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Report on the Third intercountry workshop on the Child Health Policy Initiative (CHPI)

Tunis, Tunisia 10–13 December 2006

World Health Organization
Regional Office for the Eastern Mediterranean

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1 INTRODUCTION

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO) held the Third intercountry workshop on the Child Health Policy Initiative (CHPI) in Tunis, Tunisia, from 10 to 13 December 2006.

The objectives of the workshop were to:

- review the progress of development of the national child health policy documents in four countries (Egypt, Morocco, Sudan and Tunisia) and prepare plans for their official endorsement at the highest political level in the country;
- review the progress of development of the child health situation analysis reports—representing the evidence guiding the development of the policy document—in five countries (Iraq, Jordan, Oman, Pakistan and the Syrian Arab Republic) and prepare plans for the development of the national child health policy documents; and
- introduce the Child Health Policy Initiative (CHPI) to three new countries (Islamic Republic of Iran, Palestine and Yemen).

A total of 43 participants attended the workshop, including 31 national representatives of 10 countries in the Region, four staff from four UNICEF country offices and eight staff from the WHO Regional Office for the Eastern Mediterranean, WHO Regional Office for Africa and four country offices in the Region. Countries represented in the workshop included: the five countries which had joined the CHPI since its launch (Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia); three countries which subsequently expressed interest in the Initiative (Iraq, Jordan and Oman), the first three of which had participated in the previous CHPI workshop; and two new countries interested in learning about the CHPI (Islamic Republic of Iran and Yemen). The programme and the list of participants are included as Annexes 1 and 2, respectively.

2 BACKGROUND TO THE WORKSHOP: THE REGIONAL CHILD HEALTH POLICY INITIATIVE (CHPI)

This workshop was the third of a series of annual workshops on the CHPI organized by the Regional Office to guide the process on national child health policy development, share experiences between interested countries and support and follow up their work in this area. For the first time, a CHPI activity, such as this workshop, was attended also by staff from another WHO Region, namely the African Region, showing the keen interest in the Initiative also from outside the Region.

The CHPI is essentially an initiative to assist interested countries in developing national child health policy documents. Despite the commitments made by Member States to children on many occasions, including more recently to the Millennium Development Goals (MDGs), many children in the Region are deprived of the right to better health: they still suffer from common illnesses and an estimated 1.5 million children die each year, mostly from preventable causes. Thus, there is a need in the Region to develop national policy documents which bring all key child health-related policy elements in one document, ensuring consistency, addressing policy gaps, making commitments in terms of financial and human resources and providing coordination mechanisms for child health work in a country. Such documents would provide the required long-term support to child health, indicating outcome-oriented directions, priorities and strategies, and serving as a reference to harmonize partners' actions and create a supportive environment for child health care in a country. The CHPI envisages the production of a policy which is written, evidence-based, priority- and action-oriented, owned by all concerned stakeholders through a process of wide consultation, endorsed at high level and followed by a detailed implementation strategy.

Three main phases characterize the dynamic process of national child health policy development, according to the CHPI:

1. A thorough *situation analysis,* leading to the identification of issues with policy relevance and representing the evidence platform on which to develop the policy;
2. The *development of the policy document,* including the prioritization of the policy issues identified in the previous phase and policies to address them; and

3. The *official adoption* of the policy document itself.

As emphasized in the opening address by Dr H. A. Gezairy, WHO Regional Director for the Eastern Mediterranean, the Initiative builds on country experiences while being guided at the same time by tools developed by the Regional Office to standardize the process. These tools are based on a critical review of such experiences to be more responsive to newly identified needs. As pointed out in the introductory presentation by Dr M.H. Khayat, Senior Policy Adviser to the Regional Director, the difference between policy and strategy should be kept very clear in mind, with the policy representing the decision (what) and the strategy representing the approach to its implementation (how). A plan of action would then describe in detail responsibilities (who), actions (what), timeline (when), approach (how) and costs (how much). The Initiative aims to consolidate the achievements made to date on the health of children under 5 years of age, including the neonatal period, to improve the quality of care provided to both the healthy and sick child, and thus the quality of their lives.

Conceived in October 2003, the CHPI involves intensive collaborative work between countries and the Regional Office. The first workshop was held in Damascus, the Syrian Arab Republic, in July 2004, and focused on the progress of work of the first countries pioneering the Initiative during its first phase—the preparation of the child health situation analysis reports[1]. The second workshop took place in Cairo, Egypt, in November 2005 and was attended also by representatives of new countries interested in the CHPI, while all but one country of the first batch had been able to complete their situation analysis reports by then[2]. A major aspect of that workshop was the presentation of the process recommended by the Regional Office to prioritize policy issues after their identification during the situation analysis. Finally, this third workshop was then a natural development of the previous ones, to further contribute to the work started by countries and to expose new ones to this experience.

In addition to the intercountry workshops, joint WHO/ministry of health meetings were held in Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia, followed by national workshops. Besides those activities, the Regional Office advocated for the

[1] Report available at http://www.emro.who.int/cah/activities-meetings-syr04.htm.
[2] Report available at http://www.emro.who.int/cah/activities-meetings-egy-0705.htm

Initiative also by producing flyers, posting information on the Child and Adolescent Health and Development web pages of the Regional Office website, issuing a press release, meeting with senior ministry of health staff, informing the Regional Committee and including information on the CHPI in the materials for World Health Day 2006.

3 THE SITUATION ANALYSIS PHASE

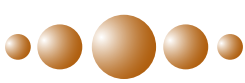
Experience has been building up on this phase over the years, guided by the Regional Office document «Development of national child health policy—Phase 1: The situation analysis»[3] and adapted by countries to suit their specific needs. A critical analysis of the child health care situation in a country—within its political, demographic, socioeconomic, educational and health system context—is essential as it goes beyond a mere description of the situation to identify strengths, weaknesses and constraints of the current system and approaches. It leads to the identification of those issues of policy relevance which may be addressed in the policy document. Challenges to data collection have included the difficulty in accessing certain information (e.g., cost-related data), the inconsistency or low reliability of some data with the need to validate them through various sources and the lack of data from the private sector and on certain conditions of illness (e.g. chronic). The formalization of the data-gathering task by official correspondence has assisted access to information.

Two different management approaches to organize and carry out the work have been followed in countries, as outlined in the presentations by Tunisia, Egypt and Sudan. One was based on just one task force working together throughout the steps of the analysis and the other one was based on a task force working through several small groups. In both cases, a multidisciplinary task force with its terms of reference has been officially established. The first approach enables the team to move together throughout the process but demands more time from each person and to complete

[3] Available at http://www.emro.who.int/cah/childhealthpolicy-situationanalysis.htm#section1

all tasks. The second approach by several groups has the advantage of distributing work to a few teams, each working on a specific topic area in parallel with the other teams; it initially takes less time but then requires a thorough review of the various sections produced by the different teams and their merging into one consistent report. Members of the task force and teams should be appointed in their personal capacity and be available personally rather than be represented by others to provide continuity and consistency during the process. The task force and its teams should be small, to enable timely, productive work. It is important to involve key resource persons and institutions in the process as sources of information within and outside the ministry of health. The recommended process ideally moves through 10 steps, from the identification and orientation of partners to the collection of information and its critical review, the preparation, circulation for comments and reviews of the draft situation analysis report up to its finalization after reaching consensus in a formal forum. The situation analysis report is typically composed of eight main sections, covering: an introduction (describing the supportive environment and rationale for a child health policy); general context (geographical, political, administrative, demographic and socioeconomic); health system elements; health care financing; human resources (management, production and capacity-building), including pre-service education; public child health issues, including trends of key indicators over the years; child health-related programmes and the extent to which they have been able to address those issues; and partners.

Countries have chosen to proceed in stages, moving through key life-cycle periods. Thus, they have first focused on children under 5 years of age, this being a priority age group in terms of vulnerability, for which ample and reliable information is available and with which substantial public health experience has been gained over the years. This age group is also specifically the target of international commitments, such as the MDGs. Subsequently, the other age groups could be addressed, benefiting from the experience acquired in developing policies for children under 5 years of age. For this particular purpose, documenting the experience and lessons learnt during the situation analysis (i.e. memory of the process) is very valuable.



4 DEVELOPING THE POLICY

4.1 The process

Similarly to the situation analysis phase, a clear plan of action should be prepared also for the policy development phase. A thorough orientation of those involved should take place. A number of technical committees, to be established formally with clear terms of reference and aided by resource persons as needed, would be entrusted with the task of preparing the draft sections of the policy document by thematic areas. The designation of the members of those committees should take into consideration recognized experts and organizations regarded as major players in the subject areas and with field experience.

The process would include the prioritization of policy issues identified in the situation analysis phase (see 4.2), the development of policy statements, the preparation of a brief document for decision-makers with the justification for the policy and its implications (i.e. legal, regulatory, financial, human and time resources), a review of the various sections by the task force, its circulation for comments and wide consultation with key players to reach consensus and finalization. Monitoring indicators and tools should also be proposed (see 4.3).

4.2 Prioritization of policy issues

The situation analysis should result in the identification of a number of issues of policy relevance by area. The next step is the prioritization of those issues following a three-step approach:

1. *Analysis into components and determinants.* Issues are often described broadly. To develop an action-oriented, effective policy, it is important to define issues more specifically. The simple question «What is responsible for those issues?», asked repeatedly, helps «break down» a broad issue into more specific issues and their determinants. This is essential, as it is those determinants that the policy with its interventions should aim at targeting.

2. *Prioritization.* When the first analysis has been completed, it is useful to see whether issues can be addressed in the mid-term, by the ministry of health, by the department which is spearheading the CHPI in the ministry, and as part of other initiatives already in place (e.g., the MDGs, Poverty Reduction Strategy Papers (PRSPs), health sector development, education reform, etc.), as those may be taken into consideration when judging the feasibility of certain policies. Criteria to prioritize policy issues should be agreed upon. Among those suggested and used to date are:

   - *Importance.* The importance of the issue here refers to the expected, measurable impact on child health if the issue is addressed and the related policy implemented;
   - *Chain of relationships with other issues.* Some issues may be related to others, one may play a role in contributing to another one: addressing one of such issues may then help address other issues at the same time;
   - *Feasibility.* This is a key criterion. It refers to:
     - *Likelihood of reaching consensus on the policy.* Another factor to consider is the probability of policy-makers and partners agreeing on a certain policy within a reasonable time. Policy development is a long process and it is of practical value at the beginning to take into serious consideration policies which can be agreed upon relatively quickly, to boost the policy initiative with results and avoid bringing the process to a standstill. As policy development is a dynamic process, policies can and should be reviewed and updated periodically, to include elements which have required a longer decision-making process and to address new issues.
     - *Feasibility of implementation.* The implementation of any proposed policy addressing one or more issues—i.e. the intervention—should be feasible, in terms of the required:
       - human resources;
       - financial resources (implications in terms of cost and availability of resources);

- time;
- legal requirements;
- acceptability of the policy by staff expected to implement it and by the target beneficiaries;
- sustainability.

The above criteria can be applied to the various issues using different approaches, aimed at ranking them in a range from high to low priority. Examples of approaches used by countries include:

- *Quantitative:* a score, within a pre-set range of values, is used for each criterion and applied to each of the identified, specific policy issues;
- *Qualitative:* the criteria are applied to the issues using personal judgement and available information;
- *Combined (quantitative and qualitative):* the quantitative approach of scoring each issue is used to «filter out» low-priority issues; next, personal judgements are applied through brainstorming on the remaining issues.

3. *Grouping into thematic areas.* The issues which have been ranked as high priority are then grouped by thematic areas. This facilitates the writing of the policy document.

The prioritization process described above should in principle involve not only decision-makers and partners but also those who should implement the policy, the potential beneficiaries and those sectors which are expected to be affected by the issue and proposed policy. A plan for the prioritization process should include among other things:

- steps and duration of the process;
- methodology (approach and prioritization criteria); and
- responsibility (a working group with a few core people and additional resource people as needed).

The importance of the prioritization process can not be over-emphasized as it forms the basis for developing related policies.

4.3 "Effective policy": monitoring indicators

The CHPI promotes the concept of «effective policy». As the word «effective» in general refers to the production of the intended results, an effective policy is a policy with a higher potential to be implemented and produce the desired outcome than traditional good-will broad policy statements. Its attributes should make it more likely to support change and action: CHPI recommends policies which are action-oriented and specific, with clear objectives and identification of strategic directions. A key and somehow innovative attribute of an effective policy as conceived in the CHPI is then the inclusion in the policy document of a section on monitoring and evaluation of the policy decisions. This section should list a few indicators to monitor at high level the extent to which the policies will be implemented («process») and achievements made («outcomes»). It becomes an integral and essential part of the policy document envisaged in the CHPI. It helps define more specifically policy statements which may have been stated too broadly. Through a feedback process, information collected through monitoring and evaluation enables future revisions of the policy.

The indicators selected should preferably be:

- specifically linked to each specific policy statement. If indicators for a given policy statement can not be identified, then that policy is too broad;
- easy to understand («simple»);
- SMART (specific, measurable, achievable, resource-based/realistic, time-bound).

In this way, indicators help to guide target-setting in time-bound strategies and operational plans that will be developed to implement the policy. As one of the key characteristics of an indicator is to be measurable, monitoring instruments should carefully be selected to make the measurement of indicators easy and not costly. Such instruments should enable the collection of reliable information which is acceptable to policy-makers and partners. This information should be:

- available, that is already collected as part of the existing system rather than collected specifically just to monitor policy implementation (e.g., avoiding ad hoc surveys or special studies); and

- easily accessible.

In this way, the monitoring process is more feasible and affordable and adds less burden to an already busy system.

The Tunisian child health policy, the first such policy to be developed in the Region as part of the CHPI, does include a specific section on monitoring and evaluation, listing indicators which meet the requirements described above.

4.4 Policy document structure

An entire session of the workshop was dedicated to discussions on the structure of the policy document, as requested by countries, to guide the process of policy writing. Two different models, each with three variants, were proposed and reviewed in groups and plenary. It was generally felt that the child health situation analysis report and the policy document should be two separate documents. This would enable the former to be very detailed and the latter to be concise and more adapted to high-level decision-makers.

Based on the outcome of working groups and discussions held, the policy document should:

- be short and concise;
- be policy-focused;
- use clear and simple language;
- be easy to consult (reader-friendly); and
- include the following sections:
    - *Introduction:* this could consist of a foreword, with introductory remarks signed by the minister of health, and a preface, describing the scope of the document, the justification for a national child health policy in the country and its initial focus on age groups and areas;
    - *Background:* this section may refer to existing commitments, laws and policies in support of child health and may be incorporated in the preface;

- *Vision* (in line with the guiding principles of the policy, e.g. the principle of ensuring equity);
- *Policy elements,* for both existing and new policies, comprising:
  - *Rationale* for the policy statement, including a reference to the issue or issues being addressed and to the situation analysis report for more information;
  - *The policy statement,* to be concise, clear and action-oriented;
  - *A list of the strategies or strategic* directions selected to implement that specific policy decision;
  - *Monitoring and evaluation* of the policy (see 4.3).

It was emphasized that the policy document should include all policies related to child health, i.e. those already existing and those newly developed as a result of the situation analysis conducted as part of the CHPI. Policies related to child health may be included in an annex to the policy document and be referred to in the text as appropriate.

5 ADOPTING THE POLICY

The road toward the official adoption of the policy document by the highest concerned political level in the country should start very early in the policy development process. This includes a proper orientation of high-level decision-makers and key partners on the CHPI at national level, when this is launched in a country, and is followed by the development of a plan for advocacy. This is done to advocate with key players and stakeholders who can support and influence the process positively and effectively. It ensures that the different steps of the process are fully understood and formally endorsed, such as the establishment of the task force and the reports produced. It also ensures that all concerned national and international partners are involved (including also national childhood or family councils) and informed throughout the process, in

order to create ownership by wide consultation. Regular, oral and written briefings of high-level decision-makers, also through flyers, should be conducted to keep them informed of any developments and to maintain their keen interest, showing progress. Given the high appeal of children in all cultures, high-level personalities, such as first ladies, may be approached and their interest stirred to become strong advocates of policies supporting child health and development. Media representatives should be informed through briefing packages to ensure media coverage of the official launching of the policy once the document has been approved. On that occasion, performances of children—who are meant to be the target and beneficiaries of the policy—may also be organized for the event to have more impact on the public and broaden the base of support.

Before the policy document is finalized, every effort should be made to ensure that all—or at least most—of the debated issues have been addressed adequately in the consultation process. It is desirable that the policy document be endorsed by the minister of health and then also by the highest possible political level in a country (i.e. parliament through its health committee, minister, cabinet or council, prime minister, head of state) in line with other high-level national and international political commitments made by the country to children and children's health. This provides further support to policy implementation.

6 THE TUNISIAN EXPERIENCE: FROM SITUATION ANALYSIS TO POLICY

6.1 Child health situation analysis

First, documents related to child health, with a focus on children under 5 years of age, were collected and key informants were interviewed, information gaps were identified and filled in as much as possible. This process took three months. The analysis of the information collected on the child health situation was coordinated by a task force, aided by subcommittees, which led to the draft report. This was reviewed

in the CHPI workshop in Damascus and revised. As a result of this analysis, key policy issues were identified, thus serving as the basis for the development of the child health policy document and offering a reference against which progress could be measured and further analysis could be performed in the future.

The report was structured mostly into two main sections: a) an overall analysis of the health system (organization, access to health services and quality of care, health financing, information system, supervision, referral system, human resource development, drug availability and management, partners); and b) an analysis of the child health situation (mortality, morbidity, disability and child health programmes).

Whilst rather intensive and long as a process (20 months), the in-depth situation analysis phase proved crucial in providing convincing evidence to policy-makers and identifying those issues of policy relevance to be considered in the development of the policy. Essential were the involvement of resource persons from different areas and a clear distribution of tasks between the various subcommittees from the beginning.

6.2 Child health policy document

The policy document was developed by a working group and through workshops following the process advised by the regional CHPI. The policy was meant to focus on children under 5 years of age at primary health care level, as a first step towards expansion to the succeeding age periods of the child, namely late childhood and adolescence. First, policy issues were broken down into their underlying causes, then prioritized according to a set of priority criteria previously agreed upon (e.g. importance—potential impact of addressing the issue—and feasibility of implementing the relevant policy), and, finally, grouped into thematic areas. Goals were then set as the ultimate aim of the policy and policies were elaborated on by different subcommittees, after developing a common template as a guide to provide uniformity to the document. After being drafted, the different parts of the document were consolidated into one document by the primary health care team of the Ministry of Public Health and reviewed in a workshop with the extended task force and during a key national public health event, with further input from high-level resource persons. After a year of work, the policy was finalized.

The document included the following sections:

- introduction, providing the rationale and context of the policy;
- background, summarizing achievements and challenges, based on the situation analysis report;
- vision and goal of the policy;
- policies, addressing the challenges;
- monitoring and evaluation, listing indicators to monitor the implementation of the policy; and
- an annex with existing policies.

The policy was articulated around five areas: access to care, organization of the system and provision of services; promotion of primary prevention; reduction of child and infant mortality and morbidity; disability prevention and control; and promotion of a healthy environment. Each policy statement was accompanied by strategic directions for its implementation. As was the case for the situation analysis, also in the development of the policy document the work of different committees was harmonized thanks to a unified template and reviewed by planning and policy resource persons of the Ministry of Public Health.

6.3 Official adoption of the policy document

The regional CHPI guidelines recommend that advocacy efforts be carried out throughout the process to provide the required political support, not only for the approval of the policy but also for its implementation. The Tunisian approach included initiatives to keep the Minister of Public Health regularly informed of the process and its outcomes—through oral and written briefings—and to ensure his support and commitment. Arrangements were finally made for a formal launching of the policy in a special ceremony during such an international event as this WHO regional workshop, in the presence of high-level personalities and country delegations, ensuring adequate media coverage. This gave further visibility to the CHPI in Tunisia.

6.4 Plan of action

The next, critical step envisaged in the Tunisian experience was the preparation of a plan of action, including targets for the identified indicators, to operationalize the strategies outlined in the policy document and thus translate policy statements into concrete action.

7 KEY LESSONS LEARNT ON CHPI

The development of a policy document as described in this report has proved to be a new experience for countries in the Region. As such, it has entailed challenges, some of which are described below as lessons learnt:

- The situation analysis is critical to develop a policy and should always be an integral part of the process with no «short-cuts». Unfortunately, there has often been a low perception among decision-makers about the key role played by a thorough situation analysis in informing the policy with evidence. The tendency is often to describe without analysing the situation and, traditionally, many policies tend not to be evidence-based.
- Programme manager's lack of analytical capacity has challenged and initially prolonged the situation analysis phase.
- The process requires substantial effort and time, a broad consultation base, the collaboration of different partners and strong commitment. The time required largely depends on the priority accorded and the resources allocated to it.
- The initial enthusiasm with which the CHPI was welcomed in countries was often accompanied by unrealistic expectations about the time and effort required.
- A plan for action, if developed at the very beginning of the process and formally approved, is instrumental in supporting the process. It should detail responsibilities,

timeline and resources required and available.

- Proper orientation of policy-makers and stakeholders to the concept of «effective policy» from the beginning is essential as is their involvement throughout the process to create full ownership.
- The demanding task of policy development has been perceived by those responsible for it as an additional task to their existing responsibilities.
- Data collection is fraught with many problems, concerning a lack of information or inconsistency from different sources and difficult accessibility. Formalization of the process has been very helpful.
- Advocacy plays a critical role throughout the process, from the situation analysis to policy development, and for the endorsement of the policy itself at the highest possible political level in a country.

8 WHAT IS NEXT? PLANS

The policy document, once approved, should be followed by the preparation of a strategic plan, to include the strategies adopted and a detailed plan of action to implement the child health policies. This was the main task for the Tunisian team, which had already finalized its national child health policy document.

For countries which had attended the previous workshop in Cairo in 2005, the respective country teams were asked to review the process followed until the time of this workshop and to compare what had been achieved with what had originally been planned in that workshop. In fact, except for Tunisia, the implementation of the plans of action in most countries had been lagging behind schedule. The recommendation was to prepare realistic plans of action, taking into consideration the constraints which had delayed the process, and have those plans endorsed by the respective ministries of health upon return to their countries. The country teams drafted their new plans

of action according to the work conducted until then, to complete the CHPI phase in which the country was and the stage they had reached. The time-frame proposed in these plans ranged from 10 to 18 months.

9 UPDATES ON REGIONAL WORK IN CHILD HEALTH

9.1 Regional training materials on "Counselling on infant and young child feeding"

While child feeding is at the heart of child health and development, breastfeeding and complementary feeding indicators show unacceptably low performance in the Region: efforts to promote infant and child feeding are therefore required as an essential part of child health promotion.

Among health providers, physicians play a role in influencing families' decisions on child feeding practices by guiding and assisting them. Decisions and advice on feeding must also take into consideration the local sociocultural environment. Promotion of practices and counselling should use a language medium which is understood by the target audience, which is Arabic in many countries in the Region. The regional Child and Adolescent Health and Development Unit has therefore undertaken work to develop a regional integrated training package on «Counselling on infant and young child feeding» in Arabic. The plan is to ultimately translate it also into English to make it available to non-Arabic speaking countries. Besides providing updated information on breastfeeding, the package covers also complementary feeding and feeding in special circumstances (e.g. HIV/AIDS). Given the importance of counselling techniques in communication, a new approach to training has been introduced compared with the one used until recently also in other WHO materials on breastfeeding. The methodology emphasizes skill acquisition with much supervised clinical practice (six two-hour sessions), similarly to what was successfully done in IMCI training courses.

The package consists of three modules[4].

- For facilitators: *A facilitator guide for clinical sessions* and *A facilitator guide for theoretical sessions*. These guides describe how to organize and run the training course to ensure a smooth flow of the various training sessions. They include details on the training methodology to assist the facilitator in carrying out the facilitation tasks throughout the course, including tools to monitor the course and trainees' progress.
- For participants: *The participant manual*. This manual can serve two purposes: one for use within the context of the training course and the other one for consultation as a technical reference on child feeding.

The main objective of training is to strengthen physicians' counselling skills on child feeding, update their knowledge and improve their practices. The competency-based training is a 56-hour full-time, intensive course, which can be delivered in seven days in most settings. A variety of training methods are employed for dynamic interaction between trainee and facilitator. Course materials have been tested in three regional courses with 70 participants from 11 Arab countries in the Region and plans are being developed to start running courses in countries at national level to expand the required pool of facilitators.

9.2 Regional IMCI pre-service training evaluation guide

Initiatives to introduce IMCI into teaching programmes of medical and allied health professional schools started in the Region 8 years ago, with an increasing number of schools and countries implementing them over the years[5].

The need had then been felt for a standard assessment of process and outcomes to identify gaps and strengths to improve the approaches used and provide the evidence base to further advocate for the initiative. For this purpose, a regional committee on IMCI pre-service training evaluation was set up with representatives from teaching

[4] Available at http://www.emro.who.int/cah/Reports.htm#counselling.

[5] Report on the Second regional consultation on Integrated Management of Childhood Health (IMCI) Pre-service Training, Cairo, Egypt, 27–31 August 2006 available at http://www.emro.who.int/cah/activities-meetings-egy06.htm)

institutions, IMCI coordinators and team members from ministries of health and WHO regional and country office staff in February 2005[6]. A guide on IMCI pre-service training evaluation at national and teaching institution level was developed by the committee through meetings and an e-discussion group, tested in two countries—Egypt and Sudan—in 2006, and finally reviewed during a consultation on IMCI pre-service training in the same year.

The evaluation guide concerns evaluation at both the national level and the teaching institution. It comprises five main sections:

- *the background:* briefly describes IMCI and IMCI pre-service training, the regional experience in introducing public health programmes into teaching curricula, main objectives, importance and relevance of IMCI pre-service training and objectives of the evaluation;
- *what to evaluate:* this section deals with the evaluation of both process and outcomes. Process is evaluated at national and teaching institution levels, while outcomes are evaluated at national, teaching institution and health care delivery levels. The purpose of the process evaluation at national level is to assess whether a supportive environment has been established, with formal commitment and a management and coordinating structure, and the planning process. At the teaching institution, the focus of the process evaluation is on the formal endorsement of introducing IMCI into the identified teaching programmes, the establishment of a management and coordinating structure, capacity building for teaching staff, planning, implementation and sustainability. The quality of activities should also be reviewed. Concerning outcome evaluation, this is mostly related to costs at national level, the quality of teaching and student competencies at the teaching institution level, and health care provider competencies at health care delivery level;
- *planning for the evaluation:* provides detailed information on all the planning tasks, the time-frame and the evaluation itself;
- *evaluation questions*: a specific list of evaluation questions on process and outcomes is then presented, to be addressed by the evaluation tools;

[6] More information available at http://www.emro.who.int/cah/activities-meetings-Egy05.htm

- *evaluation tools:* these consist of a set of 16 forms and cover both process and outcomes at national and institutional level.

A new section on indicators of student outcome (knowledge and skills) has also been drafted for review, to guide data analysis based on the experience from the two field-tests, which have yielded encouraging results.

10 CONCLUSIONS

- A strong commitment and leadership in Tunisia, supported by a wide consultative process and the involvement of key influential resource persons, has sustained the interest and enthusiasm of all those involved and made it possible to officially launch the national child health policy in line with the original plans.
- The proposed CHPI process to develop the national child health policy is systematic and follows a logical sequence of clear steps.
- The process proposed for the situation analysis has been found to be very useful, practical and critical to policy development.
- The situation analysis provides the evidence for the policy and results in the identification of policy issues.
- The prioritization approach of the issues to be addressed by the policy is based on a number of pre-set criteria agreed upon by the task force.
- Experience shows that advocacy is critical to provide the required essential support to the process if it is well planned, starts very early in the process and is carried out throughout the process.
- Monitoring is an essential component of an effective policy.
- There was a general agreement on the importance of having the policy document endorsed by the highest political level (depending on the context of each country)

to ensure high-level commitment to the policy and the commitment of other sectors and partners and to ensure strong commitment to policy implementation.

- The regional Arabic training materials on counselling on infant and young child feeding, which were presented in the workshop, were received with much interest and enthusiasm.

11 RECOMMENDATIONS

I. Child health policy

To Member States

1. Orientation of decision-makers on the child health policy initiative should be the first step to convince them of the need, importance and relevance of a national child health policy.

2. All steps of policy development should be official, according to the country context, and adequately documented. All tasks related to the development of the policy by all the task force members should be formally included as part of their work.

3. The policy should be evidence-based as an outcome of a thorough analysis of the child health situation in the country, which should not only be descriptive but should also look into the causes responsible for such a situation.

4. The policy should be guided by key principles such as those embedded in the Convention on the Rights of the Child.

5. The policy document should be short, policy-focused, written in simple and clear language and should include all the following sections: foreword; background; vision; policy elements (rationale of the policy, policy issues, policy statements, specific policies, strategy to implement the policy, monitoring and evaluation) by thematic

areas. It should also contain both existing and new policies in one of its sections.

6. The policy document should include a few, specific and measurable indicators (measurable by existing tools, providing reliable information acceptable to policy-makers and partners) for each existing and new policy.

7. The policy development process should be such as to build a broad base of consensus through wide consultation with key and influential partners and create strong ownership.

8. The process of developing, operationalizing, implementing, monitoring and evaluating the policy should go beyond the policy document and include the preparation of a strategy document and a detailed plan of action (with clear targets to be achieved by a set time-frame based on approaches consistent with the policy), including all child health-related actions of all concerned partners.

9. Member States should officially adopt and implement the plans of action developed during the workshop.

To WHO

The Regional Office should:

10. Prepare a glossary of clear working definitions of key terms for the policy development process as part of the guide on the CHPI.

11. Provide necessary technical assistance to Member States in the process of national child health policy preparation (e.g. by EMRO staff, regional resource persons).

12. Consider developing an adaptable monograph on how to advocate for the national child health policy.

13. Develop a guide on the CHPI second phase.

II. Regional training materials on counselling on infant and young child feeding

To Member States

14. Interested countries should translate the regional training materials on counselling on infant and young child feeding into their local languages to make them widely available.

To WHO

15. The Regional Office should consider developing materials for paramedics and other categories of health providers in the area of infant and young child feeding.

ANNEXES

1 Programme

Sunday, 10 December 2006

08:30–09.00	Registration
09.00–11.30	Opening session - Message of the Regional Director - Remarks by H.E. the Minister of Health, Tunisia - Official signing of the Tunisia National Child Health Policy document - Introduction of Temporary Advisers - Endorsement of the agenda and designation of chairpersons - Effective policies: instrument for change (Dr Mohammed Haytham Al Khayat, Senior Policy Adviser to the Regional Director) - Child Health Policy Initiative (CHPI): an overview of the EMRO initiative for child health policy development (Dr S. Farhoud)
11.30–12.00	Tunisian experience in national child health policy development (Dr M. Garbouj)
12.00–12.30	Child health situation analysis: recommended process and expected outcome (Dr S. Farhoud)
12.30–16.30	Group work 1: CHPI first phase - Process, outcome and lessons

Monday, 11 December 2006

08.30–09.00	Analysis and prioritization of policy issues: recommended process (Dr S. Pièche)
09.00–10.00	Analysis and prioritization of policy issues: country experience - Tunisia, Egypt and Sudan

10.00–11.00	Policy document structure: overview (Dr S. Farhoud)
11.00–12.30	Group work 2: Policy document structure - a. Sections of the policy document
12.30–15.00	Group work 2: Policy document structure - b. Policy statements and mechanism of implementation
15.00–16.30	Group work 2: Policy document structure - c. Annex on existing policies
16.30–17.00	Group presentations and discussion

Tuesday, 12 December 2006

08:30–09.00	Policy document structure: Monitoring - Indicators and mechanism (Dr S. Pièche) Discussion
09.00–11.30	Group work 3: Monitoring - Indicators and mechanism
11.30–12.00	Group presentations and discussion
12.00–12.30	Official adoption of the policy document: Road towards official endorsement and bringing the document to a higher level (Dr S. Farhoud)
12.30–15.00	Group work 4: Official adoption - Practical steps to achieve official endorsement and bringing the document to a higher level
15.00–16.00	Group presentations and discussion

Wednesday, 13 December 2006

08:30–09.00	Technical updates (Dr S. Farhoud and Dr S. Pièche)
09.00–09.30	What is next after the official endorsement of the policy document (Dr S. Farhoud) Discussion
09.30–11.30	Development of country plans of action
11.30–15.00	Presentation of country plans of action
15.00–16.00	Conclusions and recommendations

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