

Strengthening implementation of home-based records for maternal, newborn and child health

A guide for country programme managers



World Health
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Web annexes:

[Web Annex A.](#) Blank templates (for printing) for activities included in this guide

[Web Annex B.](#) Sample interview guides for women, parents, caregivers, health workers and facility managers

[Web Annex C.](#) Monitoring and supervision checklist for implementation of the maternal and child health record book

Foreword

Home-based records have a long history, initially used to record proof of smallpox vaccinations in the mid-1800s and subsequently used to document health services and provide health education to mothers in Japan in the mid-1900s. Today, countries have many different types of home-based records, ranging from records covering single health areas such as antenatal notes or vaccination-only cards to more expanded content such as child vaccination and nutrition cards, or integrated maternal and child health handbooks. These documents are used to record an individual's history of health services received and can also provide basic health and development promotion messages.

In guidance put forward by the World Health Organization (WHO) in 2018, home-based records are recommended to improve care-seeking behaviours, men's involvement and support in the household, maternal and child home care practices, infant and child feeding and communication between health workers and women and caregivers. However, the research and reports available on home-based records use for maternal, newborn and child health reveal that implementation challenges persist in many countries. Data collected through a WHO and United Nations Children's Fund (UNICEF) standard questionnaire sent annually to all Member States indicates that in 2020, 25 out of 162 countries had stock-outs of home-based records and 15 countries had stockouts over at least three years. This implies that cohorts of women and children do not receive these records, and also reveals the need to strengthen planning, implementation and monitoring of home-based records.

This implementation guide aims to provide activities and decision-making tools to strengthen processes for planning, designing, implementing, and monitoring of home-based records with the aim to maximize the benefits for all users: women, parents, caregivers, health workers and programme managers. The guide will support, and is complementary to, broader ongoing efforts to strengthen primary health care and health programming for women and children. Moving forward, digital technologies can be applied to increase access and use of home-based records and strengthen links to health management information systems.

WHO, UNICEF and the Japan International Cooperation Agency (JICA) are committed to collaborate on strengthening the use and implementation of home-based records for maternal, newborn and child health, in attainment of the 2030 Agenda for Sustainable Development, particularly in those settings where services and systems are fragile and fragmented.

We encourage country programme managers and implementing partners to adopt this guide and collaborate with national stakeholders to strengthen their own national processes and ensure their investment in home-based records achieves its objectives for improved health.



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Fina Tams (WHO), Hiroko Oishi, Maki Ozawa, Kanako Takeshita and Mai Yamaguchi (JICA) and Yesser Sebeh (independent consultant) also provided important inputs. Thanks are also due to David Bramley, who reviewed and provided inputs into the final document.

The methods used to develop the guide and the participants in all meetings to review content are listed in the Annex. WHO, UNICEF and JICA thank the participants of the review meetings held in November and December 2021, and the country review meetings organized in Ghana, Indonesia and Nepal in June and July 2022. Special thanks also to Esi Amaoful, Leela Khanal and Lucy Kiarie from JSI for coordinating the country review meetings in Ghana and Nepal.

Teams led by Catherine Adu-Asare and Isabella Sagoe-Moses of the Family Health Division, Ghana Health Service of the Ministry of Health, Nida Rohmawati of the Ministry of Health of Indonesia and representatives of the Family Health and Welfare Division of the Ministry of Health and Population of Nepal contributed to the review of content of the draft guide in their respective countries in June and July 2022 and also provided comments and additional details on the country examples included in this guide, where needed.

Funding support received from the WHO Department of Maternal, Newborn, Child and Adolescent Health and Ageing through a grant received from JICA and from the WHO Department of Immunization, Vaccines and Biologicals through various donors is gratefully acknowledged.

WHO, UNICEF and JICA are keen to learn about your experiences in using this implementation guide. If you have any feedback, please write to mncah@who.int and let us know what you liked, what you did not like and what you think should be improved to make this guide more useful to you and other programme managers working on home-based record implementation.

Acronyms and abbreviations

AIDSCAP	AIDS Control and Prevention
BMGF	Bill & Melinda Gates Foundation
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunization
HMIS	health management information system
JICA	Japan International Cooperation Agency
MCH	maternal and child health
MICS	Multiple Indicator Cluster Survey
MNCH	maternal, newborn and child health
NGO	nongovernmental organization
RMNCAH	reproductive, maternal, newborn, child and adolescent health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1

Introduction to the guide

Welcome

A home-based record is a health document that is used to record the history of health services that an individual receives. The record – which is kept at home, in either paper or electronic format, by the individual or caregiver – can contribute to improved maternal, newborn and child health (MNCH) and to achievement of universal health coverage and the United Nations Sustainable Development Goals. The World Health Organization (WHO) recommends the use of home-based records as a complement to facility-based records for the care of pregnant women, mothers, newborns and children in order to improve care seeking behaviours, men’s involvement and support in the household, maternal and child home care practices, infant and child feeding, and communication between health workers and women, parents and caregivers (1).

Most countries already implement some form of home-based record for MNCH. These records vary greatly in their design and content across countries and regions. The records range from antenatal notes, vaccination-only cards, expanded vaccination-plus cards, child health books or integrated maternal and child health (MCH) books, which often include health promotion messages. For simplicity, the term “home-based record” is used throughout this document.

The majority of home-based records – whether paper-based, digital or both – contain two types of content. The first type – which consists of the health record element (data to be recorded on health status or use of health services) and is usually filled in by a health worker – includes growth monitoring charts, vaccination status and doses received, and/or antenatal or postnatal care record information. However, there may be certain health record components such as

milestones for early childhood development that women, parents or caregivers can fill in themselves to monitor their child. The second type of content comprises health promotion messages and reminders that provide priority information to women, parents and caregivers.

For brevity, this guide refers to “women, parents and caregivers” as the main users of the home-based record. However, it is recognized that the family plays an important role in supporting MNCH.

Evidence exists that home-based records make an important contribution to MNCH outcomes (1). However, studies and conversations with country programme managers highlight common implementation problems that can impede that contribution. For instance, countries may face frequent stock-outs of home-based records, poor-quality records (e.g. poor design, material not durable, etc.), inadequate use of home-based records by health workers, and poor use and retention of home-based records by women, parents and caregivers (1).

For home-based records to have impact on MNCH, an ongoing effort is required, along with coordination across multiple health programmes and ministerial departments and links to other health data and communication activities to ensure that they are available, are being used correctly, and are valued by women, parents, caregivers, health workers and programme managers within the health system.

Who is this guide for?

This guide is primarily intended for programme managers responsible for MNCH, immunization and nutrition within ministries of health, as well as policy-makers and stakeholders – such as representatives of local governments, nongovernmental organizations (NGOs), professional associations, United Nations partners, international organizations and others – that are involved in making decisions and taking actions to strengthen the implementation and use of home-based records for improved MNCH outcomes.

This guide assumes that you, as the programme manager, collaborate with a core team of people who work with you on the implementation of home-based records. Throughout the guide, there are activities and reflections for both you and the core team as you apply the information shared to the specific country context. The concepts and activities of this guide can be applied at national and subnational levels.

The guide assumes that a country has one home-based record. For countries that have more than one type of home-based record, the concepts and activities of this guide can also be applied to these settings.

The different types of home-based records for MNCH focus on the needs of the users (women, parents, caregivers, health workers and programme managers) and the national policy objectives (**Fig. 1**). See the **Activity** on the next page for plotting a country's home-based record against the spectrum in **Fig. 1**.



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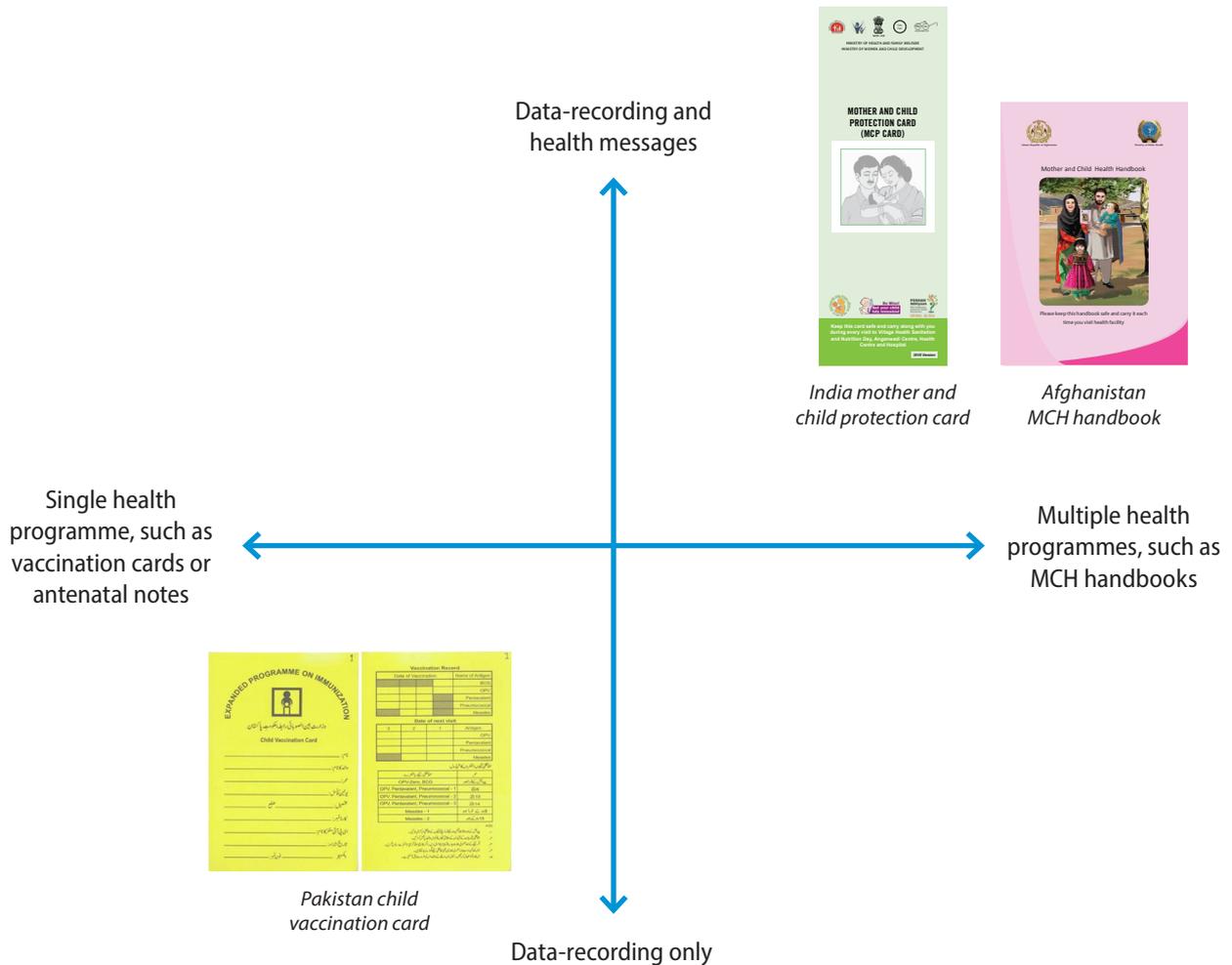
ACTIVITY – PLOT YOUR COUNTRY’S HOME-BASED RECORD AGAINST THE SPECTRUM IN FIG. 1



Where would you plot your country’s current home-based record for MNCH on the diagram in **Fig. 1**? If your country has more than one type of home-based record for MNCH, you could plot each of them on the diagram.

If you are interested in seeing different types of home-based records from different countries, you can find examples on Technet-21.^a

FIG. 1. THE SPECTRUM OF HOME-BASED RECORD TYPES



^aSee: <https://www.technet-21.org/en/topics/home-base-records>.

The purpose and scope of this guide

The purpose of this guide is to support efforts to strengthen the implementation of home-based records in your country through processes for planning, design, implementation and monitoring. The guide is structured to support both you and the core team you work with on home-based record implementation to:

- review planning and implementation processes;
- identify information needed to better understand implementation gaps; and
- make decisions to address those gaps.

The guide promotes sound management practices. Before making any decisions about strengthening the country's home-based record, it is essential to have information on current use of the home-based record by the three user groups – (i) women, parents, caregivers; (ii) health workers; and (iii) programme managers – as well as on the current performance of operational support processes (see the **Summary** below).

SUMMARY: WHEN REVIEWING HOME-BASED RECORD IMPLEMENTATION, YOU WILL NEED INFORMATION ABOUT TWO COMPONENTS:



- current use of the home-based record by the three user groups: (i) women, parents, caregivers; (ii) health workers; and (iii) programme managers (**Fig. 2**); and
- the operational support processes that ensure proper use of and access to the record – e.g. funding, printing, distribution and stock management, capacity-building and supportive supervision, promotional activities, monitoring of implementation.

The scope of this guide covers the steps in a programme management cycle that allow you to think about these two components in a structured way (**Fig. 3**), namely:

1. Planning for activities that strengthen the implementation of home-based records: this is primarily focused on methods to understand and engage with the three user groups, coordinate with stakeholders, and assess the strengths and weaknesses of the implementation of home-based records with information from routine monitoring or from a situation analysis (see **Chapter 2** – Planning for successful implementation of the home-based record; **Chapter 3** – Conducting a situation analysis; and **Chapter 7** – Monitoring implementation of the home-based record).
2. Selecting the content of the home-based record, including designing and pretesting any new or revised element of design or content (see **Chapter 4** – Selecting content for the home-based record on the basis of technical priorities and user requirements; and **Chapter 5** – Revising and testing the design of the home-based record).
3. Strengthening implementation and the operational support processes, including conducting a pilot test for major changes to the home-based record, if needed, plus budgeting and funding, printing, distribution and stock management, capacity-building and supportive supervision, building awareness and promoting use, and coordination across health programmes (see **Chapter 6** – Implementing the home-based record).
4. Monitoring of implementation of the home-based record in order to track progress, improve implementation processes and understand if the use of a home-based record is achieving its targets and contributing to MNCH programme objectives (see **Chapter 7** – Monitoring implementation of the home-based record).

What is not included in this guide

- Evaluation requires additional consideration of methods and instruments; it therefore goes beyond the scope of this guide.
- Digital home-based records are not explicitly covered in this guide, although many of the concepts and steps in the guide will be useful for countries that are transitioning to a digital home-based record.
- Health areas beyond MNCH (including family planning, adolescent health, health of older persons, etc.) are not covered in this guide. However, although the guide focuses on MNCH, the processes described could be applied to other health areas.

FIG. 2. KEY USERS OF HOME-BASED RECORDS

WOMEN, PARENTS AND CAREGIVERS

Who are they?

Women in pregnancy and after birth; parents, families or caregivers of newborns and children



HEALTH WORKERS

Who are they?

Midwives; nurses; doctors; community health workers; vaccinators; or other individuals directly involved with delivering MNCH services



PROGRAMME MANAGERS

Who are they?

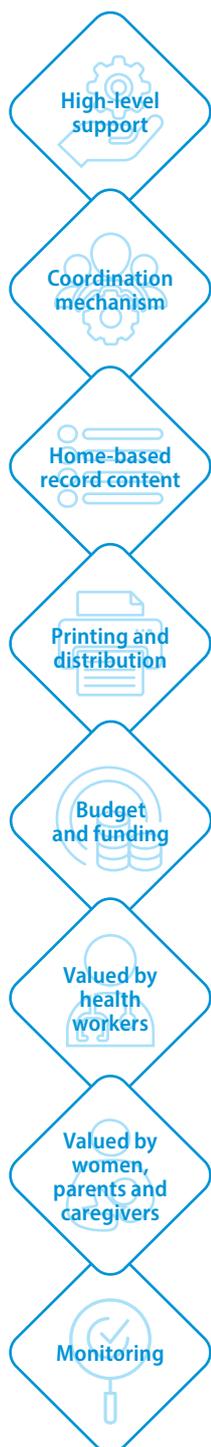
Programme managers at facility, subnational or national level; national and international organizations supporting home-based records



Eight success factors to achieve optimal use and performance of the home-based record

Eight success factors can help to ensure that efforts to strengthen the home-based record achieve their intended impact. Attention to these eight factors throughout the programme management cycle will help you to track progress in home-based record implementation and will result in optimal use and

performance of the home-based record.^b These factors encompass understanding of: (i) the users' needs; (ii) the ways in which the home-based record is currently implemented; and (iii) enablers of and barriers to achieving effective use of the home-based record which will lead to optimal home-based record implementation. More details on each of these success factors are provided throughout the guide. The success factors are:



1. **High-level support is established:** Support and buy-in from key stakeholders within relevant ministries and departments are needed to ensure that the home-based record is referred to in national strategies and policy frameworks to increase visibility and strategic alignment.
2. **Coordination mechanisms with stakeholders are in place:** In order for stakeholders to contribute effectively, a clear definition of roles is important and regular interactions and discussions are needed.
3. **Home-based record content supports health priorities and objectives:** The content of the home-based record needs to align with the national objectives and health priorities.
4. **Printing, distribution and resupply are planned and costed:** Regular estimates of needs for home-based records are made and included in planning to ensure funding for their printing and distribution as well as resupply for subsequent cohorts.
5. **Budgets are accurately estimated and sustainable funding is identified:** The costs of producing the home-based record and the different operational support processes are identified, and funding is ensured in the government budget.
6. **Health workers value the use of the home-based record:** Health workers should have a regular supply of home-based records, which they use in their interactions with women, parents and caregivers, and on which they record information.
7. **Women, parents, caregivers and community members value the use of the home-based record:** Women, parents and caregivers should have access to the home-based record, should be able to use the information to make informed decisions about their health and should retain the record for future reference (e.g. for subsequent health services, proof of vaccination).
8. **Monitoring processes are in place to ensure that objectives are met, users' needs are met and operational support processes are optimized:** Necessary information should regularly be gathered, reviewed and discussed by the core team to ensure informed decision-making about home-based records.

^bAdapted from (3).

The structure of the guide

The guide consists of chapters that cover the programme management cycle (**Fig. 3**), starting with planning (and a situation analysis if needed). Each chapter explains a step in the process and includes examples, activities, templates and decision-making tools that you can use with the core team to reflect on how to strengthen implementation of the home-based record. All tools and proposed activities can be adapted to the situation in different contexts.

- Most sections include examples (see the **Summary** on p. 9), reminders and external links to further resources.
- Activity information includes brief introductory text to explain a particular tool or activity and what you will learn or achieve once you complete it.
- Activities or tools are also introduced with guidance on how to complete the activity or to use the tool, followed by an example of how the tool or template could be filled in.
- Blank templates are included in **Web Annex A** so that they can be printed and used as appropriate.

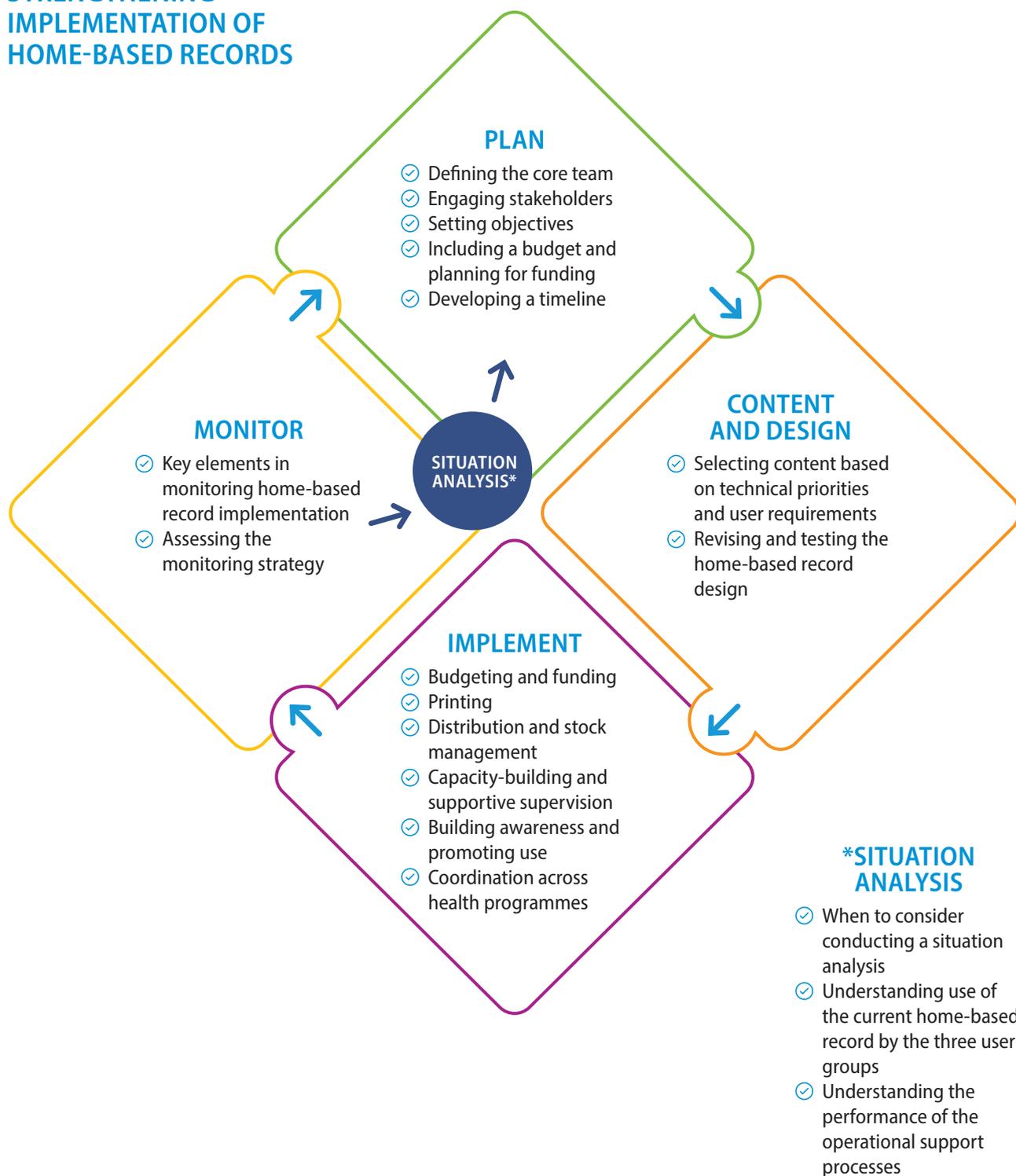
This guide is modular and is meant to complement existing tools. You can go directly to the sections relevant to your current needs – the **Activity** at the end of this chapter (see p. 11) can help you to determine what content within this guide may be most useful to you. Links to further resources are provided throughout so you can easily access them and obtain more in-depth knowledge on specific topics.

The steps in the programme management cycle may not always be consecutive. Where there are strong monitoring processes and information is available on home-based records, you may decide that a situation analysis is not needed. If you have recently been through a process to revise the content and design of the home-based record, you may wish to prioritize issues related to operational support processes. If you plan to revise the content or design of your home-based record, you may find it helpful to review all the steps in the programme management cycle.



FIG. 3. HOME-BASED RECORD PROGRAMME MANAGEMENT CYCLE

STRENGTHENING IMPLEMENTATION OF HOME-BASED RECORDS



SUMMARY: EXAMPLES PROVIDED IN THIS GUIDE COME FROM THREE SOURCES



The examples included in this guide were obtained through the following:

- A mapping exercise to collect implementation tools conducted by WHO's Department of Maternal, Newborn, Child and Adolescent Health and Ageing in 2020.
- Two revitalization workshops led by the Bill & Melinda Gates Foundation (BMGF) with UNICEF's Regional Office for South Asia in 2016 and WHO's Regional Office for Africa in 2017. The 2016 workshop was held in Colombo with representatives from Afghanistan, India, Nepal, Pakistan and Sri Lanka; the workshop in 2017 was held in Kampala with representatives from Cameroon, Ethiopia, Liberia, Nigeria, Rwanda and Uganda. The main objective of both workshops was to develop a paper-based prototype of a home-based record that meets the needs of the three user groups.
- Information provided by the Japan International Cooperation Agency (JICA) on the basis of documentation of activities and learnings in the following countries: Afghanistan, Ghana, Indonesia, Kenya and the Philippines.

Disclaimer

Where available, the writers have indicated existing resources or tools developed by country teams and implementing partners. These tools were identified in a mapping exercise conducted by WHO and may be of use to the reader when moving forward in implementation. Their inclusion in this implementation guide is not an endorsement of the tools by WHO, UNICEF or JICA.



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Key concepts

A user-centred approach

To ensure that the home-based record meets its objectives, it should respond to the needs of the three main user groups (**Fig. 2**). This guide highlights ways in which you can find out more about, and effectively engage with, the three user groups and use the information in each step of the programme management cycle so that your decisions address the users' needs.

Building high-level support for the home-based record

Strengthening implementation of the home-based record requires building senior management's awareness of the record's importance and the contributions it makes to improved MNCH outcomes and higher strategic objectives such as the Sustainable Development Goals (see the **Summary** below). This high-level support will ensure coordination between different stakeholders and can translate directly into having sufficient funding and resources.

SUMMARY: THE IMPORTANCE OF BUILDING HIGH-LEVEL SUPPORT AT NATIONAL AND SUBNATIONAL LEVELS



A global analysis of the implementation of home-based records included interviews with key informants. Many respondents noted that when a government did not give high priority to home-based records, its support of the records was less substantial and sustainable than that of more committed governments.

To achieve high-level support, advocacy is required to inform stakeholders – particularly health ministry officials, donors and coordinating agencies – about the benefits of a home-based record programme and what is required to implement it.

For the advocacy to be credible, stakeholders will need to see data about home-based records and information about their use and availability (3).

Where to from here?

Each user of this guide will have unique needs according to the status of home-based record implementation in their national context. You can begin with **Chapter 2**, which has tools and activities that support planning for implementing home-based records, with **Chapter 3**, which provides ways to conduct a situation analysis to identify areas that should be strengthened, or with **Chapter 7**, which focuses on the routine processes and information that need to be gathered and reviewed in order to understand the implementation process. With the core team, you can review the **Activity** on p. 11 and reflect on what your current needs are and which content areas would be most useful to you.

ACTIVITY – DEFINING THE AREAS YOU WANT TO STRENGTHEN IN IMPLEMENTATION OF THE HOME-BASED RECORD



Reflect with the core team on the questions below to determine the current opportunities to strengthen the programme management cycle for the home-based record. Consider which sections of this guide could be most useful to you.

It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

QUESTIONS

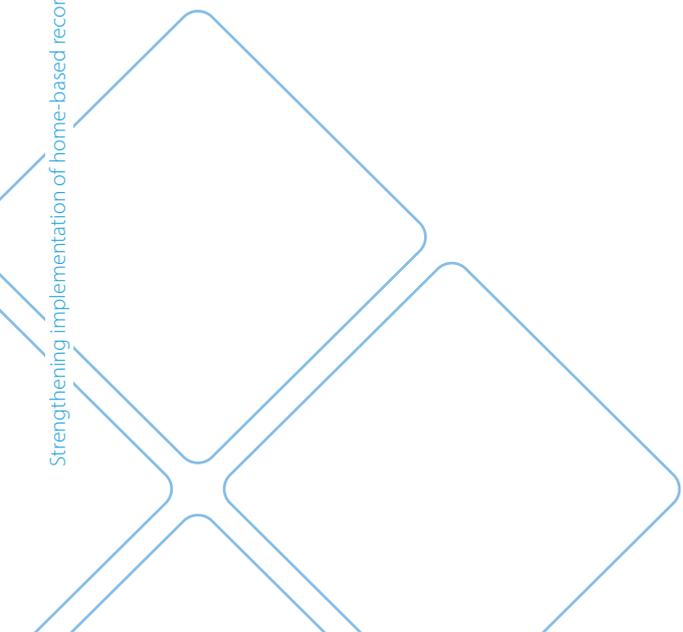
1. **How would you rate the core team's collaboration with key stakeholders?** Review **Chapter 2** if the core team needs to strengthen its coordination with stakeholders.
2. **What are the main enablers to ensure, and barriers that prevent, optimal use and performance of the home-based record?** Identify strengths and weaknesses of implementation of the home-based record by conducting a situation analysis (see **Chapter 3**) or by reviewing information collected through monitoring (see **Chapter 7**).
3. **Does the core team propose revision of the content of the current home-based record (e.g. due to a policy shift, to expand a vaccine card, to combine several personal records to integrate content into an MCH handbook or to remove content that is not used)?** Review **Chapter 4** to assess the current content and select priority content elements.
4. **What are the strengths in the operational support processes that you can build on?** If the core team needs to refine operational support processes such as printing, distribution and stock management, or capacity-building for health workers, see **Chapter 6**.
5. **How can you strengthen your approach to monitoring the implementation of the home-based record?** For suggestions, review **Chapter 7**.

Reflection

This chapter focused on an introduction to this guide and described the different types of home-based records, the three key user groups, the programme management cycle, and the eight success factors to ensure optimal use and performance of the home-based record. On the basis of the Activities and information provided in this chapter, have you started to build high-level support? Have you identified areas the core team wants to strengthen in implementation of the home-based record, and do you know where to find the relevant information in this guide?

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CHAPTER 2

Planning for successful implementation of the home-based record

Chapter overview

Planning is a fundamental management function that includes an organized and structured approach to identifying and achieving defined objectives. It involves determining what activities will be done, how they will be completed, who will complete them, within what time frame, and what resources will be needed (1,2). Common problems of home-based record implementation start from poor planning – i.e. failure to establish clear objectives, roles, responsibilities and timelines, or failure to consider budget needs and funding sources.

Good planning will allow members of the core team to reflect on their objectives and actions. **Box 1** gives an example of this from Ethiopia.

This guide assumes that you and the core team are familiar with planning processes and that you will develop a plan for implementation of home-based records and have regular reviews of progress.

The content in this chapter includes:

- defining the core team
- engaging with key stakeholders
- setting objectives
- including a budget and planning for funding
- developing a timeline.



Information is essential to planning

Good planning requires using the best information available at the time, so it is crucial to gather this information when first starting to plan. The most important information you will need can be organized into the two categories below. The eight key success factors to ensure optimal use and performance of the home-based record, introduced in **Chapter 1**, are captured in these categories:

1. **Information about how the three user groups currently use the home-based record**
This information should capture whether women, parents and caregivers have received the home-based record, retain it, bring it to the health facility and/or outreach visits, and understand and value the content that is included in the record. The core team also needs information about whether the home-based record is filled in completely and correctly by health workers, which elements are not used, and whether programme managers obtain the information they need from the home-based record.
2. **Information about the performance of the home-based record's operational support processes**
This information should highlight the various elements in the operational support processes – including information about funding, printing, distribution, stock management, capacity-building and supportive supervision activities for health

workers, and awareness-building activities for women, parents, caregivers and communities. Information should also be available on coordination of the home-based record with the national health management information system (HMIS) and with stakeholders.

You may use information collected through monitoring activities, supportive supervision sessions, health facility visits or home visits, annual reviews, feedback from the pilot test, data from

HMIS, evaluations or other studies – including Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). You can then use this information to work with the core team and stakeholders to set objectives and define the activities to reach objectives, estimate costs, secure funding and structure the timelines.

If you do not already have all the necessary information for both categories, you are encouraged to consult **Chapter 3**.

BOX 1 – ETHIOPIA’S OBJECTIVES TO IMPROVE PLANNING PROCESSES FOR SUSTAINABLE BUDGETING OF THE HOME-BASED RECORD

During a BMGF–WHO African Region workshop on revitalization of home-based records, a team from the Ministry of Health of **Ethiopia** identified multiple challenges related to strengthening operational support processes for implementation of home-based records. The Ethiopia country team noted a lack of regular monitoring to assess whether home-based records were distributed and used, as well as a lack of linking the home-based records with other programmes. The home-based record was also not included in the annual budget plan.



In response to these challenges, the Ethiopia country team prioritized the need to improve their planning processes and to advocate for sustainable budgeting. The activities they planned to address these challenges were:

- to communicate with the national Expanded Programme on Immunization (EPI) manager and partners;
- to advocate to key decision-makers at the national level;
- to develop a revitalization plan for the home-based records; and
- to incorporate the home-based record into the annual plan and coordinate with other programmes (e.g. nutrition, maternal health).

Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 [unpublished report].

Defining the core team

The core team members include those persons who work with you on a regular basis to plan, implement and monitor the home-based record in your country. The core team structure can be mapped out using the **Activity** below.

- Depending on the type of home-based record available in the country (vaccine only or multiple health areas), the core team will include representatives from the health programmes (e.g. MNCH, immunization, nutrition) that relate to the home-based record.
- A representative from the HMIS will also be important to ensure that there are effective links between the HMIS and the home-based record. If the home-based record includes health promotion messages, a representative from the health education/promotion department will be valuable to ensure links with other communication resources. Other key departments in the ministry – such as health procurement, human resources or even other development partners – may also be invited to join the core team.
- You may also wish to invite others with specialized skills – such as data analysts, logistics specialists or social science and behavioural specialists – to the core team. If they are not available to be full members of the core team, it may be possible to have them agree to collaborate at key stages.
- Core team members will normally not be dedicated to the home-based record 100% of their time, so it is important to understand each person's role and responsibilities, availability and commitment. It may be helpful to record these in a binding (written) agreement to ensure that all members have the same understanding.
- If other persons in the ministry of health are responsible for approving decisions or allocating funding to the implementation of home-based records, it is important to communicate regularly with this person or group.
- It may not always be clear which health programme has final decision-making authority or responsibility for the home-based record, so it is vital to cultivate interdepartmental working relationships and to define the governance of efforts to strengthen the home-based record implementation.

ACTIVITY – MAPPING THE CORE TEAM STRUCTURE



This Activity can help to identify who should be part of the core team, and define roles and responsibilities to create an efficient team.

It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

INSTRUCTIONS

1. If the core team has not been appointed, identify the specific health programme expertise and skills needed for the home-based record implementation.
2. Reach out to people who you believe have matching skills and expertise or to people who can help identify and connect to the right candidates to join the core team.
3. Identify the role, responsibilities and time commitment for each member of the core team.
4. Capture this information and share it across the core team to ensure transparency and clarity about who is on the core team and how the team is structured.

Engaging with key stakeholders

Different departments within the ministry of health, other ministries, organizations and partners will be vital to implementation of the home-based record. As you consider potential stakeholders, determine who can make decisions, contribute effectively and establish a strong collaboration. See **Box 2** for two examples of coordination within the Ministry of Health in Kenya and with the HMIS unit in Nepal.

- Even though it is likely that the core team in the ministry of health will lead the home-based record activities, successful implementation depends on multiple stakeholders (see the **Summary** below).
- In some countries, such as Kenya and the Lao People's Democratic Republic, existing MNCH coordination mechanisms and technical committees play an important role in the coordination of partners for the home-based record for MNCH.
- A wide variety of stakeholders can ensure that the plan for the home-based record is pertinent, can realistically be resourced and implemented, and that it addresses the needs of women, parents, caregivers, health workers and programme managers.
- The selection of stakeholders should complement the members of the core team so that together they cover all the areas of expertise, skills and resources needed for the proposed actions to strengthen the home-based record implementation.

SUMMARY: DIFFERENT STAKEHOLDERS WHO CAN BE INVOLVED IN HOME-BASED RECORD IMPLEMENTATION



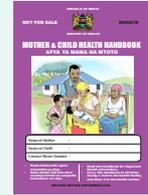
Are you currently working with any of the following groups, or would a representative from any of these groups enhance implementation of the home-based record? For instance:

- professional associations (such as midwives, doctors, paediatricians, obstetricians, gynaecologists, nurses) – to connect you to different cadres of health workers, across various locations, who can share their perspectives and support capacity-building activities;
- pre-service professional health education (such as nursing, midwifery, etc.) – to support pre-service capacity-building activities;
- the private health sector, including managers and representatives of health workers – to ensure inclusion in service delivery and efforts to reach the population;
- women, parents, caregivers and community groups – to connect to women, parents and caregivers, support efforts to build awareness of home-based records and share their perspectives;
- universities and research institutions – to support a situation analysis and any external evaluation;
- NGOs – to support efforts to reach communities, build awareness of the home-based record, strengthen their service delivery and support implementation;
- WHO, UNICEF, United Nations Population Fund (UNFPA), other international agencies and other health and non-health development partners – to provide technical and other support; and
- non-health services (such as administrative systems for birth registration, etc.).

BOX 2 – INTERNAL COORDINATION WITHIN THE MINISTRY OF HEALTH IN KENYA AND COORDINATION WITH THE HMIS UNIT IN NEPAL

In **Kenya**, the Ministry of Health internally shares tasks related to the MCH handbook. For example, the Head of the Department of Family Health coordinates printing of the most up-to-date version. The distribution of the MCH handbook is delegated to the Division of Vaccines and Immunization, while the Division of Child and Adolescent Health oversees technical reviews (3).

In **Nepal**, the HMIS unit has an annual plan to print and revise home-based records, along with other instruments that are distributed to health centres across the country. If the Family Welfare Division wishes to propose adjustments to either the design or the content of the home-based record, it needs to inform the HMIS prior to an established deadline to ensure that enough records are printed for the next year. If the Family Welfare Division cannot reach agreement before this deadline, the HMIS unit issues a warning that it may not be able to print the most up-to-date version of the home-based record (4).



Stakeholders should be engaged early in the process in order to contribute to the planning, implementation and monitoring activities. If some stakeholders have not yet committed themselves, you will need to reach out to them and explain why their participation would be important, how they can contribute, and what kind of commitment you are requesting (number of meetings, financial support, participation in activities, etc.).

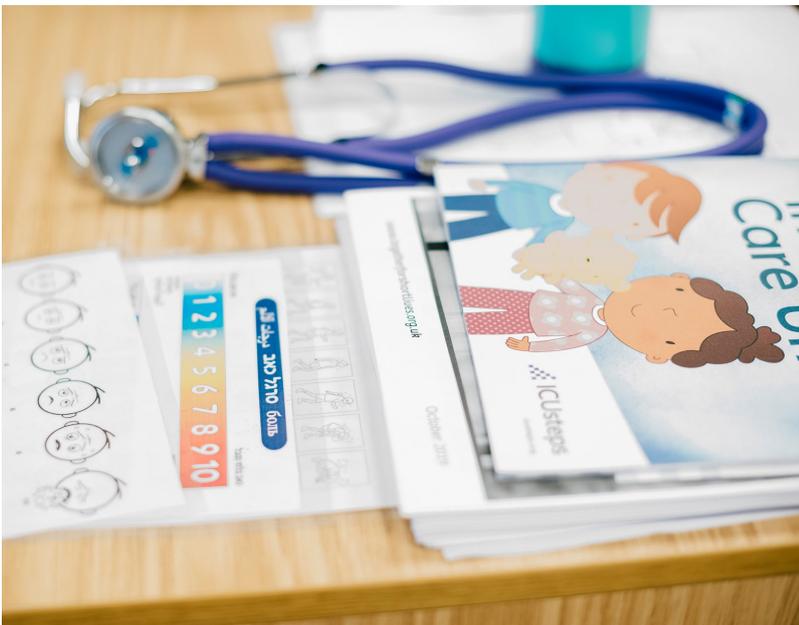
Examples of consensus-building workshops among stakeholders in Afghanistan and in Ghana can be reviewed in **Box 3**.



Further resources on this topic

For further resources on this topic, see the **WHO Stakeholder mapping guide and sample grid** (see page 4 for a blank grid to print and fill in) to determine the level of engagement with each stakeholder group (5).

The JSI guide *Conducting a situational analysis and engaging stakeholders on home-based record availability and use* includes suggestions (pages 5–6) as to which stakeholders could be involved and what topics the core team can discuss with them, and shows examples of commitments to resources and timelines (4).



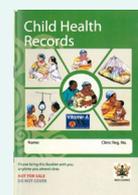
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BOX 3 – CONSENSUS-BUILDING WORKSHOPS AMONG STAKEHOLDERS IN AFGHANISTAN AND GHANA

Multiple consensus-building workshops were held between representatives of different health programmes of the Ministry of Public Health of **Afghanistan** (including reproductive health, MNCH, nutrition, health promotion and the HMIS), as well as staff from WHO, UNICEF and JICA. Before and after the workshops, a series of meetings were held with other stakeholders, including professional associations and NGOs contracted by the Ministry of Public Health. One of these workshops took place while the operational guidelines for the MCH handbook were under development. The objectives of this specific workshop were to advocate for the implementation of the handbook and to receive technical inputs from different departments. During the meeting, the stakeholders discussed the concept of the MCH handbook both globally and in the context of Afghanistan, reviewed a prototype and considered modalities of implementation (Updates on third-country training programme on MCH handbook, Yogyakarta, Indonesia, 31 July–5 August 2016 [unpublished data]).



In 2021, the Family Health Division of the Ghana Health Service, under the leadership of the Ministry of Health of **Ghana**, invited private health service providers to a stakeholder workshop in Accra. The purpose was to discuss the management guide for the MCH record book, to review the needs and issues related to the management and sustainability of the record book and to gain consensus among all 29 stakeholders who attended the workshop on how the challenges could be resolved. Core operational processes (e.g. production, distribution, use and monitoring of the MCH record book) were discussed and standard procedures agreed on. Private health facilities confirmed that they would adhere to the agreed procedures, which were captured in a revised draft management guide (6).



Setting objectives

Objectives to strengthen implementation of the home-based record are needed in order to define a realistic plan. The objectives should ensure that the home-based record contributes to national MNCH objectives, including immunization and nutrition, and addresses problems identified through routine monitoring (see **Chapter 7**).

You may already have defined detailed objectives, or at least a list of current issues to address to strengthen implementation of the home-based record. Defining SMART objectives can enable you to achieve specific, measurable objectives, within a certain time frame (see the **Summary** on p. 19).

SUMMARY: ENSURE THAT THE CORE TEAM SETS SMART OBJECTIVES**SMART objectives are:**

1. **Specific** – Set a clear and simple objective.
2. **Measurable** – Ensure that you can accurately track progress towards the objective.
3. **Achievable** – Ensure that the objective is attainable and realistic.
4. **Relevant** – Ensure that objectives are important and address the most pressing challenges.
5. **Time-bound** – Set a time frame that helps to establish priorities and workplans.

EXAMPLES OF SMART OBJECTIVES TO STRENGTHEN HOME-BASED RECORD IMPLEMENTATION**These three examples illustrate objectives that are SMART:**

- to update the vaccine content of the home-based record by the second quarter of 2023 in order to accommodate the introduction of two new vaccines and to include two additional blank rows for future vaccines that may be introduced;
- to ensure correct and complete recording of all data sections in the home-based record by 80% of health workers nationally within the next six months; and
- to allocate ministry of health funding in the amount of x during the first quarter of 2023 for printing new antenatal care cards to cover the estimated number of pregnancies in districts x, y and z for year 2023.

What information do you need to set objectives?

Before members of the core team can set objectives, they will need information about the use of the home-based record by women, parents, caregivers, health workers and programme managers, as well as information about the performance of operational support processes. If you have already gathered and analysed this information and set clear objectives to strengthen implementation of home-based records, you can move to the next section on including a budget in your plan.

If you do not have the necessary information to understand home-based record implementation and to define clear objectives, see **Chapter 3**, which deals with conducting a situation analysis to gather and analyse current usage and operational performance data related to home-based records, before moving further into planning. **Chapter 7** considers monitoring sources for this information.

Including a budget in your plan

A plan needs a budget with costs for all activities, materials and other resources. A problem that countries may face is neglecting to include costs for every item that contributes to successful implementation of the home-based record and operational support processes.

Creating an initial detailed cost estimate can be vital for gaining support and securing the necessary levels of funding. Cost estimates can ensure that funding is allocated and can help avoid common implementation problems such as stock-outs, lack of training for health workers or insufficient monitoring of the use of the home-based record. See the **Activity** on p. 20 to estimate the home-based record's costs in order to create a budget.

ACTIVITY – ESTIMATING HOME-BASED RECORD COSTS TO CREATE A BUDGET



This Activity will generate an initial budget estimation. You can create a list on paper or use a spreadsheet programme to create a more permanent budget, add formulas or connect the budget directly to data sources. This Activity can be used with any standard budgeting tools that the core team is familiar with. It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

INSTRUCTIONS

1. Identify members of the team with experience in budgeting.
2. Create a list of all items that will incur costs. The list below provides examples of items to include in your budget. You may also find it useful to go to the timeline estimation tool later in this chapter to help identify activities, materials and resources that will incur costs. (The development of budgets and timelines requires closely related processes; progress on one may directly contribute to progress on the other. It may be useful to develop them in parallel).
3. Describe each item in detail to ensure that everyone on the core team has a clear, shared understanding of what exactly is being costed.
4. Make an initial cost estimate per item; use previous planning data as a benchmark when possible.
5. Categorize one-time start-up investments separately from recurrent costs that need to be budgeted on an annual basis. For example, initial capacity-building is a start-up activity, whereas annual refresher training or supportive supervision is recurring.
6. Add up all the cost items and review them with the core team and relevant stakeholders. Is the total estimated budget aligned with available funding? If not, can you justify an increased level of funding or find ways to reduce estimated costs? Do all budgeted items align with stated objectives? If you cannot secure this level of funding, what priorities and trade-offs can you make?

Items to consider when creating your budget:

- stakeholder and coordination meetings;
- situation analysis activities (if necessary);
- human resources;
- design/layout of the home-based record;
- pretesting (when revising the home-based record) or conducting a pilot test (optional as needed) of the home-based record;
- printing, distribution, stock management and storage;
- capacity-building activities and support materials for health workers;
- activities and materials to raise awareness among stakeholders as well as among women, parents, caregivers and other community members;
- supervision and monitoring activities; and
- equipment needed for services to be noted in the home-based record (e.g. scales to measure the child's weight that is recorded in the home-based record).

How to plan for funding

If there is a gap between anticipated costs for proposed activities to strengthen the home-based record and the funding currently identified as available, you need to reduce the scope of your activities or identify additional funding. It is important to know the deadlines for budget requests for funding or, if applicable, for external funding options. **Box 4** displays an example of how Cameroon diversified its funding sources for the home-based record and developed a sustainable funding strategy. **Fig. 4** shows that different countries tend to have a mixture of different funding sources. The following questions may help you to reflect on mechanisms for additional funding.

- Is there an existing line item for home-based records in the ministry of health annual operational budget? Is this amount sufficient? If you need more funding than the current allocation, how can you approach this issue?
- If there is no current line item for home-based records, how could you get one added to the annual operational budget?
- Are there existing budgets for higher-level strategic objectives that can be supported by the core team's proposed activities to strengthen the home-based record?
- Can funding for the home-based record be guaranteed by including it as a required item within a higher-level budget (e.g. for vaccination supplies)?
- Can costs be shared across budgets? For instance, costs could be divided across health programmes, national and subnational levels and the public and private health sectors.
- Can the private health sector contribute to costs?
- Can sponsorships or public-private partnerships be used to contribute to funding your plan in ways that are strategically and ethically sound?

Note: WHO recommendations on home-based records for MNCH note that sponsorship, such as advertisements in home-based records, may present conflicts of interest and potential harm – e.g. allowing advertisements for formula milk or political parties (7). However, it is noted that responsible advertising can bring in valuable revenues. A country should carefully assess the risks and benefits. The Framework of Engagement with Non-State Actors, endorsed in 2016 by the Sixty-ninth World Health Assembly (resolution WHA69.10) may be useful when weighing benefits and risks and conducting due diligence.

- Are any other funding sources possible – such as printing through the health insurance system or delegating responsibility to subnational level to identify other funding sources to bridge budget gaps?
- Could the ministry of health select and oversee businesses to print and distribute home-based records? (This would involve electing or certifying businesses, setting quality standards and capping prices).

BOX 4 – DIVERSIFYING FUNDING SOURCES IN CAMEROON AND DEVELOPING A SUSTAINABLE FUNDING STRATEGY

The Ministry of Health of **Cameroon** had a country team that attended a BMGF–WHO African Region workshop on revitalization of home-based records in Kampala, Uganda, in 2017. The team identified the availability of home-based records at district and health facility levels as one of their main challenges because of a lack of financial resources to distribute them. Another issue at the time was that neither government nor partner funding was available to produce the home-based record, called the blue card.

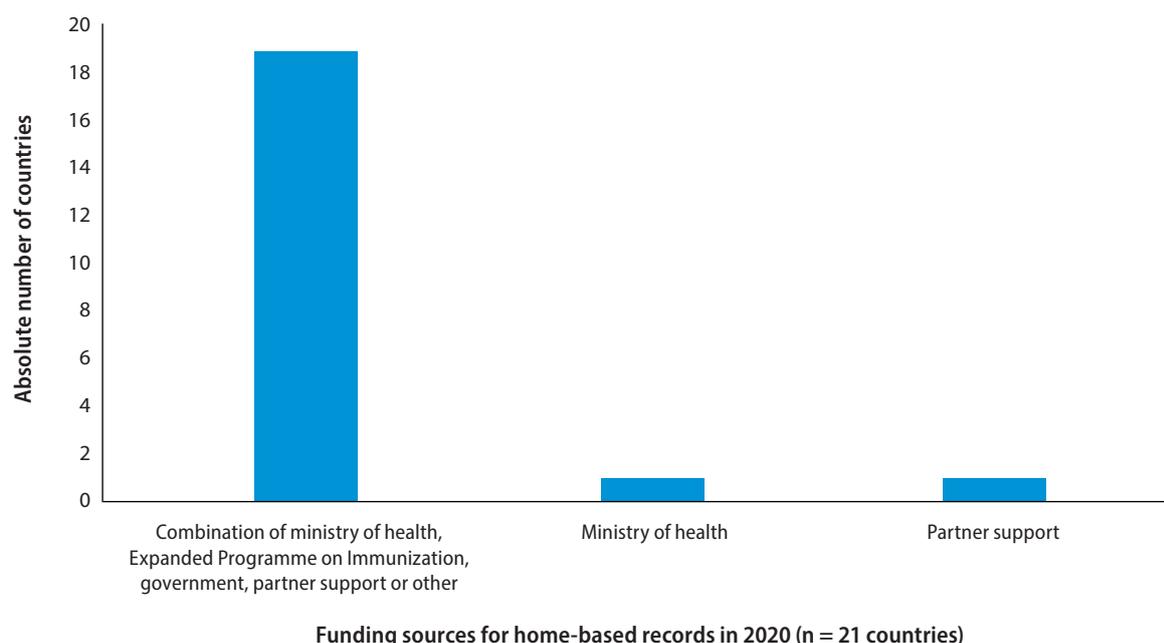


To address the funding issue in the short term, the team decided to diversify funding sources with three key partners. As an emergency measure that aimed to overcome the 2016 and 2017 stock-outs, it was agreed to discuss potential funding with the Polio Fund to reproduce the blue cards. The plan was to distribute the cards during the April polio immunization campaign. The Ministry of Health also asked the Global Financial Facility and the Canadian Fund whether they could support the production of the new blue card – the new prototype was created during the revitalization workshop – and asked that it could be distributed during national campaigns in October 2017.

After having resolved the urgent issues around stock-outs, the mid-term goal by 2018 was to develop a sustainable funding strategy. This increased the recognition that the Ministry of Health should include funds to produce the home-based record in its annual budget.

Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 [unpublished report].

FIG. 4. RESULTS OF THE 2020 WHO–UNICEF JOINT REPORTING FORM ON IMMUNIZATION INDICATED THAT MANY COUNTRIES SHARED COSTS FOR HOME-BASED RECORDS BETWEEN THE GOVERNMENT AND EXTERNAL PARTNERS



Source: WHO–UNICEF Joint Reporting Form on Immunization, 2020 (8).

How to develop a timeline to achieve agreed objectives

If you have already developed a budget estimate for the costs of all elements associated with the proposed activities to strengthen the home-based record and its operational support processes, you can translate these costed elements into a logical sequence of activities in the form of a timeline. The timeline represents a commitment to achieving milestones and the final

objectives by promised dates; it becomes a key tool for communicating what you are planning to achieve, how you plan to achieve it and over what time period. The **Activity** below shows a simple tool for creating an initial timeline, as well as the template and an example of a completed template.

ACTIVITY – CREATE YOUR TIMELINE



This Activity will enable you to generate your initial timeline for achieving defined objectives for strengthening the home-based record. It is recommended that you review these instructions with the core team and assign someone to take notes on decisions and follow-up actions.

This Activity uses a simple tool to create an initial timeline – instructions, a blank template on which to write your initial timeline and an example of a completed template are also provided.

INSTRUCTIONS

1. Break down your objectives into a list of specific activities that need to happen. Arrange them in column 1 of the blank template in a logical sequence from the first activity to the final one.
2. In column 2, provide the necessary details that explain your activity and communicate your thinking to others.
3. Identify the resources necessary for each activity (people, programmes, services, data, equipment, outside agency support, etc.) and describe them in column 3.
4. In column 4, list any dependencies – actions that must happen before you can do this activity (e.g. the results of another activity, a review, an approval). Also ask yourself if there are other activities that are dependent on completion of, or reaching, certain milestones of this activity? If so, have you sequenced that activity correctly in relation to this one?
5. Create an estimate of the time required to complete each activity (typically in days or weeks). You may need to break down larger activities into smaller tasks. Record this in column 5.
 - Use historical data to put your plan into context – from existing plans or previous years' plans.
 - Remember that time estimation is not just adding up the number of days needed, but also involves taking account of dependencies and milestones that may affect the dates of starting and finishing an activity.
6. List all milestones related to the key activities (i.e. a progress report to be delivered at a key meeting, submission of proof for funding requirements, approval before finalizing the list of key activities). Milestones will help you to develop a more realistic timeline by understanding if deliverables can realistically be completed in the periods allocated. List these anticipated milestones in column 6.

TEMPLATE: TIMELINE ESTIMATION TOOL

1. Activity	2. Details	3. Resources involved	4. Dependencies	5. Time required	6. Key milestones

EXAMPLE OF A COMPLETED TEMPLATE: TIMELINE ESTIMATION TOOL

1. Activity	2. Details	3. Resources involved	4. Dependencies	5. Time required	6. Key milestones
Situation analysis	Assess existing secondary data on operational support processes; conduct primary data collection of home-based record use	Full core team, MNCH programmes, facility health workers and home visitors to conduct interviews	Requires operational plans from each of the MNCH programmes	Two calendar months (estimated start date 15 July)	To be completed prior to October technical review to make decisions moving into next calendar year

Next steps

- Once you have completed the timeline, compare it to the cost estimate that was developed in the **Activity** on estimating home-based record costs to create a budget (see p. 20) to ensure they are aligned.
- You may want to transfer the activities to a more visual project timeline format, such as a Gantt chart,^c spreadsheet, calendar, etc. This will allow you to communicate the sequence, needs and timeline more easily with the core team and stakeholders (see **Box 5** for an example Gantt chart).

Remember that the timeline estimation tool is a living document – as you learn more, you will need to adjust estimates, identify new activities to be added and break down larger activities into smaller tasks – especially once you have specified the design for a new home-based record or changes to your operational support processes.

Create an action plan

The main output from the planning activities and the situation analysis (see **Chapter 3**) or routine monitoring activities (see **Chapter 7**) can support the development of the action plan. Each proposed activity should be assigned to specific persons/organizations, tied to a timeline for implementation and, where needed, with funding and sustainability plans identified.

To create an action plan, list the key issues identified and define these components for each:

- proposed interventions
- immediate next steps
- responsible person/organization
- timeline
- remarks on sustainability/funding.

A simple action plan developed by a Liberian team is outlined in **Box 5**.

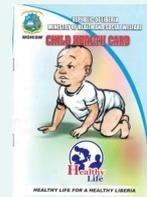
^cSee: <https://www.gantt.com/>; 2022.

If the core team is still trying to finalize proposed interventions to strengthen the home-based record in your action plan, the section on prioritization of interventions in **Chapter 3** may be useful. The list of potential interventions to include in the action plan may be long and aspirational. To improve the

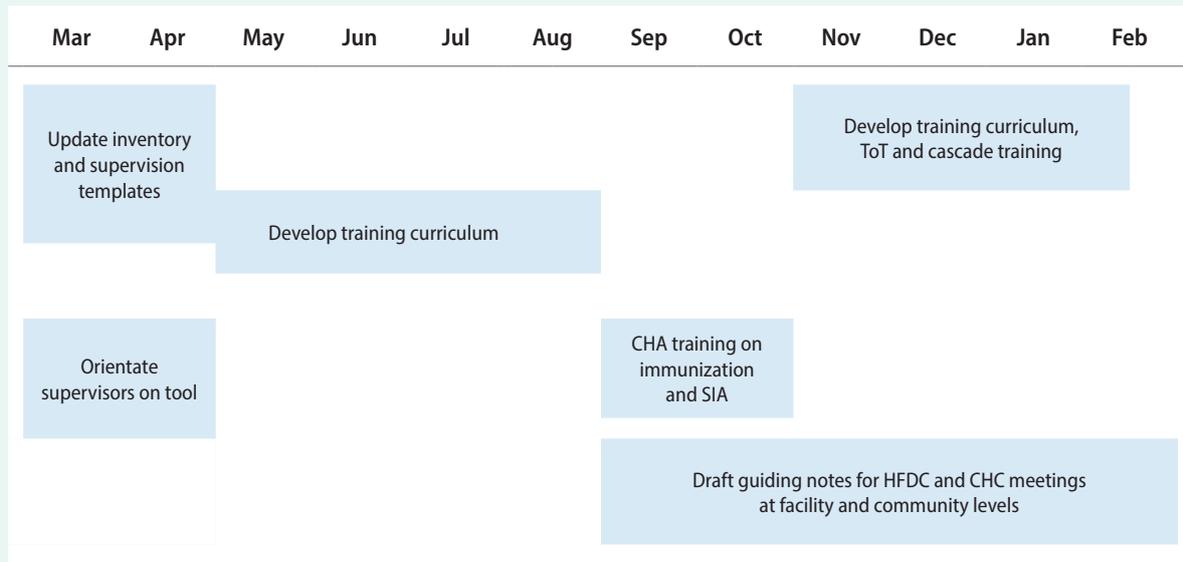
likelihood and feasibility of implementing the action plan, it is recommended to prioritize proposed interventions that will have greater impact and those that require levels of effort that match the core team, the time and the funding.

BOX 5 – AN ACTION PLAN DEVELOPED BY LIBERIA’S COUNTRY TEAM DURING A WORKSHOP IN 2017

During a BMGF–WHO African Region workshop on revitalization of home-based records, a team from the Ministry of Health of **Liberia** identified challenges with regard to stock-outs at county and health facility levels. The team also noted underutilization of the country’s child health book. They developed an action plan and a Gantt chart in order to overcome these issues within the following year.



ACTION PLAN



CHA: community health assistant; CHC: Community Health Committee; HFDC: Health Facility Development Committee; SIA: supplemental immunization activity; ToT: training of trainers.
 Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

Reflection

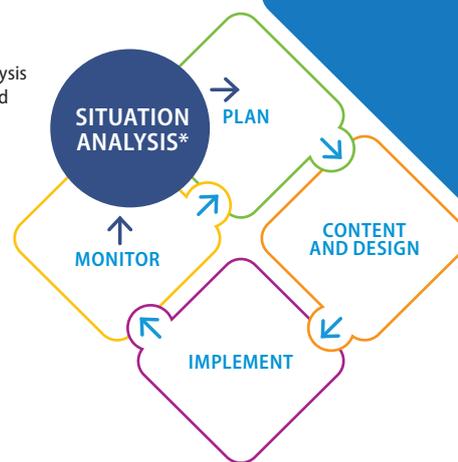
This chapter focused on planning processes for strengthening the implementation of home-based records. On the basis of the information provided and the Activities described in this chapter, what are you going to incorporate into the mechanisms that you use to plan for the home-based record? Will the core team make changes to the way in which it collaborates with key stakeholders?

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***SITUATION ANALYSIS**

- ☑ When to consider conducting a situation analysis
- ☑ Understanding use of the current home-based record by the three user groups
- ☑ Understanding the performance of the operational support processes



CHAPTER 3

Conducting a situation analysis

Chapter overview

Up-to-date information is needed for setting objectives, planning effectively, gaining support for the home-based record and identifying which operational support processes need to be strengthened. As discussed in **Chapter 1** and **Chapter 2**, information from different sources will enable informed decisions to be made about how to strengthen the implementation of home-based records.

Ideally, information is available from routine monitoring activities of home-based record implementation (see **Chapter 7**). Most countries conduct reviews of their health programmes and have sufficient information for planning implementation of the home-based record. However, the frequency and scope of these types of reviews vary. There may be times when the information available is insufficient or a certain topic related to implementation of the home-based record requires more in-depth understanding than can be obtained from routine monitoring (see **Chapter 7**). At such times, it may be valuable to consider conducting a situation analysis – a structured way of assessing the strengths and weaknesses of the implementation of the home-based record in your country that provides information for formulating strategic directions and responding to the needs of the three user groups (1).

This chapter links closely to **Chapter 7**, as well as to sections of **Chapter 6** in relation to supportive supervision.

The contents of this chapter include:

- when to consider conducting a situation analysis:
 - potential information sources for a situation analysis
 - who can contribute to a situation analysis;
- understanding the current home-based record use by the three user groups;
- understanding the performance of the operational support processes; and
- next steps from your analysis of current use and the performance of operational support processes.

When to consider conducting a situation analysis

The timing and extent of the activities in a situation analysis are closely linked to your information needs for planning (as outlined in **Chapter 2**) and the availability of information from routine monitoring (see **Chapter 7**). Several factors can trigger the need for a situation analysis:

- A structured situation analysis should be performed at least every 4–5 years to ensure that you have the most up-to-date information and a good understanding of the implementation of home-based records in your country.
- Some countries link a situation analysis with a periodic update of the content of their home-based record. For instance, Indonesia conducts a routine update of the MCH handbook every five years, while

Japan does this every 10 years.

- If you have information gaps in your planning, a more limited type of situation analysis may be conducted to address the gaps.

Potential information sources for a situation analysis

Two data sources can be used for planning: (i) a review of secondary data (i.e. existing data sources); and (ii) primary data that you will need to collect.

Secondary data sources can fall into the following subcategories:

- large routine surveys such as the MICS and DHS for information on implementation of the home-based record for immunization programmes in most countries, and in some countries for antenatal care, maternal and child immunization, and for child nutrition programmes at the national and subnational levels;
- the WHO–UNICEF Joint Reporting Form on Immunization and its summary by the Global Health Observatory for information on home-based record types, retention, stock-outs, printing responsibility and financing;
- findings from other studies, programme assessments, supportive supervision visits, routine monitoring, evaluations, WHO health facility surveys (2) or reports that can be collected either through literature searches or from stakeholders such as MNCH assessments, health service availability and readiness assessments, immunization programme reviews, etc.

If the secondary data sources are not sufficient for your needs, the core team will need to collect data on the home-based record. Alternatively, you can integrate questions about implementation of home-based records into other assessments that are being conducted by the MNCH, immunization or nutrition programmes. More information about integrating questions into existing programme activities can be found in **Chapter 7**.

Who can contribute to a situation analysis?

It is important that all health programmes that have content in the home-based record are engaged in the situation analysis and discuss the results so that they can identify good practices, understand if the home-based record is being used as intended and if actions in the workplan are needed to strengthen its implementation.

If you need to collect primary data, it is likely that you will need to work with a research organization to support you in developing the methods and collecting and analysing the data.



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Further resources on this topic

For a situation analysis of the health sector, see WHO *Strategizing national health in the 21st century: a handbook*. The third chapter contains in-depth information on how to conduct a situation analysis, what to include, how to analyse it and how to present your analysis to stakeholders (1).

WHO *Guide and workbook for conducting a situation analysis of immunization programme performance* provides step-by-step guidance for national immunization programmes on how to use available data sources to determine programme barriers. These data sources can be adapted for a situation analysis of the home-based record (3).

JSI guide on *Conducting a situational analysis and engaging stakeholders on home-based record availability and use* (see pages 2–4) includes guidance on how to gather data and reasons why a situation analysis is important (4).

Understanding the use of current home-based records by the three user groups

As part of the situation analysis, you may need to gather information on the use of the home-based record by the three user groups, including on each group's understanding of the home-based record, whether they find it useful (valuable) and whether they can use it effectively. The following three-step process may help you to identify and collect the necessary user information.

1. First, identify what the core team needs to understand about each of the three user groups' current use of the home-based record. A clear idea of what the knowledge gaps are will determine the information sources that should be included in the data review:
 - You can use the template analysing the use of the home-based record by user groups (see the **Activity** on p. 32) to record information you have gathered about how the home-based record is used and valued by each of the three user groups.
 - You can also use this template to list what you need to understand about each user group, and to identify data sources to provide this information.
2. Identify and collect existing secondary data sources. Review the data carefully to obtain a comprehensive overview of home-based record implementation. Note any outstanding gaps in the information you need that cannot be filled immediately from existing secondary sources.
3. Collect primary data to fill the gaps in the secondary data. Create a list of specific information you need to determine what forms of data collection you can use, then plan how the data will be collected, by whom, and when this will happen. Consider if you can use existing interactions with users to collect the necessary information (e.g. by adding some questions to supportive supervision sessions). **Box 6** contains an example from the Philippines. The **Summary** on p. 30 shows ideas of who to speak with to assess current use.
 - Identify the methods for collecting the information. These can include in-depth interviews, focus group discussions, exit surveys in health facilities or household surveys. Consider which geographical locations will be included and how many. How can you ensure you are getting information from a range of users, and on those users for whom you have the least amount of information?
 - The core team may decide that interviewing programme managers, health workers, women, parents and caregivers is the most effective method to collect this information about users. In this case, you will need to design methods and instruments, and consider if you need to apply for ethics approval. User interviews or discussions can be one-on-one or in small groups. Conversations can be held in health facilities and/or households.
 - To supplement user interviews, review the quality and completeness of home-based records to see how they are filled in or maintained. You can take photographs to document this. A *JSI tool to review the quality and completeness of home-based records* includes questions about home-based record ownership and whether specific sections of the record are filled in – such as the vaccine recording fields, the growth and monitoring charts, and the section on vitamin A (see pages 15–16) (4). The core team can adapt this tool depending on the type(s) of home-based record(s) in the country.

BOX 6 – COMMUNITY HEALTH TEAM SUPERVISORS CONDUCT SUPPORTIVE SUPERVISION IN THE PHILIPPINES

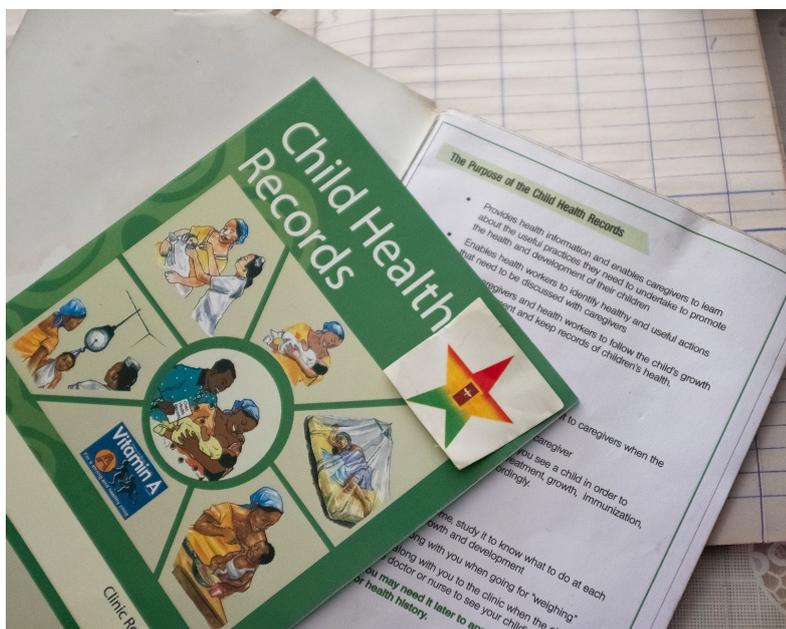
In East Visayas in the **Philippines**, community health workers play important roles as the local health team (e.g. community health team) to increase community members' awareness of how to access services and provide care at home by using the MCH handbook (5). The community health team supervisors – municipal health officer, medical officer or public health nurses – conduct supportive supervision visits using a [checklist](#), which includes some questions on the mother and child book and maternal record. The questions aim to assess whether the woman brought the record with her, the information that is recorded is satisfactory, the birth and emergency plan is filled in, and the content of the record was discussed with the woman.



SUMMARY: WHO TO SPEAK WITH TO ASSESS CURRENT USE



- You will need to engage with informants from all three user groups: (i) women, parents and caregivers; (ii) health workers; and (iii) programme managers.
- Speak to users from different ethnic, geographical, linguistic and socioeconomic contexts.
- Consider the needs of vulnerable groups who you may not be reaching with home-based records or mobile populations who may be dependent on home-based records.
- When the core team talks to health workers, also include community health workers, school-based and volunteer workers, and private sector health workers who may use the home-based record.
- To get a complete view of programme managers who use the home-based record, identify the facility and local, district, regional and national managers from both the public and private sectors.



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Further resources on this topic

You can adapt the following interview guides to your needs, the type of home-based record used and the specific issues you want to address:

- JSI interview guides for key home-based record users (see pages 11–14) (4);
- sample interview guides for each user group (see Web Annex B).

The examples in **Box 7** describe findings from research in the Democratic Republic of the Congo, Ghana, Liberia and Nepal that helped the decision-makers to identify actions to strengthen the implementation of

the home-based record. See the **Activity** on p.32 for framing the analysis of the home-based record's current use.

BOX 7 – RESULTS OF PRIMARY RESEARCH IN THE DEMOCRATIC REPUBLIC OF THE CONGO, GHANA, LIBERIA AND NEPAL

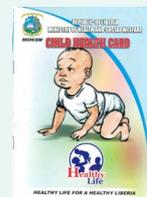
In the **Democratic Republic of the Congo**, focus group discussions, interviews and observations at health facilities showed that women, parents and caregivers would frequently not take home-based records home but instead they were stored at health centres. Health workers could use them to track children who were due to be vaccinated. However, as women could not access the records, they had difficulty in understanding the vaccination schedule and knowing the return date for the next appointment (4).



A team from the Family Health Division in the **Ghana** Health Service, under the leadership of the Ministry of Health, identified multiple gaps through a situation assessment based on anecdotal information from programme reports and implementation research conducted under the Ensure Mothers and Babies Regular Access to Care Project (6). The research identified several interventions that were done poorly, such as nutrition counselling at the facility level. Among other interventions, the team decided to: (i) strengthen the integration of nutrition counselling into routine MCH services, using the MCH record book; (ii) include written education messages on nutrition for literate women and illustrations for women with limited reading skills in the MCH record book; and (iii) train health workers on the effective use of the MCH record book for nutrition counselling and respectful care.



Prior to a BMGF–WHO African Region workshop on revitalization of home-based records held in Uganda to support strengthening of home-based records in six African countries, WHO, UNICEF, BMGF and Fuse Foresight worked with the **Liberia** country team to conduct rapid user research with all three user groups in health facilities, community centres and homes. This exercise revealed unexpected behaviours and attitudes, such as how caregivers were storing their children's home-based records in plastic bags under mattresses. Insights and ideas were recorded in photographs, notes and illustrations and were then shared remotely with the five other participating countries which then conducted similar primary research as inputs to focus strengthening of efforts in the workshop (BMGF–WHO African Region home-based records revitalization workshop, 2017 [unpublished report]).



Focus groups discussions in **Nepal** identified that poor retention of home-based records among women, parents and caregivers could have been due to the poor-quality paper of the record. Possible ideas to increase retention were to use better-quality paper for home-based records or to provide a plastic cover. Another barrier to using home-based records was that (community) health workers and women, parents and caregivers did not understand the value of the home-based record (4).



ACTIVITY – CONSIDERATIONS FOR ANALYSING DATA ABOUT USERS OF THE HOME-BASED RECORD



This Activity will enable you to organize the data that you have collected to define what is most important about how each user group currently uses the home-based record. Identifying key enablers (elements that support appropriate use of the home-based record by each user group) and barriers (elements that hinder appropriate use) across different contexts may help the core team to identify best practices and the most relevant areas to strengthen. It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

This Activity contains a simple tool to list existing enablers of, and barriers to, successful use of the home-based record by each user group. Instructions are provided, as is a blank template to complete and an example of a completed template.

INSTRUCTIONS

1. In column 1, list all three user groups of the home-based record (women, parents, caregivers; health workers; programme managers) in separate rows. Within each group, include any subgroups that have unique contexts of use, constraints or special situations that need to be considered in order to depict accurately the current use of the home-based record.
2. Identify the enablers that facilitate the appropriate use of the home-based record for each of the three user groups. Record these in column 2. If it is helpful, make a note about the specific context in which this enabler is relevant. You may wish to create a separate row for each unique context, issue or set of enablers and barriers (see the sample completed template for examples).
3. Identify the barriers that may impede the appropriate use of the home-based record for each of the three user groups. Record these in column 3. If helpful, make a note about the specific context in which each barrier is relevant.
4. Analyse and discuss the information captured to determine insights that can lead to improvement in content, design or operational support processes for the home-based record. Record these as potential actions to be taken in column 4.

TEMPLATE: ANALYSING USE OF THE HOME-BASED RECORD BY USER GROUPS

1. User group	2. Enablers (+)	3. Barriers (-)	4. Potential actions to be taken
<i>Women, parents, caregivers</i>			
<i>Health workers</i>			
<i>Facility managers</i>			
<i>Subnational programme managers</i>			
<i>National programme managers</i>			

EXAMPLE OF A COMPLETED TEMPLATE: ANALYSING USE OF THE HOME-BASED RECORD BY USER GROUPS

1. User group	2. Enablers (+)	3. Barriers (-)	4. Potential actions to be taken
<i>Women, parents, caregivers</i>	Retention: We observed a high percentage of women who kept the home-based record at home (and a relatively high percentage of women who brought it to visits with health workers).	Retention: Non-durable paper makes it difficult to keep the record clean and dry, and its quality deteriorates over time. We saw many records in poor condition and even illegible.	Consider feasibility of more durable materials and options such as providing an envelope/cover. Consider best practices for this issue from other countries.
<i>Women, parents, caregivers (in the home)</i>	Using records: Many women, parents and caregivers with limited reading skills mentioned that the inclusion of small pictures helped them to understand the nutrition section and gave them confidence.	Using records: The counselling messages are written in the official national language, which many women, parents and caregivers said they do not understand.	Provide counselling to women, parents and caregivers at facilities. Provide facilitation at home and/or by community health workers to assist women, parents and caregivers to understand the content.
<i>Health workers (in the facility)</i>	Filling in records: We observed that the majority of health workers correctly fill in the antenatal care section of the record. They said a poster on the facility's wall helped to guide them how to do it.	Filling in records: We noted that many health workers do not fill in the early childhood development section. They said there is insufficient space in the record.	Review the section on early childhood development. Many health workers are assumed to have a basic knowledge of early childhood development; however, standard procedures, including how to record, are not well known to most of them.
<i>Health workers (in the home)</i>	Filling in records: Some community health workers showed us brief guides that explain how to fill in the postnatal care section and that can be kept in their pockets.	Filling in records: Some community health workers told us they have low literacy skills and cannot understand the content of the record.	Community health workers would benefit from additional training sessions and/or from having pictures in the home-based record to guide their actions.
<i>Facility managers</i>	Using records: The facility manager said she was trained on the home-based record and knows where to find relevant MNCH data to train other personnel on how to record this in facility registers.	Using records: Some health workers do not write clearly, and facility managers say it is difficult for health administrators to read and understand the information that is recorded and to oversee quality of transcribing data into other instruments.	Review all data-recording fields on the home-based record and test with health workers to ensure they have sufficient space to record health data legibly.
<i>Subnational (regional) programme managers</i>	Using records: Regional managers generally told us they received training on the home-based record and know how to verify vaccination information during monitoring visits.	Using records: Most staff at regional management level use the record only occasionally for programme management and forget how it is used after some time.	Provide refresher training to ensure that staff continue to know how to use the home-based record for programme management.
<i>National programme managers (HMIS)</i>	Information in records: Health facility pregnancy registries and the antenatal care section of the home-based record were redesigned at the same time and are in alignment, which means that the same information is recorded in both.	Information in records: The postnatal care section of the home-based record and postnatal care registries are not in alignment. A lot of important information is captured only in one of them.	Review the health facility registries and the home-based record to ensure that the processes for recording information are aligned and that information that is recorded in one is also recorded in the other.
<i>National programme managers (training and supportive supervision)</i>	Using records: The national programme manager said a fixed annual budget allocated to training and supportive supervision allows them to train health workers on how to use the record.	Using records: Training schedules conflict with facility schedules, which is why national programme managers assume many health workers skip training sessions even if they are invited to attend.	Match the demand for, and timing of, training and supervision. Consider facility schedules when planning training sessions or consider in-service training on the importance of the home-based record.

Understanding the performance of the operational support processes

To define specific efforts that will strengthen the home-based record, it is important to understand the performance of the operational support processes as well as the use of the home-based record by the three user groups.

The core team can review existing data sources to gather information about the operational support processes. Potential information sources for a situation analysis are proposed earlier in this chapter. If information is available and there is no need to collect additional data, a template is provided in the **Activity** (on p. 36) to analyse information on current operational support processes. If the information needed is not available, you will need to consider how to collect it. Sample questions are provided in the **Activity** below on operational support processes.

Considerations when collecting information on operational support processes for home-based records

- You will need to identify what the elements in the operational support processes are, how they currently perform, how their performance compares to expectations (and what needs to be improved), as well as any best practices in place that you can build upon.
- Stakeholder organizations may be able to provide important information for this analysis and, just as importantly, may pose critical questions about the home-based record's operational support processes.

ACTIVITY – SAMPLE QUESTIONS ON OPERATIONAL SUPPORT PROCESSES



This Activity provides a broad set of questions that can be adapted for any data collection you conduct in order to better understand the operational support processes. It is recommended to review these sample questions with the core team and to assign someone to take notes on decisions and follow-up actions.

Printing:

- How is printing organized – in annual batches or on demand?
- Is printing managed centrally or at the subnational level?
- Are there mechanisms in place to ensure that the correct version is printed and to ensure quality control?

Distribution and stock management:

- Are home-based records reaching all designated distribution points? Are they reaching health facilities, health workers, women, parents and caregivers? Are there mechanisms in place to ensure that each woman, parent and caregiver does not receive more than one home-based record?
- How are distribution, stock management and resupply currently organized? Is the process performing well?
- Are there recurrent stock-outs at the national or subnational levels? If so, are stock-outs concentrated in specific subnational or district levels or at certain points or facilities?
- Do storage locations provide sufficient protection against damage from leaks, sun bleaching or other preventable loss?

Capacity-building:

- What capacity-building in the use of the home-based record has been held for health workers?
- Have these capacity-building efforts been evaluated?
- How well are these methods performing against expectations?
- What percentage of health workers has received capacity-building sessions on the use of the home-based record that might be integrated into pre-service education? Are there variations to capacity-building coverage by region, type of health worker, health facility or organizational affiliation?

Building awareness:

- What efforts have been implemented to build awareness in the community about the home-based record? If revisions were made to the home-based record, were these communicated widely to community members and health workers? How have these efforts been evaluated? Are there variations in coverage in the country and/or by any subgroups?

Alignment with HMIS and health promotion materials:

- Is the home-based record aligned with the health facility register and the health management and information plan and system?
- Are the same data that are recorded in the home-based record also recorded in facility registries or elsewhere? Is there any unnecessary duplication?
- Is the home-based record aligned with other health promotion materials?
- Are the same health promotion messages as in the home-based record also found in other health promotion materials? Is this planned and needed?

Coordination:

- Who takes the lead in activities to strengthen implementation of the home-based record?
- Are all programmes that have content in the record involved throughout the programme management cycle?
- How are you coordinating the activities between different programmes?
- How are you coordinating the work between the national and subnational levels?
- How are you coordinating with the private sector?

Considerations for analysing the information on operational support processes

After the core team has gathered information on the main operational processes that support and sustain the availability and use of the home-based record, you and the core team can analyse this information to determine whether and what changes need to be made to the processes to strengthen home-based record implementation and monitoring (see the **Activity** below).

- This analysis may reveal details of how other support elements currently operate, such as capacity-building or building awareness that influence understanding, appreciation and use of the home-based record.
- Depending on the context, some activities are likely to take place at national level while others are likely to happen at the subnational levels. It is important to understand the processes at each level and who is responsible for each activity in order to ensure smooth collaboration and to avoid problems in implementation.

ACTIVITY – ANALYSING INFORMATION ON CURRENT OPERATIONAL SUPPORT PROCESSES



This Activity will enable you to organize the data that you have collected on the performance of operational support processes to identify key enablers (elements that support optimal performance of the home-based record) and barriers (elements that prevent optimal performance). It is recommended to review these instructions with the core team and to assign someone to take notes of decisions and follow-up actions.

This Activity contains a simple tool to examine each area of the operational support processes and the existing enablers of, and barriers to, optimal performance – instructions, a blank template to fill in and an example of a completed template are provided. The format is similar to the tool in the Activity to analyse current use of the home-based record by user groups.

INSTRUCTIONS

1. Review the list of operational support processes in column 1 of the tool; add or revise the list as appropriate for your context.
2. In column 2, specify at what level – national/subnational/health facility – each support element is coordinated. If there are different aspects of a particular operational support element at different levels, you can create additional rows for that element for each level. You may also find it easier to create separate templates for each level.
3. On the basis of the information you have gathered, start with a general assessment of how each element is currently functioning – high, medium or low performance. Gain consensus for each element among the core team members and record your reasoning for the assessments. Record this assessment in column 3.
4. Identify the enablers that facilitate optimal functioning of the operational support processes for the home-based record and contribute to long-term availability and correct use. Describe each enabler in a manner that is understandable by others in column 4.
5. Identify barriers that hinder effective use and operation of support elements of the home-based record and describe them in column 5.

6. Identify the person on the core team who is responsible for that element, or a stakeholder who acts as your point of contact in this area, and note this in column 6.
7. Review the results of the situation analysis with stakeholders and partners. Are there enablers or barriers that are mentioned multiple times? How could revised operational support processes specifically address these issues? Record these in column 7 as potential actions to be taken.

TEMPLATE: ANALYSING OPERATIONAL SUPPORT PROCESSES

<i>1. Operational support processes</i>	<i>2. Level (national/ subnational/ facility)</i>	<i>3. Assessment (H, M, L)</i>	<i>4. Enablers (+)</i>	<i>5. Barriers (-)</i>	<i>6. Responsible core team member or stakeholder</i>	<i>7. Potential actions to be taken</i>
<i>Budget and financing</i>						
<i>Printing</i>						
<i>Distribution and stock management</i>						
<i>Capacity-building and supportive supervision</i>						
<i>Building awareness and promoting use</i>						
<i>Coordination across health programmes</i>						

H: high performance; L: low performance; M: medium performance.

EXAMPLE OF A COMPLETED TEMPLATE: ANALYSING OPERATIONAL SUPPORT PROCESSES

1. Operational support processes	2. Level (national/subnational/facility)	3. Assessment (H, M, L)	4. Enablers (+)	5. Barriers (–)	6. Responsible core team member or stakeholder	7. Potential actions to be taken
<i>Budget and financing</i>	National	L	External funders provide funding to help sustain the home-based record.	The ministry of health considers other projects more important and prefers to allocate funding to those rather than to the home-based record.	Ministry of health, in collaboration with external donor	Identify ways to convince the ministry of health to place more value on the home-based record and to allocate a fixed budget line annually.
<i>Printing</i>	Subnational	M	We learned from regional programme managers that home-based records are printed at the regional level, which is cheaper than at the national level.	One region mentioned that it often has power outages and sometimes cannot print the home-based records on time.	Subnational government	Explore ways to strengthen printing relationships with a neighbouring region.
<i>Distribution and stock management</i>	Facility	M	The facility manager in facility X said that she added a buffer when she estimated the number of records needed for the next quarter in order to cover lost records, mobile populations, etc.	The facility manager in facility Y said that women, parents and caregivers who visit facility Y frequently lose their home-based records. Since he did not include a buffer when estimating the quantities of home-based records needed, the facility eventually ran out of home-based records.	Local facility management	Women, parents and caregivers often lose the home-based record. They said they did not know that these are important documents that should be retained. We need to ensure that health workers emphasize the value of the home-based record during consultations with women, parents and caregivers, including by giving reminders and using the home-based records as communication tools.
<i>Capacity-building and supportive supervision</i>	Facility	H	Health workers are generally motivated to contribute to positive health outcomes.	We observed that health workers do not have sufficient understanding of the value of the home-based record and do not know how to use it to initiate consultation with women, parents and caregivers.	Local facility management	Promote pre-service training with emphasis on the value of the home-based record and how it is central to service delivery.

1. Operational support processes	2. Level (national/subnational/facility)	3. Assessment (H, M, L)	4. Enablers (+)	5. Barriers (-)	6. Responsible core team member or stakeholder	7. Potential actions to be taken
<i>Building awareness and promoting use</i>	National	H	Many women, parents and caregivers said they watch television. Therefore, mass media campaigns on television are likely to reach a lot of them.	Even if the majority of women, parents and caregivers watch television, how can we ensure we also reach those in rural or low-income areas who may not have a television?	Ministry of health, in collaboration with strategic communication	Are there opportunities to place information posters in markets, near bus depots, schools or health posts to communicate effectively with those who do not have a television or radio and who may have limited reading skills?
<i>Coordination across health programmes</i>	National	M	Regular meetings with health programmes with content in the home-based record facilitates coordination and ensures programmes are informed about implementation.	Representatives of some health programmes frequently cancel the meeting at the last minute, which makes it difficult to engage all programmes on implementation.	Managers of the health programmes with content in the home-based record	We need to emphasize the importance of inter-programme coordination and that it is crucial to optimal use and implementation of the home-based record.

H: high performance; L: low performance; M: medium performance.



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Next steps from your analysis of current use and the performance of operational support processes

Additional analysis

The completed templates from the Activities in this chapter can be useful for summarizing the information you have collected, for gathering feedback on the current situation and for gaining consensus about the strengths and challenges of implementing home-based records. A more detailed analysis may be needed to compare:

- results across different settings and populations, such as low-income, low-education, fragile, wealth quintiles, urban versus rural, and different target groups;
- consistency and inconsistency between the home-based record and health facility-based registries, and potentially between other health promotion materials and the home-based record in terminology and wording, plus the impact this has on the use of the home-based record for all three user groups; and
- use of different types or versions of the home-based records (if they exist in the country); how users use, value and perceive the home-based record (depending on which type or version they are familiar with, and what specific barriers to their use are associated with each type or version). Different home-based records may be implemented at different levels, and each may need a separate situation analysis with regard to both use and operational support.

Documenting

If conducted properly, the situation analysis should yield a clear and credible list of best practices and concerns, each supported by sources that can be cited and are easily available to others. A list of information gaps can also be generated to guide further research and data collection activities, such as routine monitoring (see **Chapter 7**) or periodic reviews.

For each topic area in the situation analysis, the following questions can help determine how best to document your findings:

- Is there a reason to believe that you have identified a best practice that can be built on or that there is a barrier to effective use of the home-based record or in the performance of the operational support processes?
 - Which findings suggest this is a best practice? Which findings suggest there is a barrier?
 - What is the source of the evidence?
 - What are the potential data limitations to the evidence?
- If information is not available in the sources you have identified, you can:
 - comment on the data limitation
 - note what can be done to gather further information.

Prioritize areas to be strengthened

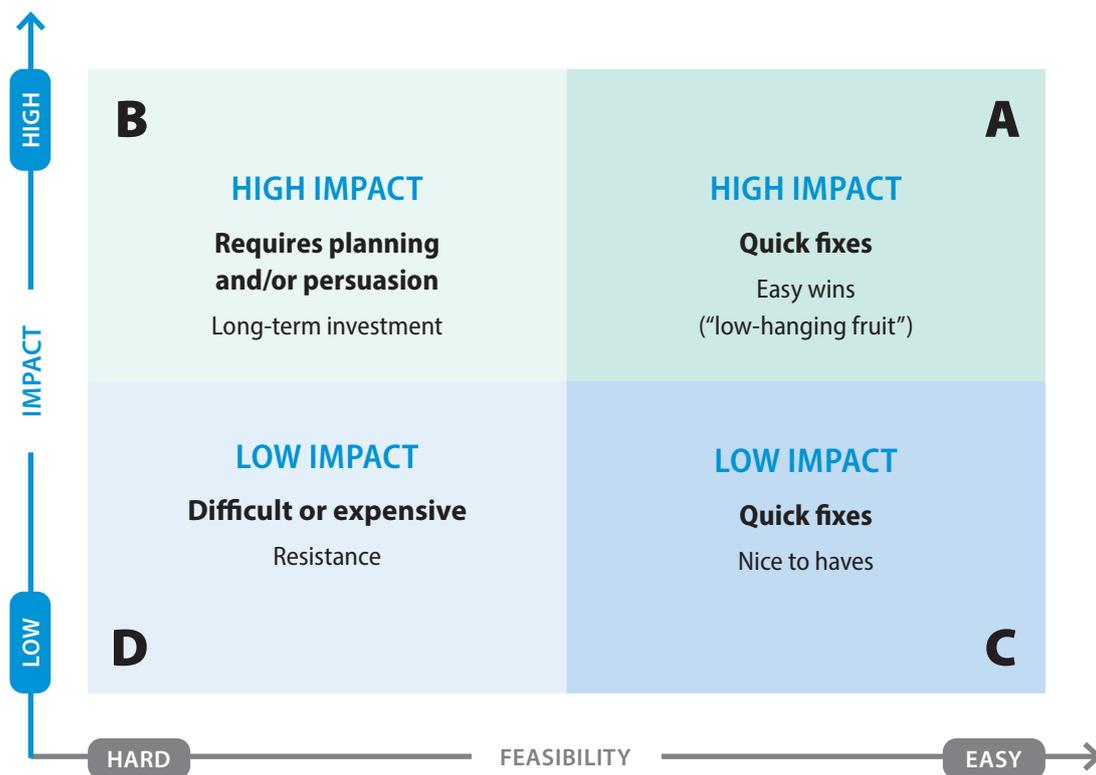
Once you have identified the key areas related to home-based record use or the operational support processes that need to be strengthened, discuss:

- Is the impact large or small of the proposed action to strengthen home-based record use or the operational support processes?
- Will making a change result in better use by one or more of the three user groups?
- Will this change better provide for underserved or vulnerable populations?
- Has the identified barrier to home-based record use or the operational support processes already been addressed by other interventions that appear to work?
- Is the barrier modifiable by specific modifications to the MNCH programme?
- How feasible is it to undertake activities to address the barrier?
- What has been done in the past to decrease the barrier, and what progress has been made to date?
- Are there other more pressing barriers?

The list of potential interventions to include in the action plan (see **Chapter 2**) may be long and aspirational. To improve the likelihood and feasibility of implementing the action plan, the core team will need to prioritize proposed interventions that will have higher impact and those that require levels of effort

that match the core team's skills, partner collaboration, time and funding. WHO *Intervention guidebook for implementing and monitoring activities to reduce missed opportunities for vaccination* (see page 5) illustrates a feasibility matrix that might be helpful to the core team when prioritizing potential interventions (**Fig. 5**) (7).

FIG. 5. IMPACT VERSUS FEASIBILITY MATRIX TO PRIORITIZE INTERVENTIONS



Source: WHO, 2019 (7).

Linking analysis outcomes with other steps in the process

With the insights from your analysis, there are different paths to create valuable impact:

- Your analysis will lead back to planning and setting objectives, better structuring of the core team, or revisions to the estimate of costs and timeline (see **Chapter 2**).
- The results of the situation analysis can provide inputs directly to the technical content review and/or to the development of user requirements (see **Chapter 4**).
- Your analysis may reveal implications for immediate ways to improve operational support processes such as printing, distribution and stock management, capacity-building and supportive supervision (see **Chapter 6**).
- The results may lead the team to reflect on the magnitude of the changes to the current home-based record design and/or the operational support processes that may require a pilot test (see **Chapter 6**).
- Lack of available data may indicate the need for improved monitoring of the use of the home-based record and operational support processes (see **Chapter 7**).

Reflection

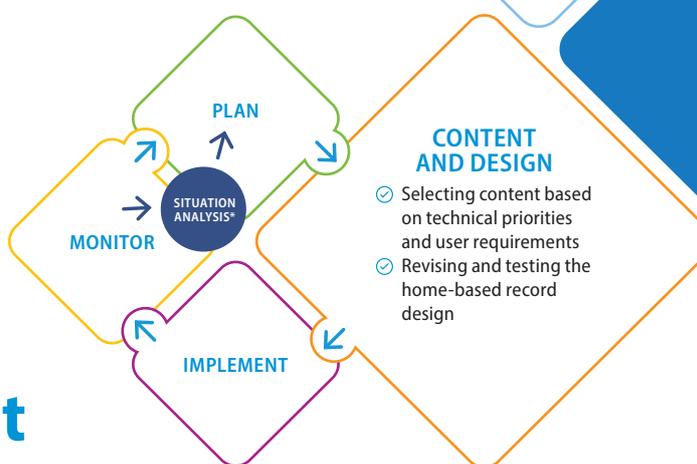
This chapter focused on conducting a situation analysis to understand the current use of home-based records by the three user groups, as well as the performance of the operational support processes. On the basis of the information reviewed by the core team and the Activities you completed in this chapter, what changes will you make to the way in which you will conduct a situation analysis for the home-based record in the future? Will you make changes to your routine monitoring process to ensure that you collect information about the home-based record regularly?

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CHAPTER 4

Selecting content for the home-based record on the basis of technical priorities and user requirements



Chapter overview

The amount of content included in the home-based record (see the **Summary** below) has an impact on readability, usability and costs. Defining the optimal content and size will be an iterative process to meet your health programme objectives, user needs and budget.

Major content revisions are relatively infrequent. Some countries limit a full technical review to once every five years. However, minor content reviews may be necessary more frequently – for instance, to add a vaccine or to accommodate changes to health programme priorities.

Selecting and justifying content to be included in the home-based record is an important step in the implementation process and can require difficult conversations. Core team members and stakeholders from different health programmes should review the information and confirm that the content is valued and used and, if not, whether it should be modified or removed. Decisions about content selection should be supported by information and selection based upon defined criteria. This will make it easier to have constructive conversations and to gain consensus across the core team and stakeholders.

SUMMARY: HOME-BASED RECORDS CAN INCLUDE TWO TYPES OF CONTENT



1. Personal health information – data fields usually recorded by a health worker but can include self-monitoring and recording of information by women, parents and caregivers.
2. Health promotion messages – text and images that provide information to women, parents and caregivers.

Additional content may also be included, such as notification of birth for birth registration, open spaces to add notes or additional information, etc.

This chapter proposes a logical path to identify health programmes' technical priorities for home-based record content and then to assess that content on the basis of user requirements.

This chapter includes:

- the selection of content for the home-based record on the basis of health programme priorities; and
- review of the selected content in order to meet user requirements.

Selecting content for the home-based record on the basis of health programme priorities

The inclusion of content in the home-based record should be based on a clear rationale. The content should be aligned with the health programmes' priorities and should be supported by information showing that the content is valued and used correctly by its intended users. The **Activity** (see p. 45) describes how to develop an inventory of all potential content, including a template that the core team can use to create an inventory of prioritized content, together with a sample completed template. An example of the content selection process in Ghana can be reviewed in **Box 8**.

When selecting which recorded information and which health promotion messages should be included in the home-based record, the core team must have criteria to support its decisions.

Criteria to be considered for recording information include the following:

- Recorded information is essential for public health purposes (for instance, it can be tied to MNCH-related priorities).
- Information is reasonably easy to collect, either being readily available and easy to report by a woman, parent or caregiver or being observed/recorded by a health worker (e.g. name, date of birth, place of birth, service provided during a health encounter).

- Recorded information can support the actions of different users.
- Recorded information is not sensitive or is recorded in a confidential manner that protects privacy (e.g. HIV status is coded so that only health workers understand it).

Criteria for health promotion messages include:

- The message can be conveyed using clear and plain language, or with an illustration.
- The message can be displayed concisely and does not require a lot of space.
- The home-based record is an appropriate place for the woman, parent or caregiver to find the message, understand it and take action.

The core team may wish to develop its own criteria.

When considering the current content or potential changes to it, the core team may find it useful to start by collecting and reviewing information in medical records and health facility registers to determine what would be strategic to include in the home-based record and to align the information with the other instruments.

Likewise, the core team can collect and review other existing health education/promotion materials (apart from the home-based record) to consider what content is already well served by these, and which priority messages need to be included in the home-based record. This inventory can also ensure that the messages in the home-based record are harmonized with other materials.



Further resources on this topic

WHO developed *advice on priority information for health across the life course – including priority messages for MNCH, early childhood development, nutrition and vaccination – that the core team can use to determine whether any priority messages correspond to the national priorities or they can be adapted to fit your context (1)*.

ACTIVITY – CREATING AN INVENTORY OF POTENTIAL CONTENT

This Activity will enable you to develop an inventory of all potential content for a new or revised version of the home-based record and to select the final content for inclusion. You can create this inventory by reviewing existing content, deciding if it should be kept, removed or modified, and adding any new content that has been proposed.

By having a comprehensive inventory of all content that could be included in the new version of the home-based record, the core team will be able to reach agreement on what is feasible for inclusion. Using the criteria, as described on p. 44, for this selection Activity should help to bring diverse opinions together to reach a conclusion. It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

This Activity contains a simple tool to create the inventory list, indicating actions that could be taken on each element of the content, along with clear justification for prioritizing this action at this time. There are instructions, a blank template to be completed and an example of a completed template.

INSTRUCTIONS

1. In column 1 of the template, list all existing content (all data to be recorded in the home-based record and all health promotion messages), as well as any new content proposed for addition.
2. For each element of content, specify the action to be taken (and by whom) in column 2.
Options are:
 - to keep the content as it is
 - to modify current content (with a description of how to modify it)
 - to remove existing content
 - to add new content (with a description of what to include).

Identification of proposed content to be modified, added or removed will typically result from new needs in health programmes or will be identified during the situation analysis. For help with the identification process, see **Chapter 3**.

3. Describe in column 3 the reason for taking this action. The reason should be along the following lines:
 - keep – the content is understandable and valued by the three user groups in its current form
 - modify – the current content is not clear to users and is difficult to use
 - remove – the content is included in another instrument; the home-based record is not the appropriate place to include it; the content is not used
 - add – the content relates to new health programme objectives, priorities and national guidelines.

For each content element, reflect on the following questions:

- Information to be recorded – Does it align with what is in the facility-based registries and medical records? How do the data align with the health programme priorities? Is the information sensitive and confidential, and is the home-based record the right document to record this information? (see the criteria for recording information on p. 44).

- Health promotion messages – How does the message align with other educational materials? How does the message align with the health programme priorities? Is the home-based record the best place to communicate this message? Are the health programme’s health objectives covered by this message? (see the criteria for health promotion messages on p. 44).
4. In column 4, include any data or information that support keeping, modifying, removing or adding this content element.
 - This information can come from sources such as routine monitoring, technical reviews or the situation analysis.
 - If you do not have sufficient information to support this rationale, determine how to find or generate it.
 5. In column 5, list the key cost implications for each element of content
 - Can you estimate the number of pages or the space required for each new content element (or the impact on space requirements of any content to be added or deleted), the complexity of printing (i.e. single colour versus multicolour), additional training of health workers that may be needed to use the content effectively or any other required changes to operational support processes?
 - If the inclusion of the content will increase the cost of producing the home-based record, has funding been secured?
 - Costing goes beyond printing, distribution and stock management; it includes training, stakeholder engagement, provision of equipment and other logistics, forecasting demand and budgeting for needed supply.
 6. How will the use of this content be monitored? Does it fit within current monitoring processes, or will new activities be required? Record observations, questions and concerns in column 6.
 7. The core team should assign each content element to high, medium or low priority. This does not refer to the value of the content itself but is a prioritization of the effort required to take the necessary action (keep, modify, remove or add), as well as the cost implications. If additional considerations are important in your context, the table can be modified to include them. List the priority for each element of content in column 7.

TEMPLATE: REVIEWING CONTENT ON THE BASIS OF HEALTH PROGRAMME PRIORITIES

1. Content	2. Action to be taken: • Keep • Modify • Remove • Add	3. Reason for the action	4. Information to support the action	5. Cost implications of the action	6. How to monitor the use of the content	7. Prioritization of the action: • High • Medium • Low

EXAMPLE OF A COMPLETED TEMPLATE: REVIEWING CONTENT BASED ON HEALTH PROGRAMME PRIORITIES

1. Content	2. Action to be taken: <ul style="list-style-type: none"> • <i>Keep</i> • <i>Modify</i> • <i>Remove</i> • <i>Add</i> 	3. Reason for the action	4. Information to support the action	5. Cost implications of the action	6. How to monitor the use of the content	7. Prioritization of the action: <ul style="list-style-type: none"> • <i>High</i> • <i>Medium</i> • <i>Low</i>
<i>Counselling messages on exclusive breastfeeding of newborns aged 0–6 months</i>	Existing content, to be modified to reduce and focus message	To promote the message that all newborns should be exclusively breastfed until 6 months of age; primary users are the women and parents.	Recent DHS data show that 60% of women do not breastfeed their newborns until 6 months of age. However, there are other educational materials that provide in-depth messages and support on breastfeeding; low literacy in some populations is a concern.	Reduce space needed from half a page to a quarter of a page; black and white; text format	As part of the annual review of home-based records, the monitoring team conducts field visits. The team talks to women, parents, caregivers and health workers to assess whether this and other counselling messages are used and understood.	High
<i>Growth monitoring chart for girls aged 0–5 years</i>	Existing content, to be kept despite low usage	The chart is not currently being used correctly or consistently. This might be due to insufficient training; need to increase training of health workers in certain regions of the country.	Data from monitoring visits show that only 30% of health workers fill in the growth charts correctly, which correlates to similar levels of training in those regions.	Maintain six pages; in full colour; chart format	Few questions on the use of growth monitoring charts will be incorporated into the nutrition programme monitoring activities; information on nutrition status is obtained by other surveys or activities.	Low
<i>Vaccination recording fields</i>	Existing content, to be kept	To document a child's vaccination history for school entry, travel, etc.	Supervisory visits found that 95% of vaccination recording fields are filled in correctly.	One page, black and white, table format	DHS includes questions about the use of the vaccination recording fields; additional supervisory visits will verify correct use by health workers.	High
<i>Oral health check-ups for children</i>	Existing content, to be removed	To document a child's oral health visits	Recent exit-survey data indicate that only 10% of oral health check-ups are filled in; 60% of women, parents and caregivers do not bring the record to dental visits.	Half a page, in black and white, table format	Data on correct use by health workers are currently not collected through routine monitoring activities.	High

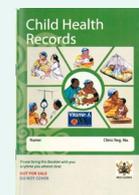
Next steps

Creating this inventory of selected content will take time, but, once complete, it will be of significant value for a pilot test and implementation. The inventory:

- documents agreed content, complete with supporting details of reasoning and potentially with implications for the operational support processes;
- provides the template for selecting which content to test with each user group; and
- can be the primary document for instructing a designer on the purpose and form of required changes (modifying existing content and adding new content).

BOX 8 – THE PROCESS OF SELECTING CONTENT FOR A NEW MCH RECORD BOOK BY THE GHANA HEALTH SERVICE OF THE MINISTRY OF HEALTH

In 2016, two books – one for women and one for children – were combined in **Ghana** into an MCH record book in colour. The MCH record book was developed by the Family Health Division of the Ghana Health Service, under the leadership of the Ministry of Health of Ghana. The content of the MCH record book was informed by a situation analysis, supporting evidence generated by research, and by a shift in policy directions at the time (2).



Several stakeholder consultations and workshops were held to build consensus and buy-in through participatory engagements. A task team was formed with representation from the key implementing government agencies, health and development partners and some civil society organizations, and was consulted at the inception stage with regard to operation or policy gaps. The team was later called on to submit a prioritized list of indicators or data fields and corresponding health messages for women and caregivers to be included in the book. The participatory process made it easier to agree on the content of the record book and contributed to streamlining the book's development process and utilization.

Additionally, the availability of existing data collection tools and reporting forms at service delivery points and in the Ghana HMIS provided criteria for standardizing key data fields for the book.

Special attention was made to include the identification and registration number of a woman and a child such as national health insurance or birth registration number to link the book with other existing health and civil registration forms. Lastly, a validation forum for the MCH record book was organized to brief stakeholders on the selected content and to provide justifications for the inclusions and exclusions. Selected content was pretested in 2016, a pilot test was conducted in 2017–2018, and the MCH record book was finalized based on the results.

Reviewing selected content to meet user requirements

Once you have identified content based on health programme priorities, you can assess how the content meets the needs of the three user groups (women, parents and caregivers; health workers; and programme managers).

User requirements are the specific needs of each user group that must be supported by the home-based record content and design decisions. For example, if there is a high proportion of women, parents and caregivers with limited reading ability in your country, the home-based record will need to include illustrations and less text.

This section focuses on the two primary user groups of the home-based record: (i) women, parents and

caregivers; and (ii) health workers. The information and processes below can also be applied to define the user requirements for any content elements that programme managers use.

Three categories of user requirements

All users have three requirements that must be met for them to engage with content successfully:

1. Do they **understand** the content?
2. Do they find the content **useful** (or valuable)?
3. Are they able to **use** the content to improve health?

These are often referred to as the Three U's. **Table 1** shows the relationship between these three categories.

TABLE 1. THE THREE U'S

Understandable (cognitive processing)	Useful (value judgement)	Usable (ability, environmental factors)
I understand the objective.	I believe the objective is important.	I can achieve the objective successfully.
I understand the information.	The information is useful to me.	I can apply the information.
I understand what to do.	I want to do it.	I can do it.

These three categories of user requirements can be used to assess content, to identify problems to resolve and best practices to build upon, and to start making informed decisions about any immediate or future modifications to the content or design of the home-based record.

Applying user requirements to selection of content for the home-based record

You can use the Three U's to assess current content, to propose modifications or to assess entirely new content. If you identify areas where user requirements are not being met adequately – that is, the user does

not understand the content well, does not find it useful, or is unable to effectively use the content – you can decide on appropriate actions to address the issue. Examples of simple actions you can take to ensure that content meets user requirements include:

- Improve the content to make it more understandable – choose language and images that match user literacy levels; provide a filled-in example of the home-based record to better orient the health worker.
- Increase the users' perceived value of the content – create public promotion materials or messages for health workers to explain to women, parents



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and caregivers at the introduction of a home-based record and hold capacity-building sessions for health workers on how to fill in and use the record.

Note: Sometimes, meeting user requirements is not restricted to changes in content and design of the home-based record but may need changes to operational support processes. For instance, during supervisory visits the health worker can include a simple example of the importance of correctly filling in the home-based record in order to encourage deeper engagement from health workers; or short training sessions might be developed to support community health workers' skills to explain content to women, parents and caregivers during home visits.

- Make the content and design easier to use, and ensure the paper for the home-based record is durable so that women, parents and caregivers can

carry it with them for visits to the health facility.

Provide sufficient space on the record to ensure that information can be filled in legibly so that it can be easily reviewed by other health workers or verified during surveys.

- Health promotion messages can be discussed with each user group separately to find out how each group understands, values and uses the content. These discussions can also help to define requirements for localization of text and illustrations.
- You may not need to assess all the content in the home-based record. Focus on the high-priority items, elements that are known to have poor current use, or new elements for which you have insufficient information to make decisions. Becoming familiar with this process will also develop the core team's ability to think in terms of user requirements, as outlined in **Table 1**.

Once you have assessed user requirements for several content elements in the home-based record (see the **Activity** below), you will start to build a set of user requirements that apply to content and encompass all

the different users, as well as specific user requirements that apply only to some types of content or specific user groups.

ACTIVITY – IDENTIFYING SPECIFIC USER REQUIREMENTS



To help assess the specific user requirements for individual content elements in the home-based record, you can use the list of questions below to assess the prioritized content identified in the previous Activity. It is recommended to review these questions with the core team and to assign someone to take notes on decisions and follow-up actions.

QUESTIONS ON USER REQUIREMENTS

1. **Which group(s) use(s) this content element?**
For content used by more than one user group, you will need to consider user requirements for each group. For example, for the breastfeeding counselling message, you will need to define user requirements for the woman, parent or caregiver and then define the user requirements for communication of the message by health workers.
2. **What is required to make this element more understandable to this user?**
3. **What is required to ensure that this element is useful, and that its purpose is seen as valuable to this user? How does this user understand the connection to her/his health and well-being or to their work?**
4. **What is required to make the content element usable by this user? How will the user recognize a successful outcome from using this content element? Can you define the successful outcome for use of this content element?**
5. **Are there any constraints, such as skills, time or other materials needed, that may affect the user's action?**
6. **Actions to ensure that user requirements are met are not limited to adjusting the content in the home-based record. Are adjustments needed to the operational support processes, such as printing, capacity-building or promotional activities to help meet user requirements?**

Once your proposed content inventory is finalized on the basis of health programme priorities and you have developed the user requirements, you can move on to another chapter, as follows:

- If you are going to revise the content and design elements of the home-based record, move to **Chapter 5**.
- If you would like to make changes to operational support processes, you may want to move to **Chapter 6**.
- If technical needs and user requirements point to the need for improvements in how you monitor the home-based record, move to **Chapter 7**.

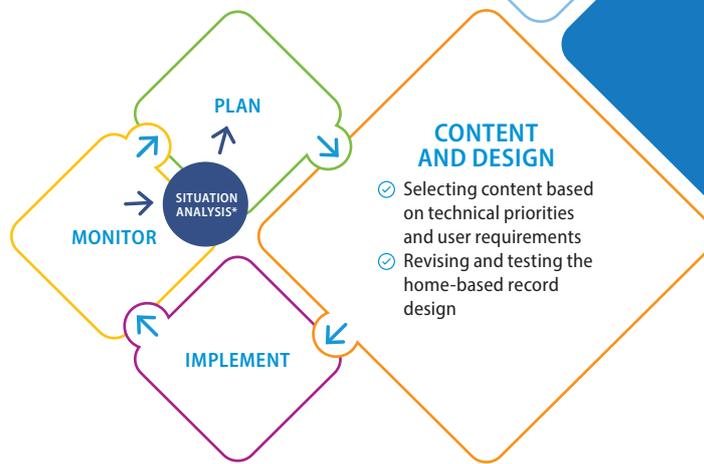
Reflection

This chapter focused on selecting content for the home-based record on the basis of technical priorities and user requirements. After reviewing the information and Activities in this chapter, do you plan to make changes to the process of assessing and selecting content?

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Revising and testing the design of the home-based record



Chapter overview

This chapter reviews steps to revise and test the design of the home-based record, including the content (i.e. health record information and health promotion messages) and the design of the record (i.e. text size, font, images, number of pages, colours, etc.). These steps will be useful if you are creating new content or revising existing content.

In **Chapter 4**, the core team identified prioritized content. Now you will need to work with a designer who will take that content, consider the current format and develop prototypes (an initial design or a redesign) of the home-based record (**Fig. 6**). Prototypes will need to be tested with the three user groups to confirm that they meet all user requirements, and they will need to be reviewed by the core team to make sure that the technical content is correct. These different consultations are key to ensuring that the final version of a home-based record (with new or modified content and design) supports programme objectives and meets the needs of women, parents, caregivers, health workers and programme managers.

The content in this chapter includes:

- considerations for working with the designer;
- testing new or revised content of the home-based record with the three user groups;
- conducting technical reviews of a revised home-based record; and
- addressing issues identified in user-testing and technical reviews.

Considerations for working with the designer

Working with a professional designer when making changes to the home-based record, especially if the changes are substantial, will increase the likelihood of achieving a professional final product.

A designer can propose details such as font size and format, sequences and hierarchies of information, appropriate use of graphics and images, and distribution of space. A designer will collaborate with the core team to specify colour printing versus black and white, the size (A5, A4, etc.) and the style (from card type, to folio, to bookbinding) of the home-based record.

Choosing a designer

- Start with professional designers who are recommended by the ministry of health or other implementing partners based on the quality of their work, their costs and their timeliness.
- Contact the ministry's health education/promotion department, which is normally responsible for developing educational and communication materials. That department may have extensive knowledge of the design process and is likely to have contact with local designers. If you have someone from the health education/promotion department on the core team, ask that person for advice.

- Ask the potential designer to show examples of previous work relevant to the home-based record – such as design experience in graphics, testing materials with low-literacy audiences, and combining information, data and communication skills.

Supervising a designer

Provide direction to the designer to ensure that she/he understands the user requirements, programme objectives, technical requirements and budget.

- Share information with the designer about the three user groups and known usage problems. It may be useful for the designer to join technical reviews or testing with users in order to listen and better understand the needs (**Box 9**).
- For images and illustrations, it may be best for the designer to look at photographs of user groups, including women, parents, caregivers and health workers, to make sure she/he understands the target audience, can represent them in images and correctly capture technical details (e.g. the correct breastfeeding position).
- Quality assurance of the designer's work will be important and should be linked to specifications defined in the programmes' technical needs and user requirements.

BOX 9 – WHEN THE MINISTRY OF HEALTH OF MADAGASCAR REDESIGNED ITS HOME-BASED RECORD, THE TEAM WORKED WITH A DESIGNER DURING THE INITIAL REDESIGN PHASE

During the redesign process, the Ministry of Health of **Madagascar** expanded the country's immunization card to an integrated booklet to enhance the home-based record as a communication tool between community health workers and caregivers and to strengthen its use as a record that documents vaccinations and other child health services.

The initial designs of the home-based record were reviewed by health workers, women, parents, caregivers and community representatives, who shared their feedback. In collaboration with the designer and the Information, Education and Communication Taskforce, the findings were reviewed, and revisions were made accordingly. To find the right design and ensure that the home-based record was easily understandable, the testing included two or more different versions of each design.

After testing the final design, relevant stakeholders had to agree on a time frame for the transition from the old version of the home-based record to an integrated booklet. The transition took 2–3 years, as it was important to allow enough time to inform users about the changes and ensure proper stock management and availability of the integrated booklet (1).



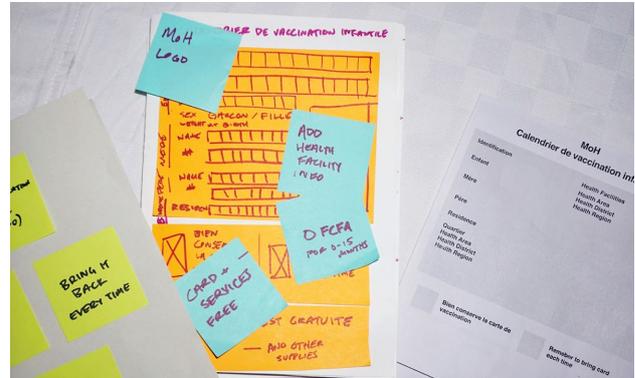
Using design prototypes

Programmes’ technical needs and the identified user requirements for the three user groups will form the design specifications for a revision to the home-based record. You have already developed both inputs if you have completed the Activities in **Chapter 4**.

A designer will start by specifying how the user requirements and programme needs will be translated into an initial prototype – a tangible mock-up or first draft of what the final home-based record could look like – for review and testing. A prototype (**Fig. 6**) may start as a hand sketch on paper to describe visually what has been defined in the review and prioritization of content for the health programmes and user requirements.

On the basis of feedback from testing with users and reviews by the core team, the designer will revise the prototype to solve identified issues and will continue to refine the overall document. Over the course of the process, the prototype will become more refined until you reach a final version that can be prepared as a digital file ready for printing. **Box 10** and **Box 11** show examples of home-based record prototypes in Nigeria and Uganda, respectively.

FIG. 6. EARLY PROTOTYPE OF A HOME-BASED RECORD

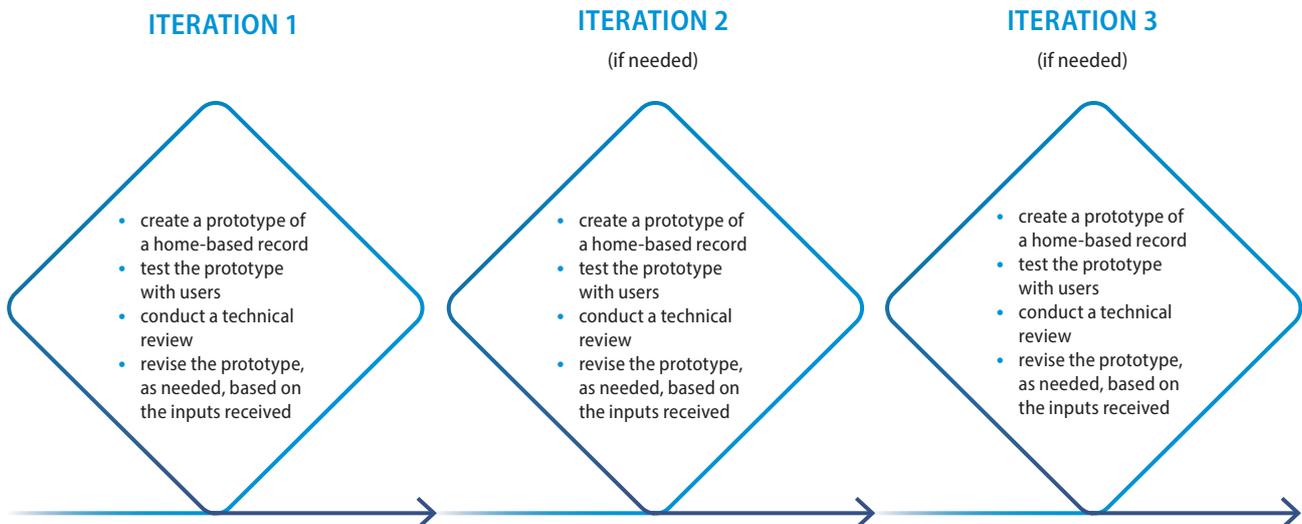


Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

Prototyping, testing with users and technical review

Depending on the magnitude of changes to the home-based record, you will generally follow this cycle of activities: create a prototype, test the prototype with users, do a technical review, and then revise the prototype, as needed, based on the input from the technical review and user inputs (**Fig. 7**).

FIG. 7. TESTING OF A HOME-BASED RECORD



Simple changes to a home-based record may require a single round of prototyping, testing with users, and a final technical review to close the design phase before moving to implementation. More significant changes, such as adding new MNCH areas to the home-based record (particularly if they will add to page length), or revising images or formats, may require

two or three iterative reviews and rounds of testing. You can confidently move to implementation only after you have solved all problems, gained sufficient understanding of how users interact with new elements, verified with the technical programme that the content is correct and finalized the design.



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Further resources on this topic

WHO *Practical guide for the design, use and promotion of home-based records in immunization programmes* provides detailed design elements not addressed in the present guide (Fig. 8) (2). Although focused on immunization, this practical guide is applicable to any home-based record for MNCH.

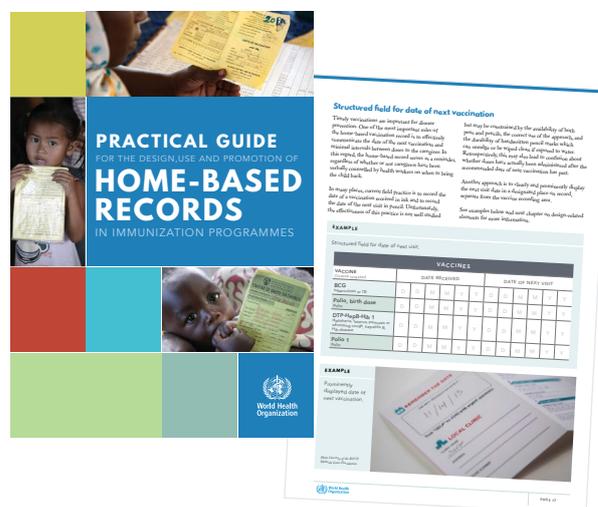
The guide has clear explanations, visual examples and suggestions of preferred design practices. For this chapter, the core team may find the following sections particularly helpful:

- Design for multiple users (p. 9)
- Core content of a home-based vaccination record (p. 13)
- Version control (p. 20)
- Additional design elements to consider (p. 21).

This practical guide may also be useful to help the designer you are working with to understand critical concepts of the purpose, use and design of the home-based record.

JSI guide on *Integrated home-based records: ensuring immunization format and function* (see page 2) provides guidance on the design, format and recording elements of the home-based record (3).

FIG. 8. WHO PRACTICAL GUIDE FOR THE DESIGN, USE AND PROMOTION OF HOME-BASED RECORDS IN IMMUNIZATION PROGRAMMES



Source: WHO, 2015 (2).

BOX 10 – NIGERIA’S HOME-BASED RECORD PROTOTYPE TO ENSURE THAT THE NEEDS OF PARENTS, CAREGIVERS AND HEALTH WORKERS ARE MET

During a BMGF–WHO African Region workshop on revitalization of home-based records in 2017, a team from the Ministry of Health of **Nigeria** developed a home-based record prototype for child health to better meet parents’ and health workers’ needs. The objective was to strengthen retention of the home-based record and to reduce health workers’ workloads.

In a refined version of the prototype almost ready for production, shown here, the outside of the child health card was revised to include information directed at parents – such as the vaccination schedule, date of next vaccination visit, illustrations and educational messages about childcare (**Fig. 9**). These changes were in response to user feedback from many parents who did not understand the need to retain the home-based record, as well as a higher-than-expected number who did not fully understand some of the record’s key messages.

The inside of the child health card was also revised to better meet the requirements of health workers to match how they typically interact with parents and children (**Fig. 10**). It allows them to record information more easily about the child’s immunization status and monitor growth.

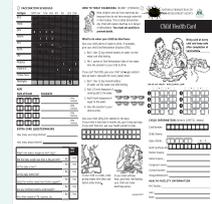
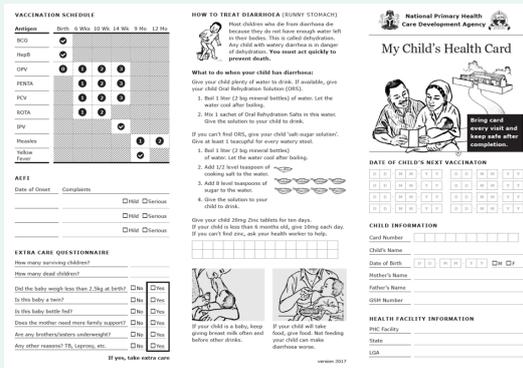


FIG. 9. OUTSIDE OF NIGERIA’S CHILD HEALTH CARD PROTOTYPE



Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

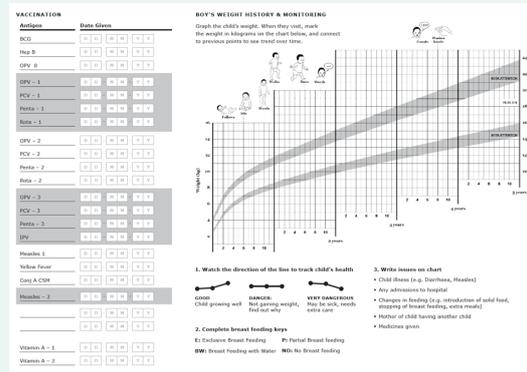
Improving caregiver retention beyond one year

- Added language emphasizing importance of retaining card
- Made it more visually appealing.

Visualized information to support caregiver literacy

- Included illustrations to visualize information
- Increased font size for easier reading.

FIG. 10. INSIDE OF NIGERIA’S CHILD HEALTH CARD PROTOTYPE



Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

User-specific hierarchy

- Structured information flow so that the inside is for health workers and the outside is for caregivers
- Prioritized information for both health workers and caregivers.

Reduced workload of health workers

- Added instruction to complete in capital letters for legibility
- Reduced loss of information with the new fold that avoids recording area
- Removed unused and unnecessary information such as batch number and home address.

BOX 11 – THE TEAM FROM THE MINISTRY OF HEALTH OF UGANDA NEEDED TO ENSURE CONSISTENT CONTENT BETWEEN THE CHILD HEALTH CARD AND THE MCH HANDBOOK

In **Uganda**, two home-based records were being used in 2017. One was a simple child health card and the other a MCH handbook, both of which were expected to be used for the foreseeable future, though their size, format and content were different. During a BMGF–WHO African Region workshop on revitalization of home-based records in 2017, a team from the Ministry of Health of Uganda identified the need to have content that was consistent between the two in order to reduce confusion among health workers and facilitate easier use of the content by all users.



The Ugandan team decided that both home-based records would include a new immunization/core nutrition section that was consistent and could be detached and used independently of the MCH handbook. During the workshop, they developed a home-based record prototype and revised the child health card by creating a tri-fold card that fits into the middle of the MCH handbook but can be removed and works as a stand-alone card (**Fig. 11**). In situations where funding was insufficient to print the entire handbook, they could print the stand-alone card, and the core data would be consistent, and one training course would apply to both versions.

Fig. 11 shows the additional content and design considerations for a home-based record prototype that Uganda’s team developed during the workshop.

FIG. 11. UGANDA’S HOME-BASED RECORD PROTOTYPE

Extended space for vitamin A and deworming.

Size/format
Tri-fold card that fits into the middle of the MCH booklet is removable and works as a stand-alone card.

Vaccination suggested timeline chart (separated from actual date to avoid confusion). Completion stamp and date.

Vaccination administration mode and diagram showing where with icons indicating mouth drop or injectable. Colour-coordinated to vaccine with explanation of its prevention.

Vaccines colour coordinated to show series. Emphasis on each visit required by grouping vaccines with rounded borders.

Date of next visit shown clearly by large column with high contrast and bold lines. Adequate spacing provided for “date given” with divisions for DD MM YYYY.

Child biodata are kept for convenience even when integrated with MCH.

Space for new required vaccines as well as additional campaign or booster vaccines.

Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

Testing new or revised content of the home-based record with the three user groups

You should test proposed changes and content of the home-based record with representatives of all three user groups. By testing the record, the core team will learn whether users understand the revisions in the home-based record, find the revisions useful, and are able to use them.

If the core team has not previously conducted testing with users, you might consider working with an experienced research team or marketing firm to do this (see **Box 12** for an example from Indonesia). If funds are not available, the core team can design and conduct the testing. The health education/promotion department is likely to have experience of testing communication and education materials and may be able to provide support.

Note: Before testing with users, ensure that the core team has signed off on the prototype and has approved the technical content so that you do not test content that will not be used or that you know will change.

Below are considerations relating to methods and procedures, selecting users and conducting tests.

Defining the methods and procedures

Identify how you will test the prototype, create a guide to conduct sessions with users to obtain their feedback, and design instruments to document that feedback.

- Identify key elements to be tested – The prototype will be the object of your testing, but you may have certain text, image or data fields that are more critical to test because of the changes you have made or because of information gathered from the situation analysis (see **Chapter 3**) or from monitoring (see **Chapter 7**).
- Develop a discussion guide – A guide to how you will conduct discussions with users will be important to lay out the objectives of sessions, the key discussion points and how the proposed prototype will be presented to users. The Three U's model introduced in **Chapter 4** (Do users understand the element, do they find it useful, and are they able to use it successfully as intended?) may be helpful in developing the discussion guide.
- Adapt the discussion guide for each of the three user groups – Many of the topics and much of the specific information you need will be different for each group.
- Define the structure of testing sessions – Decide whether to meet with representatives of each user group individually or in group sessions. To determine the most suitable method for your context, the questions on page 8 of the AIDS Control and Prevention (AIDSCAP) guide on *How to conduct effective pretests* may be useful (4).

Selecting users for testing

Decide who to test and how many users to test.

- Test with all three user groups of the home-based record and focus on the Three U's for each user group (Do they understand the element, do they find it useful, and are they able to use it?).
- Identify any specific characteristics of users that help you to categorize the user types into subgroups. This might be done across different regions at subnational level, urban or rural, vulnerable or illiterate/innumerate users, different primary-language speakers or cultural/religious groups.
- Plan how you will interact with each different user type and decide if you will conduct group sessions or one-to-one meetings – both have advantages and disadvantages. It may be beneficial to hold shorter sessions with individuals so that you can probe more deeply into the user's understanding and discuss the barriers they encounter. On the other hand, a group session enables you to hear different opinions and see where there is agreement.
- Decide on how many persons will be included from each user group. Testing with users is a qualitative approach, not a quantitative analysis that needs to be statistically representative. Including greater numbers of users may give you higher confidence, although it will also increase complexity, time and cost.
- If you are meeting individually with users, plan to have at least 10 participants for each subgroup.
- If you are conducting feedback sessions with groups of users rather than individuals, organize at least two groups per characteristic type. Keep the number of participants to a maximum of 8–10 persons for group

discussions to ensure a good dynamic in the group and to allow all users an opportunity to contribute.

- Plan testing with different health workers – i.e. include discussions with health workers engaged in different health areas across MNCH, including facility-based and community-based workers. In the case of programme managers, you might need to include different roles, workflow environments or contexts in which other data-recording instruments are used.

Conducting the test

Once you are ready to gather user feedback, you will be guided by the methods you outlined in the previous section, adapting them to the situations you encounter.

- Define the roles and responsibilities of the testing team – Generally, a team of two persons should do the testing with users, with one leading the discussion and another taking notes. In order to ensure a comfortable environment for participants to express their opinions, it is important to avoid large groups of technical persons participating in the testing.
- Create your format for recording information – The note-taker should also have an instrument or

template to help record users' feedback. This will facilitate subsequent analysis of the notes. Other methods, such as making notes directly on copies of the prototype, capture not only what you hear but also what you see users do and can help to link problem identification directly to sketches of potential improvements.

- Begin sessions with users by presenting the objective of the discussion and introducing the members of the interviewing team and what their roles are – this can help to put the users at ease.
 - The facilitator – someone with facilitation experience – will use the discussion guide to interact directly with the users and elicit their feedback.
 - The note-taker will take notes but will also observe and record any non-verbal reactions they perceive.
 - The designer may wish to participate to better understand the feedback and make notes for her/his own purposes.
- Length of session – Sessions with individuals should last ideally around 30 minutes. If the discussions are in groups, you can plan for 60–90 minutes, and you may need to provide beverages and a snack.

BOX 12 – THE MINISTRY OF HEALTH OF INDONESIA WORKED WITH THE CENTER FOR HEALTH RESEARCH AND JICA TO TEST THE MCH HANDBOOK

Prior to revising the MCH handbook, the Center for Health Research of the University of **Indonesia** conducted a review of the MCH handbook to obtain feedback from diverse informants in order to enhance the effectiveness and efficacy of the handbook and to ensure that the revised version would be relevant nationally. The research team held focus group discussions with health workers, pregnant women, and mothers of infants and of children under 5 years of age, as well as key informant interviews with programme managers at district and provincial levels. Data were collected in three urban and three rural health facilities in six provinces across multiple islands of Indonesia. Informants identified several technical and design elements that needed to be revised before the handbook could be finalized. Some of these included revisions to the handbook's cover, improvements to data-recording fields (such as multiple-choice answers and space for open answers to make it more practical for health workers), and clearer explanations of abbreviations so that mothers could better understand the promotional messages. After the testing was completed, the research team compiled a report with its findings and made recommendations for the core team to consider in making final changes to the handbook (Center for Health Research University of Indonesia. Result of pretest on reediting MCH handbook. Japan International Cooperation Agency; 2009 [unpublished report]).





Further resources on this topic

- WHO *Practical guide for the design, use and promotion of home-based records in immunization programmes* (see pages 10–11) provides information on the importance of testing the home-based record and issues that may be addressed during focus group discussions with caregivers and health workers (2).
- AIDSCAP has a project guide – *How to conduct effective pretests: ensuring meaningful BCC messages and materials*. Although this resource focuses on HIV/AIDS, it provides detailed guidance on how to conduct testing of educational materials. The following might be particularly useful:
 - Page 8 includes an overview of different methods, including considerations when to choose one over the other.
 - Pages 17–19 give advice on how to prepare for testing.
 - Pages 21–29 explain how to lead focus group discussions, how to design a focus group discussion guide and how to use the focus group discussion analysis templates.
 - Pages 31–37 provide guidance on holding individual interviews (4).
- The Ministry of Health of Zambia has developed *Guidelines for pretesting and evaluating communication materials* (see pages 3–5). These include guidance on testing, including sample questions for interviews or focus group discussions to review print materials with users (5).
- The World Food Programme has a guidance manual on *Social and behaviour change communication*:
 - Pages 67–69 provide an overview and recommendations for the main steps in the testing process, including stakeholder meetings, receiving qualitative feedback and revising the materials.
 - Pages 76–79 contain sample guides for semi-structured interviews and focus group discussions to test social and behaviour change communication messages and images related to nutrition (6). These same processes can be adapted for testing the health promotion images and messages in a home-based record.
- The Centers for Medicare and Medicaid Services has *Toolkit Part 6: Feedback sessions*, which includes step-by-step guidance on how to gather and utilize feedback to revise and enhance materials that have been tested (7).

Conducting technical reviews of a revised home-based record

After the designer has created the first prototype of the home-based record, the core team should make sure that each health programme that has content in the home-based record and potentially other stakeholders review and approve the material before user-testing. The initial technical review is also a good opportunity to align key elements of the testing plan. Representatives of the health programmes may be able to highlight areas to prioritize in the discussion guides.

Once the results of the testing have been analysed and you are able to propose changes to the home-based record, discuss these with the core team to ensure that the proposed content is technically correct and supports defined objectives and programme priorities.

- The final technical review is an important step in finalizing the design of the home-based record. The review is an opportunity to make sure that everyone agrees with all changes. The designer can finish the visual design after reviews are completed.
- Reviews can be held in person, and through virtual meetings, so that everyone has the same understanding of the content and design and they can share feedback in real time.
- Although you are asking for a review of the technical aspects, colleagues will also have opinions on colour, images or phrasing. You will need to weigh these opinions with the users' preferences and the designer's expertise.
- The technical review can be used to reach agreement on related issues such as elements that can affect costs (i.e. two-colour versus full-colour) or printing issues. Each programme should understand these costs and should support sustainable funding of the content they wish to include.
- Beyond cost, you need to make information-based decisions that meet technical programme needs as well as the Three U's for all three user groups of the home-based record.

Addressing issues identified in user-testing and technical reviews

During the process of user-testing and technical review, the core team will receive many different inputs. Collecting this information is usually straightforward, but you need a clear plan for organizing and making sense of what you have learned and for transforming the feedback into direct actions that will improve the home-based record. This is qualitative analysis; sometimes the key learning will be from a response repeated by a majority, but many times a single person says something that illuminates the issue and suggests a solution that will work for all.

You may already have your own ideas on how to structure the content to prioritize user insights most efficiently. If not, the following may be a good starting point for creating a template for organizing feedback.

1. Start by grouping the feedback by each element tested. If there is feedback that relates to more than one element, you can create a “general” category with implications about design or content revisions for the multiple sections or elements of the prototype.
2. Structure the feedback around each element for each user group that tested that element and provided feedback you feel is important. Start with feedback from women, parents and caregivers, then deal with health workers’ feedback and finally with programme managers’ feedback.
3. Organize the feedback for each user group across the Three U’s user requirements (see **Chapter 4**):
 - **Understanding the purpose or meaning of an element:**
 - feedback about how the language, images and layout help user understanding
 - feedback about barriers to the user’s understanding.
 - **Usefulness** of an element, ability to see how it relates to the user’s life, or a clear recognition of its value:
 - feedback about how the element conveys usefulness and value
 - feedback about barriers to the user’s perception of the usefulness or value of the element.

- **Usability of the content to take action to improve health:**
 - feedback about ease of use of this element
 - feedback about barriers to using the element (e.g. unclear content, user’s own limitations, environmental factors).
4. Start simply with very practical issues such as which images women, parents and caregivers liked and could understand. Then progress to how the elements of the prototype help or hinder interactions between a woman, parent or caregiver and a health worker. Finally, address more complex issues such as family interactions triggered by the home-based record. For health workers, a similar progression might begin with how they fill in a data record, when and how they refer to previously recorded data or health promotion messages, and finally how they interact with colleagues and managers regarding the home-based record.
 5. List all potential revisions to individual elements in the next prototype, and any broader implications for the prototype’s content and design. These potential revisions should include ways to address problems that were identified in understanding, usefulness and usability, and should build on identified strengths.
 6. Finally, consider implications of the feedback for operational support processes, programme goals and technical correctness.

On the basis of the feedback from users during the pretesting, you should be able to identify potential solutions to user requirements, as illustrated in **Table 2**.

TABLE 2. COLLABORATING WITH USERS TO GENERATE POTENTIAL SOLUTIONS FOR USER REQUIREMENT ISSUES

Issue	User group	Potential solutions
Explanatory text is too technical.	Women, parents, caregivers	Explain what is intended to the participants and ask how they might explain it to friends. Revise on the basis of the type of the language they use.
Images are not culturally appropriate.	Women, parents, caregivers	Confirm what specifically is considered inappropriate by participants and why. Consult the ministry of health communications guidelines or department to modify images.
Literacy is relatively low, so many people find it difficult to understand the messages.	Women, parents, caregivers Health workers	The record should have a few priority messages, and these should be in pictorial format; health workers can be trained to strengthen counselling skills using the home-based record.
The lines for recording the dates when vaccines were administered are too small to record data legibly and accurately.	Health workers	Ask participants to demonstrate how they record data now and to collaborate with you on the ideal space needed and how it can fit within the page size.



Further resources on this topic

JSI Home-based record redesigns that worked: lessons from Madagascar & Ethiopia (see pages 13–15) includes lessons learned and key recommendations from home-based record redesign processes in the two African countries (1).

Transitioning from design to implementation

Once the final design of the home-based record is available, the core team is ready to implement the home-based record. This can be done through a small-scale pilot test, if needed, or it can be sent directly to be printed, and other activities identified in the plan can take place.

Chapter 6 addresses topics relevant to implementation issues.



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Reflection

This chapter focused on testing the home-based record design with the three user groups and conducting technical reviews to revise and finalize the design of the record. On the basis of the information and Activities that the core team reviewed in this chapter, what changes will you incorporate when you test and revise the home-based record design? Will you contract a designer to work with you?

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CHAPTER 6

Implementing the home-based record



Chapter overview

This chapter focuses on implementation – the operational support processes that ensure a home-based record is available, is valued and is being used correctly. This chapter will be useful if you have a new or revised home-based record and would like to optimize the operational support processes for successful introduction and scale-up, or if you have identified implementation problems through a situation analysis (see **Chapter 3**) or routine monitoring (see **Chapter 7**).

The content of this chapter includes:

- introducing a new or revised home-based record with a pilot test
- addressing common implementation challenges.

The first section of this chapter addresses pilot tests to use if you are introducing a new home-based record or have made considerable changes to an existing one. If you focus on strengthening any of the operational support processes for the home-based record, you can go directly to the section on addressing common issues in implementation.

Introducing a new or revised home-based record – pilot test

Chapter 5 presents information about pretesting with all user groups to verify the content and design using the Three U's. If the core team has developed a new home-based record or has made major revisions, it is necessary to plan how to introduce it and ensure that different users are familiar with the revisions. You may want to start by conducting a pilot test (an initial implementation on a small scale across a limited number of facilities or a limited geographical area).

Introducing a new or revised home-based record at a small scale enables the core team to learn about the operational support processes – what works and what does not work – and whether any changes need to be made, as well as any final content or design elements that should be adjusted prior to scale-up (by expanding implementation to other areas in the country).

The **Activity** (see p. 66) can help you identify details for planning the pilot test.

ACTIVITY – SETTING THE OBJECTIVES AND SCOPE OF THE PILOT TEST

This Activity will help you determine what you want to achieve in a pilot test and what you need to test to achieve it. If you are not sure whether you are ready to set the objectives and scope of the pilot test, read the next section on addressing common issues in implementation, which may help you to think through potential issues across operational support processes.

It is recommended to review the following questions with the core team and to assign someone to take notes on decisions and follow-up actions.

QUESTIONS

1. **What are the concerns about implementation you want to address?**
2. **What are the objectives of the pilot test?**
3. **How much funding is available for the pilot test and are there sufficient funds to cover the costs of the different activities in the test?**
4. **Which districts or facilities will you include in the pilot test?**
5. **For how long and when will you conduct the pilot test?**
6. **How many copies of home-based records will you print for the pilot test, and how will you print them?**
7. **How will the home-based records be distributed and where will they be stored during the pilot test?**
8. **How will you address the introduction of the newer version to avoid confusion with the existing version of the home-based record?**
9. **How will you orient all three user groups on the new or revised home-based record and on its use?**
10. **Who will be on the team for the pilot test? What is each member's role and responsibilities? How often will you meet to discuss progress and difficulties in conducting the pilot test?**
11. **How will you monitor the activities of the pilot test? What data or information will be collected to determine if the home-based record is being used correctly and if the operational support processes work? How will you document learnings during the pilot test?**
12. **How will you scale up after the pilot test?**

You and the core team will need to share the results and what you have learned from the pilot test with key stakeholders. Together you can identify good practices and implementation challenges and how to address them before scaling up the home-based record. You may decide to continue working in the area of the pilot test, testing the solutions you propose until you have developed functioning processes that you would use for scale-up.

Monitoring the pilot test

Monitoring conducted during the pilot test is shorter in duration and more intensive than systematic, routine monitoring and supportive supervision, which is discussed in the next chapter. If you would like to have additional support on preparing a monitoring plan for a pilot test, see **Chapter 7**, where much of the

content can be applied to help frame the monitoring of a pilot test. Conversely, experience from monitoring during the pilot test can be applied to strengthening routine monitoring. **Box 13** describes an example from Afghanistan of monitoring visits during the pilot test of their new MCH handbook.

BOX 13 – MONITORING VISITS DURING A PILOT TEST OF THE NEW MCH HANDBOOK IN AFGHANISTAN

In 2015, the Ministry of Public Health of **Afghanistan** established a technical working group to design and develop an MCH handbook. Afghanistan previously had multiple types of home-based records: an antenatal care appointment card, a maternal tetanus vaccination card, a child vaccination card, a birth notification registration card, a family planning card and growth monitoring cards. These were combined into one MCH handbook (1).



The new MCH handbook was pilot tested in eight health facilities in two districts from August 2017 to June 2018. During the pilot test, midwives, vaccinators and nutritionists distributed the MCH handbooks in facilities at sessions with service users. A total of 12 monitoring visits were conducted in health facilities of the two pilot districts – one district hospital with a high patient load and basic health clinics in these districts. The monitoring visits were conducted by the project team and the provincial Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) officials. Staff from the RMNCAH, EPI and nutrition departments, JICA, UNICEF and WHO participated. At least one joint monitoring visit was conducted in each district.

After each monitoring mission, the results of the visit were discussed in the technical working group. Training sessions were held at the beginning of the pilot test and refresher training took place during the test.

The results from the pilot test informed the changes made to the prototype of the MCH handbook and an operational manual that was to be scaled up and used in all provinces.

After the pilot test

Once you have completed the pilot test, you can scale up implementation and use of the new home-based record in any way that best suits your country and context. For example, you can slowly expand the home-based record region by region or roll it out nationally. The choice of roll-out will be influenced by what needs to be in place for a successful transition to the new home-based record. Using the experience and outcomes of the pilot test, you can do the following:

- Identify any specific user groups' needs that you know will require continued monitoring in order to avoid gaps in understanding, valuation or usability of the content.
- Prioritize strengthening of the operational support processes to provide a strong foundation for scale-up with capacity-building, awareness and promotion, sufficient printing, and proper distribution and stock management.
- Apply insights from the pilot test to revise your monitoring strategy and design the routine methods and schedules for data collection so that you can test and refine the approach from the start of scale-up.

Key aspects of routine implementation that also need to be considered during the scale-up phase are examined in the following section.



Further resources on this topic

- **WHO Regional Office for Europe** *Scaling up projects and initiatives for better health: from concepts to practice for tools and advice to scale up public health activities (2).*
- **WHO** *Practical guidance for scaling up health service innovations (3).*

Addressing common implementation challenges

You may have already identified implementation issues and operational support processes that need to be strengthened in your country based on the situation analysis (see **Chapter 3**) or routine monitoring (see **Chapter 7**). To strengthen home-based record implementation, you will need to reflect on six categories of operational processes (4), namely:

- budgeting and financing
- printing
- distribution and stock management
- capacity-building and supportive supervision
- building awareness and promoting use
- coordination across health programmes.

Some common issues for each category are dealt with below. If implementation issues are identified, the **Activity** on defining specific actions for operational support processes (see p. 75) might help the core team to define specifications for the operational support processes that will strengthen implementation of the home-based record.

Budgeting and financing

Securing sustainable financing is fundamental, not only for the design of the home-based record and the first year of printing, but for printing and distribution over recurring 3–4-year periods. Funding should also cover other operational support processes, including capacity-building and supportive supervision, activities to increase awareness, and monitoring.

- A best practice is to review the budget allocated for printing and distribution of home-based records versus estimated operating costs for the next 3–4-year periods. If the estimated costs exceed the budget, you will need to explore alternative ways to secure funding. If you have not done so already, the core team might want to review the **Activity** on estimating home-based record costs to create a budget (see p. 20).
- For sustainability, funding should ideally be provided by the ministry of health and other government agencies. Different health programmes with technical content in the home-based record should contribute to funding over the long term (i.e. beyond one year or a time-limited commitment).

Collaborations may be set up with NGOs, professional associations and the private health sector to contribute to funding.

- When discussing public–private partnerships, remember that responsible advertising can bring valuable revenues but sponsorship, such as advertisements in the home-based record, may present conflicts of interest and potential harm (e.g. allowing advertisements for formula milk or political parties) (5).
- If current funding is heavily reliant on an external donor, a gradual transition to national funding is highly desirable to maintain predictable levels of funding for all steps, including design, printing and the different operational support processes.

Printing

Costs for printing can vary widely according to the size of the home-based record, the number of pages, colour printing (if available) versus black and white, durable materials such as tear-resistant or waterproof paper, and the quantity to be printed. Stitching, stapling, gluing, protective plastic covers for the rainy season, or non-standard folding can have an impact on printing costs and feasibility. It is important to work with the designer to decide the print specifications, consider trade-offs, and ascertain how many you need to print in order to get a realistic unit price. To ensure quality control and use of the official and most recent version, files for printing should be obtained from the ministry of health.

- Calculations are needed to estimate the total numbers of pregnant women, mothers, newborns and infants, and to take into consideration miscarriages, stillbirths, multiple births, projected deaths and any other factors that will affect the total number of printed home-based records required each year. It is important to include a small buffer in case more home-based records need to be distributed than expected (e.g. if there are large mobile and/or internally displaced populations, or if many women, parents and caregivers misplace, lose or damage the home-based record). An example of how the Ministry of Health of Indonesia calculates the required number of MCH handbooks, including a 10% buffer, is available in their *Management guidebook for the application of the MCH handbook* (see page 11) (6).

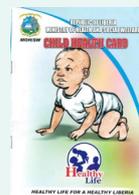
- Rural and remote regions and large transient groups will make it more difficult to estimate numbers accurately. Planning for quantity should include district health management teams using population and birth data.
- If you are printing during the roll-out of a new home-based record, it is important to consider the duration of the transition phase from the old home-based record to the new one, the eligibility criteria for distribution to women, parents and caregivers, and whether there will be a need to transcribe information from the old home-based records to the new ones. This is likely to affect forecasting of the quantities needed.
- The choice of a printing company should be based on a positive reference based on previous work with the ministry of health or a partner organization. The health education/promotion department may be able to give you recommendations. Your designer may have professional insight that can help you to select an appropriate printer. Prior to starting the mass print run, a printing proof should be delivered for the core team to review and approve (see **Box 14** for an example from Liberia). The designer should also review the printing proof to identify any design issues that may need to be remedied.
- Home-based records must avoid low-quality printing – due to poor-quality paper, poor printing technology, limited local printing services (e.g. at subnational levels) or poor quality control at the printing facility. The printer selected should be using modern printing technologies and have the in-house capability to deliver the home-based record in accordance with the printing specifications. Depending on the specifications, you may find that only a few printers in major cities are able to deliver the quality you require. Limitations in subnational capability to print the home-based record may mean that centralized printing is necessary, with delivery of the printed materials to all regions in the country (which will also have associated costs of distribution and stock management).
- Individual health facilities, the private health sector, NGOs or professional organizations may also have funds to print the home-based record. It is important to ensure that they request the authorized final printing files. Sometimes home-based records will be reproduced without authorization or content will be removed without stakeholder consensus. You will need to identify ways to manage these situations if they arise.



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BOX 14 – THE MINISTRY OF HEALTH OF LIBERIA CALLS FOR BIDS FROM VENDORS

During a BMGF–WHO African Region workshop on revitalization of home-based records in 2017, it was reported that in **Liberia** the EPI logistics working group calculates and forecasts the number of records needed. The Ministry of Health then requests bids from printing vendors. After the bidding process is completed, the team from the Ministry of Health selects the bidder who will receive the contract. This decision is based on multiple criteria, including cost, expertise of the contractor and quality of previous work. Sample copies are printed and reviewed by the team prior to mass printing.



Source: BMGF–WHO African Region home-based records revitalization workshop, 2017 (unpublished report).

**Further resources on this topic**

JSI HBR guide for frontline health workers (see pages 8–9) includes information on how to calculate the number of home-based records required (7).

Distribution and stock management

Data from the WHO–UNICEF Joint Reporting Form on Immunization indicated that supply chains of home-based records are often poorly monitored, with many countries lacking information on home-based record stock-outs at the national level (8).

- In many settings, different supply chain systems exist, operating independently of each other. Home-based records can be integrated into existing health system supply and distribution chains used for vaccines, medicines and other essential health commodities. For example, in Ghana the MCH record book is integrated into the commodity stock list and managed on the Ghana Logistic Management Information System platform.
- Storage locations for home-based records need to take into consideration some practical concerns – such as security, protection from water leakage, insect damage – as well as to ensure that the home-based records are stacked in ways that do not damage them while in storage.
- There needs to be a reliable, low-cost mechanism to enable that sufficient quantities of home-based records are distributed from storage facilities to distribution locations to ensure that health workers have supplies when they need them.
- If multiple health workers (i.e. midwives, vaccinators, community health workers) distribute home-based records to women, parents and caregivers, there is a risk of issuing more than one home-based record to the same person. In Afghanistan, measures to prevent duplication were taken by increasing coordination between different health programmes and health workers at facility level. Existing facility ledgers or registries can also be used to note who has already received the home-based record.
- Distribution is not complete until the home-based record is in the hands of the woman, parent or caregiver.



Further resources on this topic

- **JSI Stock management for home-based records: ensuring timely availability for every person/child (see page 2) provides best practices on stock management for the home-based record (9).**
- **JSI HBR guide for frontline health workers (see pages 8–9) includes information on how to calculate the number of home-based records required in order to restock and how to monitor stock levels (7).**

Capacity-building and supportive supervision

There are many reasons why health workers do not correctly fill in a home-based record or properly explain health promotion messages in a home-based record. Health workers may have limited time available, they have competing priorities, and, as there is often a high turn-over of health workers, the new health workers may not have received training on how to fill it in. Ideally, training sessions followed by supportive supervision should strengthen health workers' skills in using the home-based record.

- The capacity of health workers can be built through in-service training, workshops, technical handbooks, quick-review sheets or supportive supervision visits. In-service training does not necessarily have to take place in isolation but can be added to related training opportunities.
- The use of the home-based record can be further strengthened by including content in pre-service professional training and as a prerequisite for accreditation to a professional body. In Angola, the human resources department and nursing educational institutions are key stakeholders in efforts to facilitate the integration of home-based record content into professional opportunities.
- Several countries (e.g. Cambodia, Ghana, India, Indonesia, Lao People's Democratic Republic), some with support from JICA, have developed an MCH handbook users' guide to increase health workers' capacity to use the MCH handbook. Effective use

is defined as: (i) accurate data-recording; (ii) correct clinical assessment based on the recorded data and referral; and (iii) health education for pregnant women, parents, caregivers and other family members. For each page of the MCH handbook, the guide explains how the data need to be recorded and includes tips for health workers related to health promotion messages.

- In addition, the use of job aids for health workers can facilitate the appropriate use of the home-based record. Flipcharts designed for use in health facilities and/or communities can be used in conjunction with the home-based record to communicate health messages.
- Health workers should also be trained to use the home-based record as a tracking and reporting tool. For instance, in Indonesia the MCH handbook is used to track children who are due for vaccinations, to validate their immunization status during health facility visits, and to complete their missed vaccination status. The JSI guide *Data triangulation: use of health facility immunization reporting tools* describes how the different tracking and reporting tools link together and can be used for local decision-making (10).
- It is necessary to plan who will conduct supportive supervision on the use of home-based records and how it may be integrated into MNCH, immunization or nutrition programme supervision activities and budgets.
- During training sessions or supportive supervision, you can discuss with health workers the problems they face and how to overcome them. Health workers in either activity may raise other concerns about operational support processes. Supervisors can bring these to the attention of programme management. The supervisor can also facilitate the sharing of good practices between health workers and different implementation sites. Supervisors, facility managers or trainers also need to be oriented as to the appropriate use of the home-based record.
- It can be helpful to create a capacity-building strategy (see **Activity** on p. 72) that details all training activities, including supportive supervision and refresher training.

ACTIVITY – DEVELOPING A STRATEGY FOR CAPACITY-BUILDING



This Activity provides a simple process to prioritize efforts to strengthen health workers' capacities to use the home-based record.

It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

INSTRUCTIONS

1. Identify each type of health worker who will require support with capacity-building.
2. Identify specific needs that health workers may have regarding the home-based record.
3. Define the specific capacities that each type of health worker needs to strengthen.
4. Support capacity-building for each type of health worker to balance:
 - the time, effort and cost to create and deploy the capacity-building sessions;
 - the time and attention required by health workers to participate in training and apply it effectively;
 - flexibility of methods (such as rapid roll-out to large groups, introduced by a supervisor through daily work, delivered to individuals or even self-taught through video or other training materials); and
 - the learner's ability to internalize the training (e.g. relevant examples, trying out what they have learned, periodically checking their new skills).



Further resources on this topic

- Ministry of Health and Family Welfare, India. *Guidebook for mother-child protection card 2018 for auxiliary nurse midwife, accredited social health activist and anganwadi worker* (11).
- Ministry of Health, Cambodia. *Technical guideline for using the maternal and child health educational handbook* (12).
- Department of Health Regional Office 8, Philippines. *Handbook for community health teams* (see pages 16–19) (13).
- JSI HBR *guide for frontline health workers* (see pages 12–24) includes different materials, such as job aids, posters, and guidelines for frontline health workers to learn how to use home-based records during immunization sessions and learn about their importance (used in the Democratic Republic of the Congo, Nepal and Zimbabwe) (7).
- Ministry of Health, Indonesia. Orientation package, including *Participants' guidebook, Facilitator's notebook* and *Workplace assessment post-orientation on the use of the MCH handbook to evaluate knowledge, skills, and behaviours after the orientation* (14–16). The package was developed to orient MCH health workers on how to use the MCH handbook and can be adapted.
- Department of Health Regional Office 8, Philippines. *Checklist for supportive supervision* (see the annex 3 on supportive supervision tools and the checklist 4 on client satisfaction and mother and child book). This includes questions on the mother and child book and maternal record, including assessing whether the woman brought the record with her, whether what is recorded in the record is satisfactory and the birth and emergency plan is filled in, and whether the content of the record was discussed with her (17).

Building awareness and promoting use

You may need a strategy to ensure that users and stakeholders are aware of the home-based record, its purpose, how to use it, and why it is valuable to them (see **Activity** on p. 74).

- Women, parents and caregivers should be oriented to the home-based record starting from when they receive it for the first time. They should be aware of the value of reviewing and retaining it, and the need to bring it to every health visit.
- Every health worker also needs to be aware of the value of the home-based record and the importance of using it correctly. Health workers should remind women, parents and caregivers to bring the home-based record to all health visits. Health promotion sessions in some countries are used as an opportunity to discuss the value of the home-based record with different community members. **Box 15** includes an example from Indonesia, where the MCH handbook was used to guide mother classes for women, parents and caregivers, with the assistance of health workers, to increase birth preparedness.
- In some countries, school entry screening requires proof of vaccination completion. In other countries, such as Burundi, home-based records are used for official registration of a child's birth. These measures may increase the legitimacy and value of the home-based record.
- Health workers (including community health workers and volunteers, as well as facility managers) should be aware of any changes that were made to the home-based record. They may not always recognize the importance of the home-based record. To

build awareness of health workers in both public and private sectors, it will be useful to engage professional associations. In 2018, the World Medical Association (WMA) issued a statement on the development and promotion of the MCH handbook, including recommendations for constituent member associations (18). Universities and pre-service training programmes for health workers should also be informed. In Afghanistan the Midwifery Association took an important role in the capacity-building of health workers from the pilot phase to the scale-up phase. The Indonesian Midwifery Association included the use of the MCH handbook as a part of standard clinical care procedure for its members working in both public and private sectors.

- All stakeholders – including MNCH programmes, HMIS, NGOs, private sector providers and professional associations – need to be familiar with the home-based record, any revisions to it and the implications of those changes.
- The core team can engage with and leverage community leaders who can help convey messages on the importance of home-based records to specific audiences. In Senegal, an orientation guide was developed to educate religious leaders about the MCH handbook so that they are able to raise awareness among the population on the benefits of the home-based record. Recommendations on how and why to engage community leaders such as community health workers can be reviewed in JSI *HBR guide for frontline health workers* (see pages 9–10) (7).

ACTIVITY – DEVELOPING A STRATEGY TO BUILD AWARENESS AND PROMOTE USE



This Activity provides a simple process to prioritize awareness-building and promotional activities.

It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

INSTRUCTIONS

1. Identify the audiences you want to reach.
2. For each audience, define its role with the home-based record. Is the audience one of the core users of the home-based record? Is the audience a stakeholder, such as an NGO or a professional association? Or is the audience an influencer such as a community leader?
3. How does the home-based record have an impact on the audiences? What do they need to know and do? What message do you want to convey to them or through them?
4. Where and through which channels will you reach the audiences?

BOX 15 – THE MCH HANDBOOK IS USED TO GUIDE MOTHER CLASSES FOR BIRTH PREPAREDNESS IN INDONESIA

In 2004, a survey in **Indonesia** found that the MCH handbook was not read by mothers but had the potential to strengthen interactions between women, parents, caregivers and health workers. In response, a group learning activity called “mother class” was established in West Sumatra Province. Some districts in different geographical areas, such as a district in West Nusa Tenggara Province, adapted and implemented the mother class. Based on these experiences, the Ministry of Health designed a mother class for birth preparedness. During the class, the MCH handbook was used as the key reference, and its content was reviewed and discussed among participants (19). Participants included pregnant women who were 20–32 weeks pregnant, and occasionally their husbands or family members. The classes were facilitated by midwives or other health workers who were trained as facilitators (20). A report in 2008 found positive MCH care practices among the attendees of the classes. Based on this experience, Indonesia decided to scale up mother classes with the MCH handbook to other parts of the country (21).



Coordination across health programmes

As there is often a lack of coordination across different health programmes, it is important to cooperate and coordinate regularly with all health programmes that have content in the home-based record – such as MNCH programmes, immunization, nutrition, health promotion, etc. – to strengthen implementation.

- Operational support processes may happen at different levels of the health system, so it is

important to make sure you collaborate with stakeholders at different levels, as needed.

- Programme managers may need to strengthen their own skills and the skills of the core team to work effectively across programmes in order to plan and implement processes related to the home-based record that require cross-programme coordination. Capacity-building activities may be required to build those skills.

ACTIVITY – DEFINE SPECIFIC ACTIONS FOR OPERATIONAL SUPPORT PROCESSES



This Activity is intended help the core team to define specific actions that should be taken to strengthen the operational support processes. There is always a balance between what can be done, what is feasible in the short term, what is sustainable, and what provides immediate improvement in the performance of the home-based record. It is recommended to review these instructions with the core team and to assign someone to take notes on decisions and follow-up actions.

This Activity contains a simple tool to consider each area of operational support and the existing enablers and barriers to their optimal performance. Instructions, a blank template to fill in and an example of a completed template are provided.

INSTRUCTIONS

1. Review the list of operational support processes provided in column 1 of the template. Remove, add or adjust the elements to fit your context.
2. Review the data you have for each of the operational support processes. Which elements need to be strengthened to ensure availability and correct use of the home-based record? Describe what these changes entail, how you plan to make the changes and what their implications may be. Record this information in column 2.
3. In column 3, prioritize the changes to be made based on the impact of the action and the feasibility of implementing this change successfully (1 = high priority, 2 = medium priority, 3 = low priority).
4. Identify potential enablers that you can leverage to enact these changes. Describe each enabler separately. As always, do not forget to consider costs and funding needs (column 4).
5. Identify barriers that might prevent successful implementation of these changes. Describe each barrier separately. As always, do not forget to consider costs and funding needs (column 5).
6. In column 6, identify strategies to overcome the barriers you identified. This will ensure user access and correct use of the home-based record.

TEMPLATE: DESIGN SPECIFICATIONS FOR OPERATIONAL SUPPORT PROCESSES

<i>1. Operational support processes</i>	<i>2. Description of change that needs to be made and implications</i>	<i>3. Priority</i>	<i>4. Potential enablers</i>	<i>5. Potential barriers</i>	<i>6. Strategy to overcome barrier</i>
<i>Budgeting and financing</i>					
<i>Printing</i>					
<i>Distribution and stock management</i>					
<i>Capacity-building and supportive supervision</i>					
<i>Building awareness and promoting use</i>					
<i>Coordination across health programmes</i>					



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EXAMPLE OF A COMPLETED TEMPLATE: DESIGN SPECIFICATIONS FOR OPERATIONAL SUPPORT PROCESSES

<i>1. Operational support processes</i>	<i>2. Description of change that needs to be made and implications</i>	<i>3. Priority</i>	<i>4. Potential enablers</i>	<i>5. Potential barriers</i>	<i>6. Strategy to overcome barrier</i>
<i>Budgeting and financing</i>	We need to allocate more funding to the printing of home-based records.	1	Advocacy efforts have improved; directors expressed interest in finding additional funding.	The ministry of health does not allocate sufficient funding to the printing of home-based records. We always rely on donors to provide additional funding.	Lobby to add home-based record distribution as a line item in immunization, nutrition and MNCH programme budgets.
<i>Printing</i>	Since we redesigned the home-based record, we need to find a new central printer with enough capacity to print large numbers of records in colour.	1	The ministry of health has a contract with one printer in the capital city who has high-volume capacity, advanced printing technology and consistent quality.	New batches of records need to be printed within one month, so we need to find a new printer before that.	Task the supervisor with identifying a central printer that has sufficient capacity.
<i>Distribution and stock management</i>	Records will now be printed centrally (and not at subnational level as they were before). Therefore, we need to find a company that transports records to facilities in each region of the country.	2	The central printer has close links with a national shipper; alternatively, we could bundle distribution with immunization or other health programmes' supplies.	Before we can identify a company to help us distribute the records, we need to find a funding source (see budgeting and financing).	Discuss and identify funding source.
<i>Capacity-building and supportive supervision</i>	We added a new antenatal care visit form to the home-based record and need to orient health workers on how to use it.	1	Combine with existing antenatal care capacity-building activities.	There is a high turnover of health workers.	We can design posters and/or brief orientation guides that stay in health facilities. New health workers can use these on the spot.
<i>Building awareness and promoting use</i>	During the revision, we expanded the child booklet to an MCH handbook. We need to raise awareness of the changes among women, parents and caregivers.	3	According to women, parents and caregivers, the best channels for raising awareness are at the point of use – for instance, seeing posters and flyers in health facilities and receiving explanations from health workers about the changes made.	No barrier identified	Not applicable
<i>Coordination across health programmes</i>	Since we revised the home-based record to include maternal health, we need to work closely with the maternal health team in the ministry of health.	1	Invite the maternal health team to scheduled meetings.	No barrier identified	In case the maternal health team cannot meet during the time of our regular meeting, we need to find a new meeting time that works for everyone.



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After you have completed the template, you can use it as follows:

- Confirm impact versus feasibility of actions to provide the greatest operational improvement at a realistic level of effort (**Fig. 5**).
- Review the action plan or timeline created in **Chapter 2** to see if any of the new specifications for the operational support processes will require additions to, or adjustment of, elements of the plan or if they may have an impact on the proposed timeline.
- Document the specifications you want to see and support discussions with stakeholders and health programmes about the most efficient ways to achieve the proposed changes.
- Identify potential changes to the content of the home-based record for discussion in the technical reviews.

Strengthening operational support processes requires effective monitoring

Real-time information is needed to understand the use of the home-based record by the three user groups and to assess whether the operational support processes are functioning. **Chapter 7** addresses the monitoring of operational support processes, technical programme objectives and user requirements.

Reflection

This chapter focused on implementation of the home-based record and the definition of specifications for the operational support processes: budgeting and financing, printing, distribution and stock management, capacity-building and supportive supervision, building awareness and promoting use, and coordination across health programmes. On the basis of the information and Activities that the core team reviewed in this chapter, how will you strengthen the operational support processes for the home-based record?

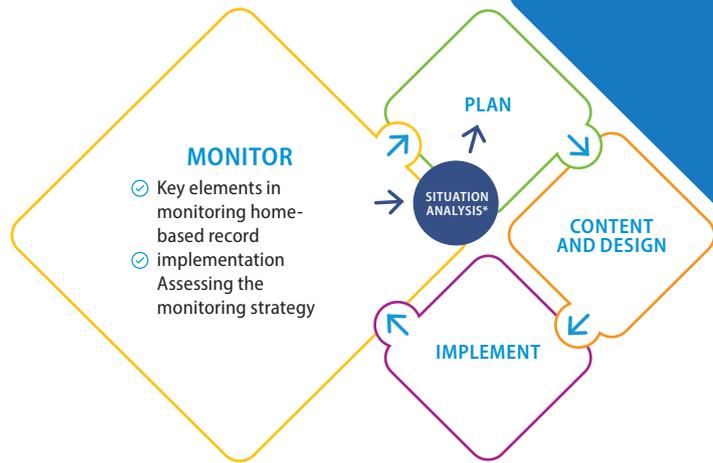
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CHAPTER 7

Monitoring implementation of the home-based record



Chapter overview

Monitoring is the systematic, routine collection, organization, analysis and use of information on different aspects of home-based record implementation for the purpose of management and decision-making. In this case, the aim is to understand if the use of the home-based record and the operational support processes are functioning as planned and, as needed, to adjust them to improve them. The frequency of monitoring may be quarterly, every six months or annually, and should align with routine monitoring processes of the health programmes. The core team will need to decide when information is needed in order to ensure that implementation is optimal and that information is available for decision-making.

Regular review and discussion of information collected on the use of the home-based record by the Three U's, as introduced in **Chapter 4**, and the functioning of the operational support processes will allow the core team and stakeholders to:

- track progress in implementation performance across different geographical areas within a country and over time;
- better ensure that the home-based record design and content meet the needs of users; and
- enable stakeholders to make informed decisions and take actions to strengthen implementation, making efficient use of limited resources.

Note: Evaluation is a more systematic and rigorous assessment conducted by an independent group that is external to the teams involved with home-based record implementation to measure impact on the objectives. Evaluation is beyond the scope of this guide.

This chapter links closely with previous chapters, including **Chapter 3** and sections related to supportive supervision in **Chapter 6**. For monitoring, you can use information that is already being collected by the different health programmes or implementing partners – e.g. through existing data from HMIS and existing surveys such as DHS and MICS. **Chapter 3** includes a list of potential information sources to identify available information on the home-based record. If the information you need is not being collected, you can explore where you may be able to add questions or make qualitative observations related to your monitoring priorities within existing activities in order to ensure regular monitoring. Observations of the use of the home-based record could be integrated into supportive supervision visit checklists, questions included in the logistics management information system covering essential medicines and commodities, or other regular data collection systems. **Chapter 3** also includes information about collecting primary data to fill gaps in the secondary data – i.e. information

about whom to speak with to assess current use, and considerations for collecting information on the home-based record's operational support processes.

Many countries struggle to establish ongoing monitoring processes or they fail to plan adequately for monitoring activities within their implementation plan. It is important to define monitoring objectives with stakeholders as part of the overall planning and implementation process of the home-based record in order to ensure that: (i) monitoring is included in operational budgets; (ii) stakeholders are aware of monitoring activities; and (iii) roles and responsibilities are clearly defined.

This chapter proposes a simplified approach to monitoring to ensure that information on core areas of implementation of the home-based record is collected, reviewed and discussed regularly. The core team requires information that allows them to determine if implementation of the home-based record is moving in the right direction and, if not, to identify and understand bottlenecks preventing successful implementation. The focus of this chapter is on monitoring the implementation of the home-based record, identifying what to monitor, how and when

to do so and how to develop a routine monitoring strategy. It is assumed that the monitoring of health programmes is ongoing and will monitor progress towards outcomes such as improved care seeking, home care practices and improved health.

The chapter consists of the following content:

- key elements in monitoring home-based record implementation
- assessment of your monitoring strategy.

Key elements in monitoring home-based record implementation

A monitoring plan for implementation of a home-based record can be broken into at least four elements. This section addresses each element to help you assess your current monitoring activities or to strengthen your approach. The section covers:

1. What should be monitored?
2. Who should be involved in monitoring?
3. Which monitoring methods and instruments should be used?
4. How should the collected information be reported so that it is useful and actionable?



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What should be monitored?

It is important to understand whether home-based record implementation is progressing as planned.

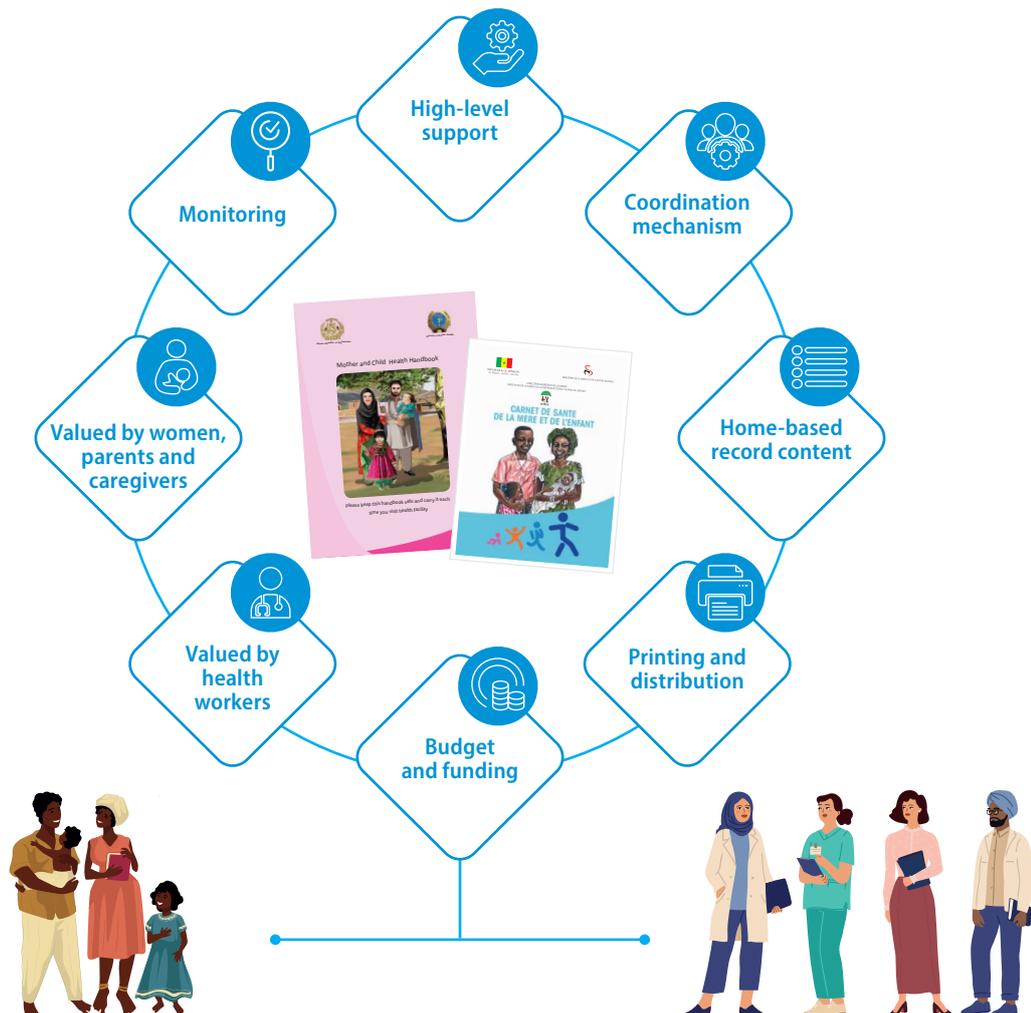
Chapter 1 presented the eight success factors to achieve optimal use and performance of the home-based record (**Fig. 12**). These success factors can form the priorities of your monitoring plan, namely:

1. High-level support is established.
2. Coordination mechanisms with stakeholders are in place.
3. Home-based record content supports health priorities and objectives.
4. Printing, distribution and resupply are planned and costed.
5. Budgets are accurately estimated, and sustainable funding is identified.

6. Health workers value the use of the home-based record.
7. Women, parents, caregivers and community members value the use of the home-based record.
8. Monitoring processes are in place to ensure that objectives are met, users' needs are met, and operational support processes are optimized.

Some countries may not have a monitoring framework for home-based records in place, with clear indicators, data sources, established frequency when the data will be collected, etc. In order to get started and to establish a reasonable way of monitoring progress in home-based record implementation, you can use the eight success factors to identify milestones and indicators that you can review regularly.

FIG. 12. EIGHT SUCCESS FACTORS TO ACHIEVE OPTIMAL USE AND PERFORMANCE OF THE HOME-BASED RECORD



Milestones to track progress and indicators

Milestones are necessary steps on the path to achieve your objectives. The eight success factors can be used to identify milestones to allow you to track progress towards improving implementation of home-based records over time. You can discuss the milestones in

the regularly planned stakeholder review meetings to determine progress and performance. These milestones can be phrased as questions that can be answered with yes or no to indicate whether certain critical elements are in place based on the eight factors. Example milestones are provided in **Table 3**.

TABLE 3. MILESTONES TO TRACK PROGRESS FOR THE KEY SUCCESS FACTORS

Key success factor	Example milestones
High-level support is established	<ul style="list-style-type: none"> Do high-level officials in the ministry of health value the home-based record and recognize its benefits for improved MNCH outcomes? Are national or subnational policies in place to support home-based record implementation?
Coordination mechanisms with stakeholders are in place	<ul style="list-style-type: none"> Do you hold regular meetings with stakeholders where home-based record implementation is discussed?
Home-based record content supports health priorities and objectives	<ul style="list-style-type: none"> Does all content in the home-based record support MNCH programme objectives?
Printing, distribution and resupply are planned and costed	<ul style="list-style-type: none"> Did any health facilities have stock-outs during the last six months?
Budgets are accurately estimated, and sustainable funding is identified	<ul style="list-style-type: none"> Do the actual costs to print home-based records during the past 12 months match the estimated costs included in the budget? Has a budget line been created in the annual budget for home-based record implementation?
Health workers value the use of the home-based record	<ul style="list-style-type: none"> Do health workers fill in home-based records legibly and correctly? Do health workers correctly explain the content of the home-based record to women, parents and caregivers?
Women, parents, caregivers and community members value the use of the home-based record	<ul style="list-style-type: none"> Do women, parents and caregivers retain the home-based record? Do women, parents and caregivers bring the home-based record to visits with the health workers?
Monitoring processes are in place to ensure objectives are met, users' needs are met, and operational support processes are optimized	<ul style="list-style-type: none"> Is the information gathered through supportive supervision and monitoring processes regularly discussed and reviewed by the core team?

In addition to the milestones, you need to identify one or two specific indicators to provide you with more accurate measurements to be collected about specific priority elements of home-based record implementation, focusing on output indicators – i.e. whether the activities that were planned are happening as intended. You would also need to identify the data source and the frequency of data collection. These indicators can be integrated into ongoing monitoring processes.

The exact indicators you select will depend on the implementation objectives of the specific context. While it is unlikely that any single indicator will be sufficient to fully inform whether implementation is progressing as planned, the one or two indicators selected can serve as a proxy. Although some teams may wish to identify more than two indicators, experience shows identifying more indicators is not always better when considering efforts necessary to collect, organize and analyse information.

Below are two example indicators for your consideration:

- The percentage of planned meetings with stakeholders that were held during a specific time period.

$$\frac{\text{Total number of meetings with stakeholders that were actually held during a specific time period}}{\text{Total number of meetings planned with stakeholders during a specific time period}} \times 100$$

- The percentage of health facilities with stock shortages during the last six months.

$$\frac{\text{Total number of health facilities with stock shortages during the last six months}}{\text{Total number of health facilities}} \times 100$$



Further resources on this topic

The Ministry of Health of Indonesia *Management guidebook for implementation of the maternal and child health handbook* (see pages 16–18) states that the MCH handbook monitoring activities can be combined with the mother and child programme monitoring activities. The core team can review their monitoring objectives, methods and indicators (1).

Who should be involved in monitoring?

You or someone else on the core team should coordinate the monitoring plan and activities.

- You will work with the persons responsible for monitoring in the health programmes that have content in the home-based record (e.g. MNCH, immunization, nutrition) as well as the programmes you coordinate with for the operational support processes.
- As you will require information from different levels of the health system, you will need to identify contact points at different levels to ensure timely and complete sharing of information about the different user groups.
- District managers can provide aggregated data of the information collected through supportive supervision visits, from direct observations during health visits, and from feedback on operational support processes such as home-based record distribution to facilities and users, as well as stock management.
- Key implementing partners and stakeholders may also capture important information that will contribute to your monitoring plan. In addition, they will be important partners in reviewing and discussing the information gathered.

Which monitoring methods and instruments should be used?

Monitoring of the home-based record can combine quantitative and qualitative methods to track the current status of both the use of the home-based record and the operational support processes. To streamline your work with the ongoing monitoring process of MNCH programmes, you may be able to add questions to existing process monitoring checklists or (rapid) community-based surveys; use administrative data such as coverage data or logistics data; add questions to focus group sessions or key informant interviews; observe sessions during supervision visits; or include monitoring of home-based record use in discussions during review meetings.

Some additional examples of where data on home-based records might be captured are provided below:

- Review administrative reports (for example, to identify the number of staff trained in the appropriate use of the home-based record).
- Review the logistic management system (for example, to identify the number of home-based record stock-outs over a period of time).
- Review the MNCH registry (for example, to identify the number of pregnant women who received antenatal care who had a home-based record).
- Review supervision reports (for example, for insights from group discussions or direct observation of responses to questions about the use of the home-based record).
- Review supervisors' notes (for example, about observations of the use of the home-based record by health workers).
- Review training and review activity reports (for example, for feedback from health workers on the use of the home-based record).

If the information that the core team wants to collect is not readily available through existing routine monitoring activities, decisions will need to be made about how to collect this information, where to collect it, and how it should be analysed and reported.



Further resources on this topic

The core team can review and use the following data collection tools:

- The Ghana Health Service of the Ghana Ministry of Health has monitoring instruments for each facility, district and regional levels that were developed with support from JICA (see Web Annex C). These instruments can be adapted so that you can develop your own monitoring instruments.
- JSI has a *tool to review the quality and completeness of home-based records* (see pages 15–16) to assess the use of multiple data-recording fields in the home-based record (2).
- There are sample interview guides for women, parents, caregivers, health workers and health administrators that were developed for the situation analysis (see Chapter 3). These can be used to collect information on the use of the home-based record and the operational support processes (see Web Annex B).
- Questions on operational support processes which were also developed for the situation analysis (see the Activity on p. 34) can be used to collect information on the operational support processes.

How should the information that is collected be reported so that it is useful and actionable?

The findings from the different monitoring activities should be communicated to the teams that need to understand the status of implementation of the home-based record. Reporting frequency should be determined by the frequency of management meetings to review the status of home-based record implementation.

- Reports should be brief, simple and based on a template. Design the report once, and update it as needed. For example, the Ghana Health Service of the Ghana Ministry of Health uses a simple template designed as a checklist to report on the status of its MCH record book to ensure that reports are straightforward, simple to read and used to plan actions.
- You can determine the frequency and level of formality of reporting, but try to standardize your documentation so it is easy to add new elements to the report, to enable comparison over time to measure progress, and to list issues that remain unresolved.

- It is helpful if the information compiled can be presented in a visual format – e.g. dashboards, graphs, photographs of home-based records that illustrate correct or incorrect use.
- You may need to report home-based record implementation activities at different levels of the health system, so reports may be created separately for the national and subnational levels.
- Reporting activities should be designed with the programme management cycle in mind because monitoring completes the cycle by feeding data and

information back into planning activities.

- Having regular meetings, perhaps on a quarterly basis, can help to update reporting and can triangulate reporting data from different tools. It is an opportunity to share and review reporting with peers. The meeting can also address common challenges and good practices for improvement in monitoring activities (3).

An example describing monitoring and supervision visits in Ghana can be found in **Box 16**.

BOX 16 – MONITORING AND SUPERVISION VISITS BY THE GHANA HEALTH SERVICE OF THE MINISTRY OF HEALTH

The approach adopted by the Family Health Division of the **Ghana** Health Service, under the leadership of the Ministry of Health, was to conduct on-the-job mentoring and supportive visits to the service delivery points immediately after the training that involved various administrative levels of the health system.

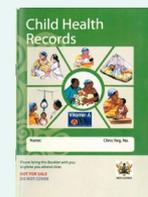
Between January and March 2019, during the national roll-out of the MCH record book, 10 regional health directorates, 34 district health directorates and 95 health facilities in 10 different regions were visited by the health monitoring teams. Monitoring teams comprised national, regional and district staff. They found that 82% of the health facilities utilized the MCH record book, although many sections were incomplete or incorrectly recorded – especially the newly added areas such as the nutrition counselling tables.

The following reasons were identified for incorrectly filling in the records: lack of equipment needed to record the information correctly (e.g. height boards and weighing scales); lack of star stamps to motivate women to come to all services; and lack of the user guide on the correct use of the book. The team also reported insufficient supplies of the home-based record and poor logistical management. They reported discrepancies in the numbers of the MCH record books distributed to regions and the numbers of books each region reported having received. Only 41% of health facilities had a tally card for the stock management of the book.

The team also identified good practices for strengthening implementation that could be shared with other districts and regions. One example was that health facility staff copied a page of the user guide and placed it on the wall of the antenatal care room for easy reference.

The team also found that 91% of community health officers were trained, while only 61% of midwives at hospitals were trained on the use of the MCH record book (5).

The tools that were used during monitoring visits in Ghana can be reviewed in **Web Annex C**.





Further resources on this topic

WHO *Intervention guidebook for implementation and monitoring activities to reduce missed opportunities for vaccination* (see pages 22–23) is useful to review a short guide to create a clear monitoring plan (4). The guide describes what to monitor, how and by whom the information should be collected and analysed, and how it can be used. Although the guidebook is focused on monitoring and evaluation, many aspects are relevant if you wish to conduct only monitoring activities.

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Assessing your monitoring strategy

ACTIVITY – ASSESSING YOUR MONITORING STRATEGY



This Activity uses the eight success factors that ensure optimal use and performance of the home-based record to assess your current monitoring strategy and adjust it as needed.

It is divided into two parts. The first part allows you to review and identify the milestones you want to use for tracking progress in home-based record implementation. In the second part of the Activity, you can identify at least two specific indicators for monitoring.

It is recommended to review the instructions for parts 1 and 2 with the core team and to assign someone to take notes on decisions and follow-up actions. The Activity contains two sets of instructions, two blank templates to fill in and two examples of completed templates.

PART 1: DEFINING MILESTONES

INSTRUCTIONS

1. Review the success factors in column 1 to frame your assessments of both the use of the home-based record and its operational support processes. Determine how to apply each success factor to your situation. The full description of the eight success factors can be found in **Chapter 1** if you need further clarification.
2. Example milestones are provided in column 2. Review them with the team to identify if you will use a provided milestone or adapt it to meet the needs of your context.
3. In column 3, record if you will keep a milestone listed in column 2, or if you will change it.
4. If you change the milestone, record the revised milestone in column 4.
5. Record which source you will use to inform the progress of the milestone in column 5.

TEMPLATE: ASSESSING YOUR MONITORING STRATEGY

1. Key success factor	2. Example milestones	3. Will you keep this milestone or will you change it?	4. What is the revised milestone?	5. What will be the source to inform progress of the milestone?
<i>High-level support is established</i>	<ul style="list-style-type: none"> Do high-level officials in the ministry of health value the home-based record and recognize its benefits for improved MNCH outcomes? Are national or subnational policies in place to support home-based record implementation? 			
<i>Coordination mechanisms with stakeholders are in place</i>	<ul style="list-style-type: none"> Do you hold regular meetings with stakeholders where home-based record implementation is discussed? 			
<i>Home-based record content supports health priorities and objectives</i>	<ul style="list-style-type: none"> Does all content in the home-based record support MNCH programme objectives? 			
<i>Printing, distribution and resupply are planned and costed</i>	<ul style="list-style-type: none"> Did any health facilities have stock-outs during the last six months? 			
<i>Budgets are accurately estimated, and sustainable funding is identified</i>	<ul style="list-style-type: none"> Do the actual costs to print home-based records during the past 12 months match the estimated costs included in the budget? Has a budget line been created in the annual budget for home-based record implementation? 			
<i>Health workers value the use of the home-based record</i>	<ul style="list-style-type: none"> Do health workers fill in home-based records legibly and correctly? Do health workers correctly explain the content of the home-based record to women, parents and caregivers? 			
<i>Women, parents, caregivers and community members value the use of the home-based record</i>	<ul style="list-style-type: none"> Do women, parents and caregivers retain the home-based record? Do women, parents and caregivers bring the home-based record to visits with the health workers? 			
<i>Monitoring processes are in place to ensure objectives are met, users' needs are met, and operational support processes are optimized</i>	<ul style="list-style-type: none"> Is the information gathered through supportive supervision and monitoring processes regularly discussed and reviewed by the core team? 			

EXAMPLE OF A COMPLETED TEMPLATE: ASSESSING YOUR MONITORING STRATEGY

1. Key success factor	2. Example milestones	3. Will you keep this milestone or will you change it?	4. What is the revised milestone?	5. What will be the source to inform progress of the milestone?
<i>High-level support is established</i>	<ul style="list-style-type: none"> Do high-level officials in the ministry of health value the home-based record and recognize its benefits for improved MNCH outcomes? Are national or subnational policies in place to support home-based record implementation? 	We will keep the second example milestone.	Not applicable	Review existing national and subnational policies.
<i>Coordination mechanisms with stakeholders are in place</i>	<ul style="list-style-type: none"> Do you hold regular meetings with stakeholders where home-based record implementation is discussed? 	This milestone will not be used. In part two of the Activity, we will define an indicator instead.	Not applicable	Not applicable
<i>Home-based record content supports health priorities and objectives</i>	<ul style="list-style-type: none"> Does all content in the home-based record support MNCH programme objectives? 	We will change this milestone to fit our context.	Does the content in the home-based record support maternal health programme objectives?	Ask the manager of the maternal health programme.
<i>Printing, distribution and resupply are planned and costed</i>	<ul style="list-style-type: none"> Did any health facilities have stock-outs during the last six months? 	This milestone will not be used. In part two of the Activity, we will define an indicator instead.	Not applicable	Not applicable
<i>Budgets are accurately estimated, and sustainable funding is identified</i>	<ul style="list-style-type: none"> Do the actual costs to print home-based records during the past 12 months match the estimated costs included in the budget? Has a budget line been created in the annual budget for home-based record implementation? 	We will keep the first example milestone.	Not applicable	Review all estimated costs for the previous 12 months against the actual costs incurred.
<i>Health workers value the use of the home-based record</i>	<ul style="list-style-type: none"> Do health workers fill in home-based records legibly and correctly? Do health workers correctly explain the content of the home-based record to women, parents and caregivers? 	We will change the first example milestone to fit our context.	Do health workers fill in the growth monitoring charts in the home-based record correctly?	Review growth monitoring charts in home-based records in facility X.
<i>Women, parents, caregivers and community members value the use of the home-based record</i>	<ul style="list-style-type: none"> Do women, parents and caregivers retain the home-based record? Do women, parents and caregivers bring the home-based record to visits with the health workers? 	We will keep the first example milestone.	Not applicable	Ask women during home visits or focus group discussions; or check existing national surveys that cover ownership and retention of home-based records.
<i>Monitoring processes are in place to ensure objectives are met, users' needs are met, and operational support processes are optimized</i>	<ul style="list-style-type: none"> Is the information gathered through supportive supervision and monitoring processes regularly discussed and reviewed by the core team? 	We will keep this milestone.	Not applicable	Review meeting notes from regular team meetings.

PART 2: DEFINING INDICATORS

You still need to identify at least one or two indicators that formally measure implementation of home-based records. In this part of the Activity, you can review all success factors again and determine for which you want to collect an indicator instead of a milestone.

INSTRUCTIONS

1. Review the key success factors in column 1.
2. If you will define an indicator for the respective success factor, record it in column 2. You can use the example indicators provided previously in this section or you can define your own indicators.
3. For each indicator, record how it will be measured in column 3. If it can be measured using a numerator and denominator, define those in this column as well. If the indicator instead requires qualitative information (i.e. information to be obtained through conversations with users, or conversations among the core team to interpret the measurement of the indicator), describe this here. You will see examples in the completed template.
4. Describe in column 4 how you will collect the information for each indicator (data source). Be sure you know what is already being collected and how you can take advantage of that before expending time and resources on new efforts to collect primary data.
5. Identify the frequency of the data collection for each indicator and note who will be responsible for its collection. Record this in column 5.

TEMPLATE: ASSESSING YOUR MONITORING STRATEGY

1. Key success factor	2. What is the indicator you will use?	3. How can the indicator be measured?	4. What will be the source of this indicator?	5. With what frequency is it collected? By whom?
<i>High-level support is established</i>				
<i>Coordination mechanisms with stakeholders are in place</i>				
<i>Home-based record content supports health priorities and objectives</i>				
<i>Printing, distribution and resupply are planned and costed</i>				
<i>Budgets are accurately estimated, and sustainable funding is identified</i>				
<i>Health workers value the use of the home-based record</i>				
<i>Women, parents, caregivers and community members value the use of the home-based record</i>				
<i>Monitoring processes are in place to ensure objectives are met, users' needs are met, and operational support processes are optimized</i>				

EXAMPLE OF A COMPLETED TEMPLATE: ASSESSING YOUR MONITORING STRATEGY

1. Key success factor	2. What is the indicator you will use?	3. How can the indicator be measured?	4. What will be the source of this indicator?	5. With what frequency is it collected? <i>By whom?</i>
<i>High-level support is established</i>	The percentage of high-level officials in the ministry of health who value the home-based record	<ul style="list-style-type: none"> “Do our key ministry of health officials value the home-based record? Are there national policies that support home-based record implementation? How is the home-based record perceived versus other priorities?” 	Engage high-level officials in the ministry of health about how they value home-based record and review national policies.	Assistant programme manager, every 12 months
<i>Coordination mechanisms with stakeholders are in place</i>	The percentage of planned meetings with stakeholders that were held during a specific time period	<ul style="list-style-type: none"> “Did our core team have an in-person meeting with stakeholders in the last four months?” $\frac{\text{The total number of meetings with stakeholders that were held during a specific time period}}{\text{The total number of meetings planned with stakeholders during a specific time period}} \times 100$	Ask focal point for coordination with stakeholders in the core team.	Assistant programme manager, every six months
<i>Home-based record content supports health priorities and objectives</i>	The percentage of content elements in the home-based record that support child health programme objectives	<ul style="list-style-type: none"> “Does the content in the home-based record support your programme’s health priorities and objectives? How do you know?” 	Conduct observations or interviews with health workers and subnational directors about use of child health content in the home-based record, then review these results with the manager of the child health programme to assess use and whether the content aligns with programme objectives.	Assistant programme manager, every 12 months
<i>Printing, distribution and resupply are planned and costed</i>	The percentage of health facilities with stock shortages during the last six months	<ul style="list-style-type: none"> “Did you have stock-outs of home-based records at your facilities during the last three months?” $\frac{\text{Total number of health facilities with stock shortages during the last six months}}{\text{Total number of health facilities}} \times 100$	Conduct an interview with the facility manager in facility X, or review existing national surveys, such as facility surveys.	Supervisor with two volunteers, every six months
<i>Budgets are accurately estimated, and sustainable funding is identified</i>	Accuracy of estimated costs versus actual costs; total amount of committed funding for the coming year	<ul style="list-style-type: none"> “Did the estimated budget for the past 12 months match the actual costs for this time period? If not, why? What are the implications for the budget versus funding for the next 12 months?” 	Review the costs during the past 12 months to understand variance and their implications for the estimated costs and available funding during the next 12 months.	Assistant programme manager in charge of tracking costs; every 12 months or more often as needed
<i>Health workers value the use of the home-based record</i>	The percentage of home-based records reviewed that are filled in legibly and correctly	<ul style="list-style-type: none"> Verify records to assess if they are filled in correctly; count the records that are filled in correctly and divide by the total number of records seen. $\frac{\text{The total number of home-based records reviewed that are filled in legibly and correctly}}{\text{The total number of home-based records reviewed}} \times 100$	Review home-based records in facility X.	Supervisor with two volunteers, every six months

1. Key success factor	2. What is the indicator you will use?	3. How can the indicator be measured?	4. What will be the source of this indicator?	5. With what frequency is it collected? <i>By whom?</i>
<i>Women, parents, caregivers and community members value the use of the home-based record</i>	The percentage of women, parents and caregivers who keep the home-based record at home during a specific period of observation	<ul style="list-style-type: none"> • “May I see your antenatal card? (Yes/no)”. • For those who answer yes, why do you keep it? • For those who do not have it, why have you not replaced it? 	Ask women during home visits or focus group discussions; need to probe why they do or do not have it to assess if/how they value the record.	Supervisor with two volunteers, every six months
<i>Monitoring processes are in place to ensure objectives are met, users’ needs are met, and operational support processes are optimized</i>	The percentage of key stakeholders who rate the report data as complete and timely during a specific time period	<ul style="list-style-type: none"> • Is the report issued quarterly? • Does the report include the agreed categories of information? $\frac{\text{The total number of key stakeholders who rate the report data as complete and timely during a specific time period}}{\text{The total number of key stakeholders who rate the report data during a specific time period}} \times 100$	Create a monitoring report assessment that addresses timeliness and completeness of each report created. Ask key stakeholders to complete the assessment.	The core team member responsible for coordinating monitoring activities; the assessment is conducted every time the report is published.

Monitoring feeds back into the home-based record programme management cycle

This guide was structured to support you and the core team you work with on home-based record implementation to review different processes related to planning, design, implementation and monitoring of the home-based record in order to identify the information needed and use it to make informed decisions.

To ensure that all decisions are well informed, it is important to establish a clear and ongoing monitoring plan that tracks the use of the home-based record and the operational support processes, and that is manageable by the core team. This ownership leads to an iterative cycle that provides the core team with up-to-date and accurate information about implementation status of the home-based record and prioritized actions to take. The sense of ownership also leads to constant improvement in the core team’s abilities to plan and conduct monitoring, effectively analyse and apply the information gathered, and continually improve the monitoring approach. This will lead to strengthening implementation of the home-based record.

Additionally, it is important that all health programmes that have content in the home-based record are engaged when reviewing the results of monitoring activities in order to understand whether the home-based record is being used as intended, and whether changes are needed in the workplan to strengthen its implementation.

Every chapter in this guide shows the management cycle of the home-based record programme. It is helpful to remember that this is, indeed, a cycle. Results from monitoring activities contribute directly to the different steps in the cycle and should be incorporated into planning activities (see **Chapter 2**) and inform decision-making. Strong monitoring processes allow you and the core team to maintain and improve implementation of the home-based record at every policy level.

Reflection

This chapter focused on monitoring. On the basis of the information and Activity in this chapter, what will you change in your processes to monitor implementation of the home-based record?

Elevate the impact of this guide

You have now reached the end of this guide, although the activities in the programme management cycle are ongoing and will ensure optimal use and performance of the home-based record.

It is important to continue to apply the eight success factors to achieve steady improvements in the implementation of the home-based record. You can continue to review and apply the reflections, tools, best practices and further resources to support your progress.

You can also share this guide with your colleagues and stakeholders, adapt the activities to improve them, and share your learning and best practices with others in your country or globally.

We are keen to learn about your experiences in using this implementation guide. If you have any feedback, please write to mncah@who.int and let us know what you liked, what you did not like and what you think should be improved to make this guide more useful to you and other programme managers working on home-based record implementation.

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Methods and contributors to the guide

How this guide was developed

Prior to the development of this implementation guide, a mapping exercise was conducted for WHO by Nina Gerlach and Anayda Portela. The main objective was to identify and collect existing tools from partners that support the use, implementation and monitoring of home-based records. A call was sent – through WHO and UNICEF country and regional offices and the website TechNet-21 – to global partners that work on implementation of home-based records. The resources on TechNet-21, a database of resources submitted by JICA, partners' websites and other online sources were manually searched and pertinent tools added. Tools were included if they: (i) related to family planning or MNCH, including vaccination, nutrition, growth and development, and early child development; (ii) aimed at improving home-based record implementation and monitoring; and (iii) were published after 2010 or (if they were published earlier) were still in use. A spreadsheet was populated, and key information was extracted from each included tool. The tools identified have been referenced throughout this guide where pertinent.

Building on existing evidence reviews and discussions with experts, a first draft of this implementation guide was developed in 2021. During the development phase, key informants were identified through networks and discussions were held with WHO, UNICEF, global partners implementing home-based records, and representatives from the Ministries of Health of Afghanistan, Ghana, Indonesia, Kenya and the Lao People's Democratic Republic,

to learn about implementation challenges and to help inform the development of the guide. A draft guide was reviewed by WHO, UNICEF and JICA staff from headquarters, regional and country offices. Two consultations were held to receive feedback on the draft guide in November and December 2021. The first meeting was attended by external partners, including representatives of ministries of health and NGOs implementing home-based records. Declarations of interest from external contributors acting in an individual capacity have been collected, assessed and managed as per WHO policy. Participants in the second meeting included WHO and UNICEF staff from country and regional offices and headquarters.

In 2022, the content was revised to integrate the feedback received. In June and July 2022, meetings coordinated by JSI to review the guide and provide feedback on selected chapters were held with representatives from the Ghana Health Service of the Ministry of Health of Ghana and the Family Health and Welfare Division of the Ministry of Health and Population of Nepal. A team from the Ministry of Health of Indonesia also reviewed chapters. Meanwhile, the draft guide was shared with WHO, UNICEF and JICA staff and technical advisors for final inputs.

The guide is intended to be a living document; while in use, efforts will be made to obtain feedback and identify how to strengthen its content and support its use.

Contributors to the guide

The following persons contributed to the development of the guide throughout the different encounters mentioned on p. 95. All names are listed in alphabetical order.

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Notes

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**BABY
BOOK**

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PASSPORT

*child health and
development passport*

CARTÃO DE SAÚDE
INFANTILE

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