WHO-EM/CAH/014/E

DEVELOPMENT OF NATIONAL CHILD HEALTH POLICY

Phase 1: The Situation Analysis

A Child Health Policy Initiative (CHPI)

World Health Organization
Regional Office for the Eastern Mediterranean
Child and Adolescent Health and Development Unit

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Cover design by Ahmed Hassanein
Printed by Borg Al Arab Al Saleh, Alexandria, Egypt

Document WHO-EM/CAH/014/E/09.04/500

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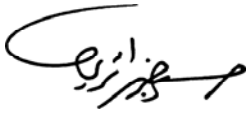
Foreword

On 8 September 2000, a total of 189 countries, including the Member States of the WHO Eastern Mediterranean Region, adopted the United Nations Millennium Declaration, recognizing that they "have a duty…to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs". A national child health policy is an important instrument for setting clear long-term directions for protecting and promoting the health of children. It brings together into one document all key policy elements to promote child health and development, identifying priorities, strategies and interventions to ensure equitable access to health care for everyone, including the most disadvantaged families, whose children often pay the highest toll in terms of health and development.

The principles and values of primary health care, as set forth in 1978 in the Alma-Ata Declaration on Primary Health Care, remain an important guide to our work in public health. Maternal and child health care are at the heart of the priority areas identified in the Declaration, and of the essential packages of health services subsequently developed as part of health sector reforms. The elements and activities of maternal and child health care need to be integrated at all levels, within strong health systems, to deliver quality services to all children in a revived primary *child* health care initiative.

It is with this aim that the WHO Regional Office for the Eastern Mediterranean is pioneering a child health policy initiative. The development of a national child health policy, and its endorsement at the highest possible national level, provides a means of supporting national efforts to achieve child health related Millennium Development Goals by 2015 and improve the quality of life of our children.

Since a key aspect of policy development is a thorough and critical review of the current child health care situation, the emphasis of this document is on the first phase of the policy development process, namely the situation analysis. It is my hope that this document will be of value to countries in developing effective national child health policies. Our Region has a young population, and our children are our future.



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Regional Director for the Eastern Mediterranean

Acknowledgements

This document is part of a series of documents produced by the Child and Adolescent Health and Development unit of the World Health Organization Regional Office for the Eastern Mediterranean to assist countries in their efforts to improve the quality of child health through integrated approaches. The experience of the first countries in the Region that have joined the child health policy initiative promoted by the Regional Office has been a valuable resource for the preparation of this document.

The Child and Adolescent Health and Development unit wishes to acknowledge the generous contribution of the Government of the Netherlands that, among other benefits, made the printing of this document possible.

This document was prepared by Dr Suzanne Farhoud and Dr Sergio Pièche.

Abbreviations

ARI	Acute Respiratory Infections
CAH	Child and Adolescent Health and Development
CHPI	Child Health Policy Initiative
CDD	Control of Diarrhoeal Diseases programme
DHS	Demographic and Health Survey
EMRO	Regional Office for the Eastern Mediterranean (WHO)
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
IMCI	Integrated Management of Child Health (originally and globally called Integrated Management of Childhood Illness)
MCH	Mother and Child Health
MDGs	Millennium Development Goals
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
WHO	World Health Organization

"All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally."

Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978

Introduction

Children are the promise and the future of every nation. Thus, they are at the core of development: investing in children's health and development means investing in the future of a nation. Children are also a vulnerable group whose needs and rights must be protected, including the right to health and development. Child health is a critical issue of concern to everyone, whether at the level of the family, the community, the nation or the international community. The international community and individual countries have repeatedly committed to improving child health. However, this commitment needs to be translated into stronger action if the silent tragedy of preventable death, illness, disability and impaired psychosocial development among children is to be avoided, and if children's quality of life is to improve. In the Eastern Mediterranean Region, as many as 1.5 million children under the age of 5 years still die every year, equivalent to almost one death every 20 seconds. Most of these deaths are preventable.

At a time when all Member States have pledged to achieve the Millennium Development Goals (MDGs), several of which relate directly or indirectly to child health, national child health policies will both enable countries to 'institutionalize' this commitment and support them in their efforts to pursue the Goals. In defining priorities and laying out strategies and interventions, national policies can help harmonize partner actions, including donor contributions.

The Child Health Policy Initiative

What is meant by "policy"

The term "policy" is often used to refer to ministerial statements and speeches, technical guidelines such as those contained in training materials, planning documents, decrees, directives and circulars, that influence public health activities in the health sector, at health facility and community levels. The term may also be used simply to refer to established, prevailing practices in a specific domain.

The term "policy" in the Child Health Policy Initiative refers specifically to a written policy document which:

- Sets long-term, outcome-oriented directions and priorities ('what to do') for child health, in line with the resources that a country can mobilize, and identifies main strategies ('how to do it');
- Reflects system views, going beyond individuals;
- Ensures commitment and continuity over time and promotes standardization;
- Formalizes decisions already made, legitimizes existing guidelines, and institutionalizes strategies and interventions;
- Commits financial and human resources;
- Helps in strategic thinking and planning;
- Brings together all [child health] elements in one document which ensures consistency and maximizes the use of available resources;
- Will be granted due importance and credibility, ensuring greater compliance, and reduces chances of misinterpretation;
- Clarifies roles and responsibilities of staff, defines lines of communication and identifies coordination mechanisms and structures;
- Serves as a reference for all partners, and establishes directions for their involvement.

A written policy document can guarantee greater continuity over time than verbal statements. Such a document should allow for flexibility, to respond to changing needs over time.

Do countries already have a child health policy?

Countries often have policies concerning specific aspects of child care, for example on exclusive breastfeeding promotion, immunization, control of diarrhoeal diseases and acute respiratory

infections, essential drugs, malaria control, primary health care, etc. However, most countries in the Region do not have child health policies that provide a holistic view and unified approach to child health and development.

The need for a national child health policy document

In recent years there has been increasing recognition of the need to develop national child health policies in countries, to bring together in one document all the main elements and issues related to child care, including both illness and health, and to provide a holistic and integrated vision for child health. In an increasingly competitive environment, a national child health policy would provide clear long-term directions and commitments, setting priorities for health systems and community approaches, resource allocation and collaboration with partners. A national child health policy, formally endorsed at the highest possible level in a country, can help "sustain primary [child] health care as part of a comprehensive national health system" and translate national commitment to the MDGs into a clear direction and driving force for action in the long term. Moreover, the institutionalization of existing strategies and interventions through a national child health policy is a recognized prerequisite for long-term sustainability.

Would a child health policy make a difference?

The existence of a document that sets clear long-term policy directions in a country and that also serves as a reference for all those working to improve children's health in the same setting, including partners, is an achievement in itself. However, a policy can make a difference only if it is implemented and adhered to, and achieves the objectives for which it was developed in the first place. Therefore, a policy document should include clear indicators and targets as well as a plan to monitor its implementation, as part of the policy itself. The plan should clearly identify key process and outcome indicators, state who is responsible for monitoring each indicator, how this will be done, when the expected outcome is to be measured and which resources will be used to support monitoring and evaluation. It is expected that outcome indicators will be included among those to be monitored by specific programmes and initiatives, while a few specific policy process indicators will be peculiar to the policy development and implementation process.

The Child Health Policy Initiative

The Child and Adolescent Health and Development (CAH) unit of the WHO Regional Office for the Eastern Mediterranean is assisting countries in the development of national child health policy documents, through the Child Health Policy Initiative (CHPI), launched in October 2003. To date five countries have formally joined the initiative, namely Egypt, Morocco, Sudan, Syrian Arab Republic and Tunisia.

The ultimate and long-term aim of this initiative is for countries to develop policies on the health and development of children up to the age of 18. It is advisable to proceed at stages, following the life-cycle approach and starting with the age group which is a recognized priority, for which information is more readily available and more experience has been gained over the years, and on which addressing specific policy issues may be expected to have a major impact. This is because the process of developing sound, evidence-based policies requires time. Generating a first product—a policy document on a selected age group—within a reasonable time-frame helps sustain interest in and commitment to the initiative, and generates additional support to expand coverage to other age groups for which the process of gathering information and developing policies may be more challenging. Furthermore, some of the information collected for one age group, for instance on health systems support and reform, and community interventions, is useful background for reviewing issues and policies on other age groups as well.

The emphasis of the initiative at this stage is on policies for children under the age of five years at primary health care level, although the process proposed to develop the policy is likely to be the same for any age group. This age group is the most vulnerable one and requires quick and effective actions, including the highest possible level of commitment in a country, to achieve the child health-related MDGs.

How long will the process take?

The time required to produce a final policy document will depend on many factors, including the priority and resources allocated to the process by the government and partners, and its scope. It is advisable to develop a policy that initially addresses some priority issues which can feasibly be addressed in the mid-term, rather than working on a comprehensive document aimed at addressing all issues. The latter would require a very long time, absorb many resources, encounter many obstacles and would be unlikely to see the light in the mid term

or be realistic. Policy-making is a dynamic process, intended to respond to current and prospective issues in light of available and foreseen resources. It must also be amenable to change as more experience is gained through implementation, new issues are identified and the policy environment changes. Although the process of development described in this document may appear daunting, most countries already have a rich amount of information available, often in the form of reviews, evaluations and studies, in which particular aspects of the health system and programme implementation have already been analysed. It is envisaged that a reasonable time to produce a first policy document on child health within a highly supportive environment should be 18 to 24 months. A longer period may reduce the level of enthusiasm and support for this initiative, in the absence of a visible product, and expose it to the risk of competing with new priorities and to the challenge of rapid turnover of key staff and officials.

An informed process

Three main phases

Three main phases characterize the process of developing a national child health policy (Figure 1).

Phase I: Situation analysis
Phase II: Policy document development
Phase III: Official adoption of the policy document

This document focuses on the first phase, the situation analysis. The situation analysis is the basis for informing the policy development process, while advocacy plays a key role throughout the entire process.

As soon as a decision is made in the country to develop a child health policy, an ad hoc management structure needs to be set up to be responsible for all related activities: the CHPI Task Force.

Figure 1. Three phases of development of a national child health policy

CHPI Task Force

Scope

The development of a national policy requires high-level political support within the health system to facilitate the process, including the management, coordination and performance of all the required tasks. Experience shows that establishing a Task Force at national level is essential for this purpose and that the Task Force must be established officially, e.g. through a ministerial decree, circular or directive, to provide it with the required support and visibility.

The Task Force will have the following terms of reference:

Concerning the situation analysis

- To identify resource persons and main partners that will be involved in the process;
- To collect all relevant documents and information;
- To review the information critically, and summarize conclusions and policy issues;
- To prepare the report on the situation analysis.

Concerning the development of the policy document

- To identify the main components of the policy document based on the situation analysis;
- To identify members of the technical committees to be set up to develop the policy document.

Concerning the whole process

- To coordinate all activities;
- To advocate for the child health policy.

Composition

To be functional and carry out its work effectively, the Task Force should be *small* and *chaired by a high official* of the ministry of health with the authority to make decisions, coordinate work across departments and programmes of the ministry, and contact partners outside the ministry. Experience across countries has repeatedly shown that small committees work faster and more efficiently than larger ones, as it is easier for a small number of members to find and set a time for meetings which is suitable for all. The members should attend Task Force meetings themselves and not delegate other people to represent them, to ensure continuity of work and minimize

disruptions in its progress. This approach gives the Task Force more flexibility. Task Force members should include people with long experience in different areas related to both child health and health systems.

The Task Force should have the following features:

- A small core team of a few members (5 to 7 persons);
- A senior chairperson;
- A focal point, acting as the secretariat;
- Members officially appointed according to their position (e.g. the director of…);
- Representation of key ministry's health departments and programmes, and partners, such as primary health care department, including child health, EPI, nutrition and perinatal care, planning department, academia, etc.

Examples of Task Forces composed in countries that have already undertaken this activity are given in Annex 1. When deciding on the composition of the Task Force, several factors of practical relevance should be considered, including the commitment of selected members to this additional and demanding task in the light of other existing commitments and responsibilities, as well as their coordination and interpersonal skills, thorough understanding of the health system, and analytical capacity.

The focal point should be an active person with good interpersonal communication skills and access to other members and partners, and possibly with good understanding of child health issues. He or she would be responsible for:

- Coordinating the work of the various members of the Task Force and of the technical committees formed to prepare the policy document;
- Communicating with programmes and departments within the ministry of health and partners outside the ministry;
- Ensuring that all the documentation collected is registered and filed by topic;
- Making arrangements for meetings of the Task Force and partners well in advance;
- Compiling the reports on the different sections of the situation analysis and of the policy document into one report and one document, respectively, and incorporating changes into revised versions;
- Circulating the situation analysis report and policy document for comments.

Resource persons

The Task Force should also identify a number of "resource persons" who would be consulted as needed during the process. These resource persons would represent almost an expansion of the Task Force, but would be contacted only to obtain their input on specific issues. In this way, the small Task Force could draw on all key resources available in the country without the need to enlarge the size of its core group. The resource persons could be from other departments of the ministry of health, health insurance, teaching institutions, professional associations and medical syndicate, the national council on childhood, nongovernmental organizations, other private sector representatives, international organizations, etc.

Steering committee

Some countries have also established a high-level steering committee to support the Task Force, provide input in the process, help arrive at consensus on the policy, and advocate at the highest levels of the health system. This committee, given the high level of its members and its functions, is expected to meet less frequently than the Task Force. The option to establish such a committee will depend on the particular context of each country and the level and authority conferred to the Task Force. In any case, the higher the level of the committee, the less frequent its meetings, and the more important and influential its decisions. For advocacy purposes, an inter-ministerial committee may be of substantial support, especially during the second and third phases, i.e. at the time the policy is being finalized and endorsement at the highest government level is sought.

Phase I: The situation analysis

The product

A thorough situation analysis on the child health situation in the country, including quantitative and qualitative information on policies, programmes, health services and child care, is a key step in the process of developing a policy. Information gaps may be identified during the process, some of them requiring studies to be filled. These gaps should be acknowledged in the report, but the policy development process should continue and should rely on the information available at the time, to avoid the risk of prolonging it for too long. When such studies are eventually conducted, the findings will enrich the process to update the policy already developed. Adequate human and time resources should formally be devoted to it, and advocacy for the CHPI should be continued throughout. Although the process mainly requires human resources, it is advisable to allocate a small budget to support it from the beginning, especially for meetings and the production of the report. The report on the analysis of the child health situation in the country is the product of this phase.

Objectives

The objectives of the situation analysis are:

- To describe the current situation of child health care within the political, demographic, socioeconomic, educational and health system context of the country;
- To analyse the situation critically in order to identify strengths and weaknesses, with special emphasis on policy issues to be addressed in the policy document; and
- To select specific priority issues that can be addressed realistically in the mid term.

Through these objectives, the situation analysis enables the development of a child health policy that is fully tailored to the country needs and focused on specific, priority policy issues for which feasible solutions can be proposed in the mid term.

Approach

The situation analysis requires the collection and review of documents and information related to any issues that may influence child health and development both currently and in the future. This is a process which requires good coordination, time and human resources, and needs to be carefully planned for. Two different approaches have been followed so far in countries to carry out the situation analysis, namely working as one group or as small sub-groups.

In the latter case, each sub-group includes a few resource persons and is responsible for collecting and reviewing information on a specific aspect of the child health situation in the country, and drafting a preliminary report on it. Both approaches have advantages and disadvantages. Working as one group enables the Task Force members to process all the information and move forward together, developing and revising sections as work progresses and additional information is collected. However, this approach requires more time, as all members must be available to carry out the work together. Working in sub-groups creates more autonomy and can speed the process, but it also requires a thorough review of the different pieces of work developed by the various sub-groups and extensive efforts to compile them into one report by the Task Force.

Whatever the approach followed, the end result should be a well-structured, detailed and consistent report analysing the different key aspects of the child health situation in a country. The situation analysis should lead to the identification of the main sections of the policy document, based on the issues identified, and the establishment of technical committees to work on those sections.

Methodology: 10 steps

Ten steps, shown in Figure 2, are recommended for carrying out a thorough situation analysis on which a broad consensus can be reached among all key stakeholders.

The time required for the process varies considerably based on the resources allocated and the priority accorded to this initiative in a country. Some countries, where the process has received high-level support and much interest has been generated through advocacy activities, have been able to carry out the first 6 steps in 4–6 months. It is important that there are no major pauses in the process, as these may result in reduced interest and support for the initiative. The remaining steps of the situation analysis depend on the partners'

response and the time the Task Force can devote to the preparation and revision of the various versions of the report. Ideally, all the steps of the situation analysis should be completed within a year of the establishment of the Task Force. It is advisable to develop an official plan of action at the beginning of the process, detailing all major steps, responsibilities, timelines and resources required and allocated. This would facilitate the task of reporting, give credibility to the process and serve as a further stimulus for the Task Force to proceed at the planned speed.

Step 1. *Identify key resource persons and partners for the policy development process*

The Task Force should identify all key persons, departments—within and outside the ministry of health—and partners that should be involved in the process and that could provide useful information and input. During the collection of documents, interviews with key individuals and critical review of the information carried out during the next two steps, additional resource persons and partners who should join the process may be identified.

Step 2. *Collect documents and information*

The documents and information collected should concern any key issue having some bearing on child health and development in the country, such as the constitution, existing (health) legislation[1], policies, strategies, national development plans, endorsements of the World Health Assembly and WHO Regional Committee resolutions, socioeconomic and demographic situation, cooperative programmes, management structures at different levels of the health system, health systems and human resources, child health problems of public health significance, ongoing programmes and interventions, studies and evaluations of child programme outcome indicators, the community and child care practices. Examples of documents collected in reviewed by countries that have already conducted this activity are included in Annex 2.

[1] See also "International digest of health legislation" by country, under "Health legislation", at http://www.who.int/idhl.

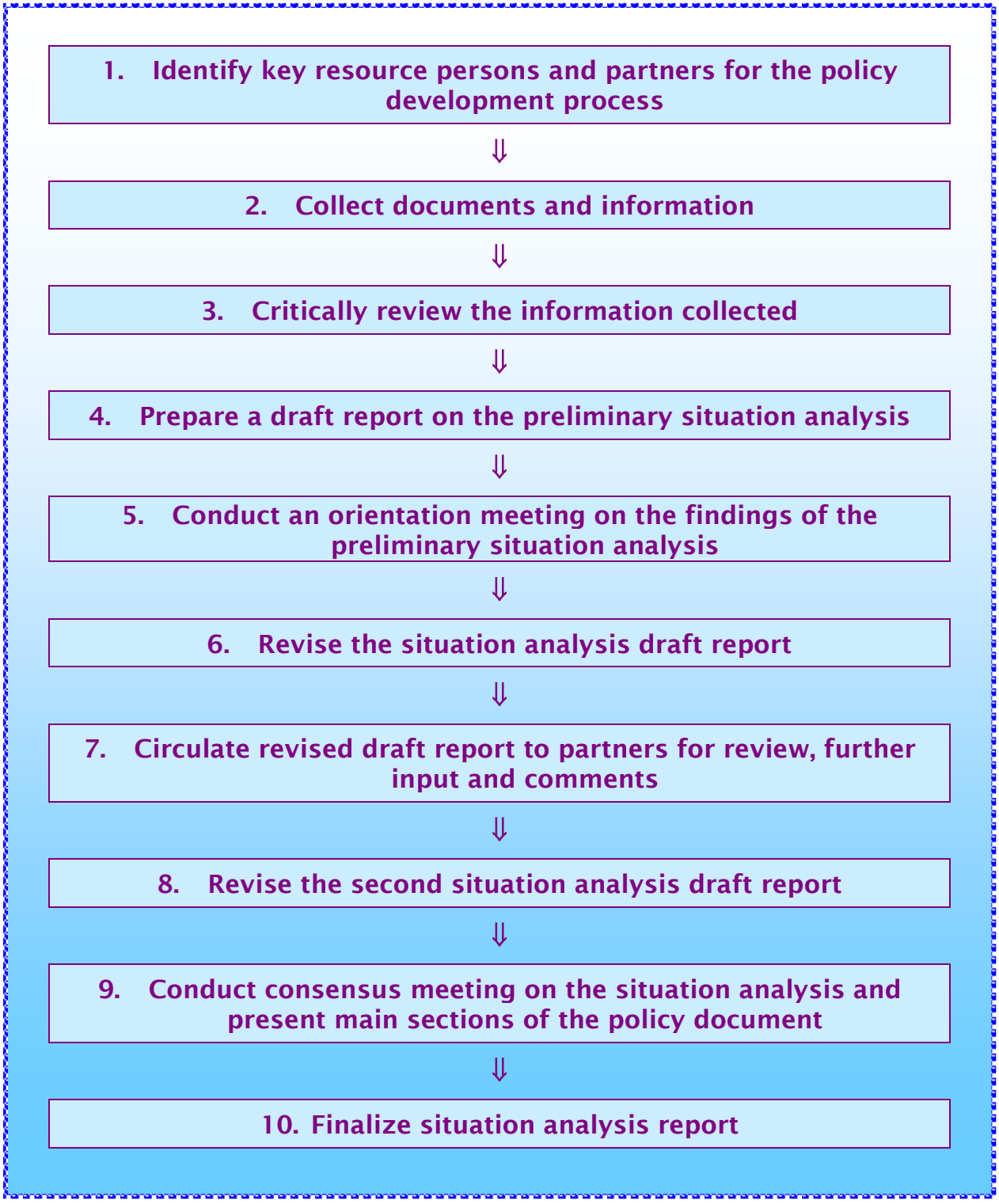

Figure 2. The 10 steps of the situation analysis

This step is crucial because policies must be informed and evidence-based. It needs full support by the ministry of health as difficulties have been encountered by most Task Forces to date in accessing some of the information, even within the ministry itself. It is recommended that all programme managers and directors of the departments concerned, within and outside the ministry of health and including partners, be informed well in advance in writing *by a letter or circular signed by a high-level ministry official, such as the first undersecretary*, and requested to provide the necessary information to the Task Force promptly. Prior to collecting documents and information, it is useful to prepare a detailed list of the documents and information needed, and key departments and persons to contact (see Step 1, page 12). Then, a brief meeting could be organized and chaired by the undersecretary to bring together the directors concerned to orient them to the initiative, appoint focal points in each department and agree on a calendar of appointments with the Task Force, to obtain copy of the documents and discuss any additional relevant information. The focal points should therefore be *formally* authorized to share information, discuss relevant issues on behalf of their department or organization, and be available to attend meetings with Task Force members as planned.

Step 3. ***Critically review the information collected***

The information gathered assumes significance only if it is reviewed thoroughly and critically, to identify areas of strength and those needing more emphasis, support and development. This is the most important step of the whole process of the policy development, as it helps in the initial shaping of the policy document itself (see also "Situation analysis report: General, key analysis points", page 18). The key task in this step is identifying both those aspects of care which are currently being addressed properly by existing policies, and also those aspects which represent issues that could potentially benefit from new policies.

Step 4. ***Prepare a draft report on the preliminary situation analysis***

This task has been performed using different methods in countries. In some cases, one person has been charged with the responsibility of writing up the whole draft report based on the conclusions of the analysis carried out in the Task Force meetings. In other cases, small working groups have been established by the Task Force to write different sections of the report according to main themes. This second approach seems

to be preferred as it generates input from more resource people, although the first approach offers the advantage of reducing the time demand on the members of the Task Force by concentrating the task in the hands of the rapporteur. An outline of the main sections of the report is provided in the section on the "Situation analysis report" (chapter on "An outline"). At the request of the countries that have joined the child health policy initiative, the CAH unit of the Regional Office has been closely involved in this step, providing suggestions and comments on the draft report. It has been acknowledged that the World Health Organization plays a key role in the revision process.

Step 5. ***Conduct an orientation meeting on the findings of the preliminary situation analysis***

The purpose of the orientation meeting is not only to brief the key stakeholders on process and findings but also to advocate for the initiative on the development of a national child health policy. The meeting, then, has the following specific objectives:

- To orient to the child health policy initiative key partners within and outside the ministry of health;
- To present and discuss the findings of the preliminary situation analysis, and obtain specific input from the participants;
- To identify partner roles and responsibilities in this initiative; and
- To agree on mechanisms to coordinate partner contributions in the process.

The meeting should be chaired by a senior and high-ranking official of the ministry of health (possibly the minister of health). Participants should be high-level officials within the ministry of health and representatives of partners outside the ministry, including other relevant ministries, the academic community, international organizations etc., essentially all the key partners in the process which have earlier been identified.

Step 6. ***Revise the situation analysis draft report***

The Task Force should revise the draft report on the situation analysis, taking into consideration the suggestions and comments offered during the orientation meeting and any further contributions received. The revised version of the draft report has often been shared again at this stage with the WHO Regional Office for review, before circulating it to a wider

audience (see next step). The version to be circulated should in fact be considered nearly final by the Task Force, and reviewed and cleared by the first undersecretary or equivalent high level officer in the ministry of health.

Step 7. ***Circulate revised draft report to partners for review, further input and comments***

The second or latest version of the draft report should then be circulated for review to all key partners, including those who attended the orientation meeting. This is a formal step and should be coordinated carefully by the Task Force to avoid its taking too long. Sufficient time—not less than 4 weeks—should be provided to partners for comments. It would be advisable for the Task Force to maintain individual contact with partners to follow up their review of the report, after agreeing on a deadline. The partners involved are expected to be many, hence the need for close follow-up.

Step 8. ***Revise the second situation analysis draft report***

As comments are received from partners, the report should be revised by the Task Force to reflect partners' concerns and suggestions as appropriate. The revised report should then be reviewed and cleared by a high level official in the ministry of health, such as the first undersecretary for health. The report should then be re-sent to all partners for review, and they should be invited to a consensus meeting. The report and invitation should reach them with sufficient notice, e.g. 2–4 weeks before the meeting date, to ensure their participation. It is advisable to contact all main partners individually before the meeting to identify any remaining issues about the information contained in the report and policy areas to be addressed.

Step 9. ***Conduct consensus meeting on the situation analysis and present main sections of the policy document***

The main objective of this meeting is to reach a consensus on the report, its findings, conclusions and policy recommendations. The meeting also provides a good opportunity to present the outline of the policy document.

Step 10. ***Finalize situation analysis report***

This step should lead to the finalization and production of the report on the situation analysis on child health and development in the country. The report should then be widely distributed to all partners concerned.

The Task Force should then establish a number of technical committees or working groups with responsibility for preparing the various sections of the policy documents (see Step 9 above).

Challenges

Three main challenges have to date been identified in the process of carrying out the situation analysis at country level.

- An inadequate level of cooperation with the Task Force by some partners, reflecting the need for stronger advocacy with the highest level of decision-makers to obtain more commitment from all those involved;
- The lack of availability of certain information or of reliable data, and the substantial difficulty in accessing some information when available; and
- Programme managers' traditional approach to reporting, which is oriented more towards describing activities and process rather than analysing the information critically to 'extract' policy issues, creating a need to re-orient programme managers for this task.

Situation analysis report

General, key analysis points

A number of points in the presentation and analysis of the information in the report should be considered for each section and chapter, namely:

- *Evidence*: any effort should be made to present information in the form of reliable data and indicators, quoting its source, interpreting its meaning, and describing its significance to child health.

- *Existing policies*: it should be stated whether policies exist for each key area, and, if so, how they relate to child health, how they have been performing over time and whether there are gaps that need to be addressed in the future.

- *Logical flow of information*:
  - First, the situation should be described;
  - Second, the situation should be analysed and the results of the analysis should be presented in terms of strengths, supporting factors, weaknesses, and constraints to change;
  - Third, all major issues having policy implications should be identified and summarized by area (e.g. human resources, financing, health services and health care delivery, public health programme approaches);
  - Fourth, brief conclusions should summarize the main findings, and an 'action list' of specific policy issues should be proposed that could realistically be addressed in the short term and medium term and included in the policy document. This is the final outcome of the situation analysis, and the core of the policy document.

- *Differentials*: for each topic, wherever possible, it is important to describe and analyse the range of differentials which may exist in the country for key indicators, such as between rural and urban areas, between geographical areas (e.g. North–South or West–East, between regions), and special groups (e.g. ethnic groups, nomads, displaced people, disabled children and those in difficult circumstances), economic inequalities by quintile and gender disparities. Indicators concern not only income levels and mortality rates, but also availability and access to health services, quality of services provided, staff management and planning

capacity, distribution of human resources, availability of financial resources, etc. (see next chapter on the outline of the situation analysis report).

- *Links with maternal care*: there is no doubt that child care closely depends on maternal care. Whenever possible, links between child and maternal care should be highlighted, yet recognising that a thorough analysis of maternal care is not part of the scope of this document, unless maternal and child care are fully integrated at all levels—including also the central level—in a particular country.

- *Partners*: key partners involved in a particular area of work should be listed and their contributions reviewed.

- *Resources*: reference should be made to the financial resources allocated and mobilized;

- *References*: all the information described and figures quoted should be properly documented and a list of the related sources and references should be included at the end of the document, with author, title, year, and indication on from which source it is available or has been obtained.

An outline

The report of the situation analysis can present the information and results of its analysis in different ways. The areas to be reviewed will most likely be reflected in the policy document, so it is important to choose an outline which is practical and oriented towards policy action. The objective of this document should always be kept in mind when describing information throughout the report, namely a situation analysis aimed at identifying policy issues influencing child health. Thus, detailed information could be presented concisely in tables or annexes, while the body of the report should preferably focus on the analysis of this information and its conclusions.

The following eight main sections should be included in the situation analysis report, noting that the list of the information provided under each section in this document is given only as an example of what could be described and is not meant to be comprehensive. This information should as much as possible be related to child health. The seventh section, on public child health related programmes, should represent the sum of all the information which precedes it, putting it in the context of the response of the health system to specific public child health issues and consolidating

potential priority issues that would need to be tackled specifically in the policy document after critical appraisal.

1. **Introduction**. This section should summarize in a few paragraphs the following information:

   - Government's commitment to children in general and child health in particular, with brief reference to the constitution, legislation, current policies and national development plan and how these have affected child health, international commitments, such as United Nations Convention on the Rights of the Child, World Summit for Children, Millennium Development Goals, endorsements of the World Health Assembly and WHO Regional Committee resolutions, and future policies and plans;

   - Issues related to current policies and approaches to child health, such as lack of coordination among vertical programmes and projects, and with and between partners, duplication of efforts with consequent suboptimal utilization of available resources, inconsistencies in technical guidelines among programmes;

   - Rationale, based on these issues, for developing a national child health policy document and its main objectives; and

   - Decision on initial focus, e.g. children under five years of age at primary health care level.

2. **General context**. This section mainly relates to the following areas.

   - *Geographical, political and administrative*. A very concise description of key geographical characteristics of the country should be presented in relation to health care issues, e.g. distances and communications, nature of terrain, seasonal and climatic changes facilitating disease occurrence. A brief mention of the administrative division into regions, governorates or provinces, districts and local areas, would make it easier to understand the organization of the health system (see related paragraph under "3. Health systems", page 21). It should also be noted if the security situation in some areas is unstable.

   - *Demographic and socioeconomic*. Population structure, distribution and growth, together with population and development policies, help understand better the context in

which a policy needs to operate. Economic and social factors play an important role in affecting the health of a population, including the quality of child care, and indicators such as literacy rate, poverty rate, gross national income, share of income, housing, urbanization, under-five and infant mortality and information on social protection systems provide valuable information. These should be reported with a brief analysis and description of possible differentials (see "Differentials" under "General, key analysis points", page 18). Health-related indicators can be described separately in the next sections.

3. **Health system**. The management and organization of the health system, including public, parastatal[2] and private sectors, is one of the most important aspects to review in the situation analysis; critical child health policy issues are likely to be identified in this area. This section of the report can describe:

- *Organization and management of the health system*

  i. Main providers of health care services and their role in child health, including the three main categories of public, parastatal and private sectors, such as medical services run by the ministry of health, ministry of defence and other ministries, universities, health insurance, government-run companies, and private sector players (e.g. private providers, nongovernmental organizations, charity services); management structure at different levels, with focus on child health;
  ii. Organizational structure of the ministry of health at different levels (central, regional, district), identifying how responsibilities and authority are delegated at central, provincial or governorate and local levels, with emphasis on child health related programmes;
  iii. Coordination mechanisms within the ministry, between levels, and with outside partners, including the community, with particular focus on child health.

- *Planning*

  i. Main objectives and priorities of the current national development plan or equivalent document, indicators and targets to be achieved;
  ii. Planning cycles: planning responsibilities among the ministry of health departments and coordination with the ministry of finance; annual planning, planning capacity and procedures at various levels of the health system; use of

[2] Includes institutions associated with the state and under its indirect control.

monitoring and other data for planning; resources for implementation of plans.

- *Access, utilization and quality of health services*

  i. Definition of access to primary and referral health care;
  ii. Number of health facilities and health providers by type and area (geographical, urban and rural) with ratio to population served.
  iii. Health facility functions by type, and health providers' job descriptions or tasks by category of provider and facility; facilities with limited or inadequate functioning hours;
  iv. Existing policies on distribution of facilities and providers by geographical and rural/urban areas and by type of facility;
  v. Utilization of health services, especially of those at primary health care level;
  vi. Quality of health services based on both technical evaluations and client's perceptions and satisfaction, and quality assurance indicators and mechanisms; health providers' "job satisfaction".

- *Drug management (procurement, supply, distribution, availability at health facilities) and use*

  i. Policy on essential drugs, concerning: whether an essential drug list exists and, if so, whether all key drugs required for child care are included, for example, as per country-adapted guidelines on Integrated Management of Childhood Illness (IMCI)[3]; for which health facility level; and for use by which provider category, including pre-referral parenteral drugs;
  ii. Legislation or other regulation on drugs removed from the national drug formulary and essential drug list, or banned from imports;
  iii. Drug quality control mechanisms for imported and locally manufactured pharmaceutical products;
  iv. Drug procurement at national and subnational levels and reordering system (whether amounts are determined by higher levels or based on actual needs estimated at health facility level);
  v. Drug availability at health facility level: situation, revolving fund or other mechanisms to make drugs available, cost to users and exemptions;
  vi. Rational use of drugs at health facility level and by the private sector.

[3] See footnote ([7]), page 28.

- *Referral system*

  i. Pre-referral care[4];
  ii. Referral pathways with feedback to referring unit, and transportation systems, and other linkages between referring and referral facilities;
  iii. Referral costs and affordability by the poor and children, community funds, and users' perception of quality of hospital services.

- *Health information system*

  i. Recording and reporting system, by level, including estimated time to fill in forms and timeliness of reporting;
  ii. Integrated versus vertical programme information system, such as duplication of information reported;
  iii. Human and financial resources available for the management of the system at different levels;
  iv. Analysis of the information collected, its reliability and consistency across the information system, and annual report;
  v. Feedback provided to the reporting units by level and use of the information for planning purposes;
  vi. Viability and reliability of the current system, and potential areas of improvement.

- *Supervisory system*

  i. Current supervisory system at central and subnational levels, integrated versus programme and administrative versus clinical routine supervision;
  ii. Supervisors' skills and training in administrative and clinical supervision;
  iii. Supervisory tools and methodology;
  iv. Recording and reporting of findings; supervisors' feedback and use of findings to improve the delivery of services, maximize the use of available resources and planning, monitoring of proposed solutions to the identified problems;
  v. Availability of transportation and financial resources for supervision;
  vi. Impact of the current supervisory approach.

[4] Quality of referral care and standard operating procedures at district hospital level may be reviewed in future if the current situation analysis focuses on outpatient child care.

- *Linkages between the health system and the community*

  i. Formal or established channels linking the health system, especially the primary health care level, and the community;
  ii. Community participation in the planning, implementation, monitoring of the health services provided and of progress of community interventions, and evaluation of community health outcomes; involvement in health promoting initiatives (community and facility-based volunteers including community support groups, support to motivational schemes for health providers including community awards and incentives, health promoting schools, village committees);
  iii. Follow-up and support of community-based initiatives by health facility staff;
  iv. Community satisfaction with existing links with the health system.

- *Health sector development:* if a health sector development initiative or reform is being undertaken or planned in the country, its main features should be reflected in the appropriate sections of the situation analysis, and summarized in this specific chapter on health sector development.

4. **Health care financing**. There is no doubt that this area critically influences child health care. The report could describe information on trends of health expenditure and health care financing schemes, including:

- *National health accounts indicators*

  i. How much a country spends on health: Total expenditure on health as percentage of the Gross Domestic Product (GDP), and as per capita expenditure; and percentage of government contribution to the total expenditure on health (the remaining percentage being private contribution);
  ii. How much the government spends on health: government expenditure on health as a percentage of total government expenditure, and per capita expenditure; and social security expenditure on health as a percentage of government expenditure on health;
  iii. How much families spend on health out of their own pockets: out-of-pocket expenditure as percentage of private expenditure on health;
  iv. How much donors contribute to total general expenditure on health;

v. What proportion of government expenditure on health goes to tertiary care versus primary health care.

- *Health insurance and similar schemes*

i. Policy on health insurance;
ii. Implementation by level of facility, service, geographical or urban/rural areas, income groups of: cost-recovery mechanisms, fee-for-service systems, informal payments, protection mechanisms such as waivers and exemptions, reduced fees especially for the poor and vulnerable groups including children;
iii. Health providers' attitudes to these initiatives and public awareness and acceptance;
iv. Impact of these policies on service access and utilization, and on the quality of health services.

- *Planning and budgeting processes at different levels of the health system.*

5. **Human resources and pre-service education**. A section on the development of human resources for child health merits a place in the situation analysis, as human resources are the backbone of any health system, which must rely on its workforce competence, motivation, attitude and effectiveness to deliver quality services. Some of the main points to include in the review are:

- *Management of human resources*

i. Management structure by level in the ministry of health and ministry of education systems, and coordination mechanisms between the two ministries;
ii. Number and distribution of health providers by category, by region and by urban and rural areas, with ratio to the population served in each area;
iii. Motivational schemes to attract and retain health providers, such as career pathways, certificates and awards, financial incentives, participation in national and international events;
iv. Policy on transfers after in-service training to reduce attrition rates; priority areas for in-service training (need-based versus donor-led);
v. Database on trained staff.

- *Production and capacity building*

i. Pre-service education: medical and allied health professional schools in the country, production planning policy in relation to needs, incorporation of public child health

elements in the curriculum and teaching of medical and allied health professional schools (knowledge versus skills acquisition, primary health care versus hospital care), accreditation systems, teachers' training, evaluation of teaching process and outcomes; previous experience of collaboration with the ministry of health;

ii. In-service training: in-service knowledge updating and skills upgrading across partners including nongovernmental organizations, continuing medical education, follow-up mechanisms after training, allocation of government and donors' financial resources to priority training areas at central and subnational levels.

6. **Public child health issues.** This is a major section that should briefly describe the situation of child health and development in the country, reporting on key health[5] indicators and trends over the years with projections until 2015, including: under-five, infant and neonatal mortality; leading causes and contributing factors to mortality and morbidity in children under five years of age, emerging problems; and outbreaks. This section, as others of the report, should go beyond a simple description of indicators and current status, to analyse past and possible future trends.

7. **Child health related programmes.** This part of the report aims at describing the "response" of the country health system to the prevailing public child health issues described in the previous chapter. Ministries of health usually run vertical programmes or integrated approaches (e.g. IMCI) to address such issues; areas of overlapping between vertical programmes may exist. Chapters on each programme or intervention should include a brief description of their main features, highlighting strengths and needs to be addressed. Programme performance should be critically reviewed against planned targets, explaining factors facilitating or hampering programme implementation and achievements. The emphasis should be on the lessons learnt from the experience in order to develop feasible ways to improve efficiency of performance. The basic question is: is there evidence proving that existing policies and programme strategies have contributed to reducing the public health significance of the child health issues for which the programmes or interventions were designed? In describing problems, the importance of a problem should be assessed according to the effect it is likely to have on achieving a target or sub-target. Some of the elements include:

- Management structure at all levels, e.g. central, provincial or governorate, district and local area according to the health

[5] In this document, "health" includes nutrition as an essential component.

administrative units in the country, specifying who manages and coordinates activities, which other responsibilities he/she has, which level of decisions can be taken at different levels in relation to the programme;
- Coordination mechanisms with other units, programmes or interventions related to child health;
- Programme objectives, indicators, targets and sub-targets[6] for medium-term (e.g. 2–5 years) and long-term (e.g. 10 years or more);
- Main strategy or strategies adopted and main activities conducted, and their impact;
- Health system elements described earlier (see 3 and 5 above, under "Health systems", pages 21 and 25, respectively) and applied to this programme area.

Among the programmes to review are those dealing with immunization, childhood illness, nutrition, malaria (where relevant), HIV/AIDS control, maternal and neonatal health, perinatal care, oral health, essential drugs, injury prevention and control, and health education and promotion. Three examples of child health related programmes are given on the following pages.

- ***Expanded programme on immunization (EPI)***

  i. Management structure by level and location of the EPI in the ministry of health organizational structure;
  ii. Immunization schedule for children under five years of age, including booster doses, and contraindications;
  iii. Immunization coverage targets and accomplishments; cases of and deaths from vaccine-preventable diseases over many years;

[6]The words 'goal', 'objective', 'indicator', 'target' are often used in different ways. Here, *objective* refers to a goal stated in general terms (e.g. to reduce deaths in children under five years), while *target* refers to a goal stated in quantified terms for a specified time, usually mid- or long-term (e.g. to reduce by two thirds the under-five mortality rate by 2015 compared with the 1990 level), and *sub-target* refers to the intermediate goals to reach a target usually in the short-term (e.g. to have trained in IMCI, and regularly supplied with key drugs for child care, health personnel of 65% of outpatient primary health care facilities in the country by 2007; to manage according to the IMCI guidelines 50% of children under-five seen at IMCI-implementing health facilities by 2007). Targets are set for *indicators,* which are parameters (numbers or proportions) indicating the extent to which planned activities have been conducted (process) and programme achievements have been made (outcome). For more information, refer to *Framework for the community component of the integrated child care strategy* (Cairo, EMRO, 2002, document WHO-EM/CAH/003/E/G).

iv. Vaccine procurement: policy on imported vaccines (procedures, taxation, clearance etc.) and quality control of locally manufactured vaccines;
v. Distribution system, vaccine stock management, schedule of vaccine delivery by level and out-of-stock situations at delivery points;
vi. Cold chain and monitoring equipment; supplies (syringes, needles, safety boxes);
vii. Immunization approaches: facility-based sessions versus mobile outreach services, availability of transportation, frequency of immunization sessions, multi-dose vial policy and policy on vaccine wastage, safe injection practices, immunization campaigns;
viii. Human resources (categories of providers by level, other responsibilities, training, monitoring of their performance, motivation initiatives, incorporation of EPI elements in pre-service training);
ix. Surveillance, information system;
x. Information on immunization for communities; advocacy within the country;
xi. Government financing schemes for immunization services.

- ***Integrated management of child health (IMCI)***[7]

  This strategy should ideally cover key aspects of public child health and, depending on the IMCI guidelines in the country, may cover also selective maternal health issues addressed in the same guidelines. In some countries, vertical programmes coexist, usually limited to geographical areas where the integrated approach has not yet been implemented. Below are some examples of policy-related issues. For some of them, such as those on clinical guidelines, one could refer to existing case management or training guidelines formally adopted by the ministry of health (e.g. the IMCI chart booklet), providing the document reference and year of endorsement. This legitimizes the guidelines as an integral part of the child health policy.

  i. Management and planning: management structure at different levels of the health system and location of IMCI in the ministry of health organizational structure; coordination mechanisms with vertical programmes (e.g. EPI, nutrition, MCH) and partners; selection criteria for areas for

[7] This strategy, originally called Integrated Management of Childhood Illness (IMCI), has been re-named Integrated Management of Child Health in the Eastern Mediterranean Region, to better reflect its objectives and underline its emphasis on preventive and promotion measures.

implementation of IMCI or other interventions; planning capacity by levels; universal versus focused coverage, and province or governorate, district, health facility and population under-five coverage;

ii. Objectives, indicators, targets and sub-targets; trends of neonatal, infant and under-five mortality;

iii. Guidelines on outpatient management of children under five years old by category of health provider and level of facility, including rational use of drugs, and on supplies:

- Pre-referral treatment of severe cases (parenteral drugs) at outpatient facilities;
- First-line and second-line treatment for malaria, pneumonia, dysentery, cholera and other communicable diseases covered by the IMCI strategy;
- Management of persistent diarrhoea, micro-nutrient deficiencies and malnutrition;
- Oral rehydration salts (ORS): formulation (composition, flavouring), expiration (shelf-life), packaging materials and unit size, labelling, number of sachets to be dispensed to each child with diarrhoea at health facilities, importation and local manufacturing (good manufacturing practices for pharmaceutical products), quality control (certificate of analysis for each batch produced), estimated annual needs for the country, provision to the three sectors (public, parastatal and private), cost (free versus low cost);
- Oral rehydration therapy (ORT) at health facilities: diarrhoeal cases treated as outpatients at, or admitted to, functional ORT corners (implications for district hospital occupancy rate and budget);
- Antidiarrhoeal medications, especially paediatric and liquid formulations, and cough and cold remedies (regulatory measures on imported drugs, locally produced drugs, sales, use by government and private providers)
- Supplies: rapid diagnostic tests (dipsticks) for malaria or supplies for microscopy diagnosis, supplies for ORT, timers, thermometers, weighing scales, tongue depressors, recording forms;
- Home care: recommended home fluids and foods (with and without salt) during an episode of diarrhoeal diseases, feeding—including breastfeeding—during illness and convalescence, care-seeking, antimalarials for fever in malaria endemic areas, use of bednets (long-lasting insecticidal nets, promotion, marketing strategies and costs).

iv. Organization of work in health facilities, including responsibilities of health personnel ("job description") by category and by type of health facility and flow of patients: triage; use of parenteral drugs, administration of antibiotics, ORT; counselling on feeding and home care;
v. In-service training (target audience, coverage, type and duration of courses by category of health provider, training of trainers, training quality indicators, follow-up, refresher training, financial resources for training);
vi. Pre-service education: involvement of the academia in IMCI adaptation and other activities; orientation on IMCI for medical schools; criteria to select medical schools for the IMCI pre-service education initiative, and coordination and support to the selected schools for related activities (establishment of an IMCI task force and coordinator within the paediatric department of the concerned school; formal approval by the faculty council of incorporating IMCI elements in the teaching curriculum; development of a plan for IMCI introduction; training of faculties; preparation of teaching and student reference materials; organization of outpatient teaching settings; inclusion of IMCI questions in examinations; monitoring and evaluation);
vii. Promotion of household child care practices (approaches: face-to-face, health education sessions, community groups, mass media);
viii. Monitoring indicators: by routine reporting (e.g. access to a health provider trained in IMCI and regularly supplied with key drugs for treatment and prevention; case fatality rates of children under five years old at hospitals implementing IMCI; proportion of under-five children seen at health facilities who have severe and some dehydration among those with diarrhoea, who have severe and non-severe pneumonia among those with ARI, who have severe febrile disease among those with fever, who have severe malnutrition and very low weight-for-age among those seen); by IMCI follow-up visits and periodic surveys (facilities with limited or inadequate functioning hours, children with an "IMCI" condition managed according to the IMCI guidelines, caretaker knowledge about home care and care-seeking, caretaker satisfaction with services provided in IMCI-implementing facilities);
ix. Referral, drug management, health information, supervision, linkages between health system and community (see section on health systems, page 21);
x. Evaluation: key findings on measured progress towards targets and sub-targets, programme achievement and priority problems;

xi. Priority research areas;
xii. Government financing schemes for child health services and child care activities.

- ***Nutrition programme***

  Some overlap inevitably exists between the areas covered by this programme and the IMCI strategy, as nutrition is an essential component of child health and development. A useful tool for reviewing policy-related nutrition issues is *Infant and young child feeding – A tool for assessing national practices, policies and programmes* (Geneva, World Health Organization, 2003).

  i. Legislation to protect and support breastfeeding among working mothers; legislative and non-legislative initiatives to give effect to the International Code of Marketing of Breastmilk Substitutes in the country, and to regulate donations and use of formula during emergencies; policy on exclusive breastfeeding;
  ii. Management structure at different levels of the health system and location of the nutrition programme in the ministry of health organizational structure; national committees to promote breastfeeding or, more comprehensively, infant and young child feeding; coordination mechanisms with child health-related programmes or strategies (e.g. IMCI, control of diarrhoeal diseases and acute respiratory infections, maternal and child health) and partners;
  iii. Planning: objectives of the programme, indicators and targets;
  iv. Guidelines on micronutrients, for treatment of deficiency disorders, supplementation (vitamin A, vitamin D, iron, zinc, iodine) and food fortification, and their impact; sustainability of the Baby-Friendly Hospital Initiative, if implemented in the country, and other initiatives to promote breastfeeding and, more broadly, feeding in infants and young children; approaches to foster psychosocial development in children;
  v. Human resources, in-service training, pre-service education, household promotion of feeding practices, monitoring and health information, supervision (see information under IMCI above).

It is important to reiterate that the report should present the results of the *analysis* of the information on programmes described above, rather than simply describe it. The purpose

of this phase, and therefore of the report, is to determine whether programmes are responding appropriately to the main child health issues, and which policy actions could further enhance the response.

8. **Partners.** The most relevant information on work with partners, partly mentioned also in previous sections, can be summarized here, such as: coordination mechanisms with the ministry of health and other relevant sectors; main agreements with the government (e.g. memorandum of understanding); orientation to and involvement in public health programmes or strategies; current and potential role played in child health in the country; interest, priorities and main cooperation programmes; funding mechanisms and financial cycles; and particular project requirements (reporting, liquidation). Involvement of the community, considered both an active partner and a recipient of services, in programmes and initiatives on health, and its links with the health system (see also "Linkages between the health system and the community", page 24) should also be summarized in this chapter.

Next phases

This document focuses on the first phase of the policy development process, namely the situation analysis. This phase is closely linked to the remaining phases of the process, as the policy document is the natural outgrowth of the situation analysis. Advocacy needs to be conducted throughout the entire process to ensure endorsement at the highest level. The next two sections, which provide a brief overview of Phase II and Phase III, are intended to enhance understanding of the place that the situation analysis occupies in the whole process.

Phase II: Development of the policy document

From issues to policy

A situation analysis carried out in the way described in the previous pages should lead to the listing of issues with policy implications for the mid-term and long-term. The long-term issues need be stated only in more general terms, as broad policy areas, to provide the context within which more specific issues will be addressed in the mid-term.

The policy issues should be selected according to their importance, i.e. the expected impact that the implementation of a specific policy would have on the main child health policy targets, the likelihood of agreeing on a policy within a few months, and the feasibility of implementing the policy itself. The selection should therefore aim to be very realistic. Policy-makers will be more likely to discuss and reach consensus on a set of reasonable and pragmatic policy proposals presented by the Task Force that appear "within reach", than an extensive list which is out of touch with the realities of the current policy environment. Policies should be both feasible and highly likely to have visible and measurable effects on child health.

Bringing policies into one document

The process of developing the policy document aims at formulating new policies and bringing together key child health related policies—both new and existing—into one document.

- The first step consists of listing by area existing, sound policies, with references, that reflect prevailing practices, guidelines or

decisions made in the past, but that may be 'scattered' in different documents or stated only verbally. This step of the process is expected to be straightforward and to meet with a positive response. Examples of existing child health policy elements may include the national EPI immunization schedule, some aspects of the essential drug list, or clinical guidelines for the conditions currently covered by the IMCI strategy. Starting in this way acknowledges efforts already made in the health system to address certain policy concerns, creates a positive disposition towards new issues, and shows the advantage of bringing together in the same document all policies related to child health.

- The next step would be to list policy proposals for the newly identified issues, detailing the expected effect that these issues would have on child health if they were properly addressed and the possible impact of the proposed solutions.

- A strong rationale should be prepared for each policy item, highlighting any implications, including financial implications, that each policy decision would likely have.

This approach, starting with existing policies and then filling in the gaps, is likely to create a more favourable environment to discuss more complex issues in the future. Some elements of the policy will probably require more intensive exchange of information and active debate with many partners, e.g. decisions to provide access equity to health services to all young children, including those whose families have very limited financial resources. Even complex issues may often be analysed and broken down into a number of smaller issues, some of which could be addressed with expected impact in the mid term.

It is recognized that the first child health policy document, while taking up some challenges, should not try and address all the issues, as doing so would be unrealistic and might generate too much controversy, eventually bringing the whole process to standstill. By maintaining a realistic scope, the process can have a catalytic effect and stimulate dialogue and actions for issues that can be addressed in the long term and in the light of international commitments such as the Millennium Development Goals.

Each country can develop its own outline for the policy document. Policy elements can be grouped by components (e.g. management, planning, access to services) and by priority public health topic (e.g. specific aspects of control of communicable diseases, injuries, nutritional status and feeding, psychosocial development).

Stating policy elements

The policy document should be concise and easy to refer to. The rationale for each policy element described in the policy document will be reflected in the conclusions of the situation analysis. The report of the situation analysis, prepared as a separate document, may simply be referenced, to keep the policy document short and handy.

The policy document should cover the following three points for each of the policy issues addressed:

1) The rationale (a very short paragraph, referring to the situation analysis for details on the issue, or a summary of the main conclusions of the situation analysis);

2) The objectives (what the policy decision aims at achieving); and

3) The policy decision in detail and its likely effect on child health.

For each major policy element, the document should clearly indicate how implementation of the element can be assessed and how its effects on child health can be measured. It is critical to include this "monitoring" feature in the policy document, to make it a valid and action-oriented instrument. The document should also note the main strategies adopted by the ministry of health to address public child health issues in the country and improve the quality of life of children.

Methodology

Technical committees or groups can be assigned the responsibility to develop the various sections of the policy document. It is important to follow a formal plan, to monitor how the work proceeds and avoid long intervals of inactivity. An essential feature of the preparation of the document is intensive interaction with all key programme managers, decision-makers and partners to address technical, financial and political concerns on the proposed policies. This may require extensive consultation and discussion, sometimes on the same policy element. It is acknowledged that the broader the consensus reached on the policy, the higher the chances that the policy will be widely accepted and implemented.

The approach to preparing and finalizing the document could be similar to that proposed for the situation analysis:

- Preparation of preliminary draft reports on the various sections of the document by the technical groups
- Review and consolidation of the section reports by the Task Force
- Revision of the document by the technical groups based on the Task Force's recommendations
- Review by the Task Force
- Consensus meeting on the draft child health policy
- Finalization of the child health policy document.

The phase of developing the policy document will require many advocacy efforts to promote the policy elements that are proposed for endorsement. A specific plan for advocacy needs to be prepared, particularly for the more difficult or sensitive policy issues, to target the most influential players. Senior officials of the ministry of health should be kept informed of the progress of work regularly, as per the plan of action, to maintain their interest and support.

Phase III: Official adoption of the policy document

Advocacy meetings for high-level policy-makers and partners

The higher the level of endorsement of a national child health policy, the more influence it will have on future decisions related to child health in the country, and ultimately the health of children.

As noted previously, advocacy for the policy initiative must accompany the whole process, from its very inception and throughout its three main phases. As the policy document takes shape and discussions on its policy elements intensify, advocacy initiatives should also intensify. Meetings with senior officials to review the proposed policy decisions also serve as opportunities to advocate for the overall policy itself and elicit continuous support. In countries with a decentralized system, orientation and advocacy meetings should also be conducted for high-ranking officials of governorates or provinces, and, where feasible, at district level, with representation from the community.

Official adoption of the policy document

Once the policy document has been finalized and all or almost all of the most debated issues have been addressed adequately, with broad consensus, the last step is the formal adoption of the national child health policy document by the highest possible political level in the country, e.g. the head of state. Sufficient time and resources need to be allocated for this last event. Preparatory work should start very early, advocating with the most influential stakeholders even during the situation analysis phase. Special performances related to children may be organized on that occasion. Media coverage of the event should be ensured.

Annexes

Annex 1. CHPI Task Force composition

Below are examples of CHPI Task Forces which have been established in selected countries. The examples are meant to show the range of membership representation. The core team of Task Forces is in general of limited size, as recommended in this document. Many resource persons have also been identified outside the CHPI Task Force to ensure wide representation of sectors and partners concerned; resources persons are not listed in the examples below.

Example 1: Tunisia

Chairperson of the Task Force

- Primary Health Care director

Members of the Task Force

- Focal point
  - National IMCI coordinator

- Other members
  - National focal point of the IMCI community component and another member of the IMCI team
  - EPI manager
  - Perinatal care programme manager
  - Epidemiologist
  - Nutritionist
  - From the field: MCH and PHC focal persons from 2 different governorates, respectively

International organizations

- UNICEF

Example 2: Sudan

Chairperson of the Task Force

- Primary Health Care director

Members of the Task Force

- Focal point
  - National IMCI manager

- Other members
  - Nutrition department director
  - Reproductive health directorate director and deputy director
  - National Health Information Centre director
  - Health planning directorate director
  - EPI manager
  - President of the national paediatric association and senior paediatrician of the ministry of health

International organizations

- UNICEF
- WHO

Example 3: Egypt

(This is an example of a country which has established both a Steering Committee and a Task Force for the CHPI.)

► ***Steering Committee***

Chairperson of the Steering Committee

- First Undersecretary for Primary Health Care and Preventive Care sector

Members of the Steering Committee

- Head of the Health Insurance Organization
- Secretary General of Teaching Hospitals and Institutes Organization
- Undersecretary for Primary Health Care
- First Undersecretary for Population and Family Planning sector
- Undersecretary for Pharmaceutical Affairs
- Director-General of Chest Diseases directorate

► ***Task Force***

Chairperson of the Task Force

- Undersecretary for Primary Health Care

Members of the Task Force

- Focal point
  - National IMCI director

- Other members:
  - Undersecretary for Research and Development (formerly IMCI director)
  - MCH director
  - ARI control programme director
  - Care for children with special needs programme director

International organizations

- WHO

Example 4: Syrian Arab Republic

(This example shows the composition of a Task Force which originally included many members. Based on the experience gained and especially on the difficulties for a large group in meeting frequently, the composition is now being re-considered in favour of having a smaller Task Force, while re-designating some of the original members as resource persons.)

Chairperson of the Task Force

- Vice-minister of health

Members of the Child Health Committee

- Ministry of Health
  - Primary health care director
  - Child health department manager
  - Reproductive health department manager
  - Nutrition department manager
  - EPI manager
  - IMCI manager
  - Life style promotion manager
  - Head of the child health department in the capital city

- Ministry of Education
  - Head of the newborns department of the university paediatric hospital

International organizations

- Nongovernmental organization
- UNICEF
- WHO

Example 5: Morocco

(The following example concerns a country in which a major initiative on children is under way. The Child Health Policy Initiative has therefore been integrated in this process, making use of the available management structures created for the children initiative. A CHPI Task Force has been created as a core group of the large child health committee established for the children initiative.)

Chairperson of the CHPI Task Force

- Population directorate director

Members of the CHPI Task Force

- Focal point
  - National IMCI strategy focal point

- Other members
  - MCH division chief
  - Paediatrician (medical faculty)
  - National micronutrient deficiency control programme manager
  - Breastfeeding promotion focal point
  - National EPI manager

Annex 2. Examples of documents reviewed

Below is a list of examples of specific documents reviewed in selected countries during the CHPI situation analysis. It should be noted that many more documents were collected and reviewed than those listed here. In some countries, a library of several folders of documents was created, to serve as a useful child health resource reference in the future.

Legislation, regulations, presidential and high-level declarations

- Child law
- Presidential declaration on child protection and care
- Laws on prenuptial certificate, breastfeeding, and maternity
- National conference for civil service legislation
- Department orders related to mandatory vaccinations
- Declaration on nursing and allied health personnel educational reform

Strategic and development plans and policy documents

- 25-year strategic plans of the ministry of health and of the ministry of education
- National health development plan; strategic directions and objectives of the national development plan
- 20-year national ministry of health strategy
- Country report on the Millennium Development Goals
- Doctor career pathway and training policies
- Human resources for health; 10-year plan for human resources development
- Achievements and future vision
- National programme of action for the next decade
- Guidelines on IMCI pre-service training for medical schools
- Capacity-building plan of the ministry of health
- Revision and standardization of health care facilities levels and functions
- Guidelines on IMCI pre-service training for medical schools

Reviews and data

- Situation on childhood and motherhood in the country (National Council for Childhood and Motherhood)
- National report on the monitoring of the global Summit for Children for the last decade
- Achievement for children in the decade of the 90s
- Situation analysis of the ministry of health capacity
- In-depth review of primary health care in the country
- The situation of children in the country
- Demographic situation and perspectives in the country
- Population projections
- National health accounts
- Report on the IMCI review
- Internal reports of ministry of health programmes
- Partners' reviews
- Annual statistical reports

Surveys

- National study on causes of under-five deaths
- CDD and ARI mortality and morbidity surveys
- IMCI health facility surveys
- Demographic and health surveys (DHS)
- Pan Arab Project for Child Health (PAP-CHILD) and for Family Health (PAP-FAM) surveys
- Multi-indicator cluster surveys (MICS)
- (Health) Service Provision Assessment Survey, community studies

This document is part of a series of documents produced by the Child and Adolescent Health and Development unit to assist countries in efforts to improve the quality of children's lives through integrated approaches. A national child health policy document is a key instrument for setting clear long-term directions and for bringing together the main elements of child health. At a time when all Member States have pledged to achieve the Millennium Development Goals, a national health policy will enable countries to "institutionalize" this commitment and translate it into stronger action, and will also serve as a valuable reference to harmonize actions among partners.

This document is one of the outcomes of the Child Health Policy Initiative (CHPI) recently undertaken by the WHO Regional Office for the Eastern Mediterranean to guide countries in formulating their child health policy and to promote primary child health care at the highest possible political level. Since the foundations of national child health policy should lie in in-depth review of the current child health care situation, the emphasis of this document is on the first phase of the policy development process, namely the situation analysis. The document proposes concrete and practical steps to organize the work in conducting the situation analysis. An outline is also provided for the situation analysis report.

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