the community-based vital registration and health information system showed a 66 per cent reduction in infant mortality and a 62 per cent reduction in under-five mortality. To check the reliability of these findings, an independent mortality assessment was carried out by experienced researchers using a pregnancy history survey based on standard methodologies applied in the Demographic and Health Survey. This mortality survey found reductions of 49 per cent and 42 per cent in infant mortality and under-five mortality, respectively.

These results demonstrated the effectiveness of the Community IMCI and validated the fact that community health workers can collect reliable health data for monitoring mortality.