



CASE STUDIES FROM THE NGO COMMUNITY ACROSS ASIA

**Strengthening the Impact of Asia's NGO Community
Maternal, Newborn and Child Health (MNCH)
Interventions: Immunization**

**Asia NGO Consultation
24 – 26 February 2009, Manila, Philippines**



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Poster Exhibit and Case Studies – In Brief

In advance of the workshop, NGO participants were asked to submit a case study and associated poster describing a program or initiative that aimed to improve the status of Maternal Newborn and Child Health (MNCH) and specifically immunization. The case studies featured many key aspects of their projects, from conception to implementation to outcomes, as well as lessons learned and obstacles encountered. The themes and innovative aspects of the case studies helped to inform the design of the agenda. At the workshop itself, participants were also given an opportunity to view each other's poster exhibits and ask questions about the projects depicted. Participants agreed that the case studies and the poster exhibits were among the most innovative and helpful elements of the two-day

All in, the projects described by the case studies had both striking similarities and informative differences:

- Most targeted the poorest and the most disadvantaged of the population but some targeted have-less or middle class segments, in part to free up public resources for the poorest populations (**Philippine NGO Council on Population Health and Welfare, Inc. (PNGOC)**);
- Most sought to provide services free of charge out of consideration for recipients' strained financial circumstances. But others found that user fees for certain services or in certain market segments that are "willing to pay" enhanced sustainability and made programs more effective (**World Health Partners (WHP)**, **Rangpur Dinajpur Rural Service (RDRS)**, **Janani**, **Pathfinder**, **PNGOC**);
- Many introduced creative tools and strategies to communicate pro-health behaviour change messages. Examples include **World Vision's** timed-and-targeted continuum of care counselling approach and the participatory communication strategy used in the **Revitalizing Community Demand for Immunization (RCDI)** project. Still others turned to innovative delivery channels and new target audiences to achieve results. **Project Hope**, for instance, trained fifth grade teachers how to educate their students about immunization and how to implement a procedure whereby the students mobilized mothers in their communities to have their babies immunized.
- Several projects highlighted the usefulness of evidenced-based arguments as a means to lobby governments to support immunization (**Christian Children's Fund (CCF)**) and the importance of information-sharing as a means to mobilize the various levels of actors necessary to effect change (**Consultation of Investment in Health Promotion (CIHP)**);
- Most relied on government or donor funding but several chose financial self-sufficiency (**People's Primary Healthcare Initiative (PPHI)**);
- Most projects worked to support public health channels rather than nurturing private ones. The majority worked closely with the national ministry of health and its local counterparts;

- One project (**Janini**) reached thousands of patients through affordable private channels and another project (**PPHI**) realized impressive results by taking over certain government health responsibilities and yet another worked with private practitioners to target the have less populations;
- Some introduced or integrated new technologies into the programming area. Path tested new methods for outside-the-cold-chain vaccine storage and WHP expanded the provision of services to difficult-to-reach areas through the use of telemedicine;
- Many enhanced the skills of government health workers and/or private health deliverers (**Japanese Organization for International Cooperation in Family Planning (JOICFP)**) including midwives (**Indonesian Midwives Associations (IBI), Plan International**);
- Many projects succeeded in securing long-term support for their efforts. **John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)**, for instance, led a project that led to an increase in budget allocations for midwife educators, while Project Hope's initiative resulted in the official integration of its approach into the curriculum of 5th grade students;
- Most led initiatives in relatively stable political circumstances but others succeeded in operating successfully in the most unpredictable conditions (**Health Unlimited, Basic Education for Awareness Reforms and Empowerment (BEFARe)**);
- Most focused on the delivery of MNCH and immunization services or the generation of demand and the mobilization of the community. Two, however, concentrated on advocacy and specifically the **Philippine Foundations for Vaccination (PFV)** and **Mother and Infant Research Activities (MIRA)**;
- Some explicitly linked health to social and economic well-being by developing skills and livelihoods, by promoting home gardening or by extending collateral-free loans for village women's groups (**Building Resources Across Communities (BRAC), Medical Assistance Program (MAP International)**). Others used incentive schemes, for example by linking the construction of wells to improvements in health behaviours (**Reproductive and Child Health Alliance (Racha)**) or by officially declaring a village to be a "child-friendly village" if certain maternal and child health indicators were met (**Adventist Development and Relief Agency (ADRA)**); and
- Most mobilized and empowered local communities in some way including to take ownership of **MNCH (Women Acting Together for Change (Watch))** and to demand better services (**MAP**).

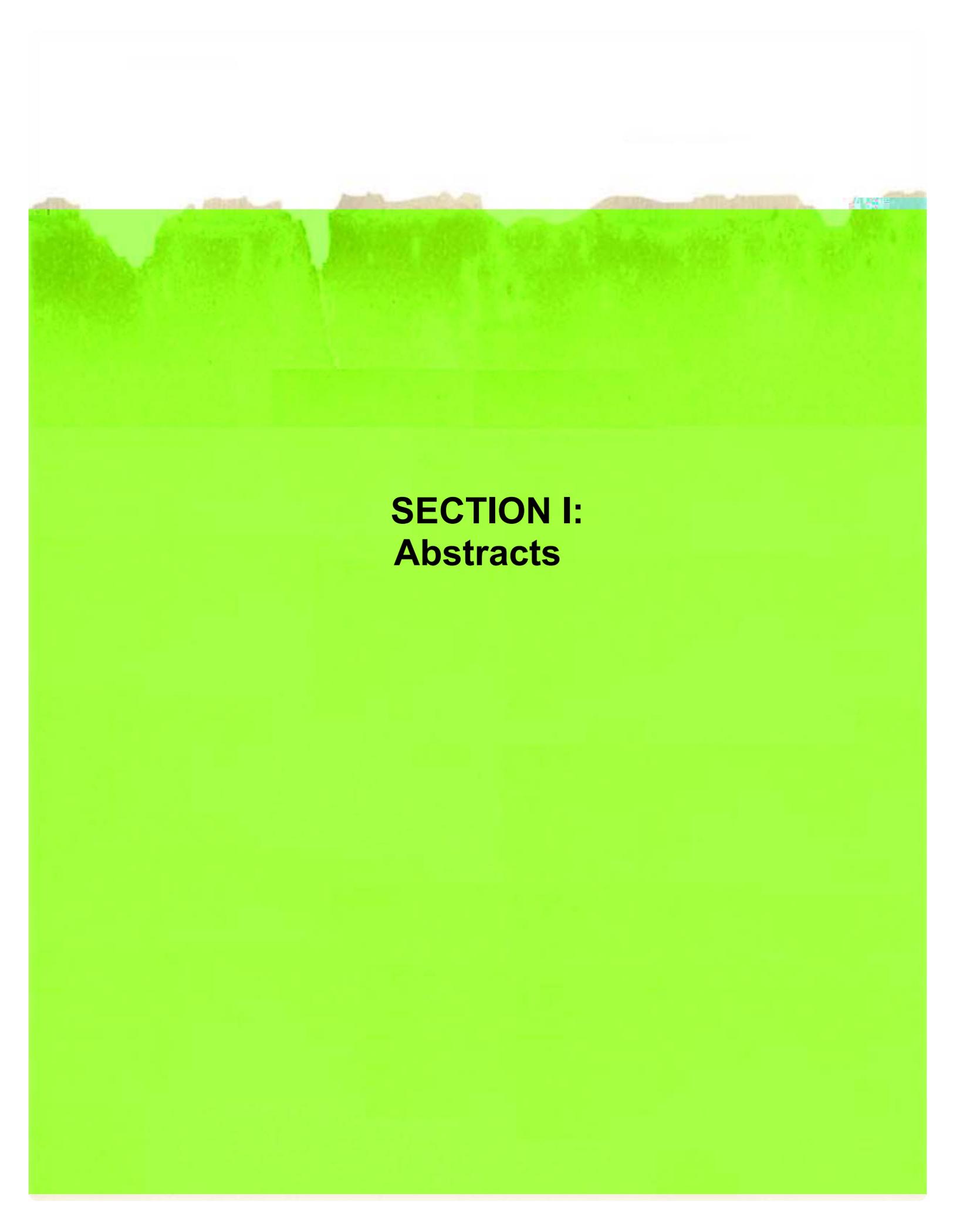
Having been provided an opportunity to reflect on the rich and diverse programming experience of NGOs from across Asia workshop participants voiced a keen interest in generating an inventory of good practices for replication and expansion elsewhere. The case study abstracts (Section I) and the full case studies (Section II) that follow represent a first step to this end.

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**SECTION I:
Abstracts**

The Child-Friendly Village Initiative in Kampong Thom Province, Cambodia



From 2001 to 2006, Adventist Development and Relief Agency (ADRA) Cambodia implemented a child survival project with the support of the United States Agency for International Development. The project was implemented in 10 health center catchment areas or 113 villages of the Baray-Santuk Operational District, Kampong Thom Province, Cambodia. Project staff approached the residents of certain villages to see if they were willing to form a child-friendly village committee (CFVC) with a view to achieving seven maternal and child health indicators. If a village succeeded in meeting these indicators, it would be officially declared a “child-friendly village”, an honor that would be acknowledged at a village health day during which a monument would be erected. CFVCs were composed of village health leaders, the commune coordinator, the vice village chief, a health center chief or staff member, a Ministry of Women’s Affairs representative (if available), the village health volunteer chief, a local trained birth attendant and a priest, monk or key local informant. CFVC members agreed to facilitate health activities such as the mothers’ club, the nutrition program, home gardening, village health days and the Expanded Program of Immunization; solve health problems within the village if possible or arrange speedy transfer to health facilities if indicated; facilitate the exchange of health-related information; and attend two meetings per month. CFVC members were trained in basic organization and planning skills and in maternal and child health. Model mothers were rewarded with sarongs on which health messages were written. In order to be named a “model mother”, a mother had to attend nutrition sessions, contribute food to the hearth nutrition program, pass an examination of her health knowledge, breastfeed her baby exclusively, learn to cook nutritious food and practice good hygiene. Approximately 17,477 children under the age of 5 and 22,575 women of reproductive age benefited from project interventions. Surveys show that in villages that achieved child-friendly status, children’s nutritional status improved dramatically, child immunization rates jumped, and mothers’ ability to recognize symptoms of disease rose significantly.

Improving Child Health in FATA, Pakistan, Through Behavior Change Communication Interventions



Together with its partners, International Medical Corps and Community Motivation and Development Organization, BEFARe is implementing the Improved Child Healthcare Project in four agencies and four frontier regions of Pakistan’s Federal Administered Tribal Area (FATA). With only one doctor for every 5,438 people and 55 mother and child health centers for a population of almost 1.5 million women, FATA is plagued by high neonatal and infant mortality rates and chronic maternal and child malnutrition alongside violence and poverty. The project’s strategic objective is to increase the use of key health services and to improve healthy behaviors in areas uncovered by the national program of lady health workers. BEFARe began by engaging and training qualified and well-connected local staff who understood local cultures and customs. Then BEFARe organized awareness sessions and advocacy events in which thousands of community leaders, teachers and school children were educated about immunization and other health-related matters. As a result, parents who once vehemently opposed vaccination vehemently consented to bring their children to be vaccinated. Staff was also required to educate and negotiate with local militants to secure their permission to provide immunization services. In terms of results, this USAID and Save the Children Fund-funded project has allowed BEFARe to hold 91 child health days in which a doctor and a nurse from Pakistan’s Ministry of Health, assisted by trained native volunteers, have provided vaccines, medicine and treatment for diarrhea, malaria, acute respiratory infections, measles and essential newborn care to over 6481 children. Involving and gaining the confidence of peaceful religious leaders; the wide dissemination of program objectives; and the project’s independent monitoring and evaluation mechanism, have played a vital role in the project’s success. The project’s practice of bringing community health workers to remote areas will be continued by national cadres after the project ends.

Achieving Immunization in Bangladesh With the Help of Non-Governmental Organizations



Bangladesh has made remarkable achievements in immunization over the past two decades, with the national coverage rate of children between 12 and 23 months rising from under 2% in 1985 to 82% in 2007. This success can be attributed to the commitment of both the Government of Bangladesh and of non-governmental sectors as well as to the technical and financial assistance provided by development partners. BRAC is one non-governmental organization (NGO) that has helped increase immunization coverage in the country. BRAC staff in districts and upazillas (sub-districts) coordinates efforts with the public and private health sectors and manages the implementation of various programs. At the community level, local health workers help BRAC staff carry out health promotion and education activities, mobilize the community to participate in immunization, organize Expanded Program of Immunization (EPI) sessions, motivate mothers to take their children to health centers, and accompany the mothers to vaccination sessions. BRAC staff also helps government EPI staff plan logistics and treat patients at outreach centers. In addition, BRAC has formed village women's groups where women are provided knowledge, skills and collateral-free micro-loans designed to help them prosper both socially and economically. BRAC emphasizes the provision of health services to these women and their families, motivates them to participate in immunization and accompanies them to outreach centers. As a result of these and other efforts, infant and child mortality rates in Bangladesh have declined significantly over the last 15 years. By partnering to improve immunization coverage, the Government of Bangladesh and NGOs have filled gaps in the country's health system as it relates to EPI.

Mobilizing the Community to Increase Immunization in Lamitan, the Philippines



Prior to this project, the municipality of Lamitan had a fully immunized child (FIC) rate of 45%, one of the lowest in the Philippines. Located in the Autonomous Region in Muslim Mindanao, an area characterized by frequent conflict, Lamitan is inhabited by various tribes and families that held misconceptions about health, specifically with regards to maternal and child health care and immunization. The Christian Children's Fund (CCF) and its partners worked with rural health unit personnel to educate communities about the importance of immunization; lobby for improved health service delivery from the local government health unit; and mobilize the community to improve its health. CCF first ensured that immunization services were available and accessible to targeted children. Certain community areas were designated as immunization sites and in hard-to-reach communities, special arrangements were made to make services available. The project then trained parent volunteers in Vitamin A supplementation, the proper weighing of children, the early detection and referral of childhood illnesses, and immunization. Once trained, parents spearheaded the organization of seminars on immunization awareness and conducted house-to-house campaigns within their tribes. They also held immunization talks mentored by rural health unit personnel. Parents' involvement was critical in reversing the tribal belief that vaccination makes children more prone to sickness. Tribal leaders accepted immunization as a means of disease prevention and Muslim religious leaders included the campaign in religious services during homilies and sharing. As a result of these activities, Lamitan's FIC rate reached 75% in 2006. A key success factor was the use by health advocates of evidence-based health information and statistics to draw the attention of community leaders and local government personnel to the extent of the problem and to available interventions (i.e. immunization).

The Cordaid-Supported Common Health Program in Viet Nam: Improving Child Health at the Community Level



In 2003, Cordaid, an international emergency aid and poverty eradication organization active in Viet Nam, instituted a project whose goals included improving the health status of women and children in eight districts with a population of about 885,000. The project was designed against the backdrop of the 1991 decentralization of Viet Nam's health system which enhanced the authority of district and provincial-level governments and allowed for the greater participation of organized community health volunteers. Aided by Consultation of Investment in Health Promotion (CIHP), a coordination and technical assistance agency, the project began by establishing a project steering committee (PSC) in each district or commune. Meeting monthly or quarterly, each PSC was composed of government health staff, representatives of mass organizations, local stakeholders, and other international agencies active in the district. Each district then produced a plan that detailed its objectives, outputs and targets based on the program's common framework. PSCs monitored progress closely and ensured that the plans were implemented on time. Training courses in the Integrated Management of Childhood Illness strategy (IMCI) and in health education and communication skills in malnutrition prevention were conducted in all districts. A child healthcare booklet was created and disseminated to all program sites and tertiary-level health colleges integrated IMCI and maternal and childcare training into their curricula. Program partners conducted health examinations according to IMCI protocol and mothers participated in demonstrations on how to prepare nutritious food for their children. A range of community-level health information, education and communication activities through the radio, clubs, direct contacts, and so forth, reached 245,685 people. As a result of the program, malnutrition rates for children under five in all eight districts dropped and the rates of children identified, treated and monitored for malnutrition rose significantly. Consolidation of the various intervention models is considered key to long-term project impact.

Kachin People's Health Development Initiative: Bringing Immunization Services to Children in a Conflict-Ridden Area of Myanmar



In 1994, Health Unlimited (HU) initiated humanitarian relief for refugees in the Kachin Independence Organization (KIO)-controlled area of Kachin State, Myanmar—an area where even today, political instability remains a considerable threat. Building on this initiative, HU initiated the Kachin People's Health Development Initiative in 2006. This program is designed to decrease the maternal mortality ratio and the mortality rate of children under 5 by reinforcing the health system, enabling local authorities to take greater responsibility for health services, and increasing access to basic preventive and curative health services in the area. Infant immunization was implemented at the very beginning of the project. First, immunization education activities were organized. Pamphlets and posters were distributed to rural health centers and 30 village health committees were created. Committee members motivated community members to participate in vaccination. Initial and refresher vaccination training was conducted, supplies were provided and incentives were introduced. Every quarter, monitoring trips were organized in which health officials participated. During these trips, project teams followed a checklist that helped them review the recording of routine immunization activities, gather demographic information, and analyze core outputs. To realize stronger results, HU also helped facilitate discussions between the KIO and the Government of Myanmar for the provision of government support for vaccines, cold storage, and training. Currently, 36 vaccinators and 17 rural health centers (including two cold chain centers and three civil hospitals) are involved in the project and monthly Expanded Program of Immunization services are being provided in 160 villages. Five basic vaccines are available and 2063 infants were immunized in 2007, bringing coverage to 83%. The next stage of the project will seek to lower the drop-out rate: at 57.5%, the percentage of children who received a full schedule of all five vaccines is considered low.

Bidan Delima: A Branding Program to Improve the Quality of Midwife Services in Indonesia



A program of the Indonesian Midwifery Association, Bidan Delima was designed to increase the standards of practice of midwives in private practice and thus combat the country's high maternal and neonatal mortality rates. The program's goal was to help ensure that midwives' practices meet national clinical standards with respect to family planning, infection prevention and safe deliveries. With the help of a facilitator from Jhpiego, technical assistance from the Johns Hopkins Bloomberg School of Public Health/Center of Communication Programs and clinical training and materials from Johnson & Johnson, nine IBI midwives were trained as midwife trainers. Once trained, these midwives approached privately practicing midwives and encouraged them to become candidates for Bidan Delima. The candidates completed a self-learning component that allowed them to compare their actual skills to standards of practice. The candidates then registered for the training components that corresponded to the areas where their skills needed improvement. When they felt ready to be tested, candidates contacted the program facilitators. The facilitators tested the candidates during site visits and observed all aspects of their practices. Candidates who failed to pass the test worked with the facilitators to improve their skills. Candidates who passed the test were certified and authorized to post the Bidan Delima logo on their name boards. To date, 7463 midwives have been certified as meeting national standards and 2536 are candidates for certification. Certified midwives have demonstrated greater professionalism and improved quality of care. Maternal and neonatal mortality rates have been reduced.

Expanding Intrauterine Device and Medical Abortion Services in Two States of India: Bihar and Jharkhand



Contraceptive use has been steadily increasing in India. At the same time, there is a substantial unmet need for contraception, particularly for long-term reversible methods. This poses a health risk to women: 8.9% of maternal deaths in the state of Bihar are caused by unsafe abortions. Janani has begun to expand the provision of intrauterine device (IUD) and medical abortion services in Bihar and Jharkhand, two of India's poorest regions. Janani's program combines the strengths of social marketing with a clinic-based service delivery program and a franchisee program through which doctors in rural areas provide low-cost services. Janani's network of franchised Titli ("Butterfly") centers is run by over 22,000 rural medical practitioners whom Janani has trained to sell condoms, oral contraceptives, over-the-counter pregnancy tests. Each rural health practitioner works in partnership with women who are family members and who serve as the conduit between the clinics and rural communities. Clients needing clinical services, including abortions, are referred to nearby Surya clinics, which pay a commission to the Titli centers for their referral. The franchisee Surya clinics have diagnostic facilities and adhere to quality norms ensured by Janani management. A mobile medical clinic is available to reach the remotest areas. This unit provides essential family planning materials and reproductive health services. Government of India subsidies for condoms and pills help make products affordable. Government support also helps Janani keep the costs of IUD insertions low. Innovative advertising campaigns have been an important facet of the program's implementation. These measures have allowed Janani to substantially exceed the number of IUD and medical abortion services it had originally expected to provide. In 2008, Janani sold, inserted or administered 15,744 IUDs and 90,977 medical abortion doses to women in the two states.

Improving Midwifery Education for Better Maternal and Newborn Care in Aceh Tengah District, Indonesia



Because only 46% of Indonesian births take place in healthcare facilities, much of the burden of ensuring safe deliveries rests with village midwives. Over a period of two years, Jhpiego Indonesia worked with GlaxoSmithKline to provide technical support to a midwifery polytechnic school located in an area whose history of isolation and civil conflict had left it with some of the country's lowest health indicators. Reflecting the poor state of services in the area, the school library was delapidated and only one member of the school's faculty had received in-service training or clinical updates since her pre-service education. The low number of births in facilities made it impossible for the school to provide meaningful opportunities for birth simulations or the supervised practice of midwifery skills and school graduates had questionable competency. As a result, the school was not recognized by the Ministry of Education and its resources were limited. The project began by upgrading the teaching skills of faculty members and enhancing the learning environment with a better library and modern pedagogic simulation equipment. It also introduced preceptor-mentorships wherein skilled midwives supervised students' practicums and students had more opportunities to attend deliveries at clinics. As a result, graduates achieved better examination results and demonstrated greater confidence in their skills, and more pregnant women chose to give birth in midwife clinics rather than at home. In addition, enrollment at the school rose sharply, local government awarded the school a certificate and budget allocations for midwifery education were increased. The school's management has also applied for accreditation from the Ministry of Education. The project is seen as a model for improving other academies in the province and elsewhere.

Viet Nam Reproductive Health Project in Nghe An Province



Between 1997 and 2005, the Government of Viet Nam, the Japan International Cooperation Agency and the Japanese Organization for International Cooperation in Family Planning collaborated to implement a project to improve reproductive health (RH) services in Nghe An, one of Viet Nam's poorest provinces. Key components of the project, which took place in two phases, consisted of improvements to healthcare facilities, the provision of equipment and logistics and the re-training of health service providers, particularly at the commune level. Steering committees were established at the provincial, the district, and the commune level with a view to ensuring support, collaboration and a sense of ownership. Various studies were conducted to determine needs and to identify cultural factors that would affect project implementation. Grassroots organizations were mobilized in a variety of ways: for example, the Women's Union conducted successful grassroots information, education and communication activities using materials supplied by the project. The project also brought key Nghe An counterparts to Japan to learn about Japan's experience improving MCH. These and other measures occasioned an increase of awareness and knowledge which brought about significant behavior change on the part of service providers and clients, resulting in reduced maternal mortality rates, reduced infant mortality rates, less obstetric complications, less abortions and less menstrual regulations. The contraceptive prevalence rate also increased. After the project terminated, the Nghe An Reproductive Health Care Center, the project's management unit, continued to improve the quality of RH services and to conduct supportive monitoring of commune health centers, leading the central Ministry of Health to recognize it as one of the best centers in the country in 2009. In 2006, Nghe An province accepted the responsibility to share its know-how and lessons learned with four neighboring provinces. The follow-up phase of the project is ongoing. A key lesson reinforced by this project is that when a donor is too rushed to obtain outcomes and places too much focus on efficiency, the counterpart's sense of ownership suffers and sustainability could be at risk.

Revitalizing Community Demand for Immunization in the Lao People's Democratic Republic



Over a period of 16 months in 2006 and 2007, Asian Development Bank, GlaxoSmithKline Biologicals and UNICEF collaborated with Lao PDR's Ministry of Health to pilot a strategy that aimed to improve childhood immunization coverage in the Lao People's Democratic Republic by testing communication measures to increase community demand for immunization. First, assessments were undertaken to understand community and health work motivation around immunization service delivery. With the help of the Lao Women's Union and other NGOs, the project then developed and piloted an innovative mix of strategies such as advocacy-building among community leaders; social mobilization measures; behavior change materials; interpersonal communication through peer-to-peer education, mass-media and info-tainment; and the social marketing of user-friendly health services. Examples include ethnic language radio spots; immunization cards featuring a frangipani flower with five petals, one for each immunization visit; the coordination of outreach visits with the seasonal calendar so as to ensure that visits did not conflict with peak periods in the agriculture cycle; and inexpensive give-aways (gifts) to parents whose children were fully immunized. Some strategies were generic to all districts while others were tailored to low-coverage communities. Results show that immunization rates in pilot districts doubled and in some cases nearly tripled over the duration of the project. A key factor of success was building on and mobilizing additional national political support to increase immunization rates across the country and ensuring appropriate synergies between national and community efforts. Replication of the pilot in other provinces will depend on buy-in from the Ministry of Health and its development partners.

Promoting Integrated Community Health Education in a Remote Island of Indonesia

Over a period of 24 months, this project promoted maternal and child health (MCH) in Tello Island, one of Indonesia's poorest and most underserved areas. Prior to the project, MCH promotion efforts and good nutrition rates in the area were extremely low due to the fact that the local posyandus (integrated community health structures) had been inactive for years. This project aimed to increase the community's capacity to implement healthy behavior; to increase access to health services for mothers and children under 5; and to revitalize the posyandus. MAP International first trained village learning groups in MCH. Four cadres from each group then underwent further training in order to initiate posyandu activities. Staffed by village cadres and a district health worker, the posyandus were conducted using a "five table" approach: a first table for registration, a second for weighing and measuring, and so on. MAP International also conducted a breastfeeding counseling course for midwives and trained health educators in breastfeeding promotion. Results show that so far, about 900 families have participated in seminars on nutrition, reproductive health, community transformation, and breastfeeding. Fifteen posyandus are now taking place monthly and 80% of children under 5 receive regular growth monitoring and vaccination services. Mothers also now report practicing exclusive breastfeeding. The most effective tool was the village learning groups. The meetings of these groups were key to revitalizing the posyandus and involving village heads, religious leaders, local elders and others in meeting project goals. The biggest challenge arose from the district's failure to supply vaccines and train and motivate health workers. By employing local human resources as facilitators to spread the message in their own language, MAP's strategy enhanced health knowledge, fostered greater acceptance of healthy behavior changes, and helped educate residents on what health services they should expect from government.



Facilitating Synergies to Scale Up Maternal, Newborn and Child Health Interventions in Nepal



This prospective project by Mother and Infant Research Activities (MIRA) proposes to facilitate the synergy between organizations working in maternal, newborn and child health (MNCH), especially immunization, in Nepal, so that they can learn about each other's best practices, internalize those practices and adapt feasible approaches to their own programs. Supported by several partners and operating under strong government leadership, Nepal's Community Based-Integrated Neonatal Care Package seeks to scale up neonatal care. MIRA' project will aid this process by organizing a national meeting of government decision-makers, external development partners, and international and national non-governmental organizations engaged in high-impact MNCH initiatives. MIRA will follow the national meeting with five regional workshops involving district public health offices and local non-governmental organization partners. Five exchange visits of high-impact intervention sites will enable workshop participants to internalize relevant information. This form of synergy-facilitating will not only accelerate the uptake of best practices by smaller programs, it will ensure that larger organizations presently engaged in scaling up their pilot activities become aware of high-impact best practices and have the opportunity to incorporate those practices into their programs at minimal cost. MIRA expects that the interactions between actors fostered by its project will improve the performance of individual programs and help reduce neonatal, infant and maternal morbidity and mortality in the area.

Evaluating the Use of Outside-the-Cold-Chain Hepatitis B Vaccination in Viet Nam



According to World Health Organization estimates, Viet Nam has a high prevalence of hepatitis B virus (>8% of the population). The proper delivery of a birth dose of hepatitis B vaccine within 24 hours of birth is estimated to prevent 80% to 95% of mother-to-child transmissions. Yet studies point to numerous difficulties in delivering the dose. Many of these problems stem from community health centers' difficulty in maintaining the cold chain, mainly due to their lack of refrigerators. Between May 2004 and July 2005, PATH collaborated with Viet Nam's National Expanded Program on Immunization (NEPI) to conduct a pilot study to evaluate the effectiveness of the birth dose of the hepatitis B vaccine stored outside the cold chain. To do so, the study population was divided into two groups. The first group consisted of newborns who received the birth dose of hepatitis B vaccine according to standard NEPI procedures. The second group consisted of newborns who received a hepatitis B birth dose that had been stored at ambient temperature in vials marked with vaccine vial monitors (VVMs). These monitors darken with exposure to heat over time. Healthcare workers were trained in immunization practices, including the reading of the VVMs. Results showed significantly increased rates of birth dose vaccinations at participating study sites with no decreased efficacy or protective immune response and no increased number of adverse events in neonates who had received the vaccine. Compared to pre-intervention rates, the study also showed a 44% increase in hepatitis B vaccine coverage within the first 72 hours of birth (89% coverage compared to 45% coverage). Qualitative results attest to widespread acceptance of the strategy by mothers and healthcare workers alike. These findings suggest that in regions where maintaining the cold chain is difficult, use of the hepatitis B vaccine stored outside the cold chain is an effective means of protecting children from hepatitis B infection.

The Grameenphone Safe Motherhood and Infant Care Project: Sponsoring Community-Level Service Providers for Better Health



From August 2007 to May 2008, Pathfinder International collaborated with Grameenphone Ltd. and the Government of Bangladesh to implement a safe motherhood and infant care project in 61 districts of Bangladesh. The largest corporate social responsibility initiative ever seen in Bangladesh, this project provided the poorest of the poor (PoP) with medicine, laboratory services, and regular consultations with trained healthcare providers in Smiling Sun clinics, a non-governmental organization network of 318 static healthcare facilities and approximately 8,500 satellite locations in underserved urban slums and hard-to-reach rural areas where the least advantaged of the population dwell. Community health volunteers, termed “depot holders”, identified PoP pregnant women and infants and registered them for health benefit cards. These cards allowed the clients to access Smiling Sun services for free. To promote the project, staff and volunteers conducted workshops that taught village leaders, religious leaders and PoP families how to access services. Depot holders and others also organized health expositions in their homes and in the homes of village leaders. In chronically poor villages, depot holders were taught how to transmit health messages and were given materials and health and family planning commodities that allowed them to service users at their own doorsteps. As a result of these activities, the utilization of health services by PoP women, neonates and infants increased significantly, and maternal, neonatal and infant mortality and morbidity in the catchments area of the Smiling Sun clinics decreased. This project suggests that providing quality services and creating awareness through a dedicated group of community workers can dramatically improve service utilization by the PoP in low coverage communities.

Revitalizing the Delivery of Maternal, Newborn and Child Health Services in Rural Pakistan



Over 19 months in 2007 and 2008, Sindh Rural Support Organization, a government-organized non-governmental organization, collaborated with the Government of Pakistan to improve the delivery of healthcare services, including maternal, newborn and child health care, in rural areas of Sindh Province, Pakistan, without external donor funding. Government officers with a reputation for integrity were assigned to head rural support organizations under the oversight of SRSO's board of directors. Program authority and certain budgets were transferred to the officers, who were given the flexibility to hire staff at incentivized salaries; plan the use of resources re-routed from district-level health facilities; mobilize community ownership of health facilities; and raise awareness of immunization, hygiene and disease prevention. The officers brought female medical professionals to rural areas for the first time, resulting in a 150% increase of health facility attendance by female and child patients. Family planning clients also increased from 14,000 to approximately 60,000 over six months. The project organized community support group meetings and paid daily visits to facilities where team members resolved issues of medicine availability, equipment needs and repairs. As a result, all dysfunctional or illegally occupied health facilities were made functional and facility utilization rose up to 400%. Within a year and a half, the project had been expanded from three to 17 provincial districts and Expanded Program for Immunization (EPI) services had been made available in 72% of facilities compared to 40% of facilities prior to the project. The availability of qualified doctors increased, absenteeism dropped, and the range and quantity of medicines skyrocketed. As a result, immunization coverage of mothers and children rose considerably, health professionals' attendance of deliveries improved, and antenatal care visits increased. Control and management for the EPI and other vertical programs will be transferred to this system to ensure fully integrated primary health services.

Strike Out Pneumonia: An Advocacy Campaign in Metro Manila, The Philippines

In spite of the availability of effective vaccines, about 2 million children below 5 die of pneumonia around the world each year. To help improve prevention in the Philippines, in August 2008, the Philippine Foundation for Vaccination (PFV) initiated a campaign to urge local governments, non-governmental organizations (NGOs), and communities to take action to prevent pneumonia in children, adults, and the elderly and to reduce deaths and hospitalizations from the disease. With a focus on local commitment and buy-in, the project organized meetings with city health officials in the Metro Manila cities of Manila, Pasig and Pasay to discuss and realize ways that health officials could support immunization programs in their communities. Officials agreed to participate in PFV's 9th Annual Philippine National Immunization Conference on the same day that the Strike Out Pneumonia campaign was being held at the campus of the University of the Philippines Manila. Recognizing that booster shots are unavailable under the Philippines' Expanded Program of Immunization, multiple vaccine missions also took place in which booster shots were administered to thousands of adults and children. Project activities were published in major newspapers and on internet news pages and blogs. As a result of these activities, local health officials introduced new vaccines into their communities. PFV has received requests for more vaccine missions and vaccine pricing negotiations among stakeholders are currently taking place. This project complements other advocacy efforts on the part of PFV, which works with local stakeholders to generate greater interest in new vaccines and forms creative partnerships with government, NGOs, the media and insurance agencies to address other issues relating to vaccine financing and public health interventions.



The Well Baby Bakuna Program: Increasing Middle Class Access to Privately Administered Vaccines



Philippine NGO Council on
Population Health and Welfare, Inc.

Only 10% of the two million babies born in the Philippines each year visits pediatricians for health services. Of the remainder, not many receive a full set of vaccinations and others visit health centers where treatment, including immunization, is free, where the stocks of vaccines are sometimes lacking, where newer vaccines are unavailable and where the quality of care varies. Many of the parents visiting these centers would be willing to pay for their children to access vaccines from private clinics if to do so was affordable. The Philippine NGO Council on Population Health and Welfare (PNGOC)'s Well Baby Bakuna Program is designed to facilitate these parents' access to affordable vaccines from private providers in order to increase coverage and free up stocks of free vaccines in government health facilities for indigent families. With the participation of GlaxoSmithKline Inc. and the Philippine Pediatric Society, Inc. (PPS), the project began by identifying PPS-member pediatricians willing to administer vaccines at a negotiated fee in areas where children's immunization rates were particularly low. A lead person administered the vaccination program and an area coordinator conducted community mapping, community surveys, hospital coordination, house-to-house visits, a community assembly and mothers' classes. The goal was to promote immunization by highlighting the program's affordability and its easy installment payment scheme. PNGOC conducted patient screening through one-on-one interviews with parents. Parents who could afford were discouraged from enrolling and the indigent parents were referred to health centers where immunization was free. Middle-income parents from C and D income brackets were directed to participating clinics where they availed of vaccination services at an affordable price. By identifying and responding to a willingness to pay among middle-income parents and securing the participation of private providers willing to reduce rates in order to generate greater caseloads and increase immunization coverage, this model can help the Government of the Philippines increase coverage and meet Millennium Development Goal 4 (Reduce Child Mortality).

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Using Community Performance Contracts to Change Health Behaviors in Cambodia



Aided by strong support from Ministry of Health entities at national and local levels and by a belief that communities are their own greatest resource, Reproductive And Child Health Alliance (RACHA), a Cambodian non-governmental organization, introduced in 2000 a program designed to change health behaviors at the village level. Under this program, villages and local health centers signed community development performance contracts under which participating villages would receive one or more water wells in return for meeting various health indicators, including immunization coverage rates. In a first step, local health centers committed to providing a package of health services to their communities at health center premises and outposts and in remote villages. Local authorities and village chiefs were then informed of the goal to increase health services in order to improve the health of the community. RACHA trained midwives, health promotion volunteers, and traditional birth attendants in safe health practices and educated village shopkeepers, nuns, wat (temple) grannies, and traditional healers about the benefits of immunization and other issues. It also trained local shopkeepers, actor/comedians, and wat grannies to deliver culturally and linguistically appropriate community health advocacy messages. Follow-up assessments were conducted every six months. Depending on the health coverage level achieved, each village earned the right to zero, one, two or three wells. Occasionally high-scoring villages' scores went down, but usually scores increased, particularly in low-scoring villages. In 2004, the project's incentives changed when USAID, RACHA's major funder, recognized that wells should be offered as a right and not as a reward. Since then, the network of village health promotion activists has continued and health-related behavior changes have been sustained. Clean water is now being provided to villages as a donation with the support of Latter Day Saints-affiliated charities.

Increasing Service Use Through Health Advocacy in Northwest Bangladesh



RDRS Bangladesh, a national non-governmental organization, sought to improve the perinatal health status of women in target areas by ensuring their access to good quality, user-friendly services; by improving the referral system; and by promoting awareness of related health issues. Consistent with RDRS' approach to complement but not replace government services, RDRS first obtained the permission of local authorities to organize antenatal clinics at government health centers and community centers. Services were provided by trained female paramedics, the supply of vaccines and medicine was regularized and clinics conducted regular education sessions about reproductive health and safe deliveries. RDRS trained 600 birth attendants in safe home birthing techniques and the early recognition of complications for rapid referral. Birth attendants were also taught to encourage mothers to attend immunization sessions and motivate pregnant women to obtain antenatal care. Community activists held people's theatre and folk song performances that counseled against early marriage; promoted antenatal, natal and postnatal care, immunization, and family planning; and educated the public about the prevention of HIV/AIDS. Regular meetings took place during which government health officials and the representatives of non-governmental organizations discussed means to improve coordination and regular refresher training was offered to all project staff. The project led to an increase in the use of health services. Of the 109,664 pregnant women who availed themselves of services in 2007, 74% had attended clinics for at least 4 antenatal check-ups and 96% had received at least two shots of tetanus toxoid vaccine. In addition, 83% of home deliveries in 2007 were conducted by trained traditional birth attendants. More women adopted family planning methods and the average number of children per woman dropped from six to three. The maternal mortality ratio of the project's registered pregnant population reached 1/1000 live births versus the national ratio of 3/1000 live births.

Barefoot Women Health Volunteers Improving Health in Rural Nepal



In this project, Women Acting Together for Change (WATCH) worked to develop a self-sustaining healthcare system in rural and remote areas of Nepal. WATCH found that in these areas, children were dying from complications due to measles; women's health was neglected; and young babies were either neglected or cared for mainly by older siblings. Pregnant women received no medical support and fertility and child mortality rates were high. Accordingly, the project aimed to decrease child mortality through safe motherhood measures, nutritious food, education about nutrition, and immunization; diminish family sizes by helping children stay healthy and thus reducing parents' desire for large families; and prepare local women volunteers to take responsibility for project measures. First, local women's groups mobilized and selected volunteers. WATCH then trained the volunteers and provided them with essential medicine, follow-up support, and birthing kits. While some medicine and services were provided free to certain clients, wealthier clients were charged according to a fee schedule elaborated by the local groups. WATCH employed an assistant nurse midwife to support and supervise the volunteers and organized monthly meetings to review activities and find solutions where needed. WATCH also developed a referral mechanism that allowed volunteers to send their clients to hospitals and local health centers. As a result, maternal and neonatal mortality in the area is now almost nonexistent. The number of pregnant women visiting healthcare centers and hospitals for check-ups and deliveries is increasing and many families are limiting themselves to two children, even if they are both girls. People have become more conscious of health and hygiene and are ensuring that their children are vaccinated. De-worming is now accepted by the community and regular de-worming camps are taking place.

Developing a Model to Deliver Sustainable Health Care on Scale Anywhere



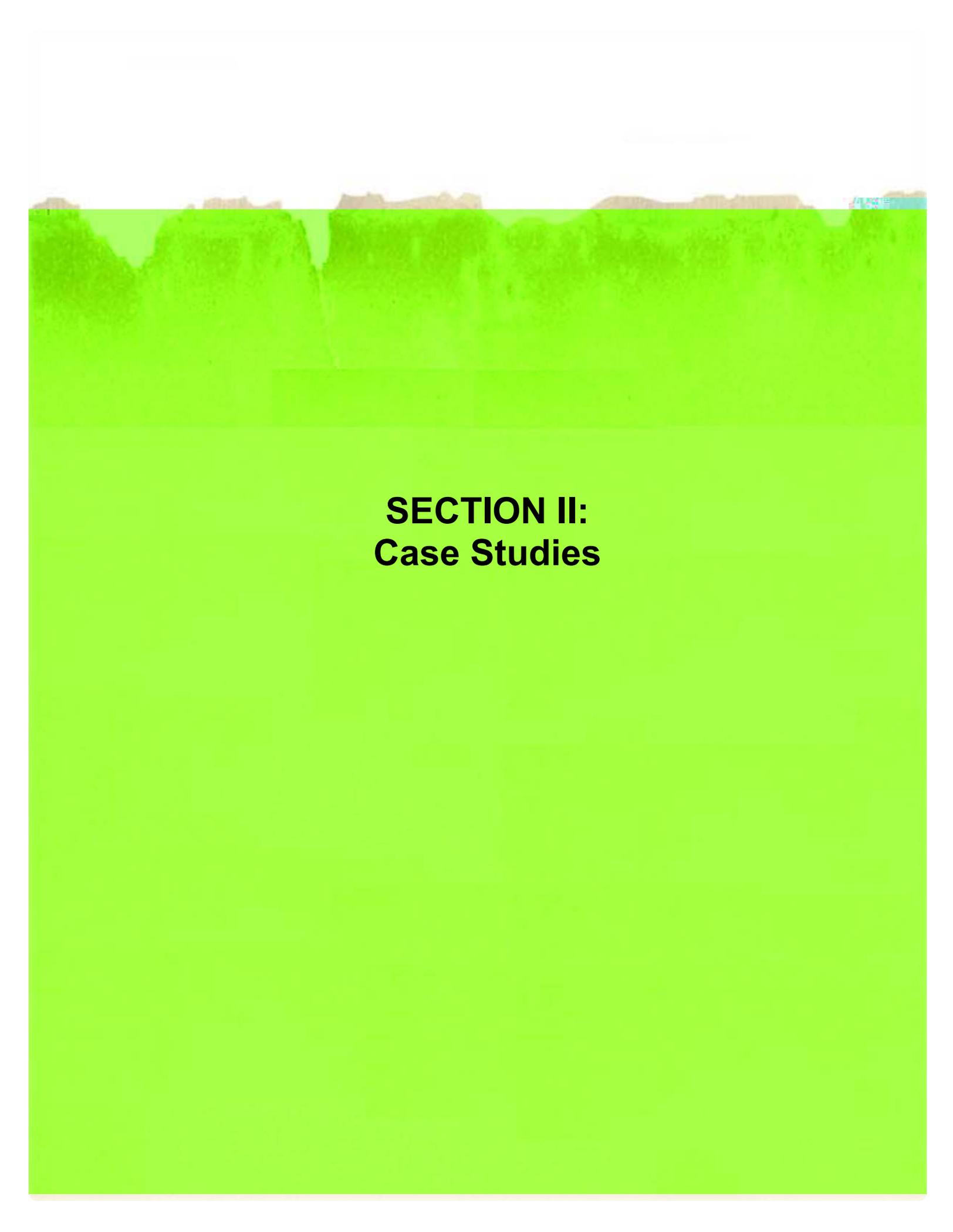
WORLD HEALTH PARTNERS

In 2008, World Health Partners (WHP), a global alliance that seeks to bring high-quality health and reproductive care to remote villages of the developing world, launched an 18-month pilot project to serve 1,000 villages of Uttar Pradesh, India. The core strategy of WHP's model is to use existing human, financial, and physical resources from the private sector to provide care to the needy by offering clients access to four tiers of health products and services, organized into sub-networks for product and supplies distribution and medical referrals. Specifically, 900 pharmacies are being recruited to sell non-clinical contraceptives and medicines and to refer patients to nearby rural health providers or telemedicine provision centers for additional counseling and services. One thousand rural health providers have been invited to acquire formal training in basic health services and to expand their clientele by virtue of their association with the network brand. Clients requiring further care will be referred to telemedicine provision centers for a formal medical consultation, a physical examination, more sophisticated diagnostic tests, therapeutic prescriptions and/or family planning services. Telemedicine services will be provided by a small staff of doctors at a central medical facility linked to villages through a satellite communication link. Finally, 20 doctors in each village health network will be given the opportunity to operate a franchisee clinic. These formally qualified doctors will enjoy the benefits of network referrals, aggressive marketing and advertising, and ongoing skills training. Throughout the tiered model, WHP looks to engage partners with an entrepreneurial sense, including those who are in need of work and who in some cases have been willing to take loans from WHP in order to be affiliated with the brand. While the project is still in the pilot stage, WHP's advocacy and advertising campaign has already generated a high enough caseload to make providers keen to participate, even though earnings per case are markedly lower than current market prices. However, the key to sustainability will be collaborating with the public sector, charging fees to reduce donor dependency, and using effective financial instruments (risk pooling, insurance, etc).

Improving Immunization Rates with Timed and Targeted Counseling in Uttar Pradesh, India



Between 2004 and 2007, World Vision India, India's Ministry of Health and other partners collaborated in a project designed to use "timed and targeted counseling" to improve immunization rates and other maternal and child survival interventions in selected districts of Uttar Pradesh, India. Prior to the project, health promotion messages, while technically correct, were found to be delivered either too early or too late to be practiced. Moreover, the messages were delivered primarily to pregnant women and to the mothers of infants, populations that had little say in the decision to use services. To address these problems, the project targeted key messages both to those who would use the services and those who would decide whether the services would be used. The messages were delivered neither too early, lest they be forgotten, nor too late for action to be taken. Community workers were trained in the use of color-coded registries that tracked their delivery of messages and beneficiaries' use of services – a registration system that not only helped inform families of needed follow-on actions but also helped health deliverers plan for immunization sessions at health outposts. They were also given a handbook that contained a list of myths and false beliefs and appropriate responses. Monthly verifications showed nearly all community workers using the registries and 83% to 97% providing adequate and timely counseling. Surveys also showed that full immunization of infants had increased from 30-33% to 50-53% and that 98% and 99% of sampled children in two districts had received at least one dose of diphtheria, pertussis and tetanus vaccine during infancy, up from 12% and 37% respectively. An unforeseen but welcome outcome of the project was strong government endorsement of the timed and targeted counseling approach and subsequent mainstreaming of its tools into the health education strategies of all 70 districts of the state. This step was facilitated by the presence of a "champion" at the state level, who embraced the approach and led the scale-up process from the top.

The image features a background of a city skyline with a green gradient overlay. The skyline is visible at the top, with buildings of varying heights. The green gradient starts as a light green at the top and transitions to a darker green at the bottom. The text is centered in the lower half of the image.

SECTION II: Case Studies

CASE STUDY

I. Project Title

The Child-Friendly Village Initiative in Kampong Thom Province, Cambodia

II. Project Summary

From October 2001 to September 2006, Adventist Development and Relief Agency (ADRA) Cambodia implemented a child survival project with the support of the United States Agency for International Development. The project was implemented in 10 health center catchment areas or 113 villages of the Baray-Santuk Operational District (BSOD), Kampong Thom Province, Cambodia. ADRA Cambodia's project principal partner was BSOD, whose local health center staff worked under the direction of the district manager and the maternal and child health (MCH) manager. Of the 126,658 residents of the project area, approximately 17,477 children under the age of 5 and about 22,575 women of reproductive age (15-49 years old) benefited from child survival interventions.

Four main strategies were used to implement the project interventions. One of these strategies consisted of community-based village-level initiatives such as mothers' clubs, village health days, hearth groups, home gardening and the **child-friendly village initiative**. This initiative recognized villages that met specific child-friendly village criteria: 20 villages committed to meeting the criteria were specifically targeted. By the end of the project, nine villages had achieved child-friendly status.

III. Introduction/Background

The goals and objectives of the child survival project were to improve the health and reduce the morbidity and mortality of women of reproductive age and of children under 5 by conducting sustainable activities around maternal and newborn care, child spacing, nutrition and immunization. The key strategies used by the project to reach these objectives were as follows:

- Village-level volunteers, traditional birth attendants (TBAs) and existing care structures were activated in multiple capacities to promote project goals and monitor growth;
- Community leaders and resources were mobilized through village-level organizations and initiatives such as mothers' clubs, village health days, community-based nutrition promotion groups, home gardening, and **child-friendly village initiatives**;
- The capacity of local health centers and the BSOD system to deliver quality maternal and child health services was strengthened;
- Partnerships with the Ministry of Health, non-governmental organizations and local associations were formed to foster integration between health center staff, community leaders, village-level volunteers and TBAs.

The child-friendly village approach, acknowledged at the 2005 Global Health Council, motivates individuals to form a committee of key village leaders, local TBAs, village-level volunteers and one staff member from the local health center. The committee undertakes to coordinate local health activities, solve local health problems and cooperate with the local health center with a view to achieving seven village-wide indicators that cover a wide spectrum of aspects of MCH. Progress towards these indicators is monitored. Once targets are achieved, a village health day

takes place during which the village is formally declared a “child-friendly village” and a monument is erected to that effect.

The capacity-building strategy used to educate village mothers and mobilize them towards achieving child-friendly status for their village incorporates elements of a multilevel approach widely recognized to be very effective (Bolger M (2000), UNDP (1998), Whyte A (2004)). The approach is considered suitable for scale-up because it is easy to replicate; uses sound capacity-building measures; need not be expensive; can be used repeatedly for different indicators; and can be applied across various programs. At the end of the child survival project in August 2006, 20 villages had committed to the approach and nine had achieved child-friendly village status. This status usually takes 2 years to achieve.

IV. Project Implementation

Under the child-friendly village approach, project staff approached residents of villages that were less than three kilometers from a health center, that had home gardening promoters and that enjoyed a reasonable water supply to see if they were willing to form a child-friendly village committee (CFVC) with a view to achieving seven specific MCH indicators. CFVCs were made up of key village health leaders, the commune coordinator, the vice village chief, a health center chief or staff member, a Ministry of Women’s Affairs representative (if available), the local village health volunteer chief, a local TBA and a priest, monk or key local informant.

CFVC members undertook to

- (a) facilitate local health activities such as the Mothers’ Club, the nutrition program, home gardening, village health days and the Expanded Program of Immunization;
- (b) Solve health problems within the village if possible or arrange speedy transfer to health facilities if indicated;
- (c) Facilitate the exchange of health-related information among the local health center, project staff and community members; and
- (d) Attend two meetings per month.

In performing these activities, the CFVC strived to help local villages achieve the following seven goals:

1. 40% of mothers with children under 24 months old use birth spacing methods;
2. 10% to 25% of pregnant women have at least two antenatal consultations at the health center;
3. The village establishes a medical emergency transport plan;
4. 28% to 40% of children under 24 months are completely immunized;
5. 25% of pregnant women have a birth preparation plan;
6. 13% to 25% of mother initiate breastfeeding within the first hour after delivery;
7. 12% to 25% of mothers with children under 24 months old give extra fluid and food to their children when the children are ill.

CFVC members were trained in basic organization and planning skills and MCH. “Model mothers” were rewarded with sarongs on which health messages were written. In order to be

named a “model mother”, a mother had to attend nutrition sessions for seven days, contribute food to the hearth nutrition program for at least eight days, pass an examination of her health knowledge after instruction by community health volunteers and staff, breastfeed exclusively when appropriate to the age of her child, take lessons on how to cook nutritious food for her children, and practice good hygiene at home as per the observations made by volunteers and staff over the course of several visits.

The capacity-building strategy for the education of village mothers incorporated the best elements of a multilevel approach. It consisted of

- Training mothers individually and in groups;
- Role modeling by model mothers and other mothers with good practices, especially those working towards achieving model mother status;
- Mothers developing personal relationships with members of the CFVC;
- Mothers undergoing social pressure by members of the CFVC in particular and other members of the community in general, all of whom were committed to having the village achieve CFV status;
- Mobilizing and organizing the capacities of local community leaders in the CFVC.

V. Outcomes, Impacts and Sustainability

In July 2006, the team conducted a final child survival project survey (the final survey) of 30 randomly selected villages in the project area. Of these 30 villages, one village had achieved child-friendly status. The team also devoted a day to surveying 12 villages not included in the final survey (the combined survey). Of these 12 villages, eight had achieved child-friendly village status and four were non-child-friendly-status villages selected at random. These populations provide the basis for a statistically significant analysis of child-friendly village versus non-child-friendly village performance in all project and Rapid Core Assessment Tool on Child Health (Rapid CATCH) indicators. Overall, the results indicated significant improvements in knowledge, attitudes and practices. Child-friendly villages outperformed expectations in almost every key project or Rapid CATCH indicator. Results were as follows:

77% of mothers in child-friendly villages had at least two pre-natal visits, versus 52% of mothers in the combined survey, 47% of mothers in the final survey and 10.3% of mothers in the baseline survey;

81% of mothers in the combined survey reported receiving at least two tetanus toxoid vaccinations during their last pregnancy, versus 76% of mothers in the final survey and 47% of mothers in the baseline survey;

85% of mothers in the combined survey reported using clean birth kits at their last delivery, versus 73% of mothers in the final survey and 71% of mothers in the baseline survey;

100% of mothers in child-friendly villages had their children aged 12 to 23 months vaccinated against five vaccine-preventable diseases, versus 63% of mothers in the final survey and 28% of mothers at baseline;

88% of respondents in child-friendly villages could recognize at least two signs of childhood illness that indicated the need of treatment for their child, versus 28% of respondents in the final survey and 4% of respondents in the baseline survey;

48% of sick children under 23 months of age in child-friendly villages had received more fluids and had continued to be fed during the prior two weeks of their illness, versus 47% of children in the final survey and 12% of children at baseline.

Overall, these results show that establishing child-friendly villages has clear advantages. Child-friendly villages are participatory and inclusive. In them, the responsibility for improving health and engaging in healthy behaviors lies with the villagers, their management committees and local health center staff and managers. Child-friendly villages also provide a unique forum for mothers' clubs, health groups, home gardening, village health days and EPI activities. In addition, child-friendly villages mobilize villagers to meet indicators, resolve village health issues, and provide feedback to their local health centers or to ADRA. When applied correctly, this initiative has strong potential for export and sustainability, both of which are highly desirable in Cambodia.

VI. Lessons Learned

- (1) Effective community education and behavioral change can be achieved by mobilizing village-level volunteers, by involving community organizations and by conducting community education events that use drama, music, and information, education and communication materials to motivate workers and recognize local participation and achievements.
- (2) A cadre of village-level volunteers can play a key role in community education and mobilization.
- (3) The improved use of health services and the greater integration of community health activities can be achieved by (i) partnering with well-established community organizations, including the local health center; and (ii) integrating the activities of community volunteers and TBAs with those of health center staff.
- (4) The development of a community-based nutrition program, consisting of a practical, locally sustainable approach to childhood malnutrition, is a successful means of sustaining improved child nutrition. Under this approach, community leaders and local mothers help develop a culturally appropriate approach to providing nutrition for malnourished children and strengthening mothers' knowledge and skills.
- (5) The child-friendly village approach helps promote community cohesion and better health.
- (6) Better health practices can be promoted through village-level volunteers, community promotion events and the establishment of child-friendly village committees.
- (7) Improved monitoring and information dissemination processes include
 - (a) The practical application of periodic lot quality assurance sampling surveys with accompanying analysis;
 - (b) The reporting of most significant changes at the project level and the development of a monitoring-and-evaluation-for-learning approach at the national level;
 - (c) A streamlined approach to health information that facilitates the collation of health information by organizing the flow of data in such a way that only data that can be used at the next level is forwarded to that level.

VII. Conclusions

This project accomplished the following:

- (1) Recognition that focused stakeholder involvement contributes to community behavior change as community leaders support health interventions and establish high standards of health behavior as the norm;
- (2) Major improvements in community knowledge and practices in the area of antenatal care, pregnancy planning, maternal tetanus toxoid vaccine, childhood immunization, knowledge about AIDS, birth spacing, breastfeeding and childhood nutrition;
- (3) Better quality of basic childbirth services and prompter referrals for pregnancy complications through the upgrading of TBAs' skills and the establishment of a sustainable network of TBAs and health center midwives;
- (4) The establishment of cadres of trained village volunteers who contributed greatly to the achievements in (2) through their one-on-one education of community members and their role in community organizations and local education events;
- (5) The establishment, training and development of functional community organizations such as mothers' clubs, a health center management committee, community-based nutrition groups, CFVCs and a community representative feedback committee;
- (6) The development of a practical, sustainable approach to childhood malnutrition: namely, community-based nutrition;
- (7) The use of the child-friendly village approach to mobilize the community and the health center and promote improved, integrated MCH.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- Mobilization of resources
- Delivery of health services
- Generation of political will
- X Advocacy for community participation

IX. Organizational Information

- a. Name of Project Contact Person: Ann Stickle, Göran Hansen (Philippines)
- b. Designation/Title: Associate Country Director, Cambodia
- c. Name of Organization: ADRA Cambodia
- d. Address: P.O. Box 105, Phnom Penh, Cambodia
- e. Email Address: anns@adracambodia.org , gorbirhan@adra.ph
- f. Website: www.adracambodia.org
- g. Telephone / Fax Number: +855 23 880 693/ +855 23 880 305
- h. Organizational Overview (2-sentence description): The Adventist Development and Relief Agency Cambodia is working with rural poor and at risk populations to reflect God's character of love through development activities that alleviate poverty and empower people to realize an improved quality of life. ADRA Cambodia implements integrated and holistic programs through close, principle-based relationships with communities and development partners in the sectors of health, food security and water and sanitation.



CASE STUDY

I. Project Title

Improving Child Health in FATA, Pakistan, Through Behavior Change Communication Interventions

II. Project Summary

BEFARe is leading a partnership comprised of International Medical Corps (IMC), a United States-based international non-profit organization, and Community Motivation and Development Organization (CMDO), a local non-governmental organization (NGO), in implementing the Improved Child Healthcare Project in four agencies and four frontier regions of Pakistan's Federal Administered Tribal Area (FATA). This project is unique for its independent monitoring and evaluation mechanism that gives credence to program activities and for its implementation in areas with little or no access to primary healthcare services. BEFARe is implementing the project in remote areas of South Waziristan and the frontier regions of Bannu, DI Khan, Lakki and Tank. CMDO is implementing the program in FATA agencies North Waziristan, Kurram and Orackzai. IMC is monitoring the program independently in all areas. The project is funded by USAID at a cost of US \$1.7 million.

The goal of the project is to improve the health status of children in FATA and frontier regions not covered by lady health workers. Its strategic objective is to increase the use of key health services and improve health-related behaviors by generating awareness among tribesmen and tribeswomen about five important aspects of health: immunization, acute respiratory infections, diarrhea, essential newborn care, and nutrition and micronutrients. It is accomplishing this goal through the work of a doctor and nurse from Pakistan's Ministry of Health and the trained native volunteers who assist them. Besides awareness and sensitization initiatives, the project organizes monthly child healthcare days where free medicine is provided with the support of the Save the Children Fund (SCF). The project benefits a vast area by bringing about behavioral changes around child health issues in conservative environments.

Strategically poised to stock areas uncovered by the national program of lady health workers, the program is innovative in its use of culturally appropriate strategies, its presence in remote areas that are difficult to work in, its independent monitoring mechanism, and its close coordination with the Ministry of Health and with SCF.

III. Introduction/Background

FATA is the tribal area of northwest Pakistan. It is divided into seven agencies: Khyber, Mohmand, Bajaur, Orakzai, Kurram, South Waziristan and North Waziristan. FATA's population is 3.6 million people (1998 Census) of which the Government estimates 21% (756,000) are women of reproductive age and 8.8% (316,800) are children under the age of five.

Tribal societies in this area are traditional and have strong social beliefs and conventional practices. Their highly conservative, locally oriented mindset makes social improvement difficult. FATA comprises some of the least developed areas of Pakistan and the majority of its population lives in poverty. FATA's special status has led to its exclusion from national surveys and data collection, resulting in little availability of comprehensive baseline health data. Still, sample data indicates a very poor overall health status with a neonatal mortality rate of 57 per

1000 live births, an under-five mortality rate of 114 per 1000 live births, an infant mortality rate of 87 per 1000 live births, and a maternal mortality rate of above 600 per 100,000 live births. The area has 655 health facilities for approximately 2.9 million people and only 55 mother and child health centers for a population of almost 1.5 million women. There is one doctor for every 5,438 people and while on paper there is one health facility for every 50 square kilometers, many of these facilities are not functional. Community-level maternal and child health coverage through lady health workers reaches only 26% of the population.

Recently, the situation of tribal people has worsened due to poor security, illiteracy, poverty, popular unawareness of communal issues, popular unawareness of basic human rights, and the unavailability and inaccessibility of resources. Major health issues in FATA include the following:

- Lack of awareness about mother and child health issues and related matters;
- High neonatal and infant mortality rates compared to other parts of Pakistan;
- Chronic maternal and child malnutrition and poor nutrition during pregnancy;
- Lack of awareness about child immunization; and
- Inaccessibility to and lack of skilled birth attendants.

Objective

The increased use of key health services and improved health-related behaviors.

IV. Project Implementation

BEFARe is organizing awareness sessions, advocacy events, and child health days to create awareness in the underprivileged tribal population of the importance of preventing five diseases prevalent among children. With the support of SCF and USAID, BEFARe is providing and administering vaccines, free medicine and treatment for diarrhea, malaria, acute respiratory infections, measles and essential newborn care. Community staff organizes regular meetings with community elders and solicits support in eradicating common diseases among children through awareness sessions, advocacy events and the holding of child health days when medicine and vaccination are made available.

Involving and gaining the confidence of peaceful religious leaders has contributed to the successful implementation of the project in areas infested by militants. BEFARe has worked around militants' threats to exclude females from the project's outreach, both as workers and as service recipients. Good communication and the wide dissemination of program objectives have played a vital role in the project's success.

V. Outcomes, Impacts and Sustainability

The project is causing a markedly positive change in tribal parents' attitude towards vaccination. Prior to this project, parents opposed vaccination vehemently. Now, parents are observing better healthcare practices. In addition, improved health services and vaccination are helping reduce morbidity and mortality. To date, more than 6481 children have participated in 91 child health days in which a doctor and medicine were brought to areas without prior access to healthcare services. With the help of community health workers, BEFARe has disseminated behavior change communication messages and information, education and communication materials to thousands of community leaders, partners, teachers and school children in hundreds of community awareness and sensitization sessions and through advocacy events at both the tehsil (roughly equivalent to a county) and village levels.

A key innovative characteristic of this program regards its sustainability. BEFARe's unique practice of bringing community health workers to remote areas not covered by the national

program of lady health workers will be continued by national cadres after the project ends. This will ensure that the national health program is extended into areas not previously covered. A key successful approach of this project is the involvement of local staff and the upgrading of their capacity. This staff is willing to work in their own remote areas on a sustained basis even after the project terminates.

VI. Lessons Learned

What critical interventions affected the project either positively or negatively?

Pakistan's national program of lady health workers, designed to bring primary and mother and child health services to areas that lack access, is spread over the country. Its coverage in FATA and the frontier regions is, however, sparse. A major challenge of this program has been to identify and train lady health workers in conservative and remote areas such as FATA. Much of the difficulty stems from the Ministry of Health's inability to mobilize communities to help identify qualified lady health workers. In addition, low literacy rates and poor education among FATA residents, particularly among women, makes it virtually impossible to train lady health workers. Much of the area has not been mapped for the presence of lady health workers and most of FATA remains uncovered. This context made it challenging to map territories that were not covered by lady health workers and to endeavor to identify and build capacity to stock these areas with those workers. This challenge was compounded by the presence of extremist militants who vehemently opposed all foreign-funded programs, particularly those that endeavored to work with women and children. As per the program strategy, Save the Children (US) works in areas that are covered by lady health workers. BEFARe therefore coordinated closely with the Ministry of Health and with SCF to map and delineate areas that were covered/not covered by lady health workers. This was the cornerstone of the project's success.

What particular barriers or enablers were crucial to the success or failure of the project?

BEFARe implemented its project in a very difficult area. One of the keys to success was engaging qualified and well-connected local staff who understood local cultures, customs and traditions and was able to interact with local communities. This expertise gave BEFARe staff the ability to convince militants of the merits of the project. Only by educating the militants and negotiating with them relentlessly did BEFARe secure their permission to provide immunization services. Although at one point the project was halted for a month due to poor security so close to the volatile Afghan border, within weeks the project was reinitiated, albeit with slight adjustments in its mode of implementation so as to better conform to local cultures.

What factors should be considered in implementing a similar project in future? (e.g. financial factors, staffing measures, policies etc.)

Working in volatile and difficult environments such as FATA's pose a very unique set of challenges in terms of socio-cultural factors, militancy and terrorism. Although normal health insurance was budgeted for and provided, no insurance was available to provide coverage against militancy and terrorism. This was worrisome as staff faced financial and health risks by venturing into dangerous areas without adequate insurance coverage. Hence, it is imperative that future project implementers engage mostly local staff and budget for insurance coverage in the planning stages. Another key factor is to link programs to government initiatives that will ensure sustainability and ownership.

What suggestions would you make to other organizations wishing to implement a similar project in the future?

When planning to operate in FATA, development programs in general and health programs in particular should take stock of some very important factors at the planning stage. All development programs should identify key stakeholders and strategize programs to enhance their capacity to ensure sustainability and ownership at all levels. Communities inside FATA have remained underprivileged for decades and programs should focus on building local capacity, both public and private, through culturally appropriate approaches and by responding to needs identified and prioritized by the communities, again using local staff.

One of the key stakeholders in this project is the Government of Pakistan, i.e., the FATA Secretariat and the departments and directorates that have primary responsibility for health, education and livelihood services. All programs should therefore look at identifying and enhancing government staff and infrastructure capacities and aim to coordinate programs closely, responding to needs that are identified and prioritized by the relevant departments.

VII. Conclusions

BEFARe's strategy revolves around enhancing community capacity through awareness sessions and advocacy seminars. It contributes to national programs by stocking trained lady health workers in remote areas and working with Ministry of Health staff to ensure that children have free access to primary and basic healthcare through the organization of child health days in areas that have no access to services. BEFARe uses culturally appropriate approaches to ensure the project's success.

BEFARe initiatives have brought markedly positive changes in the behavior of tribal parents, for example as regards vaccination. With the help of community health workers, who conduct community awareness and sensitization seminars at the grassroots level, BEFARe disseminates behavior change communication messages through accepted information, education and communication materials to community leaders, partners, teachers and school children.

A key innovative characteristic of this project that will ensure its sustainability is BEFARe's practice of bringing community health workers to remote areas not covered by the national program of lady health workers. This approach will be continued by national cadres after the project ends, ensuring that the national health program is extended into areas not previously covered. A key approach of this project has been the involvement of local staff and the upgrading of their capacity. This staff is willing to work in their remote areas on a sustained basis even after the project terminates.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges were focal points of the project:

- Delivery of health services
- Advocacy for community participation and
- Generation of political will

IX. Organizational Information

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- h. **Organizational Overview** (2-sentence description)

BEFARe strives to empower underprivileged communities and assists state actors in Pakistan through innovative and multi-pronged strategies in education, health, livelihoods, democratic norms and human rights.



CASE STUDY

I. Project Title

Achieving Immunization in Bangladesh With the Help of Non-Governmental Organizations

II. Project Summary

Bangladesh is a developing country that has made remarkable achievements in immunization coverage. The commitment of the Government of Bangladesh and of non-governmental sectors to the Expanded Program on Immunization and the technical and financial assistance of development partners have helped increase the national immunization coverage rate of children between 12 and 23 months from under 2% in 1985 to 82% in 2007. Currently, maternal tetanus toxoid coverage is at 92%. Strong buy-in coupled with adequate budgetary allocations, readily accessible outreach sites, a strong support system and mobilization efforts by both government and non-governmental organization (NGO) workers have succeeded in increasing immunization coverage and decreasing neonatal and child mortality.

III. Introduction

Bangladesh has made significant progress in the reduction of infant and child mortality. Infant mortality rates declined from 87 per 1000 live births in 1993 to 52 per 1000 live births in 2007 and child mortality rates went from 133 per 1000 live births to 65 per 1000 live births in the same period (Bangladesh Demographic and Health Surveys for 1993-94 and 2007). These improvements can be attributed to various national programs for child health, including the Expanded Program on Immunization (EPI); breastfeeding programs; programs to treat diarrhea with oral rehydration solutions and zinc; acute respiratory infection case management with first-line antibiotics conducted by government and NGO health workers; routine Vitamin A supplementation programs; and de-worming programs conducted every six months. Immunization has evolved into a modern public sector health intervention and is one of the most efficient and reliable means of improving population health. Its importance has prompted public health professionals to consider immunization coverage as a reliable and comparable indicator for measuring health services coverage.

In Bangladesh, EPI was launched in 1979 and aimed to reduce child mortality and morbidity by protecting children against six vaccine-preventable diseases by providing high quality EPI services to all children in the country. It also aimed to gradually increase coverage in order to administer a full series of routine vaccines to at least 90% of children in all districts by 2010. A 1985 survey revealed that less than 2% of the country's children were fully vaccinated. To achieve the goals of the global Universal Child Immunization initiative, the Government of Bangladesh intensified EPI in phases between 1985 and 1990. During this period, EPI was expanded throughout the country. In addition, Bangladesh instituted National Immunization Days in 1995 with the aim of eradicating poliomyelitis. Held twice a year, National Immunization Days are immense campaigns that require the mobilization of substantial human and material resources. In 2003, a seventh vaccine for hepatitis B was incorporated into the program. The Government's main function under EPI is to ensure supply and while NGOs and other organizations address demand.

Between 1986 and 1990, BRAC's Child Survival Program helped the Government increase immunization coverage and strengthen EPI through mobilization, session management,

registration assistance and monitoring and supervision in Rajshahi Division, Chittagong and Cox's Bazar District. Between 1991 and 1995, BRAC continued to work on EPI-related matters and other issues under its Women's Health Development Program. Essential Health Care, another BRAC program, was started in 1999 and also addresses EPI. To further assist the Government of Bangladesh, BRAC initiated a maternal, neonatal and child health program in rural districts and urban slums. At present, BRAC facilitates an immunization and maternal tetanus toxoid vaccine program through EPI. This program is designed to reduce neonatal and child mortality.

IV. Project Implementation

Bangladesh is divided into 64 districts, 482 upazillas (sub-districts) and 4498 unions. Healthcare activities in major urban locations are performed in collaboration with local NGOs, which work under city corporations. In rural areas, the Government is the major health care provider, offering services through upazilla health complexes and union-level family welfare centers. Each union is divided into three wards, each of which is supervised by health assistants (HAs) who cover a population of between six and eight thousand people each. With the help of grassroots family planning staff, workers from NGOs like BRAC and members of the community, HAs immunize mothers and children in eight outreach centers every month. At present, BRAC employs staff in districts and upazillas to coordinate efforts with the public and private health sectors and manage the implementation of programs at various levels. At the community level, community health workers help BRAC staff carry out health promotion and education activities, mobilize the community to participate in immunization, organize EPI sessions, motivate mothers to take their children to health centers for immunization, and accompany the mothers to vaccination sessions. BRAC staff also helps Government EPI staff plan logistics and treat patients at outreach centers.

BRAC has formed village women's groups where women are provided knowledge, skills and collateral-free micro-loans designed to help them prosper both socially and economically. BRAC emphasizes the provision of health services to these women and their families, motivates them to participate in immunization and accompanies them to outreach centers.

V. Outcomes and Impacts

- The national immunization coverage rate of children between 12 and 23 months is 82% (Bangladesh Demographic and Health Survey 2007). In BRAC areas, the rate is 90%.
- No neonatal tetanus cases have been reported. Nation-wide, 82% of mothers of infants aged less than 1 year have been received two shots of the tetanus toxoid vaccine (Bangladesh EPI Coverage Evaluation Survey 2007). In BRAC areas, this figure is over 84%.
- Polio coverage achieved by the 17th National Immunization Day was 97.5% in the first round of vaccination and 97.9% in the second round. The last polio case was reported in September 2006.

Sustainability

- Political commitment, continuous financial support, the mobilization of funds, skilled manpower, cold chain maintenance, rural electrification and the involvement of NGOs through grassroots workers were all necessary for this project to be sustained.
- BRAC is involved in all EPI-related committees from the union to the national level.
- The director of BRAC's health program is a member of the board of directors of the Global Alliance for Vaccines and Immunization in Geneva.
- A demand for EPI has been created in the population.

VI. Lesson Learned

By partnering to improve immunization coverage, the Government of Bangladesh and NGOs have filled gaps in the country's health system as it relates to EPI. It is to be hoped that the impetus to continue EPI at the same pace will continue for a long time. Initiatives in this sense have caused changes in both demand and supply.

VII. Conclusions

The importance of EPI for child survival in a country like Bangladesh is immense. In spite of the obstacles raised by poverty, Bangladesh cannot afford to let success slip away. Ensuring a better future for EPI in Bangladesh requires fundamental rethinking, particularly in the area of sustainability. In order for future endeavors to succeed, political commitment must be maintained; special attention must be given to low-coverage and hard-to-reach areas; higher authorities must increase supervision and monitoring; and more mass media must be involved.

VIII. Key Thematic Areas Addressed

- Mobilization of resources
- Generation of political will
- Delivery of services
- Advocacy for community participation

IX. Organizational Information

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h. Organizational Overview: The world's largest non-governmental organization, BRAC works in Bangladesh and beyond with the twin objectives of alleviating poverty and empowering the poor. BRAC's vision is of just, enlightened, healthy and democratic societies free from hunger, poverty, environmental degradation and all forms of exploitation based on age, sex, religion and ethnicity. In addition to health, BRAC runs programs for economic development, education, social development and human rights. BRAC has worked in Bangladesh since 1972 and covers a population of over 100 million throughout the country. BRAC employs about 60,000 staff and has an annual budget of US \$485 million.

CASE STUDY

I. Project Title

Mobilizing the Community to Increase Immunization in Lamitan, the Philippines

II. Project Summary

The Christian Children's Fund (CCF) works in the poorest regions of the Philippines to give deprived, excluded and vulnerable children the opportunity to improve their lives and become young adults, parents and leaders who bring lasting and positive change to their community. CCF's priority programs, which include a program to improve children's health and nutrition, are geared towards improving all aspects of children's development.

In the province of Basilan, CCF runs a project in affiliation with a community-based organization. The provincial health office's Field Health Service Information System suggests that in 2005-2007, Basilan's seven municipalities had dismal Fully Immunized Child (FIC) rates and an immunization coverage that was significantly below the national target of 85%. With an immunization record of 45%, Lamitan, a Basilan municipality in a CCF-covered area, has one of the lowest rankings.

Basilan's low immunization coverage, particularly in the municipality of Lamitan, prompted CCF project affiliate The Isabela Foundation Incorporated (IFI) to partner with Sustainable Health Improvements through Empowerment and Local Development Project (SHIELD), a USAID-assisted family health project, and with rural health unit personnel to educate communities about the importance of immunization; to demand improved health service delivery from the local government unit; and to mobilize the community to improve its health. As a project affiliate, IFI implements development programs through funding received from CCF. Through their partnership with SHIELD, they were able to consolidate immunization efforts by pooling resources, synchronizing activities and conducting joint lobbying to the local government unit for increased support of child survival programs. As a result of these activities, in 2006 Lamitan surpassed other municipalities' performance by increasing its FIC rates from 45% to 75%.

IFI's partnership and engagement paved the way for parents to become actively involved in organizing local families for immunization education and helping map unimmunized children, a phenomenon dubbed "the parents prime mover factor". Parents' involvement resulted from a series of capability trainings in early detection and referral, the prevention of childhood illnesses, Vitamin A supplementation and timely immunization. Once trained, parents formed health support groups that went from house to house disseminating information and counseling caregivers. This role on the part of parents was critical in reversing old beliefs and misconceptions about immunization. Because of the sponsorship program, the campaign initially focused on CCF partner families. The CCF parents then expanded the campaign to non-sponsored families, changing the behavior of caregivers, tribe leaders and Muslim religious leaders in the process.

Through the support of non-governmental organizations (NGOs) and rural health unit personnel, educating families about immunization misconceptions increased the FIC rate to 75% in 2006. Thereafter, the further increase of FIC rates was hampered by the escalation of kidnappings and the deterioration of peace and order in the province.

III. Introduction/Background

The province of Basilan is part of the Autonomous Region in Muslim Mindanao (ARMM), a region located across the tip of the Zamboanga Peninsula in Western Mindanao, the Philippines. The bodies of water surrounding this province consist of the Basilan Strait to the north, the Moro Gulf to the east, the Sulu Sea on the west, and the Mindanao Sea to the south. Home to 408,520 inhabitants according to 2007 national statistics, the province's residents are of different ethnicities such as Yakan, Samal, Tausug, Badjao and Ibanag. The province has seven municipalities. Lamitan is the largest with a population of 82,074.

Prior to the project's implementation, Lamitan had been described as a geographically-challenged municipality (it has both mountains and coastal areas) where conflict was common. The local government's low budget allocations and poor health services revealed the little importance it accorded to health. Lamitan is inhabited by tribes and families with numerous misconceptions on health, specifically with regards to maternal and child health care and immunization.

Among the tribes of Yakan, whose members live in the highlands, and Samal, who are sea gypsies, popular belief holds that vaccinated children are more prone to sickness. Health workers must overcome these beliefs in order to persuade parents to bring their child to a clinic and allow him/her to be immunized.

CCF's objective is to serve the deprived, the excluded and the vulnerable and to help all children reach their full potential. Accordingly, CCF seeks to have children immunized during the most vulnerable stage of life, when they are most prone to infection.

CCF covered 30 communities out of 45 in the Lamitan area. The program maximized all resources, including human and financial resources, to ensure that immunization would be given proper attention. CCF families, particularly parents, formed health support groups and acted as a conduit for raising public awareness of the importance of immunization and for increasing public demand. Together with health personnel and health volunteers, the community identified target children for immunization, educated their parents and referred them for vaccination.

In collaboration with rural health personnel and SHIELD, CCF ensured that immunization services were available and accessible to targeted children. Certain community areas were designated as immunization sites. Parents' association and health volunteers assisted rural health personnel during special immunization activities such as the Knock-Out Tigdas campaign, which made services available in hard-to-reach communities.

IV. Project Implementation

CCF's partnership with SHIELD and with rural health unit personnel resulted in the development of health strategies including community and municipal health planning, capacity building of health personnel and parent volunteers (including parents in health action teams that delivered health services to the community), and lobbying the local government unit in frequent meetings.

Parent volunteers, who attended the capability trainings on Vitamin A supplementation, proper weighing, early detection and referral of childhood illnesses, and immunization, spearheaded the organization of seminars on immunization awareness and conducted house-to-house campaigns within their tribes. They also held "immunization talks" mentored by RHU personnel. These activities resulted in tribe leaders' and Muslim religious leaders' acceptance of immunization as a means of disease prevention. Indeed, religious leaders included the campaign in church services during homilies and sharing.

A motivating factor for families and communities was the presence of local non-governmental organizations that acted as watchdogs, supporters and co-lobbyists with parents, health teams and rural health unit staff in their demands for demand greater health allocations on the part of the municipality.

The capacity-building activities and the upgrading of their skills motivated health personnel to better deliver health services in their municipality. They involved themselves deeply in the “Garantisadong Pambata” and the “Reach Every Barangay” (REB) campaigns to ensure that children were vaccinated. A health facts and figures presentation helped the principal advocates draw the attention of community leaders and personnel from the local government unit so that all could work and plan together.

V. Outcomes, Impacts and Sustainability

- Lamitan’s Fully Immunized Child rate increased from 45% to 75%
- Community and health plans were developed as guides to improve community services
- Parents’ involvement as health advocates transformed the misconceptions of the Yakan and Samal tribes into acceptance and action
- Rural health unit personnel became involved in the initiative as a result of community and NGO support

VI. Lessons Learned

- Community mobilization is a critical factor in overcoming geographical and political barriers and tribes’ misconceptions about immunization.
- Health partners are important to motivating health personnel to perform their tasks and meet their responsibilities
- Health information and statistics helped communities realize the extent of the problem and come up with shared goals and actions. Visual depictions of the problem’s magnitude helped them better appreciate the intervention at hand, i.e. immunization
- Child health remains a significant issue in the farthest and poorest communities that can be only address by a cost-effective health education sessions and correct information dissemination.

VII. Conclusion

Lamitan’s “Community Mobilization for Immunization” campaign played a key role in delivering and motivating health personnel and the local government unit to pay attention to community health issues such as immunization.

The tremendous 45% to 75% increase in child immunization coverage can be attributed to the interaction of community members, community leaders, rural health teams and health partners (NGOs). The interface between actors such as these can surmount political allegiances and tribal misconceptions (in this case, among the Yakan and Samal tribes); encourage families; and provide services that benefit the deprived, the excluded and the vulnerable. This interface could have an even wider reach if local government units were to provide greater logistical support.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Mobilization of resources | X | Delivery of health services |
| <input type="checkbox"/> Generation of political will | X | Advocacy for community participation |

IX. Organizational Information

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- g. Telephone: 632 631-1575 to 78 loc 107
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Organizational Overview (2-sentence description): CCF's mission is to give deprived, excluded and vulnerable children the opportunity to improve their lives and become young adults, parents and leaders who bring lasting and positive change to their community. It promotes societies whose individuals and institutions value, protect and advance children's worth and rights.



CASE STUDY

I. Project Title

The Cordaid-Supported Common Health Program in Viet Nam: Improving Child Health at the Community Level

II. Project Summary

In 2004, Cordaid, an international emergency aid and poverty eradication organization, revised its work program with its Viet Nam partners. Designed to help improve the health status of women and children in eight districts with a population of about 885,000, the new program aimed to introduce the Integrated Management of Childhood Illness strategy (IMCI); increase knowledge about child care, nutrition, and the prevention of reproductive tract infections and HIV/AIDS; strengthen commune health centers; and enhance community participation and capacity. Results showed that malnutrition rates in intervention districts had dropped remarkably by the end of the program and that health professional capacity had improved. This case study presents the child health care component of the program.

III. Introduction/Background

Following a long period of firm control by the central Government, Viet Nam's health care system was decentralized in 1991 and district health centers were made responsible for all health care in the districts. The health sector was also given responsibility for some 25 national health programs organized by disease category. These programs addressed acute respiratory infections, diarrhea, nutrition and other health problems. The restructuring of the healthcare system allowed for the greater participation of organized community volunteers as well as more independent and constructive roles for health authorities and professionals at the district and provincial levels. In response, in 2003 Cordaid instituted a 3-year program entitled, "Common Programming and Shared Indicators 2004-2006". The program was designed to bring greater unity to the objectives, strategies, outputs and indicators of Cordaid-funded health activities in Viet Nam. The program was implemented in eight districts where partnerships with 14 local and international organizations were already in place. Examples of such partnerships were Save the Children UK and Tien Yen District, Hanoi Medical University and Phu Luong District, and the Center for Reproductive and Family Health and Lap Thach District. The Consultation of Investment in Health Promotion (CIHP) is a coordination and technical assistance agency.

IV. Implementation

Project steering committees (PSCs) were established in all districts. Each PSC was chaired by the vice-chairman of the District People's Committee and usually included district health staff and representatives of mass organizations such as the Women's Union, the Fatherland Front, and the Youth Union. Commune PSCs had similar membership. PSCs met monthly or quarterly to discuss project progress, problems and solutions and to plan upcoming activities. All planning was done in a participatory manner, often operating from the bottom up and involving multiple local stakeholders. Based on the program's common framework, each district produced its own logframe detailing its own objectives, outputs and targets. This gave each district the flexibility to respond to district-specific needs while maintaining planning consistency within the overall program. PSCs monitored progress closely and ensured that plans were implemented on time.

The mid-year and annual reviews created opportunities for districts and partner organizations to reflect upon progress and to make relevant amendments.

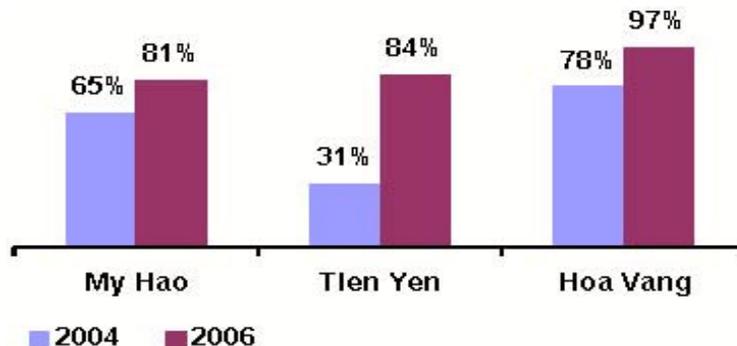
Training courses in IMCI for district and commune health workers and courses in health education and communication skills in malnutrition prevention for village health workers were conducted in all districts. Between 2004 and 2006, 190 district health staff, 438 commune health workers, 783 village health workers and 36 provincial staff attended IMCI training. In addition, the Hanoi Medical University and the Quang Nam Medical College integrated IMCI, malnutrition prevention and childcare training in their curricula. A booklet entitled “*Manual of Community-based Child Health Care for Village Health Workers*” was tested during the pilot period and was finalized for dissemination to all program sites. All program partners agreed to conduct health examinations according to IMCI protocol at both the district and the commune level. Demonstrations on how to prepare appropriate foods for children also took place. Mothers with children under five years old were eager to participate in these sessions because it gave them the chance to practice what they had learned in group discussions on nutrition. During these demonstrations, the children actually received food prepared by their mothers. A total of 245,685 people were reached through health education activities.

Health information education and communication (IEC) activities took place in various forms at the community level in order to improve local knowledge and practices. These forms included clubs, small group discussions, one-on-one counseling at individual households, and mass communication through the radio, loudspeakers and television. The development of IEC materials was considered a priority. Each project developed different kinds of materials with which to transfer health messages to the community. Some projects also conducted other activities. For example, in some areas, hygienic water supplies were upgraded for crèches and kindergartens and village health workers were equipped with first aid kits in order to provide IMCI services to households.

V. Outcomes, Impact and Sustainability

In total, nine projects were implemented over a period of 3 years. The costs of the program approximated €800,000 and came to less than €1 per capita. As a result of the program, malnutrition rates for children under five in all eight districts dropped by between 15% and 33% over a two or three-year period. The rates of mothers and pregnant women able to correctly cite three child home health care rules rose from 60% to 90% in Phu Luong and from 90% to 97% in Tien Hai, and the rates of children identified, treated and monitored for malnutrition rose to 66% in Tien Yen to 100% in Lap Thach, Tien Phuoc and other districts. See the chart and tables below for more program results.

Increased rates of sick children correctly assessed, classified and treated according to IMCI protocol



Change in malnutrition rates among children under five in eight districts

District	2003	2004	2006	Decrease
My Hao	28.2%	25.3%	21.3%	24%
Phu Luong		32.2%	23.5%	27%
Tien Yen		33.9%	28.4%	16%
Tien Hai	27.1%	25.3%	21.4%	21%
Hoa Vang	25.2%	---	18.9%	25%
Huong Tra	27.7%	25.3%	18.5%	33%
Lap Thach		28.2%	24.1%	15%
Tien Phuoc	Tien Cam commune	37.3%	30.6%	18%
	Tien Tho commune	35.1%	25.2%	28%

Insofar as sustainability is concerned, the program seems institutionally sustainable by virtue of the fact that almost all program activities and management techniques have been firmly integrated into existing health services. Programmatic sustainability, that is, the degree to which the program design continues to focus on user needs, is also assured to the extent that child health and nutrition continue to be relevant issues and that the program's principal interventions are well aligned with national policies and programs. The program boasts good resource sustainability in that newly acquired knowledge and skills have been consolidated in a majority of districts/commune health stations and will continue to be applied after the project's end. The program's complementary nature and the complete integration of project activities into the existing health system also contribute to its sustainability. Finally, the program's low running costs mean that it will continue to be funded even after external funds are withdrawn.

VI. Lessons Learned

- Although extra and refresher training courses were provided to health staff, especially to village health workers, the communication skills of some workers remained limited and the monitoring and supervision skills of some district health staff members was considered poor. To remedy this situation, continuous capacity-building for staff at all levels and supportive supervision will be necessary.
- Structural changes to Viet Nam's districts had serious impacts for personnel at almost all project sites. Many staff members who had been trained and were deeply involved in project activities were assigned to other tasks and administrative working mechanisms were altered. These changes impaired the coordination of health care activities at the grassroots level and program implementation slowed as a result. In future, a risk assumption and contingency plan should be prepared at the project's inception in order to save time and energy should similar events occur.
- The membership structures of the project steering committees were effective at ensuring good leadership and decision-making, increasing advocacy and promoting multi-disciplinary, district/commune-wide management of community health programs.
- The project applied a participatory approach by involving partners from different levels in the planning and management of project activities. This strategy allowed leaders to recognize community health issues more easily. It also provided them with greater support to solve their health problems. The role of village health workers was also promoted, giving those workers the enthusiasm to act as real change agents within their community. It is important to include provincial authorities in a monitoring and evaluation capacity. This would also facilitate scaling up project activities in future.
- In the future, this program could be improved by strengthening the information management system, especially by using indicators with standardized measurements and data collection methods.

- Because the program was implemented in different project sites with the participation of different partners, it will be important to consolidate and document the various intervention models with respect to IEC activities, nutrition education, and IEC materials. These documents could be useful sources of information to share with program partners and others working in the same field.

VII. Conclusions

Children's health status can be improved by partnerships between organizations, district-wide interventions and capacity-building of health staff at all levels.

VIII. Key Thematic Areas Addressed

- | | |
|--|---|
| <input type="checkbox"/> Mobilization of resources | <input type="checkbox"/> Delivery of health services |
| | <input type="checkbox"/> Advocacy for community participation |

IX. Organizational Information

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CASE STUDY

I. Project Title

Kachin People's Health Development Initiative: Bringing Immunization Services to Children in a Conflict-Ridden Area of Myanmar

II. Project Summary

This four-year project was designed to decrease the maternal mortality ratio and the mortality rate of children under 5 by reinforcing the existing health system and increasing access to basic preventive and curative health services. The project's integrated approach addresses maternal, newborn and child health (MNCH), the expanded program for immunization (EPI), tuberculosis and malaria prevention and control, community health education, the construction and equipment of health facilities, and advocacy.

As an essential component of this approach, infant immunization was implemented at the very beginning of the project. By conducting initial and refresher training, providing supplies, introducing incentives and regularly monitoring activities, the project has provided monthly EPI services to about 160 villages so far. In 2007, 2063 infants were immunized and coverage reached 83%.

III. Introduction/Background

When Myanmar's Kachin Independence Organization (KIO), the local insurgent minority authority, ceased fire with the Government of Myanmar in 1994, Health Unlimited (HU) initiated humanitarian relief for refugees in the KIO-controlled area officially named Special Region 2 in Kachin State, Myanmar. This area borders De Hong Prefecture, Yunnan Province, the People's Republic of China. Prolonged conflict between the insurgent troops and the government and the complete blockage of assistance from the international community had left some 100,000 indigenous people living in destitution. With the exception of some traditional healers, no health services whatsoever were accessible at that time, and scarce resources meant that health needs could barely be satisfied either by the central government or by local authorities. Infrastructure was in terrible condition: 72% of villages had no electricity and 87% of families had to visit health facilities on foot. More than 70% of households had reported moving their place of residence at least once: they were unfamiliar with the health services of their new area and were often more concerned about their security and indeed their survival than they were about their health.

Over 14 years of close collaboration with the KIO health department, HU has strived to create a basic healthcare system, to make the system accessible, and to build local capacity for the delivery of health services. Primary healthcare approaches were adopted and after years of effort, an integrated services package that addressed maternal and child health (MCH), the expanded program on immunization (EPI), community health education, endemic disease prevention and control measures (for malaria, tuberculosis, and other diseases), and the supply of essential equipment, was made available in the project area.

The total budget for the 2006 to 2010 period is €1.187 million. Basic healthcare services will be delivered to around 240 villages, reaching a population of some 60,000 people.

IV. Project Implementation

Since 1994, vaccines have been directly provided to refugees by HU staff. Step by step, HU set up two cold chain centers and constructed and equipped a number of rural health centers (RHCs). It also trained 418 health staff personnel in immunization.

Currently, 17 RHCs (including two cold chain centers and three civil hospitals, which are larger than regular RHCs) are involved in EPI. 36 vaccinators either conduct outreach services or provide fixed site services at two cold chain centers. Mobile trips to cover remote areas are organized by HU. RHCs obtain vaccines from the cold chain centers and HU covers basic needs such as a travel allowance for the rental of motorbikes and the purchase of gasoline and a per diem. Every quarter, monitoring trips are organized in which health officials participate. During these trips, project teams follow a checklist that helps them review the recording of routine immunization activities, gather demographic information, and analyze core outputs.

Community health education activities around EPI were conducted when vaccination first took place in the communities. IEC materials such as pamphlets and posters were distributed to RHCs, and RHC personnel redistributed these materials to villagers. Thirty village health committees were set up and in those villages, committee members were requested to motivate community members to participate in vaccination.

In addition to routine vaccinations, HU and the KIO Health Department also cooperated with the Government of Myanmar around National Immunization Day, which usually takes place twice a year. The project team also collaborated with the Government of the People's Republic of China in a measles virus booster shot campaign.

As previously mentioned, monthly EPI service are being provided in approximately 160 villages so far. Five basic vaccines (BCG; oral polio virus (OPV); diphtheria, pertussis and tetanus (DPT); measles and hepatitis B) are available. In 2007, 2063 infants were immunized, bringing coverage to 83%. Nonetheless the percentage of children who received a full schedule of all five vaccines was only 57.5%. This implies a high number of drop-out cases. Follow-up efforts to motivate community participation are still underway.

V. Outcomes, Impacts and Sustainability

The coverage has reached 83% of the target population, with 57.5% of children having received a full schedule of vaccines.

We facilitated discussions between the KIO Health Department and the Government of Myanmar with a view to securing greater cooperation for immunization. In the end, the Government agreed to provide vaccines, cold chain equipment and staff training to the KIO Health Department free of charge. However, due to the political uncertainty around the upcoming 2010 election in Myanmar, we're not sure how long this cooperation will last.

Sustainability can also be seen in the basic EPI system set up by this project. A number of professionals were trained, EPI facilities were provided, and a series of regulations was developed. Even without HU's support, therefore, the KIO Health Department will be able to continue the EPI.

VI. Lessons learned

Regular monitoring trips and refresher training created opportunities for vaccinators to communicate with HU and the KIO Health Department. The monitoring trips also allowed participants to identify and solve minor problems. The humanitarian relief efforts of this project have created a good relationship between HU and the local community, whose members have come to trust in the services provided.

But several factors have hindered the project's progress. Political instability is one of the most troublesome issues. The military regime dampens the enthusiasm of lower level health staff members, who have no room for latitude in the exercise of their functions: they are restricted to following orders from above. Communication is definitely insufficient. The fragmentary health administration system has no guidelines, no job descriptions, and no mechanisms for staff recruitment, training or motivation. Health staff is paid in rice and salt and earns no more than US\$6 per month, which causes them to feel de-motivated and to lack commitment. The persistent scarcity of budget resources and the lack of stable academic and technical support have also slowed progress.

The project team has learned the following lessons:

- It is important to generate political will and to help local authorities take responsibility for managing the health initiative
- It is difficult to build capacity in an existing health system but it is worth the time and effort
- For efficient service delivery, it is important to tailor services to the particularities of a community's geographic location, its language, its economic status, and so forth
- It is possible to help community members manage their own health by setting up village health committees and recruiting community health workers
- The connections between various health service components must be designed properly: health services must be delivered in an integrated manner.

VII. Conclusion

Through training, supplying, and monitoring activities, and by proper identification of the best means to reach the targeted villages (whether by fixed services, outreach services or mobile services), the project team reached most marginalized communities of the project area. A high number of beneficiaries was served but the high drop-out rate must be addressed and more efforts to mobilize the community are required. Delivering health services in settings as difficult as this one in a sustainable manner will always challenge the capacity of service providers. In this sense, the greater clarification of best practices would be of great benefit.

VIII. Key Thematic Area Addressed

Delivery of health services
Mobilization of resources
Generation of political will
Advocacy for community participation

IX. Organizational Information

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CASE STUDY

I. Project Title

Bidan Delima: A Branding Program to Improve the Quality of Midwife Services in Indonesia

II. Project Summary

Bidan Delima is an Indonesian Midwifery Association (IBI) program designed to increase professionalism and the standards of practice of midwives in private practice. The program's goal is to help ensure that midwives' practices meet national clinical standards and to recognize those midwives who practice according to standard. The standards in question cover the areas of family planning, infection prevention and safe deliveries.

Bidan Delima began in early 2004. It is assisted by the STARH (Sustaining Technical Achievements in Reproductive Health/Family Planning) program and is funded by the United States Agency for International Development. Bidan Delima is currently active in 204 districts in 15 provinces and has been expanded to another 25 districts in order that it be implemented more widely. To date, 7463 midwives have been certified as meeting national standards and 2536 are candidates for certification. In 2006 and 2007, Johnson & Johnson Indonesia facilitated clinical training programs to help 1200 midwives achieve certification. In 2008, Johnson & Johnson helped fund facilitator training for an additional 200 midwives.

III. Introduction/Background

Indonesia is an archipelago consisting of more than 13,000 islands of varying size. The maternal mortality ratio is high (307/100,000 live births). Some healthcare delivery services are below standard, particularly in the areas of infection prevention, family planning counseling and safe birth management. As healthcare providers who are on the front line of maternal and child healthcare services, midwives should practice safely and according to standard. Since midwives provide 63% of Indonesia's family planning services and assist more than 50% of deliveries, it is essential to improve midwives' skills and knowledge in maternal and child services and standardize their practices through programs such as Bidan Delima. We believe that once properly trained, midwives could help decrease the maternal mortality ratio to 125/100,000 live births and the neonatal mortality rate from 25/ 1000 live births to 15/ 1000 live births by the year 2015.

IV. Project Implementation

Implementation of the Bidan Delima program began with the help of a facilitator from Jhpiego. The Johns Hopkins Bloomberg School of Public Health/Center of Communication Programs provided technical assistance and Johnson & Johnson supported clinical training and provided materials. A group of trainers was constituted and consisted of midwife representatives of nine IBI chapters in North Sumatra, South Sumatra, West Java, Jakarta, Yogyakarta, Central Java, East Java, Bali and South Sulawesi. After the group had been trained, the trainers informed privately practicing midwives of Bidan Delima and encouraged them to join. All midwives had the opportunity to ask any question they liked about Bidan Delima. Those interested in joining were invited to register as candidates and to complete a pre-qualification form. Following the registration, each candidate completed a self-learning component, after which she measured her skills. If the candidate realized that she did not reach the standards, she could register for

specific training according to her needs. Once the candidate had completed her training and felt ready to be tested, she could ask a Bidan Delima facilitator to validate her skills. To validate the midwife's skills, the facilitator conducted a site visit and observed all aspects of the midwife's practice, especially her knowledge and skills. If the candidate passed the test, she was certified as a bidan delima ("bidan" means midwife and "delima" means pomegranate) and was free to put the Bidan Delima logo on her name board. Mothers who saw this logo on the board knew that the midwife's qualifications had been validated. If the midwife failed to be validated, she could ask the facilitator for feedback on which areas to strengthen in preparation for a re-test.

V. Outcomes, Impacts and Sustainability

The outcomes of the Bidan Delima program were as follows:

- Improved quality of care by the providers of reproductive healthcare services;
- Greater professionalism among midwives;
- Encouragement of the midwives' leadership role;
- Improved quality of reproductive services; and
- Reduced maternal and neonatal mortality rates.

VI. Lesson Learned

The Bidan Delima program showed tremendous improvements to Indonesia's midwifery services and more and more people have recognized the distinct services of Bidan Delima. The process of becoming a bidan delima allows midwives to evaluate the extent of their skills and remedy any weaknesses before applying for validation. This program is unique in that it allows midwives to decide when to be tested.

VII. Conclusions

Bidan Delima is one way to control midwifery standards of practice, particularly for midwives in private practice.

VIII. Key Thematic Areas Addressed

Family planning counseling, infection prevention and safe delivery management.

IX. Organizational Information

The Indonesian Midwifery Association (IMA), known as Ikatan Bidan Indonesia (IBI), was established in June 1951 and has been a member of the International Confederation of Midwives since 1956. It counts 87,338 members and has 32 chapters, 435 branches, and 1900 sub-branches.

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CASE STUDY

I. Project Title

Expanding Intrauterine Device and Medical Abortion Services in Two States of India: Bihar and Jharkhand

II. Project Summary

Contraceptive use has been steadily increasing in India. At the same time, there is a substantial unmet need for contraception, particularly for long-term reversible methods. Janani proposes to substantially expand the provision of intrauterine device (IUD) and medical abortion services in Bihar and Jharkhand, two of India's poorest regions. It will do this through advertising; training more paramedics and women outreach workers; increasing the number of franchisee doctors who will counsel patients and insert IUDs; and greatly increasing the number of medical abortions performed at clinics. In addition, Janani will make medical abortions dramatically more accessible in rural areas beyond the clinic networks.

III. Introduction/Background

India's contraceptive pattern is characterized by the predominance of sterilization, the limited use of male/couple-dependent methods, substantial discontinuation, the negligible use of contraceptives among married and unmarried adolescents, and wide regional variations. The states of Bihar and Jharkhand have some of the lowest reproductive health rankings in the country. Of 689,000 abortions induced annually in Bihar and Jharkhand, an estimated 517,000 are unsafe. At 452 per 100,000 live births, Bihar also has one of the highest maternal mortality rates in India. Fully 8.9% of maternal deaths in the state are caused by unsafe abortions. Furthermore, the unmet need for contraception in Janani's program area is 13.2%. Half of these women have an unmet need for spacing because they want to delay their next birth, the other half because they want to stop childbearing.

The goals of this project are to double the IUD contraceptive prevalence rate in Bihar and Jharkhand from 0.6% to 1.2%; to perform 175,000 medical abortions by the end of 2013; to reduce unsafe abortions by at least 15% by the beginning of 2013; and to improve post-abortion care.

IV. Project Implementation

Janani's program combines the strengths of classic social marketing with a clinic-based service delivery program and a franchisee program through which doctors in rural areas provide low-cost services. Janani's network of franchised Titli ("Butterfly") centers is run by over 22,000 rural medical practitioners whom Janani has trained to sell condoms, oral contraceptives, over-the-counter pregnancy tests. Each rural health practitioner works in partnership with a woman who is a family member. These individuals serve as the conduit between the clinics and rural communities. Clients needing clinical services, including abortions, are counseled and referred to nearby Surya clinics, which pay a commission to the Titli centers for their referral. The social marketing infrastructure of shops and stockists serves as a channel to sell products in rural, urban, and semi-urban areas and to replenish supplies of the Titli centers and Surya clinic providers.

The franchisee Surya clinics have diagnostic facilities and adhere to established quality norms that are ensured by Janani management. Infection control, waste management, and counseling are part of the norms. A mobile medical clinic is available to reach the remotest parts of the program area. This unit provides essential family planning materials and reproductive health services. Janani's clients are predominantly poor, and pay significantly less than they would for commercial health services. Franchisee doctors pay an annual membership fee.

Janani's program is aided by certain government measures. The Government of India provides a substantial subsidy for condoms and pills, enabling the program to make contraceptives available at the affordable prices of 3¢ per condom and 11¢ per cycle of oral contraceptives. This subsidy also contributes to the goal of eventual financial self-sufficiency for the project. Janani's IUD program has benefited from the Government of India's National Rural Health Mission Public-Private Partnership. Through the Public-Private Partnership, the government accredits non-governmental organizations (NGOs) and private sector health facilities and provides financial support for certain kinds of health services, especially sterilization. Services must be provided free to consumers by accredited doctors or clinics.

Advertising has been an important facet of the program's implementation. Janani developed point-of-purchase materials such as stickers and posters that inform consumers about medical abortions at pharmacies. Janani also placed billboards announcing the availability of medical abortion at its Surya Clinics and through its mobile clinic and exhibits at local fairs. Finally, Janani widely distributed its booklet about IUDs, medical abortions, and other family planning options.

Janani also restructured its distribution system whereby all urban markets are now covered by 94 redistribution stockists and rural markets are covered by their own field team. During 2008 Janani placed two medical abortion drugs at 2,857 rural chemists under a special display scheme. In India, medical abortion is a prescription drug, which means that a manufacturer cannot market branded promotions to consumers. However generic promotion to the public is underway as is brand promotion to the medical profession. The combination of intense urban coverage and the opening up of rural chemists have resulted in better distribution.

Janani also identified and provided brief orientations to thousands of doctors, paramedics/auxiliary nurse midwives, and Surya health promoters. The latter are grass-roots level workers who refer clients to Janani clinics; sell condoms, emergency contraception drugs, and oral contraceptives; and brief clients about IUDs, medical abortion and sterilization. Many are Janani Titli Center representatives; the rest are rural health practitioners and government community health workers.

VI. Outcomes, Impacts and Sustainability

In nine years, Janani has protected 10.2 million couples and averted 5.8 million unwanted pregnancies. In 2008, Janani sold, inserted or administered 15,744 IUDs and 90,977 medical abortion doses, substantially exceeding estimates for both services. Janani is in the process of expanding the number of its Surya Clinics from 18 to 40, which should boost IUD use and medical abortions in years to come.

VII. Lessons Learned

Demonstrating a replicable franchising model in a poor resource setting. Janani has shown that resources available beyond the public sector can be leveraged and brought within an operational framework to deliver services to the poorer and rural communities on a large scale at very high levels of cost efficiency. Even in areas where the public sector is efficient, such a strategy can be used as a force multiplier.

Program planning, implementation and management. Janani's core competence is in planning, designing, and managing large programs that address the scale and urgency of need. Janani uses private sector resources for two purposes: service delivery, and, through outsourcing, the administration of the management structure. This enables the organization to keep the core team small. Last year's headquarters salaries accounted for less than 5% of Janani's costs. It costs Janani only 90 rupees (US \$2.20) to avert an unwanted pregnancy.

Training and capacity building. Janani's programming focuses on sustaining service delivery networks rather than just creating them. This means the strategic thrust is toward continuous value addition and aggressive marketing and an indicator-based management system. Janani constantly focuses on upgrading the surgical skills of doctors and correspondingly upgrades the non-clinical skills of the rural centers that serve as the first contact point for counseling and communication within the villages. Janani's training center is government approved and so far over 1,000 doctors from the public, private and NGO sectors have been trained and certified. Janani develops curricula and protocols by using its links with various national and international organizations, and it has entered into partnerships with specialist NGOs and commercial organizations to accomplish this goal.

Information, education, and behavior change communication. While establishing a supply-side mechanism through its networks that create access to every household in the program area, Janani also mounts communication campaigns that use mass and local media to address the demand side of programming. Janani has used extremely innovative media to deliver messages to communities living in remote areas.

Creating access to technology. Janani also uses technology to continuously improve programming. This has also been a major focus area and has led to significant changes in the general use of de-medicalized technologies. Modern training aides are used extensively and are offered to other NGOs and the government as well.

Extending the reach to the remotest communities. Rural centers, each with a rural practitioner and his woman partner, ensure the availability of products and over-the-counter technologies to communities in remote and very poor areas. These centers also provide counseling and communication for the clinical services provided by the medical network. A fully equipped mobile van operational in the program area helps bring services to the farthest and the remotest areas of Bihar and Jharkhand.

Advocacy with government. Janani has played a significant advocacy role with policymakers on the basis of its experience in large-scale service delivery, especially in very poor and rural settings. Janani was instrumental in upgrading technologies related to oral contraceptives and the safe provision of abortion services and IUDs.

VIII. Key Thematic Areas Addressed

Delivery of health services

IX. Organizational Information

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CASE STUDY

I. Project Title

Improving Midwifery Education for Better Maternal and Newborn Care in Aceh Tengah District, Indonesia

II. Project Summary

Over the past two years, Jhpiego Indonesia, in collaboration with GlaxoSmithKline (GSK), has provided technical support to the Aceh Tengah district government, the local midwifery polytechnic school, and local communities to strengthen midwife education and better train midwife graduates. Jhpiego's approach combines several strategies: upgrading the teaching skills of faculty members, introducing preceptor-mentorships whereby skilled midwives help supervise students' practicum and enhancing the learning environment with modern pedagogic simulation equipment that stimulates learning and teamwork. The project has already generated increased demand for enrollment at the Takengon Midwifery Academy and graduates have shown more confidence and better examination results. Based on these recent improvements, the school has petitioned for accreditation. Local government has also taken notice of the progress made by the academy and has realized that more competent midwife graduates will improve maternal and neonatal mortality, especially in remote villages. The Takengon Midwifery Academy is now looked upon as a potential model for improving other academies in Aceh province and elsewhere in Sumatra.

III. Introduction/Background

The reduction of maternal and neonatal mortality and the achievement of Millennium Development Goal 5 by 2015 are priorities of the Indonesian Government, which has charged all district health offices with addressing these critical matters. The cornerstone of the Government's Making Pregnancy Safer strategy is to assure that all births are attended by skilled providers. Due to the fact that only 46 % of Indonesian births take place in healthcare facilities, much of the burden of ensuring safe deliveries rests with village midwives. Jhpiego and GSK are supporting the Takengon local government in its efforts to assure that all communities have access to quality midwifery services and that all births are attended by a competent midwife or other health provider. At this time, we estimate that between 25% and 30% of 284 target communities do not have access to the services of a trained midwife.

The Takengon Midwife Academy is located in a mountainous region of Nanggroe Aceh Darussalam Province, approximately four hours from the more populous northern coastal zone of Lhoksumaewa. With a population of 180,000, this area has been heavily impacted by two decades of civil conflict and almost complete isolation from the rest of Indonesia until the 2004 earthquake and tsunami. As a result, when compared to the indicators from more accessible and prosperous regions of Indonesia, this region's maternal health indicators are poor. The region's isolation has also contributed to a general lack of exposure among the school's management team and its faculty members to new and updated pedagogic and technical information regarding maternal and newborn care.

Prior to the Jhpiego/GSK intervention, the Takengon Midwife Academy, like many midwifery schools in Indonesia, was operating with very limited resources provided by the local government. As a result, many inadequacies in the quality of midwifery education had emerged. With the exception of one faculty member, teachers had not received in-service training or

clinical updates since their own pre-service education. Basic amenities that enhance the learning environment, such as a functioning library and a learning laboratory, were either inconducive to learning or nonexistent. The absence of pedagogic equipment and the relatively low number of births in facilities also made it impossible for the school to provide meaningful opportunities for birth simulations and the supervised practice of midwifery skills. As a result of these adversities, the academy was neither accredited nor recognized by the Ministry of Education. In addition, its graduates had questionable competency and low levels of confidence.

The financial resources allocated to this project totaled US\$330,000. All funds were contributed by GSK. The program was implemented in Aceh Tengah District, which covers 14 sub-districts and a total population of 180,000 including 260 academy students.

IV. Implementation

The multi-faceted strategies adopted by Jhpiego to address the strengthening of pre-service midwifery education focused on building capacity among the faculty, procuring pedagogic material and equipment for facilitating interactive and applied learning, and introducing a preceptor-mentorship model that enhanced students' practicum. The objectives for the three-year program, initiated in January 2007 and scheduled to continue through 2009, are as follows:

1. Improve the overall quality of midwifery education in Central Aceh by strengthening classroom teaching, lab practices, and clinical practicing in hospitals, community health centers and midwifery clinics;
2. Improve service delivery at the clinical practice sites used by students;
3. Strengthen the overall leadership and management capacity of the academy's administration in order to produce high quality midwifery education;
4. Improve the school library to ensure that students have access to an effective, functioning library with up-to-date resources.

During implementation of the program, Jhpiego was the academy's main facilitator for technical assistance. Jhpiego successfully attracted resources from the district health office, the midwives' professional association and more advanced midwifery schools in Bandung, Jakarta and Banda Aceh.

The strategy for updating faculty teaching skills took place in Years 1 and 2 of the project. This strategy comprised the following: faculty development training, technical training for normal deliveries, maternal and neonatal health (MNH) update training, an effective teaching skills module, preceptor training, training in interpersonal communication and counseling skills, and training in infection prevention. The purpose of this training was to update faculty members' knowledge and skills so that they could teach more effectively and in accordance with new MNH standards.

A preceptor-mentorship system used in a previous Jhpiego project was also introduced. New private midwife clinical sites were identified and clinical preceptors were trained to mentor students working there. As a result, students may now work toward compliance with their practicum requirements in any of 25 private midwife practice sites. In addition, the academy initiated a longer rotation system that allows students to remain in one clinical site for eight full weeks. In 2008, 50 students in their fifth semester were supervised in this program under the guidance of a trained preceptor. These students were distributed among the 25 private practices, one hospital and six community health centers. Preceptor meetings were conducted in the middle and at the end of the eight-week rotation in order to monitor student's process and gather input from preceptors and students.

Prior to the program's implementation, the academy library did not function properly and could only be used by a few students at any one time. It had essentially no books, magazines, journals or other reference materials. In order to strengthen the library, the program helped provide 200 volumes of essential textbooks written in Bahasa Indonesia, the official language, all of which were materials required by the Ministry of Education (the program acquired three copies of each title). Books on national MNH standards, family planning, infection prevention and interpersonal communication and counseling were also provided (100 copies of each book). Other materials included 11 Indonesia journals published by universities and professional organizations. The program also assigned two staff to on-the-job library management training at the University of Indonesia in Jakarta.

In Year 3, the project will introduce a monitoring and evaluation activity in order to ensure that results to date are matched by long-term impact. The project still needs to demonstrate that it is improving remote communities' access to trained midwives. For this reason, the project will assess 2007 and 2008 graduates to track their employment decisions and their practice of skilled deliveries.

V. Outcomes, Impact and Sustainability

- The Jhpiego/GSK collaboration has increased confidence among the academy's management, who, encouraged by improvements to the faculty's teaching skills and to the overall learning environment, have approached the Ministry of Education for accreditation. Even as the academy pursues excellence, its award of a B Certificate is welcome recognition of the success it has already achieved. In the initial phase of the project, there were only four midwife teachers among 20 teachers. Now in the third year of the program, that number has grown to 10.
- The midwife preceptors who received clinical skills training have become more confident in providing quality and effective services to their clients. They show confidence in motivating pregnant women to give birth at a midwife clinic and pregnant women are increasingly convinced that they will be safer if they give birth there rather than at home.
- The new preceptor-mentorship approach has increased students' opportunities to attend deliveries at clinics under the supervision of their preceptors. This phenomenon represents a change of behavior for both parties. Students demonstrate greater capacity and confidence to attend deliveries and preceptors are more aware of their roles in clinical supervision.
- With more textbooks and reference materials available, increased motivation from the teachers, and easy access to library resources, students have demonstrated more interest and utilization of the library. At the beginning of the program, the library had only 50 or so outdated books in poor condition. Most of the time, these books remained on the shelf, hardly used. The library is now supplied with some 200 textbooks, all published after 2000. The library also has new sources of professional journals which are used by both faculty members and students to update their knowledge.
- Local government now pays greater attention to the improvement of midwifery education as it has realized that improving the quality of midwives who graduate from the academy will ultimately lead to decreasing maternal mortality. The local government began to increase budget allocations for midwifery education last year.
- An unexpected result of this program is that Takengon Academy has seen an increase in applications over each of the past 3 years. Communities now know that the Takengon Academy has received assistance from GSK/Jhpiego and community members have

witnessed improved quality at the school. Instead of holding one class for 50 students, as at the beginning of this project, the school now uses three classrooms to teach 125 students. The downside of this situation is that the school is accepting a larger number of students than before and is possibly exceeding the capacity of its faculty, its clinical practice sites, and its laboratory.

VI. Lesson Learned

In order to improve the quality of midwifery education, a comprehensive, multi-faceted set of strategies is required to address faculty teaching skills, school management techniques, learning facilities, learning materials, evaluation tools, clinical practices, the need for preceptors, and stakeholder collaboration. By successfully addressing all of these variables of midwifery education, districts such as Takengon can significantly improve the quality of its midwifery graduates and respond to the serious challenge of reducing maternal and neonatal mortality.

VII. Conclusions

Program results have not yet been completely measured and issues of sustainability and impact measurement will be addressed in the project's final year. Through observation and anecdotal evidence, however, we know that management, faculty, and students have increased confidence in their skills and in the academy's overall direction. Increased demand for enrollment is another positive indicator of the project's success. However, we still do not know the extent to which midwives' practices have improved in Takengon and more particularly, how many deliveries have been attended by the new graduates. We also do not know how many remote communities have benefitted from their services. This information will be compiled in the final year of the project in order to estimate the longer-term impacts of this program.

VIII. Key Thematic Areas Addressed

- Mobilization of resources
- Generation of political will
- Delivery of health services
- Advocacy for community participation

IX. Organizational Information:

- | | | |
|----|---------------------------------|---|
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| g. | Website | www.jhpigo.net |
| h. | Organizational Overview | |

Jhpiego is a nonprofit international health organization affiliated with Johns Hopkins University of Baltimore, the United States. Jhpiego works to improve the health of women and families in more than 50 countries. Jhpiego's work spans a continuum of client-centered care ranging from prevention to treatment in reproductive health, family planning, HIV/AIDS, maternal and newborn health, and cervical cancer.

CASE STUDY

I. Project Title

Viet Nam Reproductive Health Project in Nghe An Province

II. Project Summary

Between 1997 and 2005, the Government of Viet Nam, the Japan International Cooperation Agency (JICA) and the Japanese Organization for International Cooperation in Family Planning (JOICFP) collaborated to implement a project to improve reproductive health (RH) services in Nghe An, one of Viet Nam's poorest provinces. Key components of the project, which took place in two phases, consisted of improvements to healthcare facilities, the provision of equipment and logistics and the re-training of health service providers. These measures occasioned an increase of awareness and knowledge which brought about significant behavior change on the part of service providers and clients. The project interventions helped reduce the maternal mortality rate (MMR), the infant mortality rate (IMR), obstetric complications, and the number of abortions, including menstrual regulations. It also helped increase the contraceptive prevalence rate. The project has served as a model for community-based RH promotion in other provinces. After the project terminated, the Nghe An Reproductive Health Care Center (RHCC), the project's management unit, continued to improve the quality of RH services and continued supportive monitoring of commune health centers (CHCs). As a result, the Ministry of Health of Viet Nam has recognized the province as the country's leader in RH promotion. In 2006, Nghe An province accepted the mandate to share its know-how and lessons learned with four neighboring provinces. The follow-up phase of the project is ongoing.

III. Introduction/Background

Phase I (June 1997 – May 2000) and Phase II (September 2000 – August 2005) of the JICA Reproductive Health Project were implemented with the purpose of improving RH services in Nghe An Province, Viet Nam. Phase I covered eight provincial districts and focused on realizing safe and hygienic deliveries in communes by improving prenatal care, developing midwives' skills and knowledge, and upgrading facilities and equipment. Phase II expanded the project area to the entire province, applying the approaches of Phase I with modifications that reflected Phase I experiences and achievements. Phase II also worked to improve the quality of services in order to meet emerging needs. During this phase, the project's areas of activity were expanded to postnatal care, the prevention of reproductive tract infections, the reduction of abortions, and the promotion of a health management information system.

At the time that the project took place, Nghe An Province had a population of nearly 3 million people in one city, one town, 17 districts and 469 communes. Of Viet Nam's 64 provinces (59 provinces and five cities under the direct administration of the central government), Nghe An's average per capita income ranked around one fourth from the bottom. Two thirds of Nghe An is mountainous and one third consists of plains and coastline. The high number of rivers makes boats one of the principal means of transportation. Health statistics in Nghe An were generally poorer than national figures and the majority of the midwives at the province's CHCs were

primary midwives who lacked adequate professional training. Several CHCs in mountainous areas lacked midwives entirely. In areas where geographical conditions are very difficult, where there were no means of transportation to the nearest health facility and where people are extremely poor, the home delivery rate was 100%. In the plains and in areas that were less poor, the delivery rate at CHCs was reported at between 40% and 80%. Although the government encouraged deliveries at healthcare institutions, many CHCs were old and some lacked even minimal equipment. The knowledge and skills of commune-level health workers were lacking as many workers had had no training opportunities since leaving school. As a result, the quality of the health services provided in communes was very poor. Residents were in urgent need of the means to have safe and hygienic deliveries and improved pregnancy care, especially prenatal care and tools to reduce the risks that threaten the lives and the well-being of mothers and babies.

Provincial leaders recognized the urgency of RH improvements and demonstrated strong commitment to project objectives. Accordingly, the Joint Committee, the project's decision-making body, was chaired by the vice-chairperson of Nghe An People's Committee and included members of the provincial health service, the Women's Union, RHCC, and the Committee for Population-Family-Children. RHCC acted as project secretariat.

Viet Nam (1999)	Nghe An Province (1999)
* Birth rate: 19.9‰	* Birth rate: 21.01‰
* MMR: 5.6‰	* MMR: 6.72‰
* Total fertility rate: 2.33	* Total fertility rate: 2.73
* IMR: 36.70‰	* IMR: 30.65‰
* Tetanus toxoid coverage: 85%	* Tetanus toxoid coverage: 90%
* Deliveries attended by health workers: 78%	* Deliveries at a health facility: 90% (plain area only)
* Number of health staff: 1/403 population	* Deliveries attended by health workers: about 70%
* Secondary midwife: 1/7,757 population	* Number of health staff: 1/426 population
	* Secondary midwife: 1/13,419 population

IV. Project Implementation

Prioritizing the commune level

The project supported all 469 communes with a package of measures: CHC staff re-training, CHC facility improvements, and the provision of basic equipment. The distribution of project funds (Phase II: US\$2,210,000) confirms that the commune level was given priority: 71% of costs were expended on commune and grassroots-level activities, 19% on district-level activities, and 10% on provincial-level activities.

Establishing a management structure

In order to ensure project support, collaboration among agencies, and a sense of ownership and commitment, the project established numerous steering committees under the leadership of the aforementioned Joint Committee. These steering committees were established at the provincial level (within RHCC); at the district level; and in all 469 communes. Representatives of the People's Committee, the public health sector, the Women's Union, and the Committee for Population-Family-Children participated in the committees. The project's purpose and its commune-oriented approach were explained to all committee members. The project shared its

annual activity plan and its results with committee members every year and the member agencies implemented activities jointly. This organizational network ensured the smooth operation of project activities and strengthened commitment and ownership.

Strengthening the existing health system and existing health personnel and structuring regular responsibility for RH promotion in all institutions at all levels

The project helped strengthen the capacity of personnel working in existing healthcare institutions so that they could better pursue their roles and responsibilities. All project activities were designed to improve the quality of regularly-defined tasks of existing personnel without creating additional posts or systems. The project did not hire staff and did not provide salary top-ups for project counterparts. These approaches helped increase the sustainability of RH promotion after the project's termination.

Instituting supportive monitoring for continuous stimulation and encouragement

Training and follow-up monitoring were inseparable activities that helped CHC staff maintain the knowledge and skills that they had obtained through re-training. These activities were found to be essential to sustaining better quality RH services. The key word is "supportive": the idea is to find achievements that can be praised and points that can be improved through solutions found by and acceptable to all parties. Accordingly, the project trained provincial and district-level personnel in supportive monitoring methods. The project also trained members of commune steering committees since they were responsible for promoting RH within the communes.

Creating a supportive environment for promoting RH at the grassroots level

The project involved a number of grassroots agencies in project activities. It invited these agencies to a RH knowledge dissemination seminar and made project goals known to male and female leaders in all areas with a view to creating an environment conducive to RH promotion.

Ensuring the effective utilization of the information, education and communication (IEC) materials

The project ensured the effective utilization of the IEC/(behavior change communication) materials supplied. Distributing IEC materials can be relatively easy compared to ensuring their proper utilization: although the proper use of materials can be critical to project outputs, materials are often found to be underused or not used at all. Grassroots IEC and health education activities organized by the Women's Union played an important role in the promotion of RH.

Conducting realistic and practical training in order to respond to real needs

Throughout the implementation of project activities, the project adhered to the principle of first grasping the situation, then responding to changing environmental and people-related conditions, all the while working in partnership with Vietnamese counterparts.

Conducting counterpart training: meeting needs and interests

The project provided counterpart training in Japan. Under this program, key Nghe An personnel travelled to Japan to learn about Japan's experience in improving MCH. JOICFP in Tokyo collaborated closely with its experts in the field to organize a training program that met participants' needs.

Conducting project-related studies and reflecting the research findings in project activities

Various studies and surveys were conducted in the project area: a RH situation and needs assessment (1997-1998); a study on mass organizations (1998-1999); a study of staff activities at commune health centers (1999-2000); a media survey (2001); a study of the folk childbirth customs of Nghe An Kinh (2001); a study of traditional beliefs, customs and practices surrounding pregnancy and childbirth among Nghe An ethnic women (2002); and the prevalence of reproductive tract infections among pregnant women (2003). The findings of these studies were used to confirm the project's orientation and to plan activities.

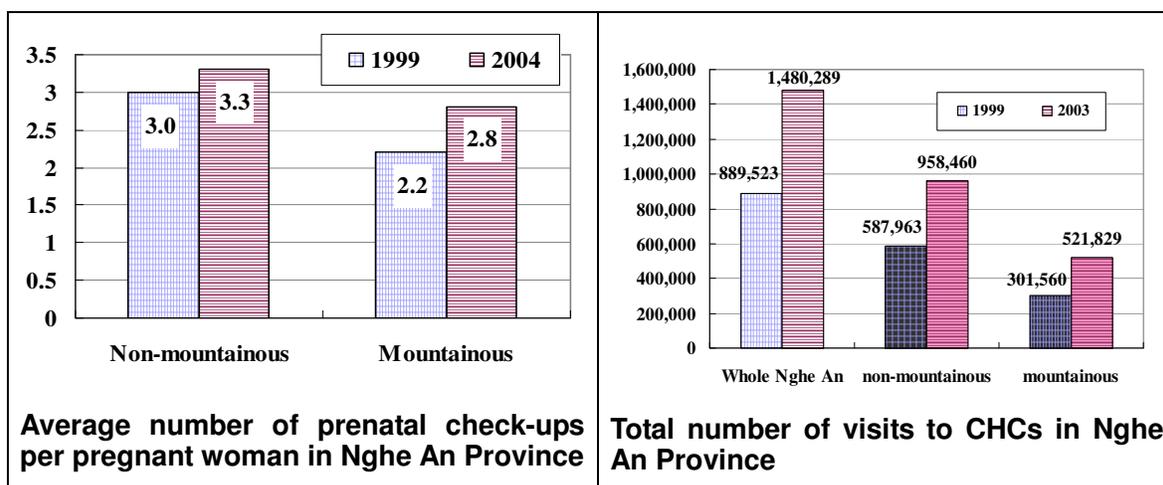
Difficulties encountered

- (1) Difficult physical access to health facilities in mountainous and remote areas;
- (2) Cultural and religious beliefs that counteracted the promotion of RH;
- (3) Financial constraints on the part of Viet Nam.

One measure used to overcome difficult access to remote areas was to strengthen the network of hamlet health workers and CHC staff. The project supported the training of hamlet health workers. In the future, health education sessions should be conducted regularly by the communes' women's unions and services that reflect new knowledge and information should be made available. When people recognize the merit of new information, knowledge, and practices, they change their behaviour.

V. Outcomes, Impacts and Sustainability

Improved conditions at the CHCs have benefited the women who chose to deliver their babies there. The benefits of the improved delivery services were more qualitative than quantitative, as the number and proportion of deliveries at CHCs did not significantly change between 1999 and 2004. Nonetheless, the total number of deliveries at institutions increased. In 2001, home-based maternal records (Viet Nam's version of pregnancy records) were used for 83.9% of births in non-mountainous area and 83.1% of births in mountainous area. In 2004, these numbers increased to 95.3% and 94.2%, respectively. The number of prenatal check-ups per pregnant woman and the total number of visits to CHCs also increased significantly from 1999 to 2003/2004 (see graphs, below). The proportion of pregnant women who received two doses of tetanus toxoid vaccine grew from 95.1% in 2000 to 97.2% in 2004 in non-mountainous areas and from 73.8% to 89.1% in mountainous area. These figures exceed the national benchmark of 95% in plain areas and 85% in mountainous areas for 2010. The average gestational age at the time of the first prenatal check-up has also shown dramatic improvement, dropping from 29 weeks in 2001, when the baseline survey was conducted, to 15.6 weeks in 2005 (this according to the final assessment conducted by the Population Council). Differences were observed between the mountainous areas and the plain areas (14.6 weeks and 16.9 weeks, respectively).

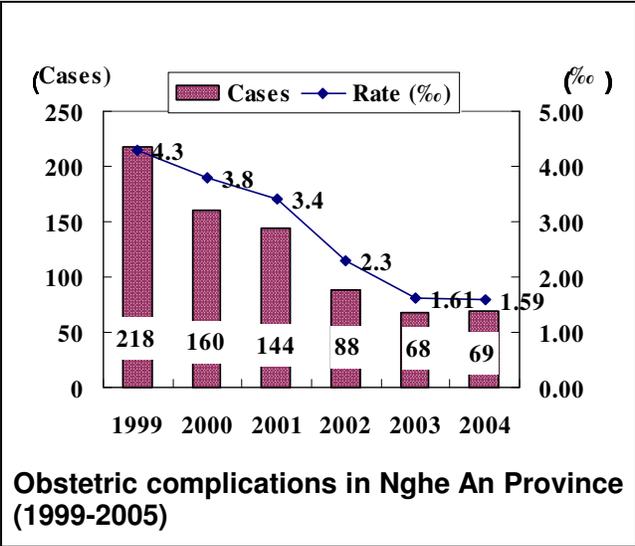


The percentage of mothers and newborns having received at least one home visit by a health worker increased from 66.4% in 2000 to 85.4% in 2004. The percentage of mothers and newborns having received at least two home visits did not show much difference: 44.2% in 2000 and 42.5% in 2004. The number and the rate of obstetric complications in Nghe An Province have shown a steady and significant decrease over the last five years, indicating the improved quality of prenatal and delivery services.

A general decrease was also observed for MMR, IMR, and the perinatal mortality rate, although a one-time increase was observed in MMR in 2003 and the perinatal mortality rate went up again in 2004. Although MMR figures are considered to be generally unreliable in Viet Nam, the reliable data collection methods introduced by this project showed a clear decline in the number of maternal and infant deaths in the communes of the project area. The proportion of babies born with a weight inferior to 2,500g decreased from 5.2% to 3.2% but rose again to reach 4.9 in 2004.

(data as of June 2005)	Target	2000	2001	2002	2003	2004
(a) Total fertility rate	2.0	2.8	2.8	2.6	2.4	2.6
(b) MMR	70	42.9	19.2	23.8	25.0	11.6
(c) IMR	25	9.3	9.0	8.7	7.2	n/a
(d) Perinatal mortality rate	18	10.9	9.6	9.5	9.2	10.6
(e) Low birth weight rate (below 2500g)	6%	5.2%	4.2%	5.2%	3.2%	4.9%
(f) Couples using modern contraception	70%	67.6%	71.9%	73.1%	80.6%	80.8%

The implementation of this project caused RHCC to change dramatically. The process of conducting activities such as CHC staff retraining and monitoring visits caused the center to improve its management capacity. Its promotion of client-friendly services also showed outstanding progress. Even today, RHCC continues to pay attention to clients' comfort, renovating its facilities, improving the registration procedure in order to shorten waiting times, providing polite and careful explanations, adopting a welcoming attitude, etc. The number of clients who visit RHCC for prenatal check-ups and gynecological examinations has increased drastically as services have expanded. In 2009, 4 years after the project was completed, RHCC was recognized by the Ministry of Health as one of the best centers of the country. RHCC has sustained its supportive monitoring visits to CHCs and its promotion of client-friendly services. It also conducts training for trainers from the four neighboring provinces in order to disseminate the "Ngeh An Model" 's know-how in community-based RH promotion.



VI. Lessons Learned

- 1) An environment conducive to promoting RH should be created by involving leaders of various agencies at all levels. To disseminate the project's goals, it is necessary to conduct IEC outreach activities that mobilize large numbers of people.
- 2) It is essential to identify organizations with powerful grassroots networks and to collaborate with these organizations in order to disseminate project outcomes.
- 3) Existing healthcare and human resource systems should be strengthened in order to enhance regular functions and roles without introducing foreign elements. This is important to the sustainability of the project.
- 4) Training and post-training support (supportive monitoring/follow-up) are inseparable. It is not an exaggeration to state that the quality of post-training support determines training outcomes.
- 5) Training must be realistic, repeated and steady. Human development and capacity-building is time-consuming. It may sound basic but surprisingly, this point is often forgotten, as most donors are in a hurry to see outcomes.
- 6) The process of implementation is as important as the final outcome. Patience is necessary for human resource development. When a donor is rushed to obtain outcomes and places too much focus on efficiency, activities become donor-driven and counterparts' sense of ownership suffers. An output-oriented approach does not necessarily ensure sustainability.
- 7) The merit of dispatching experts to remain in the field should not be underestimated. The role of experts is not merely to provide technical support. When experts remain in the field for a longer time, they
 - (1) have close, daily communication and contact with counterparts;
 - (2) involve counterparts in the entire project implementation process;
 - (3) appreciate counterparts' daily efforts and progress;

- (4) understand the difficulties that counterparts encounter and the reasons why certain activities are not implemented as planned;
- (5) wait for the right timing before they act;
- (6) know when and how much to be flexible in meeting changing conditions and needs; and establish mutual confidence and trust by revealing their informal side.

VII. Conclusions

Model for the Implementation of Viet Nam’s National Strategy on Reproductive Health Care (2001—2010):

This project promoted activities in line with national health policy and Viet Nam’s 10-year National Strategy on Reproductive Health Care (2001—2010). By accumulating experiences in the area of RH and bringing evidence to the Ministry of Health, the project demonstrated how to implement national health policies and strategies in real-life settings. The project’s activities and achievements, which focused on communes, were highly supported by the Ministry of Health and the Ministry of Planning and Investment (MPI). The project developed a “Nghe An Model” for RH promotion.

RH services in Nghe An Province improved significantly as a result of project interventions to develop human resources, upgrade CHC infrastructure and provide equipment for prenatal and delivery services. Improvements were tangible in both plains and mountainous regions, although the achievements in mountainous regions were not as great. Some project areas, such as the maintenance of facility/equipment/supplies, required further progress. The establishment of a project steering committee with representatives from four agencies at all levels was effective in implanting the health project in rural areas. Project activities were an appropriate and practical means of improving women’s RH status and enhancing the capacity of relevant organizations, especially those at the grassroots level. The readiness/package approach was fundamental to improving the quality of services. Local leaders demonstrated optimism and the desire to sustain the project’s achievements and activities. The local officers’ heightened awareness of the benefits of the improvement in the RH care for women was an important foundation for the continuation of good quality service provision activities.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- | | | |
|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Mobilization of resources | <input checked="" type="checkbox"/> | Delivery of health services |
| <input type="checkbox"/> Generation of political will | <input type="checkbox"/> | Advocacy for community participation |

IX. Organizational Information

- a. Name of Project Contact Person: Mayumi Katsube (Ms.)
- b. Designation/Title: Program Manager
- c. Name of Organization: Japanese Organization for International Cooperation in Family Planning
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- f. Website: www.joicfp.or.jp
- g. Telephone / Fax Number: 81-3-3268-3450 / 81-3-3235-7090
- h. Organizational Overview: Founded in 1968, JOICFP has been a leading agency in the field of population and reproductive health in Japan. It has contributed to the improvement of the quality of life of people in developing countries in Asia, Africa, and Latin America.



CASE STUDY

I. Project Title

Revitalizing Community Demand for Immunization in the Lao People's Democratic Republic

II. Project Summary

Over a period of 16 months in 2006 and 2007, a collaboration of private and public-sector partners aimed to improve childhood immunization coverage in the Lao People's Democratic Republic by testing communication measures to increase community demand for immunization in Luang Prabang province. First, assessments were undertaken to understand community and health work motivation around immunization service delivery. The project then developed and piloted an innovative mix of strategies such as advocacy-building among community leaders; social mobilization measures; behavior change materials; interpersonal communication through peer education, mass-media and info-tainment; and the social marketing of user-friendly health services. Some strategies were generic to all districts while others were tailored to low-coverage communities. Results show that immunization rates in pilot districts doubled and in some cases nearly tripled over the duration of the project. A key factor of success was building on, and mobilizing, additional national political support to increase immunization rates across the country and ensuring appropriate synergies between national and community efforts. Replication of the Luang Prabang pilot in other provinces will depend on buy-in from the Ministry of Health and its partners in development.

III. Introduction/Background

Prior to this project, immunization in the Lao People's Democratic Republic had been stagnant since 2000. Although the country implemented a national immunization drive in the mid-1990s, by 2005 service delivery problems and declining demand had left only half of Laotian children receiving a full course of vaccinations. Immunization rates were even lower among ethnic minorities. A 2004 UNICEF-sponsored Participatory Learning and Action (PLA) study highlighted the need to build community-based communications approaches to generate demand for immunization through messaging tailored to the different literacy rates, ethnicity, and income levels in various villages.

From September 2006 to December 2007, Asian Development Bank (ADB), GlaxoSmithKline (GSK) Biologicals and UNICEF collaborated with Lao PDR's Ministry of Health (MOH) to pilot a strategy to increase the demand for vaccination among the rural poor, including ethnic minorities. The project aimed to determine (1) how to create demand for immunization in low coverage communities; (2) how to create demand for immunization services in fixed sites; and (3) how to partner with and mobilize other sectors to advocate and communicate about immunization (e.g., mass organizations, teachers and media). It also considered related issues of supply.

The financial resources allocated to the project totaled US \$264,000, including an in-kind contribution of \$30,000 by the Government of the Lao People's Democratic Republic and excluding UNICEF's operational costs of the delivery of immunization services (salaries, per diems, etc.). The project was implemented in 12 districts and reached 966 villages covering a

total population of 487,000 persons, including 18,400 children under the age of one (the target population).

IV. Project Implementation

This project used a participatory learning-by-doing framework to test interactive behavior change materials designed to engage village leaders and villagers in immunization activities. One such material was an immunization card featuring a five-petal frangipani flower. Every time the child was vaccinated, one petal of the flower was marked with the program's signature elephant stamp, making it easy for parents to keep track of how many more vaccination visits their child needed in order to be fully immunized. Another material consisted of a certificate of completion for fully immunized children, publicly awarded to parents by a prominent individual. A third material consisted of a target household flag, the pocket of which contained information about the community's next immunization outreach visit. One to two weeks before the visit, flags were placed in front of the homes of children who required vaccination. Parents were asked to return the flag at the time of the outreach visit.

Several initiatives targeted increased advocacy among local leaders. Project staff conducted advocacy workshops that taught village leaders, village health representatives and Lao Women's Union representatives how to champion immunization in their communities. Villages were also encouraged to run immunization events such as health fairs and were advised to link immunization to important days in the community. Immunization was also promoted with limited numbers of inexpensive give-aways (presents) to parents whose children were fully immunized. An 85% coverage village competition was also held in 10 villages. Under this program, villages that had attained 85% coverage by the end of one year were publicly awarded a certificate of excellence. Teacher training also took place, with middle school teachers in low coverage villages taught to design games that educated children about immunization and to talk confidently to parents about the benefits of vaccines.

In addition, specific strategies were developed for ethnic minority villages where language and cultural beliefs were barriers to accessing immunization services. One such strategy was peer-to-peer education. Under this program, a village leader or volunteer selected five to 10 influential and communicative individuals to act as peer educators (mother-to-mother or father-to-father) during their normal day-to-day activities. Village leaders met with the peer educators once every one to two weeks to help them plan their work and overcome difficulties. Another strategy consisted of ethnic language radio spots. Under this program, local ethnic language radio programs were contracted to run dramas, jingles, and knowledge spots about immunization. These spots were recorded in the local language and were relevant to the local culture.

The project also sought to improve outreach strategies by implementing a policy of routine pre-notification whereby health providers gave village leaders at least three days' notification before conducting an immunization outreach. Immunization health providers were also encouraged to visit the village the night before an immunization outreach to run pre-vaccination education sessions. Some districts tried coordinating immunization outreach visits with the seasonal calendar so as to ensure that visits did not conflict with peak periods in the agriculture cycle. Health workers were also trained in communication and social marketing skills and were given jackets, badges and stickers marked with the immunization program logo to publicize the program and motivate their performance. Awards of excellence to highly performing EPI health providers and other performance-based initiatives were also tested. To improve public use of fixed vaccination sites, the project regularized the provision of services and marketed services through low-cost advertising.

Additional project tools included centrally located notice boards. Constructed by the village with support from the district team, these boards were used to post immunization calendars that specified the dates and locations at which immunization services were available. Calendars were also posted at fixed site health centers. Posters detailing the immunization status of local children were also displayed.

To build partnerships and mobilize actors, the project instituted a participatory monitoring and evaluation procedure. Districts also tested strengthening the feedback loop to village leaders by informing them of the immunization status of village children. The project coordinated the delivery of immunization services with partners and involved them in planning and implementing activities.

V. Outcomes, Impact and Sustainability

In the pilot districts, immunization rates nearly doubled over the duration of the project and were expected to reach or come close to reaching the national immunization goal of 85% by the end of 2007. Nonetheless, results varied across districts depending on capacity of the district's project team and the duration and intensity of the interventions.

Insofar as sustainability is concerned, villagers were motivated to continue project resources and activities such as notice boards and the peer education program. In some villages, immunization had become a social norm. Furthermore, many community leaders who were committed to continuing their immunization efforts were incorporated into the human resource pools of existing structures. Existing radio programming and advocacy meetings for leaders were also expected to continue without further support. Other aspects of the project, however, require additional external support (for example, the production of new radio dramas). Still others, such as teacher training and the expansion of the program into other districts, require more substantial external support.

VI. Lessons Learned

Enabling factors. The most effective materials in low coverage communities were the frangipani flower, the target household flag, the certificate of completion, the posters, the radio spots, the peer-to-peer education program, the notice boards and the feedback loop. In fixed sites, the most successful strategies were the permanent advertising of services, low-cost advertising in catchment areas and the offering of reliable, quality services. The teams further reported that the monitoring and evaluation process was extremely fruitful. The Minister of Health's public emphasis of the importance of immunization as a top health priority during the project period and a concomitant measles campaign helped to heighten awareness and improve coordination.

Barrier factors. The short, 16-month duration of the project hindered its ability to build capacity, develop systems of operation, and bring about behavior change (widely recognized to take years). Plans to partner with religious leaders and the private sector were not fully explored and the project was impacted by a lack of vaccines from January to March 2007.

The project team retained the following principal lessons:

- ◆ Institute a systematic process of multi-sectoral information collection, dissemination, participatory planning, and monitoring and evaluation for continuous delivery improvement;
- ◆ Use tailored bottom-up approaches developed by communities rather than top-down approaches that are perceived as irrelevant and imposed from the outside;
- ◆ Take a learning-by-doing approach through ongoing capacity building, knowledge exchange, on-the-job training, coaching, and teamwork;

- ◆ Recognize that the health system itself needs to improve service quality in order to generate greater demand;
- ◆ Actively promote and market quality, user-friendly health services to make communities more responsible for their own health;
- ◆ Be innovative and creative in delivering health services and learn from the private sector how to market health services in new ways;
- ◆ Prioritize and use existing resources more effectively rather than asking for more money;
- ◆ Mobilize ethnic minority communities to become more active in improving their own health using advocacy, radio, and peer education strategies;
- ◆ Mix communication strategies rather than rely on a single strategy; and
- ◆ Recognize that change takes time and requires sustained efforts in order to institutionalize outcomes and create new social norms.

VII. Conclusions

Although this project was short in duration, it measurably demonstrated that strategic, tailored and targeted interventions can increase the demand for immunization. At the outset of the project, some leaders and government officials believed that low coverage communities composed of ethnic minorities, the poor, the poorly educated, and those in remote areas, would not accept immunization services. Certain health providers also believed that villagers would not come to a fixed site health service for immunization and would only access immunization services offered by outreach teams at the village level. But project outcomes showed that the contrary is true. Once remote and ethnic populations understood the purpose and the advantages and disadvantages of immunization in their own language and in terms of their own cultural beliefs, they participated with enthusiasm. Parents also turned out to be more than willing to access immunization services in fixed sites. For these transitions to occur, it was necessary to devise and implement interventions that reached into each community through that community's unique systems, networks and peer groups; and to ensure and market reliable, quality services at fixed sites. Partnering and advocacy-building activities have helped to ensure the sustainability of these results.

VIII. Bibliography

The text in this case study was drawn from the following sources:

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Ruth Landy. 2006. Immunization is an Act of Love: Revitalizing Community Demand for Immunization in the Lao People's Democratic Republic. *Global Healthlink* October-November (141): 10-11, 16.

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IX. Key Thematic Areas Addressed

The project addressed the following immunization challenge in a particularly innovative way: Advocacy for community participation.

X. Organizational Information

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- e. Website: www.adb.org/projects/project.asp?id=40004:
- f. Telephone / Fax Number:
- g. Organizational Overview (2-sentence description):

The *Revitalizing Community Demand for Immunization* (RCDI) Project
Lao People's Democratic Republic
TA Number 4787; Project Number 40004-01

Implemented in Lao People's Democratic Republic of Republic (PDR) from September 2006 to December 2007, the project aimed to improve childhood immunization coverage in Lao PDR by helping the Government conduct an operational research to test different communication strategies to increase community demand for immunization using participatory approaches.

CASE STUDY

I. Project Title

Promoting Integrated Community Health Education in a Remote Island of Indonesia

II. Project Summary

Over a period of 24 months in 2006, 2007 and 2008, this project promoted maternal and child health (MCH) in Tello Island, one of Indonesia's most remote islands located in Pulau-Pulau Batu sub-district, South Nias district. The project aimed to increase the community's capacity to implement healthy behavior; to increase access to health services for mothers and children under 5; and to revitalize community healthcare system structures known as posyandus. Results show that maternal and child health (MCH) promotion efforts and nutrition and immunization knowledge and practices doubled. Some community empowerment with regards to healthy behaviors has also been seen.

III. Introduction/Background

This project was implemented in Tello Island, Indonesia, where it covered all 15 of the island's villages and reached a population of 7000. Part of the earthquake-prone region, Tello Island suffered mild effects from the 2005 earthquake. Historically, the region had been greatly underserved by government and various programs, both before and after the tsunami and the earthquake. Suffering from chronic poverty and under-development in all sectors—transport, infrastructure, electricity, communications, education (both community and formal education), health care, livelihoods and trade—, the area still ranks as one of Indonesia's poorest and most vulnerable. A recent survey of eight sub-districts of this region found an infant mortality rate of 56 per 1000 live births, a maternal mortality ratio of 348 per 100,000 live births, and a malnutrition rate of 12% (Nias Health Profile, 2004). Clinic utilization rates were also very low. The underutilization of community health centers is related to factors such as patients' knowledge, beliefs and values; economic conditions; and the quality of services.

Prior to the implementation of this program, MCH promotion efforts and good nutrition rates were very low due to the fact that the Tello Island posyandus had been inactive for years. Posyandus are community health outreach programs linked to puskesmas (sub-district health clinics). Most of the posyandus on Tello Island had never been fully developed, and some posyandus that had previously functioned had fallen into disuse due to the lack of resources and support by the puskesmas. The earthquake disaster further strained the system by diverting responsibility from the Ministry of Health (MOH) at the kabupaten (district) level, cutting into the resources of the puskesmas and making it more difficult for even dedicated cadres to continue.

The Tello Integrated Community Health Education project (TICHE) aims to improve the health and nutritional status of Tello Island mothers and children under 5 by pursuing two strategic objectives: (1) increasing the community's capacity to implement healthy behavior and increasing access to health services for mothers and children under 5; and (2) revitalizing posyandus/puskesmas for mothers and children under 5 in order that they access MCH knowledge and benefit from early detection of at-risk health conditions for timely referral.

IV. Project Implementation

This project sees self-empowerment as a key to building community members' capacity to take responsibility for their own health. To promote self-empowerment, MAP International conducted progressive trainings of health promoters, teaching them to facilitate learning groups; conduct mini-seminars on health issues; hold training meetings and seminars in faith-based organizations, community-based organizations, and schools; and hold other community meetings using a community participation approach. The topics addressed in these meetings consisted of MCH and other issues that surfaced as the project advanced. About 200 mothers and cadres participated in village learning groups called *sondoro* (care groups), of which at least one was formed in every village. Composed of eight to 10 cadres each, the *sondoro* met regularly every two weeks. After 8 months of training, four cadres from each village dedicated themselves to initiating *posyandu* activities and underwent training by MAP International and by *puskesmas* of Indonesia's Ministry of Health.

Posyandu activities in the villages were conducted using a "five table" approach. At each *posyandu*, the first table was for registration, the second for weighing and measuring, the third for growth monitoring and documenting results in a child wellness card, the fourth for health education and basic consulting, and the fifth for vaccinations, family planning and other services. The first four tables were staffed by village cadres and the fifth table was staffed by a *puskesmas* health worker. Since April 2008, 15 *posyandus* in 15 Tello Island villages have taken place monthly with minimal supervision from MAP International and with the growing support of *puskesmas* staff members. Village heads have acted as advisers. Eighty percent of children under 5 are now receiving regular growth monitoring and vaccination services. As of December 2008, 19 *sondoro* in 15 villages had involved 156 active cadres in learning about health threats and disease prevention. These activities were being linked to qualified health service providers.

About 900 families have participated in a series of mini-seminars on nutrition, reproductive health, community transformation, and breastfeeding. The project's seminar on leader participation and its regular coordination assistance to local authorities and *puskesmas* helped boost support for the project and build capacity among community leaders. In the project's fourth semester, the community instituted a pilot project whereby they began planting vegetables in five vegetable gardens. By the end of 2008, they had planted vegetables in 15 villages, thus ensuring daily vegetable consumption.

To revitalize MCH knowledge and capacity within the *puskesmas*, MAP International conducted a breastfeeding counseling course for midwives. It also trained health educators in how to promote breastfeeding. MAP International has encouraged health workers to become involved in *sondoro* meetings.

V. Outcomes, Impacts and Sustainability

After 2 years of implementation, this project has served more than 1000 *puskesmas* staff members, *sondoro* and *posyandu* participants, youth, village heads, breastfeeding counseling course participants, vegetable garden participants and mini-seminar attendees. We found some improvement of knowledge and behavior among mothers who had participated in the pregnant and lactating mothers' groups. In home visits made to mothers, mothers reported that they had given colostrum to their babies and had practiced exclusive breastfeeding. In summary, the original project goals and strategies were found to be efficient in serving the Tello Island community. Sustainability has been ensured through the implementation of a contextual approach. An ongoing process of soliciting support from health offices through *puskesmas* has also shown progress.

VI. Lessons Learned

Enabling factors. The most effective approach used by this project to improve community participation was the sendoroge meetings. These meetings have been key to revitalizing posyandus and involving related parties such as village heads, religious leaders, village elders and so on. By employing local human resources as community facilitators who can spread the message in their own language, the strategy has enhanced health knowledge and encouraged greater acceptance of healthy behavior changes. Gaining the support and the involvement of local authorities and existing health providers has laid a good foundation for sustainability. The fact that project team members shared the life of the community helped create trust and increase community members' willingness to adopt healthy behaviors and make other transformations. *Barriers.* The biggest challenge to the success of this project was the District Health Office of South Nias' failure to supply vaccines to posyandus and its failure to train and motivate health workers. Very strong cultural beliefs such as that the consumption of eggs damages children's teeth, that immunizations transfer evil, that it is desirable to feed solids to babies before the age of one month, and that the death of a child under the age of two increases parents' earning power, required extra effort. Low self-confidence and poor access to information due to low levels of education also forced project participants to think creatively and adopt an innovative approach.

Factors to be considered for future initiatives include a good logistical plan for the provision of materials and supplies and a community participation plan to be developed by researching the community's culture and its character. Empowering puskesmas/health offices through motivational coaching and upgraded training will also help revitalize the posyandu system.

VII. Conclusions

In 3 years of non-governmental organizations (NGOs)' earthquake assistance to Indonesia's Nias and South Nias districts, Tello Island received little attention. This project is proof and encouragement to government and other NGOs of the value in building up Tello Island and the Pulau-Pulau Batu sub-district. As a result of this project, the residents of this remote island, characterized by poor access to services, poor infrastructure and little capacity, now have greater confidence in taking responsibility for their own health. They have been educated about the resources available to them and are now demanding that the government healthcare sector give them their rights.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- Mobilization of resources
- Delivery of health services
- Generation of political will
- Advocacy for community participation

IX. Organizational Information

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- h. Organizational Overview: MAP International promotes the health of those living in the world's poorest communities. It does this by partnering initiatives that facilitate the provision of essential medicines, prevent and eradicate disease, and promote community health.



CASE STUDY

I. Project Title

Facilitating Synergies to Scale Up Maternal, Newborn and Child Health Interventions in Nepal

II. Project Summary

Mother and Infant Research Activities (MIRA) proposes to facilitate the synergy between organizations working in maternal, newborn and child health (MNCH), especially immunization, in Nepal, so that organizations can learn about each other's best practices, internalize those practices and adapt feasible approaches to their own programs. Some activities have already been initiated under the community-based expanded program for immunization (EPI) and MIRA proposes to aid this process by carrying out a series of meetings, workshops, exchange visits and follow-up activities that will help bridge the communication and knowledge-sharing gap between MNCH programs. The project involves major partners and government and is already underway.

III. Project Implementation

MIRA proposes to facilitate the synergy between organizations working in Nepal on MNCH so that organizations can learn about each other's best practices, internalize those practices and adapt feasible approaches to their own programs. MIRA does not work in isolation: the Community Based-Integrated Neonatal Care Package (CB-INCP), a large initiative to scale up neonatal care, is already underway with the support of major partners and strong government leadership. MIRA proposes to aid this ongoing process by organizing a national meeting of decision-makers from the Department of Health Services of Nepal's Ministry of Health and Population; external development partners; and international and national non-governmental organizations engaged in high-impact MNCH initiatives. MIRA's aim is to facilitate the synergy between these organizations so that the organizations and the districts involved in their projects adapt successful initiatives into existing programs. MIRA's country team will also follow the Fostering Change Global Health e-Learning Course at <http://www.globalhealthlearning.org/login.cfm> and the Advanced Immunization Management e-learning course. Because MIRA's initiative is part of a bigger process, the outcome and sustainability of its efforts will be tied to the success of CB-INCP.

As part of the synergy-facilitating process, MIRA proposes to follow the national meeting with five regional workshops that involve district public health offices and local non-governmental organization partners. Five exchange visits of high-impact intervention sites will enable workshop participants to internalize relevant information. This form of synergy-facilitating will not only quicken uptake of best practices by smaller programs, it will ensure that larger organizations presently engaged in scaling up their pilot activities will become aware of some of the higher-impact best practices to incorporate into their programs prior to scale-up at minimal cost.

These meetings, workshops and exchange visits will help bridge the gap in communication and knowledge-sharing among high-impact MNCH programs. The interaction among many program officers and the adaptation of high-impact changes will improve the performance of individual programs and will help reduce neonatal and maternal morbidity and mortality. For example, the Government of Nepal plans to scale up its Community-Based Integrated Management of Child

Illness program (CB-IMCI) throughout the country over the next two years. Although CB-IMCI provides care for newborns under 2 months, Child Health Division data show that the use of health facilities for such care is rare. Nepal has made great progress in reducing child mortality but its progress in neonatal mortality has been slower. As part of our synergy-facilitating initiative, the proposed exchange visits to pilot program sites with MNCH programs could lead to CB-IMCI's adaptation of certain program structures to strengthen the neonatal component at little or no additional cost. This could greatly reduce neonatal mortality.

In summary, the project's main objective is to work within CB-INCP to facilitate the synergy between organizations and government institutions engaged in MNCH initiatives in order to encourage them to scale up high-impact maternal and neonatal best practices and reduce maternal, newborn and child morbidity and mortality. Its specific objectives are (i) increased communication and knowledge-sharing among MNCH programs; (ii) the internalization of best practices by organizations engaged in similar efforts; (iii) the adaptation of best practices into those organization's own programs and the scaling-up of successful efforts; (iv) improved MNCH in Nepal; and (v) meeting the Millennium Development Goal (MDG) on reducing maternal and infant mortality.

IV. Outcomes, Impacts and Sustainability

MIRA expects that the project will produce the following outcomes: (i) a national-level meeting of stakeholders engaged in high-impact best practices in MNCH; (ii) workshops in each of Nepal's five regions that will guide the planning of the exchange visits in order that the visits take place at sites and programs with high-impact best practices; (iii) training, orientation and five exchange visits. The list of five sites proposed by MIRA may be revised after the national-level meeting and the five regional workshops. MIRA will also perform a baseline survey and construct progress indicators before the project is implemented in order to monitor progress during the follow-up stage. Three to 4 months after the exchange visits in the five regions, MIRA will document adaptation of MNCH programs and initiatives. MIRA will also document success stories, prepare a final report of its findings, and hold a dissemination meeting to conclude the program.

V. Expected Outcomes

MIRA believes that synergy will be created when different MNCH programs interact and adapt their respective practices. MIRA also expects that this interaction will improve the performance of individual programs and help reduce neonatal and maternal morbidity and mortality. This synergy-facilitating initiative is already underway and will not only quicken the adaptation of best practices by smaller programs but will also ensure that larger organizations engaging in scale-up of their pilot activities are aware of high-impact best practices and have the opportunity to incorporate those practices into their programs at minimal cost.

VI. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- | | |
|---|---|
| <input type="checkbox"/> Mobilization of resources | <input type="checkbox"/> Delivery of health services |
| <input type="checkbox"/> Generation of political will | <input type="checkbox"/> Advocacy for community participation |

VII. Organizational Information

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- **Organizational Overview (2-sentence description)**

Established in 1992, Mother Infant Research Activities (MIRA) is a non-governmental organization run by experienced and committed Nepalese health and development professionals. MIRA's mission is to improve the health of mothers and newborns by reducing maternal and neonatal mortality and morbidity through research, training, and advocacy.

CASE STUDY

I. Project Title

Evaluating the Use of Outside-the-Cold-Chain Hepatitis B Vaccination in Viet Nam

II. Project Summary

Between May 2004 and July 2005, PATH collaborated with Viet Nam's National Expanded Program on Immunization (NEPI) to conduct a pilot study that evaluated the effectiveness of birth doses of the hepatitis B vaccine stored outside the cold chain (OCC). The project also increased awareness of this vaccine among healthcare workers and trained them in its proper administration. Results show significantly increased rates of birth dose vaccinations at participating study sites with no decreased efficacy or protective immune response and no increased number of adverse events following immunization in neonates who had received the vaccine. Qualitative results attest to widespread acceptance of this strategy by mothers and healthcare workers alike.

III. Introduction/Background

According to World Health Organization (WHO) estimates, Viet Nam has a high prevalence of hepatitis B virus (>8% of the population).¹ According to 2003 survey data, the rate of Vietnamese pregnant women who are chronic carriers of hepatitis B is also high. This situation increases the likelihood of mother-to-child transmission of the virus during or soon after birth.^{2, 3, 4} The proper delivery of a birth dose of hepatitis B vaccine within 24 hours of birth is estimated to effectively prevent 80 to 95% of mother-to-child transmissions.¹

NEPI introduced the hepatitis B vaccine in Hanoi and Ho Chi Minh City in 1997 and by 2000 had expanded its use to 39 provinces. The program scaled up in 2001 and with the support of the Global Alliance for Vaccines and Immunization (GAVI), the vaccine became available to children under one year old nationwide in 2003. Initially, NEPI recommended giving the first of three doses within 72 hours of birth. This recommendation has now been revised to giving the first dose within 24 hours of birth.

In 2005, NEPI data showed that coverage of the hepatitis B birth dose within 24 hours in Viet Nam was 62.2%. This rate was inferior to NEPI's target of 80% to 95%. The data also showed large variances in vaccination rates between provinces. Studies conducted by NEPI in collaboration with PATH and WHO demonstrated numerous difficulties in delivering the hepatitis B birth dose, especially in the central and southern provinces.⁵ Many of these problems stemmed from community health centers' difficulty in maintaining the cold chain, mainly due to the lack of refrigerators.

Recent studies have evaluated the effects of storing the hepatitis B vaccine at temperatures of up to 37°C for as long as 30 days. These studies found that these conditions affected neither the immunogenicity nor the efficacy of the vaccine⁶. The OCC vaccine can be further enhanced by the use of Vaccine Vial Monitors (VVMs) printed directly on the vaccine vial labels. VVMs darken with exposure to heat over time, thus helping to ensure that communities use the vaccines in a timely manner. Given remaining barriers to the provision of widespread vaccine

coverage in Viet Nam, these new technologies can greatly reduce the risk of mother-to-child transmission of hepatitis B.

PATH collaborated with NEPI, the Thanh Hoa preventive medicine center and the Nong Cong, Tinh Gia, Thach Thanh and Cam Thuy district health centers to conduct a pilot project to evaluate the use of OCC storage of the hepatitis B vaccine in community health centers where the cold chain is not possible. The project assessed the immunogenicity and the safety of using hepatitis B vaccine OCC and gathered evidence in support of this model in regions where maintaining the cold chain is exceedingly difficult. This study's qualitative and quantitative results provide insight into the use of OCC storage and shed light on a variety of programmatic issues such as operational measures, training, vaccine management, and increasing coverage within the now recommended 24 hours of birth.

IV. Implementation

For the purposes of this intervention, the study population was divided into two groups. The first group was made up of newborns in four district hospitals who received the birth dose of hepatitis B vaccine according to standard NEPI procedures. Subsequent hepatitis B vaccine doses were delivered to these babies in community health centers. The second group was made up of neonates born in community health centers or at home where the cold chain is unavailable. These babies were vaccinated with the hepatitis B OCC birth dose that together with the attached VVMs had been stored at ambient temperature.

District health centers provided community health centers with the hepatitis B vaccine twice a month. The vaccines were stored at room temperature in a dark box for up to two weeks in a cool, dry place outside direct sunlight. Before vaccinating newborns, health workers were required to check the VVM and the vaccine expiry date. The second and third doses of the vaccine were stored in the cold chain and administered on monthly immunization days at the same time as the first and third doses of the diphtheria, pertussis and tetanus vaccine (DPT). Village health workers (VHW) reported all deliveries in their communities to commune health workers. They also encouraged mothers to vaccinate their newborns as soon as possible and ensured that mothers had immunization cards. For home births, commune health workers administered the birth dose at home and documented the vaccination on the baby's immunization card. Study-related information was documented in the children's immunization register and the monitoring logbook.

Health workers at all levels were trained in immunization practice skills, safe injection techniques, the reading of VVMs, and the implementation of the birth dose of hepatitis B OCC. In addition, information campaigns were organized for communities and governmental institutions. Databases were developed to compile data on vaccine management and newborns' demographic information. Coordinators were trained to manage the monitoring logbooks and the research data.

Immunization cards were used to monitor the children enrolled in the study. District-level coordinators were responsible for collecting and compiling data from district and community health centers on a weekly basis. Health workers recorded vaccination information into monitoring logbooks as per NEPI protocol. This information was reported to and compiled by district coordinators each month.

Adverse events following immunization were reported according to standard NEPI requirements. The ambient temperature of storage containers for hepatitis B vaccine OCC were monitored hourly at participating community health centers using electronic thermometer devices.

Serum samples from children born between February and July 2005 were collected in December 2005. This method allowed for the analysis of serum between 30 days and 6 months of the children's third dose.

V. Outcomes, Impact and Sustainability

The study population consisted of 10,463 children from four study districts, all of whom were vaccinated with a birth dose of hepatitis B. Of the 3,306 children born at district hospitals, 82% received their first dose of hepatitis B vaccine within 24 hours of birth. Of the 7,157 children born at community health centers or at home, 83% received their first dose within 24 hours of birth. That there was no significant difference in coverage between the different cold chain strategies, demonstrates that the hepatitis B vaccine OCC can be effectively administered within 24 hours of birth.

When compared to pre-intervention rates, this study saw a 44% increase in hepatitis B vaccine coverage within the first 72 hours of birth (89% coverage during the study period compared to 45% coverage between May 2004 and April 2005).

Of the 967 children who received all three doses of either vaccine, results from the serosurvey show that 88% had a protective immune response (anti-HBs ≥ 10 mLU/ml). Geometric mean titres demonstrating positive immune responses were compared between each group and showed no significant differences. Furthermore, there were no significant differences in the occurrence of adverse events reported by the two groups.

Interviews and discussions held with health workers and community leaders testify to widespread support of the OCC delivery strategy. In addition to the clear advantages of the approach, the pilot study strengthened community awareness and acceptance of vaccination. Mothers expressed their satisfaction at having their child receive the birth dose of the vaccine and health workers expressed a desire to see the model approved by the Viet Nam Ministry of Health.

VI. Lessons Learned

Although Viet Nam's NEPI has achieved high vaccination coverage rates, this study highlights how simple interventions can further increase the efficiency and efficacy of a national immunization program. In addition to technological solutions, barriers to optimal vaccine rates in different areas can be resolved by strengthening the local healthcare infrastructure. Though this pilot study demonstrated the effectiveness of the vaccine and its acceptance by both healthcare workers and mothers, it has yet to be implemented nationwide. To translate these results into practical application throughout Viet Nam would require policymakers to support increased community awareness of the burden of hepatitis B and of the importance of preventing mother-to-child transmission of the disease. It would also require them to help demonstrate the efficacy and safety of the OCC vaccine.

VII. Conclusions

Results of this pilot model for the use of hepatitis B vaccine OCC in Viet Nam demonstrate the following:

- Children vaccinated with a birth dose of hepatitis B vaccine OCC have an immune response as good as the immune response of children vaccinated at birth using the vaccine stored in the cold chain.

- The number of adverse events is no higher with the birth dose of hepatitis B vaccine OCC than with the birth dose of hepatitis B vaccine stored in the cold chain.
- Both health workers and mothers accept and advocate for a strategy that promotes the use of birth doses of hepatitis B vaccine OCC.
- In regions where maintaining the cold chain is difficult, the coverage of birth doses given within 24 hours could be significantly increased by using OCC vaccines. This strategy would help reach the goal of reducing hepatitis B infections in children aged 5 to below 2% by 2012.

VIII. Key Thematic Areas Addressed

Delivery of immunization services.

IX. References

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6. David B Hipgrave, James E Maynard and Beverly-Ann Biggs. Improving birth dose coverage of Hepatitis B vaccine. Bulletin of World Health Organization. January 2006, 84 (1).

X. Organizational Information

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- g. Organizational Overview: PATH is an international nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public and private-sector partners, PATH helps provide appropriate health technologies and vital strategies that change the way people think and act. PATH's work improves global health and well-being.

For more information, please visit www.path.org.

CASE STUDY

I. Project Title

The Grameenphone Safe Motherhood and Infant Care Project: Sponsoring Community-Level Service Providers for Better Health

II. Project Summary

A safe motherhood and infant care project was implemented through the Smiling Sun branded non-governmental organization (NGO) network of healthcare clinics from August 2007 to May 2008. This project provided maternal, neonatal and infant healthcare services to communities in 61 districts of Bangladesh with a focus on the poorest of the poor (PoP). Services included free medicine, laboratory services, and regular consultations with trained healthcare providers such as doctors, paramedics and community health volunteers, termed “depot holders”. Sponsored by Grameenphone Ltd. (Grameenphone), Bangladesh’s largest telecommunications company and an affiliate of Grameen Bank, recipient of the 2006 Nobel Peace Prize, and by Pathfinder International (Pathfinder), an internationally acclaimed reproductive health organization that has provided reproductive health services around the world for over 50 years, this project was the largest corporate social responsibility initiative ever seen in Bangladesh. As a result of Grameenphone’s generous sponsorship of services provided in Smiling Sun clinics, and with Pathfinder’s organizational support, the utilization of health services by PoP women, neonates and infants increased significantly. Maternal, neonatal and infant mortality and morbidity in the catchments area of the Smiling Sun clinics decreased as well. Smiling Sun’s depot holders played the most significant role by identifying PoP clients and providing them with frontline support in the prevention and treatment of minor ailments and by referring them to government health centers and Smiling Sun clinics.

III. Introduction/Background

Bangladesh’s Constitution states that health care is a fundamental responsibility of the People’s Republic of Bangladesh, whose Ministry of Health and Family Welfare provides health services to citizens. Because Bangladesh is a developing country with limited resources, however, the Government is unable to provide health care to all. For that reason, a large network of NGOs and private sector providers supplement and complement government efforts to provide health care. As an emerging economy, Bangladesh seeks to embrace the challenges of Millennium Development Goals 4 and 5 and reduce maternal, neonatal and child mortality. Its expanded approach to providing essential care services through a large network of healthcare facilities in both rural and urban areas has achieved many advances, such as universal immunization coverage. The aim of these services is to provide quality health care in a more sustainable and integrated manner to the country’s unserved and underserved population. Nevertheless, many challenges remain, one of the most important of which is the poor utilization of healthcare services by the PoP. Currently, the Government’s main priority is to deliver an essential health service package with an emphasis on the PoP. As part of its commitment to social responsibility, Grameenphone Ltd. extended its support to the Government and partnered with Pathfinder International to implement the Grameenphone Safe Motherhood and Infant Care Project. The objective of this project was to lend tactical support to 61 districts of Bangladesh in order to provide safe motherhood and infant care services to PoP mothers and infants.

IV. Project Implementation

This project was implemented by a network of Bangladeshi NGOs operating under the Smiling Sun franchise program, which runs service delivery clinics in 61 of 64 districts of the country. The Smiling Sun-branded network includes 31 indigenous NGOs and covers a population of about 20 million people through a network of 318 static healthcare clinics. This network deploys approximately 8,500 satellite/outreach locations, 5,000 staff and 6,500 community volunteers, termed “depot holders”. It operates in underserved urban slums and hard-to-reach rural areas where the least advantaged of the population dwell.

By fostering partnerships and working with local resources, notably government agents from the health sector, the project established a joint participatory supervision and monitoring modus operandi with Grameenphone, Pathfinder International and the Government of Bangladesh. This process was immensely helpful in supplementing and complementing government efforts to reach the PoP with the services they most required. The project also coordinated the delivery of healthcare services with local government health services in order to enhance the distribution of family planning materials and other commodities, which it supplied for free at the grass-roots level. All these activities were performed based on intensive business planning and other implementing modalities conducted prior to start-up.

Smiling Sun clinics use a three-tier service delivery structure made up of static clinics, satellite clinics and a host of depot holders. Service provision at static clinics is assured by doctors and paramedics, including nurses, midwives and family welfare visitors (family welfare visitors are static and satellite health centre staff who visit clients’ homes as required). The satellite locations are operated by paramedics. The depot holders, finally, are agents of change within their communities and play a crucial role. They provide services to the community by identifying the PoP and channeling PoP individuals towards mainstream healthcare services. Depot holders are volunteers identified by their communities and sponsored by Pathfinder to carry health messages and be at the side of PoP families to help with treatments and referrals.

Under normal circumstances, the standard practice of Smiling Sun clinics was to share costs with the community by charging a nominal service fee at the service delivery point. Smiling Sun clinics also provided free healthcare services to PoP pregnant mothers, including antenatal care, natal care (home deliveries, normal vaginal deliveries and emergency obstetric care) and postnatal care. In addition, the network provided services for neonatal and infant care that included universal immunizations and integrated management for childhood illness. This project complemented this system by distributing health benefit cards to PoP families with pregnant women and/ or infants, which allowed clients to access Smiling Sun services for free. The depot holders acted as the primary healthcare services contact points for the card holders. It was they who registered the mothers and the infant as beneficiaries of the project.

A number of endeavors were pursued to increase marketing and promotion of the system among PoP families. Project staff and community volunteers conducted formal and informal workshops that taught village leaders, religious leaders and PoP families how to access healthcare services at existing facilities. Depot holders and NGO staff organized events such as health expositions in their own homes and in the homes of village leaders, where attendees were told how PoP women, neonate and infants could access health care through the community’s satellite and static clinics. Specific strategies were also developed for chronically poor villages where hard-core poverty was the single most important barrier to accessing services. One such strategy consisted of bringing healthcare services to users themselves. Depot holders were taught how to transmit health messages and were given materials and health and family planning commodities that allowed them to provide users with essential products at their own doorsteps.

VI. Outcomes, Impacts and Sustainability

In the area of infant care, a comparison of pre-project and post-project data show an upward trend in services utilization by PoP infants with respect to diphtheria, pertussis and tetanus vaccines (DPT), the measles vaccine, treatment for the management of pneumonia, and treatment for dehydration due to diarrhea. A total of 10,017 infants received the first dose of DPT. Of these, 4,946 infants were also fully immunized against six infectious diseases (diphtheria, pertussis, tetanus, polio, tuberculosis and measles).

Among PoP pregnant women, 48,877 antenatal care services, 1357 normal vaginal deliveries at healthcare facilities, 982 paramedic-assisted home deliveries and 513 caesarean section deliveries took place during the project period. Pre-project and post-project data on safe motherhood services show an upward trend of service utilization for antenatal care, paramedic-assisted home deliveries, deliveries at healthcare facilities, caesarean section deliveries and tetanus toxoid vaccinations among PoP pregnant mothers. The mortality rate among those who received services under this project was zero.

An evaluation carried out at the project's end revealed the following success factors:

- Continual identification and updating of the PoP population so that no PoP family would be overlooked;
- Optimum utilization of service providers' time and technical knowledge;
- Empowerment of depot holders to help them provide free services to PoP pregnant women and infants;
- Increased utilization of clinics by family members of the project's target population (PoP pregnant mothers and children);
- Encouragement of paramedics by sharing the costs of home deliveries and increasing the number of aseptic normal home deliveries assisted by trained professionals.

VI. Lessons Learned

- *Utilization of services by the poorest of the poor:* Prior to this project, the Smiling Sun clinics network only provided consultation services to the PoP. With the support of this project, the network provided PoP pregnant women and infants with consultation services as well as medicine, laboratory tests, ultrasounds, delivery services, and more. Data show that 940,250 PoP pregnant mothers and infants availed themselves of necessary services from 318 Smiling Sun clinics during the project period. This figure suggests that by creating awareness through a dedicated group of community workers, the project played a vital role in bridging the gap in services for that segment of the population that is unable to access necessary healthcare services from other community service providers.
- *Management practices for identifying and keeping records on the beneficiaries:* The health benefit cards developed to allow the PoP to access services within clinics worked very well. Clinic staff followed specific guidelines to identify PoP individuals. Record keeping was important in ensuring that service records were regularly updated and that the identification of the PoP population was kept current.
- *Orientation for frontline service providers:* Frontline service providers constitute the link to PoP customers. Their motivation, knowledge and skills were critical to the smooth implementation of the project. Indeed many stakeholders in the focus group discussion viewed these qualities as a precondition of the project's success. Accordingly we recommend that a one-day orientation on the goal, strategies, outputs and expected impacts of a project be conducted at the beginning of the project. In addition, quarterly meetings may be conducted to review progress and plan action for the next quarter.

- *Partnerships between private sector workers, NGO staff and community workers:* These partnerships can bridge gaps and increase the accessibility and utilization of healthcare services.

VII. Conclusions

The increased number of paramedic-assisted home deliveries and facility deliveries attended by health professionals occasioned by this project demonstrates that premeditated and personalized interventions can increase users' access to and use of healthcare services and reduce morbidity and mortality.

At the beginning of the project, some NGO officials were skeptical that service utilization by the PoP in low coverage communities could improve so dramatically. They were proved to be wrong. Some health providers also believed that the PoP would not visit referral centers when referred and would only seek to access delivery services offered by trained or untrained people within their villages. But project statistics showed that the PoP did indeed avail themselves of referred services on condition that they had already received quality services and support by well-trained staff who had demonstrated a helpful attitude. Once the PoP understood the purpose and the advantages and disadvantages of their referrals, they participated with enthusiasm and demonstrated gratitude for the fact that the lives of the mother and the newborn had been saved. Even parents of infants attended satellite centers and clinics when depot holders referred them there by reason of their own inability to help.

For this kind of projects to be successful, it is essential to conduct staff orientation and training, not just in service delivery skills but in how to treat each and every client with dignity and respect. The depot holders' role in correctly identifying the PoP and reaching clients through their networks was a crucial success factor, as was Pathfinder International's great experience in this field. This private sector partnership is helping the Government of Bangladesh achieve Millennium Development Goals 4 and 5 without excessive investments. While sustainability is always a burning issue for this kind of short-duration project, our model was tested and is replicable. Initiatives such as this one can be sustained if and when large corporate bodies come forward to fulfill their social responsibilities in similar partnerships.

VIII. Key Thematic Areas Addressed

Advocacy for community participation
 Mobilization of resources
 Delivery of health services

IX. Organizational Information

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h. Organizational overview:

Pathfinder International works to improve access to quality health care for poor and marginalized women, men and children throughout the developing world. Pathfinder has worked in Bangladesh since the 1950s. Since 1980, its projects, implemented in partnership with Bangladeshi NGOs, have been worth over US\$120 million. Pathfinder has developed comprehensive contracting, monitoring, institutional capacity-building and financial oversight systems. Pathfinder's success in Bangladesh is based upon its deep understanding of community-based health programs, especially in difficult-to-reach coastal areas; its globally renowned project management skills; and its strong background in institutional strengthening. All of Pathfinder's work is geared to supplementing and complementing the Government of Bangladesh's efforts to achieve its constitutional commitment to health.



CASE STUDY

I. Project Title

Revitalizing the Delivery of Maternal, Newborn and Child Health Services in Rural Pakistan

II. Project Summary

Over 19 months in 2007 and 2008, a government-organized non-governmental organization (GONGO) collaborated with the Government of Pakistan to improve the delivery of healthcare services, including MNCH services, in the rural areas of Sindh Province, Pakistan. A replicate of the RY Khan Model, the project applied an innovative management re-engineering strategy that placed government officers with the best reputations in rural support organizations under the board of directors of the Rural Support Programme. The officers had the flexibility to hire staff at incentivized salaries; the autonomy to plan the use of the resources available from district-level health facilities; and the mandate to use community mobilization techniques to develop community ownership of health facilities and create awareness of the importance of immunization, hygiene and disease prevention. The officers were in charge of distributing health literature and bringing female medical professionals to rural areas for the first time in order to break cultural taboos and help restore the community's confidence in public sector hospitals. Results show that all dysfunctional or illegally occupied health facilities were made functional and that their utilization increased up to 400%. The availability of qualified doctors increased from 52% to 98%, absenteeism dropped from 45% to 2% and the range and quantity of medicines increased by 300%. In addition, the immunization coverage of mothers and children rose considerably, health professionals' attendance of deliveries improved, and antenatal care visits increased.

III. Introduction/Background

Although Pakistan has invested billions of rupees in its primary healthcare systems, basic health units continue to underperform (Loevisohn et al 2006). This is one of the core reasons why investments in vertical programs, including immunization campaigns, have not achieved results. Nor can results be achieved unless health facilities at the basic level are made functional. This is evident from the fact that even though at 64.6 years, life expectancy in Pakistan is one of the highest in South Asia (India's life expectancy is 63.7 years and Bangladesh's life expectancy is 63.1 years), most indicators in Pakistan are worse than those in other South Asian countries. At four children per woman, the country's 2000-2005 fertility rate was higher than that of India (3.1 children per woman) or of Bangladesh (3.2 children per woman; Human Development Report 2007/2008). Pakistan's 2005 infant mortality rate was also high, with 78 deaths/1000 live births compared to 56 deaths/1000 live births in India and 54 deaths/1000 live births in Bangladesh. Indeed only Afghanistan, with 165 deaths/1000 live births, had a worse rate than Pakistan in the South Asia region. Sindh is Pakistan's southernmost province and home to a population of about 30 million. Over the last few decades, Sindh has experienced increasing poverty and growing income disparities and worsening educational and health indicators.

The government of Sindh (GOS) signed a memorandum of understanding with the Sindh Rural Support Organization (SRSO), a non-governmental organization established with GOS endowment funds. The Peoples' Primary Healthcare Initiative (PPHI) was housed with SRSO and aimed to replicate the RY Khan model. Under this structure, the SRSO's Rural Support

Programme selected government officers of the highest integrity to act as deputies at the provincial and district levels and to manage and administer the program with complete autonomy. PPHI management used the administrative and financial rules of SRSO to administer the program under the oversight of SRSO's board of directors. The terms of partnership stated that the management of all basic health units, mother and child healthcare centers and dispensaries would be transferred to PPHI along with the budgets of the districts concerned. These budgets were to be determined on the basis of salaries allocated for positions that were not filled, non-salary monies (budgets for medicine, electricity and other needs), and repair and renovation funds. The funds were to be transferred as single line grants, giving program leaders the freedom to perform need-based planning and make expenditures subject to the approval of SRSO's board of directors. The federal government underwrote administrative expenditures for 3 years. All government medical and paramedical staff members were given complete service protection. PPHI had the latitude to hire the doctors and paramedical staff for vacant positions, to repair buildings and more generally to involve the community in improving preventive and curative health services. More recently, the highest government authorities elected to transfer the control and management of the expanded program on immunization (EPI), the lady health workers program, and other vertical programs to PPHI in order to create comprehensive and integrated primary healthcare services through a single decentralized institution. Implementation of this decision will take place soon.

This program involved no donor funding. The federal Government decided to underwrite three years' worth of administrative program expenditures (PRs249 million or US\$3.07 million), including a one-time grant of PRs 1 lac per basic health unit for equipment and furniture. The district government transferred existing budget shares for 17 districts, amounting to PRs 600 million or US\$7.5 million, and the provincial government provided a one-time development grant of PRs 5 lac or US\$6142 per basic health unit and PRs 3 lac or US\$3703 per dispensary in order to improve infrastructure. In all, GOS has provided the project with PRs 200 million or US\$ 2.5 million.

IV. Implementation

1. The program is based on the tools of participatory management & community mobilization and on the creation of vertical and horizontal community ownership. The program design and the results from a pilot project in Rahim Yar Khan District and 12 other districts in Punjab were presented to top political leaders at the federal, provincial and district levels. Pakistan's prime minister adopted the program and ensured that it was free of all political intervention. The program director personally visited each district and briefed the nazims (indirectly elected district health officials) and their teams. Agreements were only signed once the nazims and their teams were convinced of the merit of the approach. The next step was to render the health units functional and to ensure the provision of basic primary healthcare services by making doctors accessible and providing free medicine at all facilities. This strategy automatically functionalized all services including immunization and curative and health promotion programs. The third step was to create awareness and ownership of healthcare structures within the community and to strengthen the bond between community members and service providers so as to achieve better accessibility and broaden the appeal of various healthcare programs. This was achieved with the creation of community support groups of 15 to 18 members each within each health facility. The members of any given community support group came from all walks of life but were all from the same village. The fourth strategy was to guide and help policymakers to gradually integrate all primary healthcare services in rural areas at and through basic health units in order to achieve national objectives as agreed in view of the Millennium Development Goals.

2. Government employees hired officers to manage the program at the provincial and district levels. Officers were hired on the basis of merit and reputation: specifically, their ability to resist bribery, favoritism and other illicit behavior. Closed and illegally occupied health facilities were made functional by appointing doctors and paramedical staff at the higher wages on a contractual basis. Medical officers appointed at clusters of two or three health facilities were paid twice as much as government doctors but were not allowed to practice privately. In addition, female medical officers were appointed for the first time ever. Initially, they were appointed at clusters of five health facilities at a salary range of PRs 35,000 to PRs 50,000. This salary is five times higher than what female registrars earn at the private medical college in Mirpurkhas. Female medical officers' salaries are higher in areas where the terrain is difficult or where security is poor. Visits by female doctors restored the confidence of community members, especially women, who began to take their children to visit healthcare facilities. For cultural reasons, this had not previously been the case. Community mobilization was ensured through the presence of doctors, the availability of a wide range of medicines, and community support group meetings. Each health facility was also provided with a V Wireless telephone for communication purposes. The project developed a highly effective monitoring and evaluation strategy whereby four teams riding in cars or on motorbikes carried out daily facilitation visits to each health facility where they resolved issues of medicine availability, equipment needs, repairs and so forth. A mandatory feature of the program was the regular monthly review meetings where all district government and district-level health facility stakeholders were invited to discuss the health situation in the presence of all doctors. A specialist was also invited to conduct doctor capacity development sessions. Every month, the best doctor and the best lady health visitor of the month were acknowledged and awarded a trophy. The district health team and the district coordination officer (head of the district bureaucracy) also attended this meeting in order to help devise an action plan to improve the delivery of health services such as immunization, malaria prevention measures and family planning measures, and to combat any outbreaks of disease. In addition, a mobile ultrasound facility was also started. This unit performed antenatal care and detected cases of obstructed labour or other gynecological issues. The ultrasonologist visited 10 health facilities in each district so that entire district would be covered. In addition, female medical officers were provided with glucometers, hemoglobin meters, and pregnancy strips, with which they delivered proper antenatal care. All doctors were required to conduct weekly community health sessions and to stress immunization and hygiene.

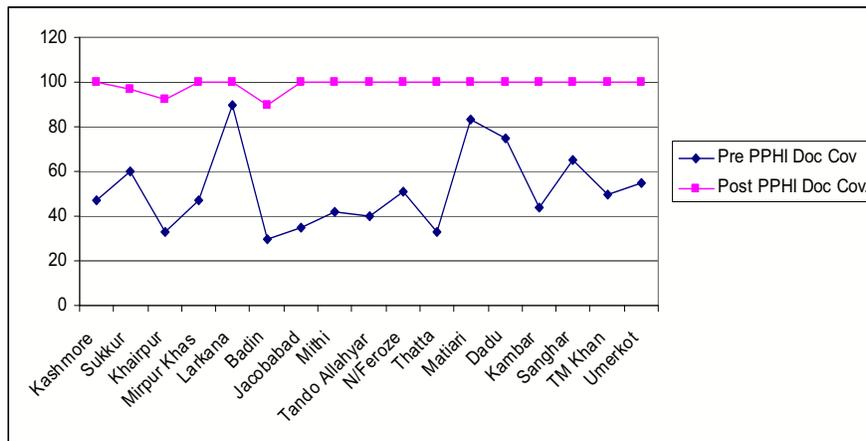
3. ***This program resolved very old problems with the availability of health services in rural areas. It triggered activities in all vertical programs: by making doctors available, the presence of other staff in health facilities was also mandated. We started this program in three districts in May 2007. In a span of a year and a half, it has been expanded to 17 districts of the province. Its principal success is the scale of its activities, its holistic approach and its focus on revitalizing all services at the facility level.*** PPHI's expansion to all provinces has met challenges such as the project's lack of appeal to mid-level government officials and resistance within the health sector due to fear of losing control of services and losing financial and administrative powers. This resistance was evident from the beginning, when the project was not even allocated office space until an official memorandum of understanding between the provincial government and SRSO was signed—this, although personnel had already been hired (Memon, unpublished). The PPHI idea was, however, introduced at meetings with provincial and district level government staff, where the expectations and transparencies of the program and the responsibilities of each actor were explained. District governments were generally supportive of the plan to improve basic health units because it was generally understood that these units were dysfunctional. The lack of government oversight had caused infrastructure to deteriorate substantially and some facilities had fallen into local hands and were being used for personal activities. Other facilities had been built by the district without provincial authority and were therefore not officially part of the provincial budget.

V. Outcomes, Impact and Sustainability

a). Restoration of illegally occupied health facilities: Of the 883 health facilities transferred to PPHI in 17 districts of Sindh Province, 87 were being illegally occupied by influential police and local council offices. These 87 facilities were restored and made functional by the appointment of doctors, paramedics and other staff.

b) Approval of new schedules of new expenditures: Of 883 health facilities, 158 were being managed without sanctioned staff or an authorized budget. This meant that health facilities had been constructed without prior budget approval for staffing and the purchase of medicine. Prior to the take-over by PPHI, therefore, management commonly allocated staff and other resources from an approved health facility to another health facility. After taking over the management of these facilities, PPHI prepared sought approval of about 118 of them. The extent of the apathy previously at play can be judged from the fact that out of the recently approved health facilities, 15 had been constructed in 1989, 26 in 1992, 10 in 1993, 20 in 1995 and 23 in 2000 without anybody bothering to obtain budget approvals for staff and medicine.

c) Percentage of doctors employed per district, before and after implementation of the PPHI project



d) First-time appointment of female medical officers in rural areas: About 140 female doctors were appointed over the course of PPHI's project. One doctor was appointed for each cluster of three, four or five health facilities. These appointments resulted in a 150% increase of health facility attendance by female and child patients. And whereas only 5% of pregnant women previously visited antenatal clinics, that number rose by 200%.

e) Female medical officers changed the healthcare system culture, resulting in an increase in family planning materials and a higher number of assisted deliveries. Family planning clients increased from 14,000 to approximately 60,000 over the last six months of the project. The number of deliveries at rural health facilities increased from 5% to 18% of all rural area deliveries.

f) The utilization of health facilities increased more than 100% over the past 6 months. This increase is due to the greater availability of doctors and to the greater range and quantity of available medicine. Over the past 1.5 years, about 604 community support groups were organized, 3,286 preventive healthcare sessions were conducted and 33,401 monitoring visits took place. Some 65,000 free ultrasounds were conducted in last 8-10 months. At the time of PPHI's take-over, about 40% of health facilities had EPI coverage: this increased to about 72%. All non-functional refrigerators were replaced and health facilities that lacked electricity are now

energized. The number of tuberculosis cases referred by PPHI to the diagnostic centers increased to 15%.

VI. Lessons Learned

Enabling factors. One enabling factor of this project was its holistic approach: more specifically, the fact that entire health facilities and their budgets were transferred to PPHI authority. Flexible planning and participants' power to take action when faced with a given situation also proved to be important, as was top level political patronage. Nonetheless, the most important factor was the community's ownership of the project, which facilitated the project's execution and ensured its sustainability. **Barrier factors.** The principal barrier to this project was resistance and opposition on the part of health department officials. "We recommend a learning-by-doing approach through ongoing capacity-building, knowledge exchange, on-the-job training, coaching, and teamwork. Recognition that the health system itself had to improve the quality of its services also generated healthy competition between the PPHI and district-level health structures in each district.

VII. Conclusions

Because this project is still in the early stages, its output indicators are yet to be measured. It has however earned substantial backing by governments and communities and the government has now resolved many irritants relating to fiscal transfers. The program is now beginning to focus on maternal and child health. Its future policies include the establishment of 24-hour free maternity services at least in 5% of health facilities in the next 6 months' time.

VIII. Key Thematic Areas Addressed

The project addressed the mobilization of resources; the generation of political will; advocacy for community participation and the delivery of health services.

IX. Organizational Information:

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Organizational Overview: The Peoples' Primary Healthcare Initiative (PPHI) is the umbrella of the Sindh Rural Support Organization, which works to eliminate poverty from rural areas of Sindh Province, Pakistan. The Sindh Rural Support Organization also deals in micro credit and other tools of poverty elimination.



CASE STUDY

I. Project Title

Strike Out Pneumonia: An Advocacy Campaign in Metro Manila, The Philippines

II. Project Summary

The objective of this project was to launch an advocacy campaign to increase awareness of the burden and prevention of pneumonia—the disease that causes the most deaths in children today, not just in the Philippines but around the world. About 2 million children below 5 die of pneumonia every year; in the Philippines, the World Health Organization estimates this figure at 9,000. Initiated in August 2008, this project culminated in a call for action, a program with local government, academe and NGOs and a vaccine mission. A conference was also held at the University of the Philippines Manila on 7 November 2008 in conjunction with the 9th Annual Philippine National Immunization Conference.

In April 2008, the Johns Hopkins Bloomberg School of Public Health organized an Asian workshop entitled “Developing Advocacy for the Prevention of Pneumonia”. From this, a grant was awarded to Dr Lulu Bravo, Vice Chancellor for Research and Executive Director of the National Institute of Health and Executive Director of the Philippine Foundation for Vaccination, for her proposal of a campaign to urge local governments and communities to take action to prevent pneumonia and reduce deaths and hospitalizations from the disease. Additional funds and resources for the project were provided by private donors and by the Philippine Foundation for Vaccination (PFV), the project’s non-governmental organization partner. Other partners were the BATA Movement, the city health office of the City of Manila and local government officials of Pasay City.

Project outcomes were deemed most successful. First, the project generated substantial goodwill among local health officials, who introduced vaccines not included in the Expanded Program of Immunization (EPI) into their communities for the greater protection of children, adults and the elderly. Second, the project stimulated interest and support from local officials including councilors and mayors. In addition, four vaccine missions were held between August and November 2008. As a result of these missions, thousands of children and adults received a diphtheria, pertussis and tetanus (DPT) booster; the tetanus and diphtheria (Td) vaccine; the measles vaccine; the measles, mumps and rubella (MMR) vaccine and the hepatitis B vaccine, all free of charge. These vaccines had been solicited from various donors. Project activities were published in major newspapers as well on internet news pages and blogs.

III. Introduction/Background

The EPI program of the Government of the Philippines and the Department of Health includes only seven vaccines (BCG; diphtheria, pertussis and tetanus (DPT); the oral polio vaccine; the measles vaccine; and the hepatitis B vaccine). These vaccines are only provided to children below 1 year of age. Booster shots and new vaccines recommended by the World Health Organization, PFV and various vaccine experts are not provided, despite the fact that evidence gathered from around the world has demonstrated the safety and effectiveness of several newer vaccines, including those that can prevent pneumonia. These vaccines include the H influenza B vaccine (Hib), the influenza vaccine and the pneumococcal conjugate vaccine (PCV). Despite

the success of these vaccines in reducing child morbidity and mortality, the Philippine government and the Philippine public has made little effort to have these vaccines included in the EPI, even for sectors at risk.

PFV was established in 2000 by a group of vaccine advocates who realized the need to increase public awareness of the merits of vaccination in order to prevent disease and reduce mortality. PFV began by training and conducting conferences to educate healthcare workers of the benefits of immunization. As this advocacy reached more and more people, PFV began to target local governments and public health officials, placing greater emphasis on newer vaccines and on vaccine financing and public health interventions. PFV also increased its partnerships with government and non-governmental organizations, civic organizations, the media, and health maintenance and insurance agencies.

Since PFV first started its vaccine advocacy activities, it has undertaken several projects in addition to the annual convention. These projects have included workshops to promote vaccine safety, participation in professional society conventions where PFV has provided expert opinions on vaccines, and media activities to help promote the publication of vaccine-related information. PFV's operational budget comes from industry and private donors, with all members and officers of the society contributing to the success of all activities without honoraria or other remuneration. Members of the Philippine Foundation for Vaccination are committed to undertaking child and advocacy programs and activities including vaccine missions and the promotion of child survival interventions.

IV. Project Implementation

Once the grant for the Advocacy for Prevention of Pneumonia was awarded, the project's initial activities consisted of meetings with city health officials in the cities of Manila, Pasig and Pasay to discuss the advocacy campaign and ways that health officials could support immunization programs in the community. In some communities, discussions were held on what kind of patients should be given special immunizations, such as the pneumococcal conjugate vaccine (PCV), and when vaccine missions should be held. Suggestions that the program be held during the 9th Annual Philippine National Conference were considered and various committees worked hard to bring city health officials, particularly from the cities of Pasig, Marikina, Makati, Las Pinas and Taguig, to make presentations at the conference. These presentations were made on 7 November 2008, the same day that the Strike Out Pneumonia campaign was held at the campus of the University of the Philippines Manila. A vaccine mission also took place. This mission consisted of administering booster shots of DPT, measles and other vaccines to at least one hundred children brought to the event by the Rotary Club Manila.

Various committees and volunteer health workers were given assignments to ensure that all tasks were successfully implemented. Networking and engaging partners were crucial in the implementation of this project. Since almost all of the members of the team had experience in various aspects of organizing conferences and medical missions, few problems were encountered and all were resolved immediately once identified. The problems in question usually related to funding and to schedule conflicts: in response, some speakers were substituted for others and new arrangements for meetings and venues were quickly arranged.

V. Outcomes, Impacts and Sustainability

The project sought mainly to increase government and non-government agencies' awareness of pneumonia and to suggest ways for these entities to deal with the problem. As such, outcomes were measured in terms of conference and vaccine mission participation on the part of local health officials, municipal mayors, other public officials, NGOs, academic personnel, families and community members. Aside from being educated about the burden of pneumonia, participants were vaccinated against various diseases and were asked to urge their public officials to include additional and newer vaccines into their programs. The conference and the vaccine missions also provided participants with information about disease prevention, child survival strategies and other relevant subjects.

It is expected that this new knowledge and the motivation provided by health officials and the academe will persuade more local governments to turn to vaccination as the best way to save resources and improve children's health. Efforts to sustain this initiative are ongoing and there is evidence that local governments are considering the addition of new vaccines. PFV has received requests for more vaccine missions and vaccine pricing negotiations among stakeholders are currently taking place.

VI. Lessons Learned

Above all, this project showcased the necessity of obtaining funds prior to a project's implementation in order to defray the costs of meetings, materials, gasoline, and miscellaneous expenses. In this, PFV was inspired by the experience of other countries, particularly Mexico, whose former vice health minister visited the Philippines to discuss how Mexico was able to incorporate new vaccines into its EPI. In the case of Mexico, the program started with HIB, continued with rotavirus, PCV, and influenza, and shifted from the oral (OPV) to the inactivated polio vaccine (IPV) over the last 10 to 15 years. The vice minister's visit was made possible by the sponsorship of a pharmaceutical company, which awarded PFV an educational grant to organize the vice minister's lectures to health officials and healthcare workers. In order to avoid undue influence, this sponsorship was not revealed to meeting attendees.

Factors crucial to the success of the project thus include the following:

1. Adequate funding and resources;
2. The participation of experienced and dedicated health workers, the majority of whom were volunteers;
3. Models and health authorities that commanded respect and inspiration;
4. Administrative support from superiors and cooperation by peer groups and colleagues;
5. Creativity and resourcefulness among those spearheading the program;
6. The availability of partners from all sectors of society, including families, communities and political figures at the highest levels.

VII. Conclusions

It is important that a project of this nature have a definite objective and a clear plan of action. Increasing public awareness of the burden of pneumonia is neither easy nor necessarily sustainable, given the short memory of the public. It is sometimes the case that newspaper stories must be horrifying in order to catch public attention. The fact that local officials have started requesting more vaccine missions and have introduced new vaccines into local immunization programs are positive steps towards the allocation of additional resources to communities' immunization and health programs.

We have also observed that programs like this one may be started in one community but can be replicated in one neighboring community after another until all communities have joined in prioritizing health and vaccination. Engaging other stakeholders, whether governments, NGOs or private enterprise, is also part of the formula for success. However the biggest role must be given to those individuals with the vision, the dedication and the experience to handle and undertake the task of conducting child and vaccine ADVOCACY!!!!

VIII. Key Thematic Areas Addressed

x Mobilization of Resources
x Generation of Political Will

x Delivery of health Services
x Advocacy for community participation

IX. Organizational Information

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Organizational Overview:

A non-profit, non-stock organization established in April 2000, the Philippine Foundation for Vaccination is composed of professionals, academics, governmental employees, non-governmental workers and private individuals who have joined together to promote vaccination as a means of preventing disease and contributing to better health for all both now and in future. The foundation accomplishes its objectives through seminars, workshops, research, service-oriented activities and other means. It holds increasing partnerships and networks with various stakeholders.



CASE STUDY

I. Project Title

The Well Baby Bakuna Program: Increasing Middle Class Access to Privately Administered Vaccines

II. Project Summary

This program aims to ensure that babies—particularly those born in low immunization coverage areas—receive a full set of EPI vaccines before their first birthday. Specifically, by working with a group of private practitioners, the program seeks to provide awareness of and access to affordable vaccines to “have less” families, thereby increasing vaccination rates and offering Filipinos an alternative channel for immunization services. The “have less” population segments in the Philippines correspond to C and D income brackets. These groups have some of the lowest immunization rates of the country and constitute 60% of its estimated population of 85 million people.

As a middle income country, the Philippines is not eligible for support from the Global Alliance for Vaccines and Immunization (GAVI). Nonetheless, the Government is committed to immunization and has taken responsibility for purchasing the bulk of traditional Expanded Program for Immunization (EPI) vaccines with some donor support. Gains over the past few years in hepatitis B vaccinations have been impressive, for example, but Hib vaccine, pneumococcal vaccine, and rotavirus vaccine have not been added to the EPI schedule. At the same time, the Philippines has a strong private market for newer EPI vaccines (e.g. multivalent vaccines) as well as for vaccines outside of the EPI. EPI coverage rates hover around 90% but wide variations across the country mask grave pockets of concern.

Currently, individuals in higher income brackets—such as the A, B and upper C classes—generally turn to private practitioners for health services, including vaccination. These clients also tend to pay for higher-priced pediatric combination vaccines which reduce the overall number of injections for their babies and the number of clinical visits they must make for immunization to be complete. Some people in C and D brackets also seek out small private clinics or health providers for vaccination services even though local public health centers offer EPI vaccines for free. Among the reasons why these clients prefer to pay to obtain vaccines from private practitioners are the types of vaccines available (monovalent versus multivalent vaccines); the better quality of private health facilities; the sometimes difficult attitudes of certain public health deliverers; shortages in vaccine stocks at public facilities; and the limited range of vaccines at public facilities. However, for many in the C and D income brackets, the higher-priced vaccines provided by private practitioners are out of reach.

The Philippine NGO Council on Population Health and Welfare, Inc. (PNGOC)’s Well Baby Bakuna Program was designed to complement government immunization services by responding to a clear willingness to pay among some members of C and D income brackets for either improved vaccines (e.g. pediatric combination vaccines) and/or privately provided health services. By securing the participation of select private practitioners willing to offer pediatric combination vaccines at more affordable prices including through an easy installment payment plan, it was hoped that more C and D members would access immunization through private

channels and that stocks from government health facilities would be preserved for indigent families.

The Well Bakuna Project began in July, 2007 and as of December 2009 was operating through Philippine Pediatric Society, Inc. (PPS) members and PPS-recognized hospitals and clinics that included the following:

1. Philippine Children's Medical Center, Quezon City, Metro Manila
2. De La Salle University Medical Center, Dasmariñas, Cavite
3. James Gordon Hospital, Olongapo City, Zambales
4. Los Baños Doctors Hospital, Los Baños, Laguna
5. St. John the Baptist Medical Center, Calamba, Laguna
6. San Jose Hospital and Trauma Center, Calamba, Laguna
7. Metro Lipa Medical Center, Lipa City, Batangas
8. Daniel Mercado Medical Center - Tanauan City, Batangas
9. St. Frances Cabrini Medical Center, Sto. Tomas, Batangas
10. St. Michael Medical Hospital, Bacoor, Cavite
11. San Jose Hospital and Trauma Center, General Mariano Alvarez (GMA), Cavite
12. Little Angels Specialty Clinic, Tanauan City, Batangas
13. St. Clement Medical Clinic, Alaminos, Laguna
14. Partners in Therapy, Marikina City, Metro Manila
15. Damayan Foundation, Mandaluyong City, Metro Manila
16. Sarmiento Medical Clinic, Muntinlupa City, Metro Manila
17. Health Index MultiSpecialty Clinic, Bacoor, Cavite
18. Alliance of Two Hearts Polyclinic, Silang, Cavite
19. Barangay Inocencio Polyclinic, Trece Martires, Cavite

III. Introduction / Background

To protect children from certain preventable diseases, babies must be vaccinated at birth and vaccination must continue until the child reaches one year of age. In the Philippines, only 10% of the country's two million babies born each year visits pediatricians for health services. The remainder visits health centers where treatment, including immunization, is free. In these centers, vaccines are not always readily available. For this and other reasons, many parents prefer to obtain and even purchase their children's vaccines from private clinics. But private services are unaffordable to a great number of Filipinos.

In response, PNGOC developed the Well Baby Bakuna Program. This program aimed to make quality vaccines more accessible and affordable to Class C and D income bracket families. The Well Baby Bakuna Program is a social enterprise project supported by GlaxoSmithKline Inc. and the Philippine Pediatric Society, Inc. (PPS), who are acting as partners with the Department of Health to help attain Millennium Development Goal 4 of reducing child mortality in the Philippines. The program was designed with a view to introducing an effective and viable business model that would address unmet demand among C and D populations while ensuring reasonable profits for private and NGO partners.

IV. Implementation

Following the development of the project concept, PNGOC presented the program to PPS chapters to solicit their support and input and to secure a list of pediatricians who might be willing to offer immunization services to target groups according to a certain fee structure. The program targeted areas identified by the Department of Health as exhibiting low immunization rates and underserved populations.

As each program administration site was finalized, PNGOC designated a lead person to administer the vaccination program and an area coordinator to conduct community mapping, community surveys, hospital coordination, house-to-house visits, a community assembly and mothers' classes. The goal was to promote immunization by highlighting the program's affordability and its easy payment scheme.

A key challenge was to ensure that the program would only cater to the C and D income market. To address this concern, PNGOC conducted patient screening through one-on-one interviews with parents. Parents from Class A, B and upper C income brackets whose babies had already been seen by a private pediatrician were discouraged from enrolling. Class E families were encouraged to seek the services of health centers or other government facilities where immunization was free. This tiered pricing approach ensured that the program helped health centers serve "have less" community members rather than families that could afford to pay full prices or families that could not afford to pay at all.

This strategy mobilized the program effectively by enhancing social awareness and educating the public about the value of immunization. PNGOC consulted with Class C and D patients and learned about their health demands, particularly with respect to immunization. The program team took the position that difficulties challenged it to succeed in vaccinating all children without exception.

V. Outcomes, Impact and Sustainability

The program has been well accepted and is appreciated by most parents, who are eager to complete their child's first-year-of-life vaccination program. These parents are given the opportunity to access private pediatric services at affordable prices. PNGOC's awareness-building around the importance of vaccination has given parents a better understanding of the values and principles of child immunization and has generated greater demand for immunization services. Nonetheless, the sustainability of the program largely depends on advocacy to increase client volumes and the continuing willingness of private practitioners to provide lower prices for parents from C and D economic segments.

VI. Lessons Learned

Studies from around the region have suggested that a growing low to middle-income class is both willing and able to pay for select health services—in this case, vaccines. By raising awareness of the importance of immunization, stakeholders of the Well Baby Bakuna Program helped tap this unmet demand. In doing so, it mobilized interest in both private and public sectors.

Buy-in from all stakeholders—the public sector, private practitioners, and individual communities—was crucial to the success of this project. PNGOC's involvement helped drive the initiative and generate demand among mothers, but ultimately the success of the program will depend on the interest of players in the private sector and on the Government's role as facilitator.

To ensure the program's sustainability, it is important that funds are allocated on time and that vaccine availability (including inventory) is double-checked. For those who wish to implement similar programs, we recommend beginning with a feasibility study, making careful budget allocations, verifying locations, planning for staffing needs, confirming vaccine availability and creating the necessary links with partners to ensure the sustainability of supply.

VII. Conclusion

Immunization is considered one of the most cost-effective ways to prevent sickness among children. The Well Baby Bakuna Program, a joint project of PNGOC and PPS supported by the Philippines' Department of Health and GlaxoSmithKline, has enjoyed success in helping to meet Millennium Development Goal 4 (Reduce Child Mortality).

VIII. Organizational Information

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- 8) **Organizational Overview:**

The Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC) was founded in June 1987. PNGOC is a national umbrella organization of 95 NGOs. Its objective is to become the voice of population and development advocates within NGO, government and funding circles. It also serves as a channel for the exchange of information, resources, and technical assistance among NGOs.



CASE STUDY

I. Project Title

Increasing Childhood Immunization in the Philippines With a Practical and Coordinated Approach

II. Project Summary

Our study of the project “Practical and Coordinated Approaches to Child Health” suggests that if mothers have complete and accurate information on childhood vaccinations and can access the corresponding immunization services, childhood immunization coverage will improve significantly. Mothers who understand the benefits and the importance of childhood vaccination and do not have reservations about children’s vaccines and the tetanus toxoid vaccine exude positive attitudes towards childhood vaccination and are resolute in seeking out immunization services for their children. Furthermore, the residents of villages that have developed a network of trained midwives and volunteer workers who (i) have a good handle of the key messages to be emphasized during counseling and other information dissemination efforts and (ii) are competent in providing and delivering childhood vaccination and other maternal and child health care services, use more childhood vaccination services than do residents of villages without such networks. Early identification of target children, the mobilization and reminding of mothers to avail themselves of services through regular community rounds, and the follow-up of children who did not avail themselves of services, are ways that village health workers (VHWs) have increased coverage. Functional village health committees and village committees for the protection of children are critical and effective mechanisms to ensure that community members, local officials and health staff are truly committed to an improved delivery system.

III. Introduction/ Background

The Philippines is one of 42 countries that account for 90% of deaths of children under 5 worldwide. One of the reasons for the Philippines’ high mortality rate is the low immunization coverage of Filipino children. Plan Philippines’ 2003 Multi-Cluster Indicator Survey showed that only 65% of children aged 12 to 23 months living in its partner communities had been fully immunized before their first birthday and that only 38% of pregnant women had received two or more doses of tetanus toxoid vaccine.

To increase immunization acceptance and coverage and to ensure the effectiveness and sustainability of improvements to mother and child vaccination services in Plan Philippines’s partner communities, Plan Philippines has worked since 2004 to promote strategies designed to (i) ensure that caregivers receive complete and accurate information on safe vaccination and (ii) improve the delivery of the services in order to better meet demand.

IV. Project Implementation

The barangays’ (municipal communities’) main means of identifying clients for maternal and immunization services is through weekly or monthly community rounds and home visits conducted by VHWs. Word of mouth helps bring in clients as well. In practice, women who have just given birth and newly pregnant women are easily recognized within the community

and it is common for them to be pointed out to the VHW or to the midwife. In these cases, the only tools required are the midwives' master lists and/or simple notebooks in which VHWs record the names and addresses of the women in question. If clients do not respond positively to the initial contact by volunteer health workers, the midwives take the time to follow up with them. In some cases, barangay midwives have asked clients to sign a waiver that absolves them of liability should complications arise as a result of clients' refusal to avail themselves of necessary services.

The barangay midwives and the VHWs counsel mothers on the welfare of their children. Their counseling addresses what constitutes full immunization and proper maternal care. It emphasizes that fever and redness at the injection site are normal reactions after immunization and tells mothers what to do if such reactions occurred. Mother and child health cards are given to mothers to remind them when to return to the facility. One factor that encourages mothers to pursue vaccination is that services are provided free of charge by local government unit (LGU) health facilities and that there is an adequate provision of all six childhood vaccines as well as the tetanus toxoid vaccine, Vitamin A for lactating women and ferrous sulfate for pregnant women.

Improvements to the health delivery system undertaken by this project have included the training of midwives and VHWs by municipal health officers and public health nurses; the development and issuance of clinical program guidelines for midwives' easy reference; the supervision of midwives by municipal health officers and public health nurses; the holding of logistical reviews; the provision of support by the local barangay council; the Department of Health (DOH)'s introduction of mechanisms to identify and follow up with targets; the promotion of community participation in healthcare initiatives; and program review and planning activities with the support of Plan Philippines.

All midwives in the project's partner barangays have been trained in maternal and child health by DOH trainers and LGUs. Midwives regularly confirm that they have manuals and references, most of which were provided during their training, to use in their day-to-day work. The interaction between midwives and nurse supervisors includes on-the-job training and the discussion of problems or other developments encountered. VHWs also attend their federation meetings on a monthly or quarterly basis, during which time they are updated by health staff at the municipal health office on selected health topics.

V. Outcomes, Impacts and Sustainability

In 2005, Plan Philippines conducted a survey designed to determine whether public acceptance of safe mother and child vaccination services and immunization coverage had improved since the 2003 baseline survey. The survey was also designed to identify facilitating factors. The primary data collection method was key informant interviews of mothers of children below 5 years of age, service providers (particularly midwives), village heads and VHWs. In areas where the village head was joined by his/her council members, a focus group discussion took place. Focus group discussions were also held when more than one VHW was assigned to a given village.

The survey found that access to safe mother and child vaccination services had improved significantly. In 2005, 97% of children were found to have received complete immunization with all six antigens, compared to 65% of children in 2003. In 2005, 92% of pregnant mothers had received at least three doses of tetanus toxoid vaccine, whereas in 2003, only 38% of mothers who had received at least two doses.

VI. Lessons Learned

Insofar as lessons learned are concerned, the project showed that communities seeking to increase immunization coverage may benefit from (i) reviewing health promotion and education strategies that have worked at the community level and (ii) developing dynamic information-giving schemes and interactive sets of materials. Content focus should be selected carefully to identify key messages for target mothers and children's caregivers. Midwives should have a good handle of the key messages to be emphasized when they counsel and talk to mothers. Communities should also be able to monitor and assess the effectiveness of the community-based monitoring information scheme as a tool in identifying target clients. Through their regular community rounds, VHWs are very effective at the early identification of target clients and the mobilization and follow-up of clients to persuade them to avail themselves of services. Local officials should participate in a short orientation course on major public health programs and key interventions in order to improve their appreciation of and increase their commitment to health development in their communities. Village councils typically produce an annual barangay development plan, a component of which is a health plan. Annual health plans are developed in consultation with village development committee members, midwives, selected VHWs, school teachers, and community representatives. The process is chaired by the council chair for health. Finally, communities should develop a comprehensive package that includes not health interventions alone but also measures to improve the poor economic status of community members.

VII. Conclusions

Access to safe motherhood and childhood vaccination services is generally good, as evidenced by the significant proportion of pregnant women who have received at least two doses of tetanus toxoid vaccine and the high number of children who have received complete immunization with the six antigens. Mothers' access to childhood vaccination services is influenced by their knowledge, attitude and practices (KAP). The other set of factors that significantly influences mothers' access to childhood vaccines is the availability of services.

VIII. Key Thematic Areas Addressed

- Delivery of health services
- Advocacy for community participation

IX. Organizational Information

Plan Philippines was established and registered in the Philippines in 1961 at the invitation of the Carlos P. Romulo, then president of the 4th Session of the United Nations General Assembly. Plan Philippines' goal is that children live and grow in a safe and nurturing child-friendly environment at the family, community and society level. Plan Philippines works in approximately 420 poor barangays in 32 municipalities in eight of the country's 79 provinces.

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CASE STUDY

I. Project Title

Multisectorial Approaches to Increasing Immunization Rates: Saving Lives by Promoting Health and Improving the Quality of Care in Aceh Province, Indonesia

II. Project Summary

In 2005, Project HOPE began to implement a five-year project aimed at improving the health of mothers and children Indonesia's Nagan Raya District by supporting the Ministry of Health (MOH)'s Integrated Management of Childhood Illness (IMCI) strategy, revitalizing integrated health posts (IHPs, known locally as posyandu), and improving the quality of maternal and neonatal care. More specifically, the project trained healthcare providers and community health workers in immunization and introduced health information management techniques. It also recruited community leaders to promote vaccination. One of the project's most innovative strategies consisted of child-to-child health education methods whereby fifth grade elementary school students reached out to the mothers of children under the age of three to promote the importance and benefits of immunization and other IHP services. As a result of the project, immunization rates have more than doubled in the district, which has now integrated project activities into regular MOH and Department of Education procedures.

III. Introduction/Background

Before the introduction of this project, immunization services in Nagan Raya District had been in decline since the civil war in Aceh Province escalated in 1998. Severely damaged by the 2004 tsunami, this district had suffered massive deprivation and hardship throughout the 30-year armed conflict between the central government and the Aceh independence movement (GAM), for which Nagan Raya was a stronghold. Security issues related to the conflict meant that several MOH healthcare initiatives were not introduced in Nagan Raya; as a result, the health status of the district population was worse than the national average. In 2005, Project HOPE's baseline survey revealed that only 32% of children aged 12 to 23 months had received the BCG vaccine; just 15% of women had been immunized against tetanus during their pregnancy; and according to mothers' recall, only 18% of children aged 12 to 23 months had been vaccinated against measles and against diphtheria, pertussis and tetanus (DPT). Both access to and demand for immunization services were very low compared to the national standard and only 25% of villages had community-level IHPs where routine vaccination, growth monitoring and antenatal care were offered. This lack of vaccination coverage increased the likelihood of death for women and children, especially infants.

In 2005, Project HOPE began to implement a privately funded maternal and child health project in Nagan Raya. The project aimed to improve the health of mothers and children by supporting the MOH's IMCI strategy, by revitalizing the IHPs, and by strengthening maternal and neonatal health initiatives. The project was implemented in close collaboration with the district health office (DHO) and with Department of Education with full authorization from the Bureau of Reconstruction and Rehabilitation. The financial resources allocated to the project totaled US\$2,754,000 and came from the tsunami pooled funds and a grant from the United Kingdom's Big Lottery Fund. The project was implemented in eight sub-districts.

IV. Project Implementation

To augment immunization coverage, the project increased access to services by revitalizing IHPs, where most vaccinations are conducted, and by training health center staff in IMCI in order that they avoid missing opportunities to vaccinate children at the facility level. During the initial implementation phase, the poor quality of vaccination services provided by healthcare workers was found to be an important barrier to immunization. During health facility assessments and coordination meetings with health center staff, the project team learned that none of the village midwives and nurse immunizers responsible for vaccination had been formerly trained in immunization. They were not familiar with the national immunization schedule and could not counsel mothers on the purpose of vaccination and on side effects and their management. They also had difficulty completing the immunization registers. As a result, many mothers who came to the posyandu refused to allow their children to be vaccinated (more specifically, injected). Indeed, when immunizers arrived at the IHPs, many mothers left immediately. Parents' refusal to allow immunization by injection was due to their lack of information about the side effects and benefits of immunization.

To address these issues, the project collaborated with DHO and health centers to train village midwives and immunizers in proper vaccination procedures, including infection prevention methods. At the community level, the project trained community health volunteers, known locally as kaders, in how to interpret immunization cards, how to promote immunization, and how to conduct mapping exercises through which children under 12 months were registered and their vaccination status was recorded. The project also called upon health center staff and community leaders such as imams to promote immunization. In addition, the project introduced a child-to-child school health education program using fifth grade students as agents to promote mothers' IHP attendance. The project first trained fifth grade teachers to conduct health education classes with their students. Topics included nutrition, immunization, diarrheal disease control, acute respiratory infection, malaria, and personal and environmental hygiene. Using the student workbook provided by the project, each student was then required to share the health information just learned with a mother of a young child as part of his/her weekly homework. The teacher also gave each student a mini-survey in which the student identified at least two priority mothers with children under three whom s/he would encourage/remind to attend the IHP, or posyandu, each month. One day before the monthly posyandu session, the student visited the mothers and reminded them to bring their children to the posyandu the following day. Using reporting forms provided by the project, the teacher collected the information gathered by the students each month. Project staff collected this data in turn and shared it with health center staff.

To further mobilize the community, the project partnered with the Indonesian Women's Family Welfare Organization (PKK), the organization responsible for supporting posyandus and community health volunteers. The project helped to strengthen PKK's capacity to supervise and monitor community health volunteers and village midwives at the sub-district and village levels. Selected PKK members were also trained as community health volunteer trainers and joined the supervisory team that supported and monitored the work of the volunteers. Project staff and the supervisory team (PKK members, health center staff and DHO) conducted quarterly monitoring to support the IHPs.

Because health information management at health centers was also found to be lacking, the project collaborated with the DHO to develop a standard community-level immunization register and to train immunizers to make consistent use of National Road to Health cards (vaccination cards). The project provided each IHP (posyandu) with health information booklets and other forms which the IHP used to record the health information and IHP consultation history of all the pregnant women, children under five and infants in the village.

V. Outcomes, Impacts and Sustainability

To date, the project has upgraded and established 247 IHPs in a district where only 56 functional health posts had previously existed. Offering pre-natal consultations, child growth monitoring, immunization and other primary healthcare services part of the MOH program, these IHPs reach 121,961 people including 25,351 women of reproductive age and 14,635 children under five. The project has trained over 1,200 community health volunteers to operate the monthly IHPs. It also trained 200 healthcare providers (doctors, midwives and nurses) in 10 health centers and 37 sub-health centers in IMCI and IMCI protocols. 20 MOH healthcare providers have been trained as trainers of community health volunteers and eight healthcare providers have been trained as trainers of IMCI, thus strengthening the MOH's capacity to continue training activities. One hundred village midwives have received birthing kits and the DHO monitoring system has been improved with respect to its monitoring capacity, its use of the standardized immunization register and IHP recording and reporting. Forty village midwives have been trained in basic normal delivery and 30 in maternal and newborn care; 26 village midwives have been trained as breastfeeding counselors and 25 community health volunteers as breastfeeding support group leaders.

Indicators	Baseline 2005	November 2008
Percentage of women who had four or more antenatal visits during their last pregnancy	14%	56%
Percentage of mothers and newborns who received postpartum visits	36%	45.7%
Percentage of children who received oral rehydration solution during recent bouts of diarrhea	23%	40%
Percentage of children 6 to 59 months old who received vitamin A	59%	69%
Percentage of mothers with children under 23 months who were breastfeeding their newborn within one hour of delivery	15%	38.3%
Percentage of newborns who received postnatal care	36%	45.7%
Percentage of deliveries attended by a healthcare provider	44%	68%
Verifiable maternal tetanus toxoid immunization	15.1%	79.5%
BCG vaccinations	32.3%	70.9%
DPT3 vaccinations	19.8%	66.4%
Measles vaccinations	17.7%	62.5%

Several months of promotion of immunization by health center staff and community leaders left the community feeling more comfortable about having their children vaccinated. As a result of this and other actions, immunization coverage in the district has doubled. Now three years after the project was initiated, immunizations rates for BCG, DPT, measles, and maternal tetanus toxoid (TT) are expected to reach or nearly reach the national immunization goal of 85% by project end in 2010. Data from a survey conducted in November 2008 revealed that compared to baseline rates, BCG coverage has increased from 32% to 71%; DPT coverage from 20% to 66%; measles coverage from 18% to 63%; and polio coverage from 58% to 76%. Maternal

tetanus toxoid immunization rose from 21.8% to 85% for TT1 and from 15% to 80% for TT2. Other maternal, neonatal and child health indicators are presented in the table above.

In total, this project has served 6,618 infants, 17,179 children less than five years of age and 3,425 pregnant women and their families thus far.

Insofar as sustainability is concerned, the IHPs and community health volunteers can be considered sustainable since they form part of the government health system. Healthcare providers, community leaders and community health volunteers are motivated to continue immunization activities and there is new community demand for regular monthly IHPs. IMCI protocols for the treatment of sick children continued to be employed at healthcare facilities and in October 2008, the local ministry of education officially integrated the child-to-child health education approach into the fifth grade curriculum of local elementary schools.

VI. Lessons Learned

- Identifying barriers to access to services early in the project's implementation (in this case, the barrier in question was healthcare workers' need for training) allowed the project to devise appropriate strategies
- Adopting numerous interventions at the community, the facility and the societal levels helped increase immunization rates
- Multisectorial approaches (working with both the MOH and the Department of Education) increased the traction and sustainability of the project's innovative approach
- To stimulate demand, the healthcare system had to improve its quality of care
- Enlisting religious leaders to act as disseminators of health messages increased the demand for services (in this case, vaccination)
- Involving the community and utilizing community resources such as community health volunteers to promote immunization led to greater success than would have using healthcare providers alone
- Partnering with the Indonesian woman's organization (PKK), recruiting PKK members to act as trainers and including PKK members on the monitoring and supervisory team was an effective way to incite the community to make healthy behavior changes
- The child-to-child health education approach was effective in mobilizing the community to participate in health prevention activities

VII. Conclusions

At the outset of this project, immunization was not a social norm in the communities of Nagara Raya. Improving access to immunization services, training healthcare providers to improve the quality of care, initiating a child-to-child health education strategy and directly involving the community and community leaders all helped to improve coverage. Close collaboration with project partners also played an important role. This project demonstrates that innovative strategies and a multisectorial approach can be successful in increasing the demand for immunization. The child-to-child health education intervention was a particularly innovative facet of the project, and one that will be sustained by local health and education authorities. At the time of writing, the child-to-child health curriculum had been implemented in 125 elementary schools district-wide and the local ministry of education had adopted the subject as an official part of the local curriculum, meaning that students will be formally evaluated in the subject as part of their scholastic report. This approach could be replicated in other districts in Indonesia and elsewhere.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- | | |
|--|--|
| <input type="checkbox"/> Mobilization of resources | <input checked="" type="checkbox"/> Delivery of health services |
| <input checked="" type="checkbox"/> Generation of political will | <input checked="" type="checkbox"/> Advocacy for community participation |

IX. Organizational Information

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- h. Organizational overview: Founded in 1958, Project HOPE is an independent, international non-profit health education organization whose mission is to achieve sustainable advances in health care around the world by implementing health education programs and providing humanitarian assistance in areas of need. Project HOPE operates 80 programs in 38 countries and has a staff of 600 worldwide. Project HOPE's programs focus on infectious disease, women's and children's health, health professional education, health systems and facilities improvements, and humanitarian assistance.

CASE STUDY

I. Project Title

Using Community Performance Contracts to Change Health Behaviors in Cambodia

II. Project Summary

We describe one strand of a local Cambodian non-governmental organization (NGO)'s strategy to change health behaviors at the village level. Under this strategy, a village enters into a contract with Reproductive And Child Health Alliance (RACHA) to improve various health indicators including immunization coverage rates. RACHA rewards the villagers for signing the contract by providing water wells and continues to monitor the village's performance against the terms of the contract.

III. Introduction/Background

Cambodia performs poorly against Millennium Development Goals for maternal and child health (MCH). RACHA is a local NGO that runs a broad-based program of reproductive and child health in rural communities. RACHA was formed in 1996 as a major USAID-supported maternal and child health project. In February 2003, RACHA was registered a local NGO. It received a direct award from USAID for a 5-year MCH program that began in 2003. Recently, RACHA was granted support by USAID for another 5-year MCH program that will run until September 2013.

RACHA's mission is to improve the lives of Cambodians by providing safe and accessible reproductive health; maternal, newborn and child health; infectious disease; HIV/AIDS and other important fields.

Over the years, RACHA has developed a strong commitment to holistic approaches that stress the importance of working at all levels of the healthcare system, linking those levels, and maximizing the use of existing resources. Arguably, Cambodia's greatest resources lie at the community level. RACHA works with the Cambodian Ministry of Health to identify, link and mobilize community-level resources and ensure greater access to quality health services.

In addition to working at the national policy-making level with the Ministry of Health, RACHA trains midwives, provides support and continuing education to health promotion volunteers at the village level (village health support groups, or VHSGs), and trains and supports traditional birth attendants. It also works with village shopkeepers, nuns and wat grannies, respected female elders who live at temples and whose influence among villagers gives them an important role in health promotion work. RACHA has staff at its head office in Phnom Penh and an equal number of provincial staff who work with provincial health departments, with operational districts (ODs) and in villages.

Community Development Performance Contracts

Introduced in 2000, community development performance contracts were agreements between health centers and villages under which villages were offered certain incentives in return for committing to a health development plan. RACHA supplied the incentives and the ODs and RACHA monitored the plans every 6 months.

RACHA and the Ministry of Health have been impressed by community resources that make health care work more efficiently for residents of the extremely poor, rural Cambodian environment. Having the Ministry of Health recognize the community as a valuable resource and

teaching the ministry how to access this resource are essential parts of RACHA’s holistic approach. They are also essential ingredients to improved health in rural Cambodia.

IV. Project Implementation

Step 1: RACHA negotiated with provincial health departments, ODs and health centers for the improvement of health indices in their catchment areas. Health centers committed to providing a package of health services to their communities at health center premises and outposts and by visiting remote villages.

Step 2: Local authorities and village chiefs were informed of the goal to increase health services in order to improve the health of the community. ODs and health centers helped people pass through various stages of behavior change, stages influenced by community norms and beliefs, perceived risks, and access to health care. Assisting people to live healthier lives requires more than raising awareness and providing information: it also requires an approach that addressed behavior change and the factors that influenced behaviors.

Step 3: The health center entered into a contract with willing villages whereby the villages agreed to improve coverage and have their performance measured by several indicators. In return, RACHA provided participating villages with water wells through ODs. RACHA and ODs conducted follow-up assessments in participating villages every six months in order to measure progress. They also offered incentives linked to behavior changes within the villages. In this way, the Ministry of Health and RACHA helped rural Cambodians to better understand health care and to see themselves as their own most important healthcare resource.

An independent team from RACHA conducted a population-based survey in the catchment area every six months to assess the following:

Indicator	Target
Women who received 90 iron pills during their pregnancy	≥50%
Pregnant women who can name five danger signs of pregnancy	≥50%
Women whose baby was delivered by a midwife	≥30%
Women who started breastfeeding the baby within 60 minutes of birth	≥70%
Babies under 1 year who received full immunization	≥80%
Women of reproductive age who had two or more tetanus injections	≥70%
Women of reproductive age who know at least four birth spacing and how to access these methods	≥70%
Women who know correct home care practices for children with diarrhea	≥70%
Women who know three out of five danger signs for diarrheal diseases	≥70%

Depending on the health coverage level achieved, each village earned the right to zero, one, two or three wells.

Step 4: A baseline study was conducted within interested villages. About 20% of each of the following group was sampled: married women; women of reproductive age; new mothers within 42 days of delivery; mothers of infants under 1 year; and mothers of infants aged 1 to 5 years. All pregnant women were sampled.

Step 5: The OD and the health center provided the villages with support. The health center provided villagers with health education before challenging the village—including village elders, VHSGs, and others—to take responsibility for seeing that villagers accessed health services. The challenge included achieving targets for the indicators listed above.

These steps were accompanied by ongoing assessment and monitoring.

V. Outcomes, Impact and Sustainability

The agreements between villages and RACHA introduced in 2000 were altered in 2004. USAID, RACHA's major funder, recognized that wells should be offered as a right and not as a reward. RACHA used all its capability to mobilize community resources in its focus areas, at very low cost, to build effective bridges between communities and the public health sector. So far, the agencies have worked well together with strong support from Ministry of Health entities ranging from national-level structures to health centers. They have also enjoyed the strong support of local authorities, grassroots communities and NGO partners.

The size of the village assessment samples were small, varying between 18 and over 100 interviews. Occasionally high-scoring villages' scores went down, but usually scores increased, particularly in low-scoring villages. Pteah Pring Village in Sampao Meas OD, for example, originally scored 43% and was not entitled to a well. Six months later, the village scored 80% across all health indices, achieving the highest category. Part of that increase was due to the percentage of babies under 1 year who had been fully immunized: this figure rose from 40% to 83% in the interviewed samples. Another part of the increase was due to the percentage of women of reproductive age who had received two or more tetanus injections, which percentage rose from 72 to 77.

With its strong foundation of community health networks, RACHA reached 2,329 villages in 259 communes within the catchment areas of 164 health centers. This corresponds to a population of about 2,292,000 people in 13 ODs.

Sustainability was principally achieved through the development of a network of health promotion activists. VHSGs, traditional birth attendants, traditional healers, nuns and wat grannies were all involved. VHSGs continued their health promotion role after the end of the project. We also found that health-related behaviors were sustained after the wells were supplied. The health-related knowledge acquired through the activities of this project had not been lost.

VI. Lessons Learned

- It is no longer necessary for NGOs to provide incentives because decentralized planning has meant that village councils now have their own community infrastructure resources.
- Incentives must be considered carefully. A well was necessary for many villages, but it was probably not right to make the well a reward. A well is a necessity.
- RACHA is now providing clean water to health centers and to villages as a donation negotiated with Latter Day Saints-affiliated charities.

VII. Conclusions

- RACHA's partnership with the Ministry of Health created a synergy that enhanced RACHA's ability to carry out its programs in line with national policy and with its donor's strategic framework, thus contributing to Cambodia's achievement of Millennium Development Goals.

Cambodia's greatest resources lie at the community level. Local human resources such as VHSGs, nuns, wat grannies, village shopkeepers, traditional healers, and local, RACHA-trained actor/comedians are versatile and effective conduits for the delivery of culturally and linguistically appropriate community health advocacy messages at the grassroots level. Investing in existing community resources to empower the general population to participate in health and health-related activities and strengthening the healthcare network at all levels have reinforced the foundation of RACHA's broad-based health programs.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Mobilization of resources
(community) | <input checked="" type="checkbox"/> Delivery of health services |
| <input checked="" type="checkbox"/> Generation of political will | <input type="checkbox"/> Advocacy for community participation |

IX. Organizational Information:

- | | |
|----------------------------|---|
| a. Name of Project | Dr Sun Nasy |
| Contact Person: | |
| b. Designation/Title: | Deputy Executive Director |
| c. Name of Organization: | Reproductive And Child Health Alliance (RACHA) |
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Fax: (023) 213725 |
| h. Organizational Overview | Reproductive And Child Health Alliance (RACHA) is a USAID-funded local NGO in Cambodia that runs a broad-based program in reproductive and child health in rural communities. As well as training midwives and working with the Cambodian Ministry of Health at the national policy-making level, RACHA provides support and continuing education to village health support groups and to traditional birth attendants. RACHA also collaborates with traditional healers, village shopkeepers, nuns and wat grannies. |

CASE STUDY

I. Project Title

Increasing Service Use through Health Advocacy in Northwest Bangladesh

II. Project Summary

The delivery of antenatal care services by trained paramedics from government health facilities and federation/community-based organization (CBO) centers working jointly has enhanced the uptake of antenatal care and immunization services. This project increased community demand for services by applying mixed strategies such as the use of trained traditional birth attendants; the involvement of the CBOs' women and youth forums; and communication measures such as people's theatre and folk songs. The maintenance of strong coordination with government health officials also helped achieve satisfactory utilization of previously under-utilized government health centers. All of these safe motherhood efforts have produced a low maternal mortality ratio of <1/1000 live births in the affected population.

III. Introduction/Background

RDRS Bangladesh is a national non-governmental organization active in 11 districts in northern Bangladesh. The situation of women in RDRS's working area is hardly better than the rest of Bangladesh: if anything, it is worse. Husbands or mothers-in-law are often the key decision-makers. The area suffers from high maternal mortality as a result of women's low status in society, the poor quality of maternity care services, the lack of trained providers, and women's low uptake of services and infrastructure. The healthcare centers in RDRS's districts of operation consist of district hospitals, upazilla health complexes (UHCs), and union health and family welfare centers (UH&FWCs). These formal healthcare facilities, established and operated by the government, are seriously under-utilized and are unable to provide satisfactory services mainly because of staff absenteeism, the irregularity of the services provided, a lack of motivation, and the low number of female service providers present, especially in UHCs and district hospitals. The problem is exacerbated by the fact that women living in rural Bangladesh find it difficult and unsafe to travel the distances necessary to access available services. The need for non-government organization (NGO)-operated services therefore remains great, especially in the field of preventive and curative health. RDRS seeks to complement Government of Bangladesh (GOB) health services and encourage their development rather than replace them.

This project's interventions for improving maternal health focused on ensuring the friendly provision of services by 60% of the 266 antenatal clinics located at UH&FWCs; using trained traditional birth attendants (TTBAs); strengthening referral services for emergency obstetric care; and enhancing community participation.

With permission from the deputy directors at the local level, family planning arrangements had been made to organize antenatal clinics at UH&FWCs. Monthly activity reports were sent to all deputy directors of family planning and to all civil surgeons. Regular meetings at the office of the deputy commissioner took place and all NGO representatives and government health officials were present to discuss means to improve coordination.

The first phase of the project took place between January 2005 and December 2007. During this time, the project was implemented in 29 upazilla (sub-districts) of six northwestern districts of the country comprising a population of almost 300,000 pregnant women. The overall goal was to improve the perinatal health status of women in these districts. The main project objectives were as follows:

- To ensure that the pregnant women of the project area had access to antenatal, natal and postnatal care;
- To promote adolescents' and women's awareness of their reproductive health rights;
- To promote community awareness of safe motherhood and HIV/AIDS;
- To ensure that the referral system for high-risk and complicated cases worked well;
- To ensure that the services offered at district hospitals and upazilla health complexes were user friendly;
- To foster strong collaboration between the government and RSDS; and
- To achieve a maternal mortality ratio (MMR) of under 1/1000 live births.

The project was funded by CORDAID of the Netherlands. The financial resources allocated to the project over the first 3 years total €1,099,201. Phase Two of the project began in January 2008 and will continue until December 2010.

IV. Project Implementation

RSDS's Community Health Program in Northwest Bangladesh is filling the gaps and helping the government deliver health services to its constituents. Close collaboration with the government health sector has resulted in both preventive and curative reproductive health services, has earned the project a positive reputation and has played an important role in improving the lives of women and newborn babies. The key strategy of the program is to supplement and complement government health services and help attain the health-related Millennium Development Goals (MDGs).

The project has been implemented in six northwestern districts of Bangladesh and operates through 224 weekly antenatal clinics and one maternity center. The clinics are organized at the union level (the lowest tier of government administration) and take place in government centers such as the UH&FWCs, on federation premises (federations are the second tier of people's organizations through which RDRS works), and in community facilities. Services are provided by trained paramedics assisted by trained traditional birth attendants (TTBAs). As 90% of women in rural Bangladesh prefer to give birth at home, RDRS has trained rural birth attendants in safe birthing techniques. The birth attendants have also been taught to recognize early complications during the delivery in order to make rapid referrals. 600 TBAs have been trained and given certificates and attractive side bags that contain the materials essential to their tasks. Medical officers, staff nurses, trainers, and trained staff of various categories have extended technical support. Regular refresher training is offered to all project staff to update their knowledge and skills.

Women are charged a one-time fee of Tk15 to register at the clinics. Health education sessions are conducted regularly on clinic days and women are taught about their reproductive health rights and how to have a safe birth. All pregnant women are given iron folate tablets and calcium lactate or vitamin B complex tablets are also distributed to women in need. The maternity center is open for indoor delivery facilities around the clock and services are rendered by trained paramedics. Complicated cases are referred to the nearby health complex. Tetanus

toxoid injections (TT) are available in the center on clinic days and each village's immunization schedule is obtained from government officials and shared with all of the mothers who visit the center. The TTBA's also have the immunization schedule and have the responsibility of disseminating this information during their routine field visits. In addition to providing assistance to the vast majority of women who deliver at home, TTBA's are also responsible for motivating pregnant women to use antenatal care services at clinics. Postnatal and newborn care are provided at the mother's home through two or three home visits.

Under this project, several advocacy workshops were organized by local federation leaders, the women and youth forum, and college students. These groups held people's theatre and folk song performances at different villages. The performances promoted the uptake of antenatal, natal and postnatal care, immunization, and family planning; counseled against early marriage; and educated the public about how to prevent HIV/AIDS. A good number of large, colorful billboards were posted in public places. Posters were also put up at tea stalls and village markets and leaflets were distributed. At the district level, advocacy workshops and dialogues were organized with service recipients and duty bearers (government health staff): this helped to overcome gaps in service delivery and brought satisfaction to service recipients and duty bearers. During the project period, 21 advocacy workshops on user-friendly hospital services took place. While some improvements have been noticed, change is slow. Nonetheless, we are hopeful that more improvements will take place. In addition to the above, quarterly monitoring meetings with government health officials are also taking place.

For any maternal death, a medical officer must visit the place of death and determine the cause of death. The deaths are discussed with staff in monthly meetings where staff can learn how to prevent similar deaths in future.

V. Outcomes, Impact and Sustainability

These project initiatives have led to an increase in public use of the health centers. Of the 109,664 pregnant women who availed themselves of services in 2007, 74% had attended clinics for at least 4 antenatal check-ups and 96% had been immunized with at least two shots of tetanus toxoid vaccine. 83% of home deliveries in 2007 were conducted by trained TBAs. TBAs trained by RDRS are well respected in the rural community and act as effective media for the dissemination of health messages. The maternal mortality ratio among our registered pregnant population is 1/1000 live births, compared to the national ratio of 3/1000 live births.

Indicators	Achievements in 2004	Achievements in 2007
Pregnant women registered	106,316	109,664
4 or more antenatal visits	70%	74%
Percentage of mothers immunized	94%	96%
MMR	0.92	0.82

In terms of the overall scenario, the trend has gone to smaller families. More women are adopting family planning methods and the average number of children per women has dropped from 6 to 3. In addition, pregnant women now visit antenatal clinics rather spontaneously, the

incidence of eclampsia has dropped noticeably and cases of vesicovaginal fistula are rarely seen. The greatest need now is for comprehensive emergency obstetric care in government hospitals at the upazilla level. Although services are available, they leave room for improvement.

Insofar as sustainability is concerned, villagers have been made aware of their reproductive health rights and federation members and CBOs are committed to continuing to dialogue with duty bearers. Project participants also continually encourage women to avail themselves of reproductive health care and immunization services. The RDRS-trained TBAs are trained in assisting normal deliveries at home and in recognizing complications for rapid referral and they enjoy a good reputation in the community. It is expected that the government will continue to provide services through the UH&FWCs and the federation centers and that the TTBA's will continue to help poor rural women.

VI. Lessons Learned

Women who attend the clinics attest to the value of the following elements: the fact that the health centers are operated by solely female paramedics; the fact that the TTBA's come from the same areas as the women they serve; the punctuality and caring nature of the staff; the regular availability of vaccines and medicine at the centers; and the provision of information on reproductive health rights and safe motherhood. The fact that regular refresher courses and on-the-job training has improved the skills of paramedics and TTBA's has boosted patient confidence in their care providers. In addition, advocacy workshops and people's theatre and folk songs on immunization and safe motherhood have helped reduce maternal mortality among the women of the project area. The TTBA's refer to clients in need to government hospitals. Although services at these hospitals have improved, emergency obstetric care is still not available around the clock. With regular coordination meetings, this situation can be partly overcome, but a central policy decision will be necessary.

VII. Conclusions

Public realization of the importance of safe motherhood; the regular delivery of quality services, medicines, vaccines, and other logistics; and good coordination by the government and RSDS, have increased the demand for services among the pregnant population. While it is true that the role of TBAs has been debated, in the case of Bangladesh, where 90% of rural women give birth at home, where there is a shortage of nurses and midwives and where not all government sub-district hospitals have delivery facilities, stakeholders have no choice but to use their services. We have observed that with training and close supervision, TTBA's can play an important role in safe motherhood. It is therefore our position that their role can no longer be ignored. We have also observed that tapping into the federations/CBOs, particularly the women and youth forum, is effective in reaching remote populations. This forum has helped us inform a wider audience of the benefits of immunization and antenatal check-ups, the importance of safe deliveries and the possibility of referral assistance through transportation arrangements and other measures.

VIII. Key Thematic Areas Addressed

This project trained traditional birth attendants (TBAs) into a reliable workforce to promote safe motherhood. In addition, Federation/CBOs' community participation efforts helped widen poor rural women's access to service centers for immunization and antenatal care. Advocacy workshops have brought changes to duty bearers' delivery of health services, which have increased public use of health centres. This project thus addressed the following key thematic areas:

- Mobilization of resources
- Generation of political will
- Delivery of health services
- Advocacy for community participation.

IX. Organizational Information

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Organizational overview: RDRS Bangladesh is a leading integrated development non-governmental organization working in northern Bangladesh. Its vision is to see the rural poor achieve meaningful political, social and economic empowerment, peace and justice and, through individual and collective efforts, create a positive and sustainable environment.



CASE STUDY

I. Project Title

Barefoot Women Health Volunteers Improving Health in Rural Nepal

II. Project Summary

Women Acting Together for Change (WATCH) principally initiated healthcare activities for community integration purposes: rapport-building, trust-building, and the like. Later, WATCH attempted to develop a self-sustaining healthcare system in disadvantaged communities in rural and remote areas. WATCH did this by providing training, skills and materials for essential treatments and by offering maternal and family planning services.

Among the innovative features of this project was the project's focus on involving communities of illiterate, rural, disadvantaged women in decision-making and the development of a healthcare system. As a result, for example, de-worming, which was initially frowned upon, has now been accepted as a means for decreasing child mortality and improving health and nutrition.

III. Introduction/Background

WATCH started working with poor and indigenous communities in Nepal, including Tamang, Sherpa, Magar and Rai peoples in the hilly area and Tharu, Musehar, and Dalits peoples in the Terai area. One of WATCH's core strategies is to integrate with communities. In this regard, WATCH found health to be a medium through which its staff would be accepted by people in rural and remote areas, as there were major challenges to be addressed. Many children, for example, were dying due to measles complications. It also found women's health to be neglected, with husbands sometimes preferring that their wives die so that they could remarry. Because of poverty that pushes families to work hard from morning to night, young babies were either neglected or cared for mainly by older siblings. Pregnant women never consulted doctors or received any medical support, and both fertility and child mortality rates were high: indeed parents had numerous children so that after some of the children died, some children would still be left living. Basic sanitation and hygiene were quite poor, as was nutrition. Mothers and children were almost always sick with many diseases, including worms.

In response, project objectives were developed to decrease child mortality through the provision of safe motherhood measures, nutritious food, education about nutrition, and immunization; reduce family size by helping children stay healthy and thereby reduce parents' desire to have larger families; and prepare local women volunteers to take responsibilities for project measures.

To succeed, the project mobilized volunteers selected by local women's groups. These volunteers coordinated with government and non-governmental health agencies to provide services. WATCH provided the volunteers with training, essential medicine, follow-up support, and birthing kits.

The project required financial resources for a trainer; a primary healthcare provider or an assistant nurse-midwife; delivery kits; for essential drugs; and incentives for volunteers.

V. Project Implementation

Key project activities included the following:

- The selection of volunteers by local women's groups and their federation;
- The training of volunteers by WATCH, which adapted a manual and conducted a nine-day training course;
- The development of a policy regarding the sale and replacement of medicine. This policy was driven by the women's groups and the women's federation. In this regard, some essential drugs and maternity kits were provided. Volunteers also sold medicine and charged for services according to a fee schedule decided upon by the local groups, whereby higher prices and fees were charged to those who could afford it; and
- Supervision and support by health staff and women's groups. WATCH employed an assistant nurse midwife to support and supervise the volunteers. Monthly meetings were organized to review activities and find solutions. WATCH developed a mechanism whereby volunteers could send their clients to hospitals and local health centers.

The success of this project is in large part a result of the involvement of local women's groups in decision-making. However, as many non-governmental organizations (NGOs) operating in the area provide salaries for services and per diems for training and travel, the participants of this project also started demanding salaries and per diems. This created problems as early as the training phase. WATCH explained its philosophy about making the community self-reliant and able to stand on its own feet. The issue was settled for the time being but remains latent.

V. Outcomes, Impacts and Sustainability

The project trained a group of women cadres to provide local treatment and information about maternal child health. Many of these women were later employed as female health volunteers. As a result, maternal and neonatal mortality in the area is now almost nonexistent. The child mortality rate is decreasing and health is improving. Families are aware of the importance of immunization and of other aspects of children's health and are making greater use of available services. The number of pregnant women visiting healthcare centers and hospitals for check-ups and delivery is increasing. Many families are limiting themselves to two children, even if they are both girls. People have become more conscious of health and hygiene. De-worming has been accepted as a means of improving child health and nutrition and stopping child mortality. Consequently, families and communities spend less time and money treating common diseases. It is a good start to a healthy way of life.

However, as mentioned previously, the volunteers expected salaries and per diems. In Nepal, voluntarism is considered a luxury for those who can afford it, and NGOs are seen as having money and being able to pay their volunteers. Many NGOs who are only concerned about achievements do indeed pay their volunteers. So an organization like WATCH always has problems helping people stand on their own.

Overall, the project has not been sustained but its concept and its results have been sustained. Regular de-worming camps continue. Pregnant women have started consulting healthcare personnel and many have started accepting hospital services. Families and communities are aware of immunization and now have their children vaccinated. Local cadres provide essential drugs and immediate treatment. De-worming has been accepted by all.

VI. Lessons Learned

- De-worming affected the project positively. Training was effective and relevant. The distribution of medicine was not self-sustaining.
- The dependency mentality was a barrier. The common NGO and governmental approach of providing vegetables to eat rather than the skills and seeds to grow the vegetables is a big barrier and a significant development issue.
- Big projects never reach the poor, and money is not a solution. We need to identify what we want from people and from communities. Many projects turn people into beggars.
- Development is a political decision. We need to decide whether we want people to be self-reliant and responsible for their own development, or whether we wish to impose our ideas on them. Many materials on this issue have been published, but few measures are practiced. We need to walk our talk.

VII. Conclusions

- The project looked for solutions that were locally and economically feasible and found de-worming to be a way to improve health and nutrition and to decrease mortality.
- Communities were found to be ready for immunization and family planning even though urban areas are more aware of these issues.
- Local barefoot health workers are needed to provide essential treatments and drugs and boost awareness.
- Local female health volunteers are able to provide primary health care and maternal services if training is practical and suits their level of education.
- WATCH has had to be flexible in order to accommodate communities' needs but its principle that communities are capable, have the right to make decisions, and should be steered towards self-reliance, must remain forever non-negotiable.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- Mobilization of resources
- Delivery of health services

IX. Organizational Information

- a. Name of Project Contact Person: Ms. Sarmila Shrestha
- b. Designation/Title: Chairperson
- c. Name of Organization: Women Acting Together for Change (WATCH)
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- e. Email Address: watchftp@wlink.com.np
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- g. Telephone / Fax Number: 977 1 4492644/ 977 1 4494653
- h. Organizational Overview (2-sentence description):

Women Acting Together for Change (WATCH) is a women's non-governmental organization established in March 1992. WATCH advocates for self-reliant, rights-based and participatory development rather than development that creates dependency. WATCH believes that imposed and donated development is neither sustainable nor desirable.

CASE STUDY

I. Project Title

Developing a Model to Deliver Sustainable Health Care on Scale Anywhere

II. Project Summary

World Health Partners (WHP) is a global alliance that brings high-quality health and reproductive care to millions of people living in remote rural villages of the developing world. Our model employs private and non-government sector resources to serve a public need by harnessing the latest advances in communication, diagnostic and medical technology, and existing social and economic infrastructure. Local communities are being mobilized through advocacy-building and other social mobilization measures, word-of-mouth publicity, a responsible mix of mass-media and info-tainment, and the social marketing of user-friendly health services. This unique and innovative model is not only designed to serve those in need but also offers business opportunities to WHP's partners and stakeholders.

In 2008, WHP launched an 18-month pilot project to provide health services to 1,000 villages in three underserved districts of the state of Uttar Pradesh in northern India. The project will serve an estimated 3.6 million people, of whom 2 million live in rural areas. To reach such a large population, WHP is establishing a network of local and regional providers. WHP's central operations are based in New Delhi.

III. Introduction/Background

The paradox faced by global health care today is that technologies that have improved the general and reproductive health of citizens in the developed world for decades continue to be unavailable to the poor in the developing world. In WHP's Uttar Pradesh pilot project area, statistical data suggests that the unmet need for family planning is 24.6%. For other aspects of health care, needs are even higher. The situation is reaching crisis proportions and the large demand for services, coupled with the fact that the financial resources required are not excessive, is causing disaffection. The main obstacles to a solution are the public sector's administrative incapacity to address the demand and the fact that the private sector lacks the incentives and competency to step in.

Given this situation, the WHP project aims to:

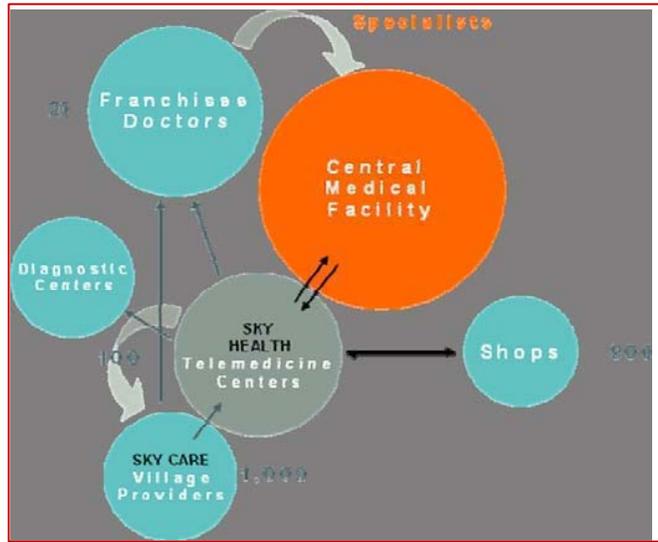
- i. Make a basket of quality health and reproductive health services easily accessible to clients;
- ii. Unleash entrepreneurial energy by developing local partnerships and making it financially viable for these partners to provide services;
- iii. Optimize resources in the public sector, the NGO sector and the private sector by forging collaborative ventures;
- iv. Establish an efficient delivery system by combining the latest communication, diagnostic, management and medical technology to deliver services in any part of the project area;
- v. Develop a model that can be replicated elsewhere, both in India and abroad.

The core strategy of this model is to use existing human, financial, and physical resources from the private sector to provide care to the needy. The model does this by organizing competencies into an operational framework and deploying them on the basis of location and skill. Service delivery needs are also identified and organized into smaller components before being matched to competencies readily available to clients. When a given service is not available, clients are referred to a higher level of care within the network. All providers are compensated for providing care, for facilitating care by making referrals through an affiliate network, and for helping WHP provide care to clients by managing local arrangements.

The Uttar Pradesh pilot project healthcare network consists of local providers (SKY Care rural health providers) in 1,000 villages linked to 100 telemedicine provision centers (SKY Health Centers), 20 medical clinics, 20 diagnostic laboratories and 900 rural pharmacies. A central medical facility (CMF) based in New Delhi will coordinate and supervise all medical and healthcare services and all communication with clients in rural villages. The financial resources allocated to the project totaled US\$ 3.5 million.

IV. Implementation

Our health service model works on the principle that at the service delivery level, the best efficiencies can be achieved not by guaranteeing providers' incomes but by linking earnings to performance. For that reason, the project outsources implementation to specialist agencies, with a small core team overseeing implementation. Data are regularly analyzed against targets so that corrections can be undertaken immediately.



Within the WHP network, clients have access to four tiers of health products and services. Network providers are organized into sub-networks for product and supply distribution and for medical referrals. Lower-level providers profit from referrals to higher-level providers. This structure helps ensure the timely provision of care and minimizes competition between different levels of service delivery.

Tier1: Shops

Small shops and pharmacies that sell a small range of products are ubiquitous in the most remote rural areas. Approximately 900 pharmacies will be recruited to sell non-clinical contraceptives and medicines and will be referred to nearby rural health providers or telemedicine provision centers for additional counseling and services.

Tier 2: Rural health providers (RHPs)

Villages without access to medical care depend on local health providers who lack formal training. We have invited 1,000 of these providers to acquire formal training in basic health services by joining our village health network as rural health providers (RHPs). In addition to benefitting from training, providers at this tier will also expand their clientele by virtue of their association with the network brand and quality recognition. At this tier of service provision, clients may purchase non-clinical health products, undergo basic diagnostic tests (e.g. pregnancy, blood pressure) and obtain first aid. RHPs may refer clients requiring further care to telemedicine provision centers for a formal medical consultation.

Tier 3: Telemedicine provision centers (TPCs)

Simple yet powerful rural telemedicine equipment is allowing clients to access highly qualified doctors and an extensive array of reproductive health and medical services. This tier of service is staffed by locally trained telemedicine providers. Here, clients can undergo physical examinations and more sophisticated diagnostic tests and receive therapeutic prescriptions and family planning services. By servicing the 100 network of TPCs by a small staff of doctors at the central medical facility, we will ensure affordability which in turn ensures access. These centers connect with the central medical facility consisting of city-based doctors through a satellite communication link.

Tier 4: Franchisee clinics (FCs)

Each village health network gives 20 doctors an opportunity to operate a franchisee clinic (FC). As the highest tier of service provision, these formally qualified FC doctors enjoy the benefits of network referrals, aggressive marketing and advertising, and ongoing skills training. Any client in need of immediate or in-person medical services can access a FC for a wide range of general and reproductive health services (e.g. diabetic foot ulcer treatment, sterilization).

Central medical facility (CMF)

A small and efficient team of highly qualified physicians and specialists at the central medical facility (CMF) have been trained to provide consultations to clients at the village TPCs. This urban facility is based at the project's management headquarters. The CMF will be made virtual once the need for a large number of doctors arises. All medical records are stored online so that all project tiers can access this information.

V. Outcomes, Impact and Sustainability

In the pilot project districts, the need for quality health services is immense. The government is aware of its inability to fulfill this need and has encouraged service supplementation through WHP's health network. An aggressive advocacy and advertising campaign has helped WHP generate high enough caseloads to make providers keen to provide care even though earnings per case are markedly lower than current market prices.

The project is yet to be fully established but the response to date gives us confidence that we will be able to fulfill the need gap and reach our goal of providing quality services to people who are currently bypassed by the public sector or who depend on low quality services.

Project sustainability will be accomplished by i) collaborating with the public sector to make the currently underutilized service delivery infrastructure more available to clients; ii) charging a fee, however small, for almost all services in order to reduce dependence on donors; and iii) using financial instruments like risk pooling, insurance and vouchers to safeguard the interests of the poorest communities without compromising on the quality of care.

VI. Lessons Learned

One of the most significant lessons already learned in this ongoing pilot project is that the need for the entire range of health services is immense. In remote, rural and poor India, morbidity rates are high, child mortality rates are high and the demand for health services is strong. Uttar Pradesh has the highest mortality rate for children in the country. It also has the second highest crude death rate and the third lowest life expectancy. In order to serve the healthcare needs of the rural population, we must offer a full range of health and diagnostic services.

We have also learned that rural clients look for a single contact point where all their health needs, both preventive and curative, can be addressed. When they require further care, they

want advice and hand-holding for the next step. WHP seeks to fill this gap and bring health services closer to the client's doorstep. Through the use of telemedicine technology, the project is making health-related services accessible to even the most remote rural clients. The benefits of this technology are ample:

- i. Easy accessibility by patients through sky health centers;
- ii. Credible medical advice;
- iii. Savings to patients' time and money as patients no longer need to travel for care.

Another remarkable observation we have made so far is that rural clients are not intimidated by the use of technology; rather, they are quite at ease to be diagnosed in front of a computer. This is a very positive start to our endeavor and we look forward to providing a high volume of effective and efficient medical consultations through the use of technology.

An important component of this service model is the involvement of local communities. This involvement is being achieved by partnering with local entrepreneurs. We learned early in the project that partners who have an entrepreneurial sense, who are adept at business development and who take genuine interest in WHP's cause are an asset to the project. Need and interest are also proving to be directly related when it comes to finding the best network entrepreneurs. Hence, WHP has adopted a policy to partner with people who need work. To our surprise, these entrepreneurs have been willing to take on loans from WHP in order to be affiliated with our brand.

VII. Conclusions

The WHP approach to creating access to quality health care and healthcare technology for poor, rural populations has the strength and capacity to be replicated on a much larger scale because it leverages the social and economic infrastructure that already exists in most of the developing world. Difficult terrain, a pitiable standard of living, poverty, and illiteracy plague the rural developing world. Health needs are immense and caseloads are high. WHP has managed to overcome these barriers and is confident that this is the best model to cater to the health needs of the rural poor.

VIII. Key Thematic Areas Addressed

Inclusion of the community sector and the rural private sector to fill the gap between unmet healthcare needs and available resources; the use of technology, particularly telemedicine, to meet healthcare needs in rural areas.

IX. Organizational Information

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- g. Organizational Overview: World Health Partners (WHP), a registered Indian non-profit society, will set up a service delivery system in the private sector with the goal of reducing unwanted pregnancies and improving health status on a large scale in the poor rural parts of three districts in Uttar Pradesh, India.

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CASE STUDY

I. Project Title

Improving Immunization Rates with Timed and Targeted Counseling in Uttar Pradesh, India

II. Project Summary

Between 2004 and 2007, a child survival project in the State of Uttar Pradesh, India, brought together World Vision India, India's Ministry of Health (MOH), the Integrated Child Development Scheme (ICDS),¹ local non-governmental organizations (NGOs) and local communities in a bid to increase community awareness and demand and fill gaps in peripheral health service delivery. Household-level counseling was provided at appropriate times using India's "timed and targeted counseling" method. Beneficiaries were mobilized and linked to health facilities by a dedicated team of community workers. Full immunization coverage and individual vaccinations, notably measles, increased significantly in target districts. By the end of the project, immunization had reached 181,645 mother-infant pairs.

III. Introduction/Background

Mortality and fertility rates in the State of Uttar Pradesh have long helped to lower national averages. And yet an analysis of the proximate determinants of survival and fertility from the most recent National Family Health Survey (2005-2006) highlighted the need to change critical behaviors at the household level in order to secure continued progress. The survey found that only 7.3% of the state's children had received a vitamin A supplement in the six months preceding the survey and that only 22.9% of children were fully immunized by their first birthday. A mere 8.7% of women reported having consumed at least 90 iron and folic acid (IFA) tablets during their previous pregnancy. Significantly, most of these figures had changed very little since the previous survey in 1998-1999. These findings demonstrated the need for improved health services and indeed a paradigm shift in the state's approach to household behavior change.

Accordingly, the Pragati Child Survival Project (Pragati) implemented a four-year partnership with MOH, ICDS and NGOs in Uttar Pradesh state. The goal of the project was to scale up a wellness package of critical child survival interventions consisting of immunization, infant feeding practices, care during pregnancy, birth preparedness, birth spacing and vitamin A supplementation.

Pragati found that existing approaches to behavior change communication were built around the calendar year or around the providers' workweek: ICDS's weekly "Nutrition and Health Education Days" and "Child Health and Nutrition Month" are two examples. While technically correct and appropriate, the messages were delivered either too early or too late to be practiced. Moreover, they were delivered to groups of pregnant women and to the mothers of infants, populations who have little say in decisions about using health services. Pragati therefore decided to adopt a different approach that would better meet its behavior change objectives. This new approach was based on the "continuum of care" model and was designed to time messages neither too early, lest they be forgotten, nor too late for the behavior to be practiced. Pragati's approach was also designed to target messages both to those who would

¹ This is a program implemented by the Ministry of Human Resources Development, Government of India. It is the world's largest early childhood care and nutrition program and is also tasked with mobilizing children and women for health services delivered through its community outposts.

practice the desired behaviors as well as to those who would influence the decision for a targeted individual to adopt the behaviors. This approach allows messages to be communicated in a secure environment that encourages open discussion about current belief systems and personal concerns with a skilled and knowledgeable healthcare provider.

Key messages related to birth spacing and nutrition and immunization in pregnancy and infancy were organized into sets (called the counseling plan) to be delivered at scheduled times during pregnancy and infancy. For this approach to be implemented, three requirements were necessary: a cadre of community workers who would identify women in early pregnancy, track them over time and deliver timed counseling; registries with which community workers could track conception and birth cohorts as well as selected outcomes; and a simple job aid that detailed the benefits of each behavior and helped dispel the myths that deterred people from practicing the behaviors.

IV. Project Implementation

Community workers from ICDS and local NGOs were trained in the project's intervention, the use of timed and targeted counseling and the use of the registries. A total of seven scheduled visits—three during pregnancy, one after childbirth, and three during infancy—were found to be sufficient to (i) deliver key messages and discuss and clarify myths; (ii) follow up on previously delivered messages; (iii) link beneficiaries to services; and (iv) document services (like Expanded Program on Immunization services) utilized and changes in behavior. The community workers used formatted, color-coded registers to identify and track cohorts of women in the same months of their pregnancies. The same registers were later used to track birth cohorts of infants and their mothers for up to three years.

Pregnancy register: The pregnancy register records the background details of each identified pregnant woman (including her last menstrual period and her expected date of delivery) and the details of each of her visits. Each visit is recorded by date and notes the counseling plan used. The date for the next visit planned is also recorded. Between the spaces designated for recording the early pregnancy visit and the mid-pregnancy visit, the register has two columns, one for tetanus toxoid (TT) shots and one for 50 IFA tablets. Each TT/IFA column contains two rows each, one for the planned date of administration and the other for the actual date of administration. At the end is a reminder to transfer the name of the infant to the infant register.

Infant register: This register has essentially the same format as the pregnancy register, with columns for the BCG vaccine and the oral polio virus vaccine after the post-delivery visit and columns for the three diphtheria, pertussis and tetanus/oral polio virus vaccines between the visits of the first and fifth months. A column at the end of the eighth-month visit records the details of the measles vaccination and the first dose of Vitamin A supplement. Each immunization entry has two cells, one for the date of the planned vaccination visit and one for the date that the vaccine was actually administered. The former cell helps community workers plan how they will take cohorts of mothers/infants to the health facility or outpost and the latter cell helps to track immunization outcomes.

These registers were thus used not only to plan for and provide timely counseling to households but also to help community workers plan for and inform and/or escort beneficiaries to immunization sessions at health outposts. Local-level problem solving and close coordination with peripheral health providers were critical skills used by workers to ensure that all beneficiaries availed themselves of immunization services in a timely manner.

Job Aids: The counseling plan is provided at the bottom of each page of the register for easy reference. In addition, a handbook containing an almost exhaustive list of myths and false

beliefs and appropriate responses helped community workers to communicate with patients about these issues.

Training of Providers: Protocols for the use of the three registers and the job aids were explained in providers' standard five-day training. The entire toolkit for implementing the strategy consisted of the counseling plan, the tracking registers, protocols for the use of the registers, a monthly reporting template, a template for capturing the data from the monthly reports, a standardized supervision checklist, a compilation of the checklist findings and a community workers' handbook.

V. Outcomes, Impacts and Sustainability

Eighty five to 93% of community workers were supervised every month by supervisors who used the standardized supervision checklist. Compilations from these checklists showed nearly all community workers using the registries and 83% to 97% of workers providing adequate and timely counseling through scheduled visits. Nearly all community workers were found to be using the registers during every reporting period.

Pragati tracked key outcomes with household surveys that used the two-stage 30 cluster sampling method and a sample size of 300 mothers in each of the project districts. These surveys showed that full immunization of infants had increased from 33% to 53% in Ballia District and from 30% to 50% percent in Lalitpur District (n(Ballia)=222 and n(Lalitpur)=225 in the 2007 survey). Ninety-eight percent and 99% of sampled children in the two districts had received at least one dose of diphtheria, pertussis and tetanus vaccine during infancy, up from 37% and 12% respectively.

Scale up to the state: An unintended outcome of this project was that the timed and targeted counseling approach, including its tools, was mainstreamed into the health education strategy of ICDS of Uttar Pradesh state where it was scaled up to all 70 state districts and will potentially benefit 106,000 community workers and a population of 166 million. This strategy was not intended to replace existing strategies for child nutrition and health month but rather to supplement them. Several steps led to the scale-up, particularly the presence of a "champion" within ICDS. This champion embraced the logic and recognized the feasibility of the timed and targeted counseling approach and led the scale-up process from the top down. Negotiation and teamwork between Pragati and ICDS in adapting the tools and training staff in all districts and the issuance of a government order from Uttar Pradesh State ICDS to its district functionaries completed the process.

VI. Lessons Learned

1. A key factor in this project's success has been the alignment of the counseling approach with life cycle events.
2. Intense initial training and the hands-on support and supervision of community workers were critical to successfully implementing this approach. It was found that workers took 8 months to a year to fully understand and implement the approach and to reach their entire community with this method.
3. The approach can be laborious and complicated, especially for those workers without prior experience in counseling and other forms of mobilization. The literacy level of the workers is critical to their effectiveness. Pictorial versions of the registers could be used in areas where literacy is low.
4. Counseling was combined with mobilizing beneficiaries, linking beneficiaries to health services and closely coordinating with health providers to ensure that beneficiaries were

immunized on time. This judicious mix of actions helped change behavior and reduce gaps in the use of services.

VII. Conclusions

The timed counseling approach took full advantage of the concept of birth cohorts and helped participants choose propitious points during the life cycle at which to advocate for behavior change. It also provided a context for beneficiaries to discuss and clarify myths and beliefs surrounding immunization. Pragati's training and support gave community workers the skills to combine timed counseling with well-planned mobilization of beneficiaries in such a way as to link beneficiaries to health facilities. While efficient, however, the rigorous nature of this approach and its tools could make implementation difficult in certain contexts.

VIII. Key Thematic Areas Addressed

Please identify which of the following four challenges was/were a focal point(s) of the project:

- Mobilization of resources
- Advocacy for community participation

IX. Organizational Information

Contact information

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- h. Organizational Overview:

World Vision is a Christian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. World Vision serves all people regardless of religion, race, ethnicity or gender and works in more than 97 countries worldwide, including 23 in the Asia-Pacific region.