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Innovations in Maternal Health Programming

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“We live in a world in which women and men lead healthy and pleasurable sexual lives, choose the timing and spacing of pregnancies for healthier families, and create stronger and more just communities.”

Sexual, Reproductive, and Maternal Health Vision
CARE USA

Acknowledgements

The development of this reference guide highlighting lessons from innovations in maternal health programming would not have been possible without the tremendous commitment and support from CARE staff from across the globe. We are especially grateful to the CARE country offices highlighted in this guide for their contributions to the development of this product. The rich programmatic experiences and lessons contained in this reference guide came from the following CARE country offices: Bangladesh, Bolivia, Democratic Republic of Congo, India, Madagascar, Nepal, Peru, and Tanzania.

In particular, we would like to acknowledge Anne Eckman, Catherine Toth, Lynn Heinisch and Luis Ortiz-Echevarria as the main writers for this guide. Ariel Frisancho Arroyo, Camille Collins Lovell, and Jill Gay also made significant contributions to the writing. The planning committee for the guide was led by Luis Ortiz-Echevarría, Jodi Keyserling, Marcie Rubardt, and Jesse Rattan; these individuals also served as lead reviewers for the various chapters. Additional reviewers included staff from the following CARE country offices: Bangladesh (TBD) Bolivia (Gonzalo Calderón), Nepal (Nirmala Sharma and Dipak Tiwari), Peru (Ariel Frisancho Arroyo), Tanzania (Racheal Boma, David Lyamuya, and Mande Limbu), and USA (Christina Wegs).

We would also like to extend much appreciation to copy-editors Anthony Jaffe and Gillian Ruland and the beautiful graphic design by Jason Abbot of Abbot Creative.

Finally, I would like to especially thank, Luis Ortiz-Echevarria, without whose vision, guidance and tenacity this guide would likely not have seen the light of day. His hard work planning, writing, editing, reviewing, and supporting every step in the process are why we can share this reference guide with you today.



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Acromyn List

ANC	Antenatal care
ARV	Antiretroviral
BCZ	Bureau Central de Zone (DRC)
BPP	Birth preparedness planning
CBD	Community-based distribution
CHW	Community health worker
CmSS	Community Support System
CSC	Community score card
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and neonatal care
FCHV	Female Community Health Volunteer (Nepal)
FEMME	Foundations to Enhance Management of Maternal Emergencies
FP	Family planning
GBV	Gender-based violence
HEqP	Health Equity Project
ICRW	International Center for Research on Women
ISOFI	Inner Faces, Outer Faces Initiative
JICA	Japanese International Cooperation Agency
MINSA	Ministerio de Salud (Peru)
MISP	Minimum Initial Service Package
MNH	Maternal and newborn health
MOH	Ministry of Health
MOHP	Ministry of Health and Population (Nepal)
MVA	Manual Vacuum Aspiration
NGO	Non-government organization
PAC	Post-abortion care
PEP	Post-Exposure Prophylaxis
PLA	Participatory learning and action
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPH	Post Partum Hemorrhage
SAA	Social Analysis and Action
SAFCI	Salud Familiar Comunitaria Intercultural
SBCC	Social and Behavior Change Communication
SMPP	Safe Motherhood Promotion Project
SRMH	Sexual, Reproductive, and Maternal Health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee (Nepal)
WHO	World Health Organization

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Introduction

Despite encouraging improvements in maternal health over the last 20 years,¹ maternal mortality and morbidity indicators remain important reflections of inequity, discrimination and the denial of rights. The women who die are usually the poorest women, often in rural areas, lacking education, with little autonomy and without access to quality health services. Even when such services are available, other powerful factors influence a woman's ability to make use of them, such as affordability, cultural and gender norms, and community confidence in the health care system. In many contexts, women are denied the ability to decide if and when to have a child, or how many children to have, leading to unintended pregnancies ill-timed and spaced for the optimal health of mothers and newborns. Poor quality services and insufficient political prioritization of maternal health also significantly factor in the ability of a woman to have a safe pregnancy and delivery.

In developing countries, problems due to pregnancy and childbirth are often the leading cause of disease burden for women. When a woman dies due to pregnancy or childbirth there are high direct and indirect costs related to her death. For example, there are profound and long term implications for the immediate survival of newborns, as well as the health and well-being of families, communities, and societies. In fact, considering the health needs of women before, during and after pregnancy is an important part of global efforts to reduce poverty.

For more than 50 years, CARE has worked to improve the lives of poor and marginalized women, their families, and their communities. Improving maternal health is closely aligned with CARE's mission to reduce global poverty and to increase equity. CARE's maternal health global portfolio, including broader sexual and reproductive health programming, both deliver high-quality technical interventions² to improve maternal health outcomes and identifies and addresses underlying social determinants of poor health. Through close collaboration with local and national partners, communities, and health providers, CARE strives to enhance the social status of women and improve women's access to quality care throughout her reproductive years.

These interconnected strategies at various levels fall under the broad categories of interventions to empower communities, strengthen health systems, and advocate for policies all aimed to make improvements in maternal health. The intersection of these broad categories represents the collaboration and cooperation needed to reduce structural and social barriers to quality health care, to empower women and influence political, social, and gender norms. By catalyzing change in each of these areas, CARE will not only create short-term improvements in maternal health and equity, but will also influence power dynamics and the distribution of resources in ways that provide broader and long term benefits to women and their communities.

In recognition of the global significance of maternal mortality and the challenges of addressing it in a comprehensive way, this reference guide brings together a range of lessons and experiences to address the broad range of influences on maternal health in order to guide future replication.



These strategies fit into a model commonly used when examining maternal health programming: the Model of Three (or Four) Delays. These are:

1. The delay in recognizing there is a problem (i.e., knowledge and identification of pregnancy and delivery related complications)
2. The delay in deciding to seek care (including family decision-making and resource considerations)
3. The delay in getting to care (i.e., lack of available or affordable transportation to reach an appropriate obstetric facility)
4. The delay in getting appropriate care once a facility is reached (quality and competency of services, reaching the appropriate level of services, and availability of essential supplies)

By identifying where along this continuum delays occur, this model offers a way for projects to identify and prioritize interventions.

CARE believes that to achieve long term success in reducing maternal mortality and morbidity—including sufficient attention to each of the four delays and improving maternal health at each point along the care-seeking continuum—that action is required at all levels, including: a) empowering women and girls, their families and community, b) strengthening health systems to provide quality and equitable services to all, and c) advocating for and promoting policies intended to improve maternal health care.

CARE's decades of experience in and learning from maternal health programming has resulted in the accrual of a rich body of knowledge. This reference guide on innovations in maternal health programming provides practical examples, evidence, innovations, lessons learned and solutions to new and old challenges to improve program quality and to increase impact.

¹ A WHO, UNICEF, UNFPA, and World Bank study released in 2012 found that the number of maternal deaths has dropped from 543,000 in 1990 to 287,000 in 2010.

² Technical interventions include access to voluntary family planning services; skilled attendance during pregnancy and delivery; emergency care for life-threatening complications; and postpartum care for the mother and newborn – all of which need to be grounded in a strong and equitable health system.

³ These objectives are consistent with CARE's Unifying Framework for Social Justice and Poverty Eradication and address human condition, social position, and enabling environment.

Structure

The reference guide is divided into three chapters (each summarized below), consistent with the strategies to improve maternal health and with CARE's unifying framework for social justice and poverty eradication.³ Each chapter includes specific project examples, including project context, project operation, outcomes, and lessons learned. Each project example also includes a brief summary of how it addressed one or more of the four delays to critical care.

The reference guide also includes step-by-step ideas for adaptation and replication—in recognition that each project is situated in a highly complex social experience, such that applying project experiences across social and cultural contexts can often be challenging. In addition, relevant resources, reading materials and other helpful insights are also provided in each chapter.

Empowering Communities

This chapter profiles program experiences from Bangladesh, India and Bolivia, highlighting how CARE worked with communities at various levels to improve maternal health — specifically, to ensure that women receive quality care before, during and after pregnancy. Given that three out of the four delays occur at the community level, these interventions were initially designed to focus on these delays, taking both the physical and the social causes for these delays into account.

The chapter shares some of the ways that CARE uses critical reflection and social analysis to identify underlying causes of maternal and newborn mortality and morbidity, and the strategies to build community-wide action to address them. The chapter also illustrates how CARE partners with poor communities to ensure that mechanisms for citizen oversight and social accountability are in place, so that service providers and government officials can be held accountable for providing quality care.

Health System Strengthening

This chapter highlights CARE's role in supporting country-specific approaches to strengthening health systems in order to reduce maternal mortality by improving and extending quality care to remote, underserved populations. Here the meaning of "health system strengthening" is examined in two very different settings: a functioning but underfunded health system in Nepal and a post-conflict, neglected health system in DRC. While several delays are addressed, the two examples in this chapter offer two very different strategies to address the fourth delay: a more traditional technical approach compared to a more innovative approach to bringing essential services to the community level. This chapter illustrates the range of possible interventions that CARE can implement to extend and deliver quality health care services to poor, marginalized populations.

Policy Action

This chapter shows how CARE uses policy action to influence local, regional, and national government action to prioritize and support maternal health. The approaches described include efforts such as: 1) grounding advocacy in field work, 2) engaging citizens and health care providers, 3) working with and through partners, and 4) appealing to, and influencing, the agenda of policymakers. Drawing on two program examples from Peru and Tanzania, this

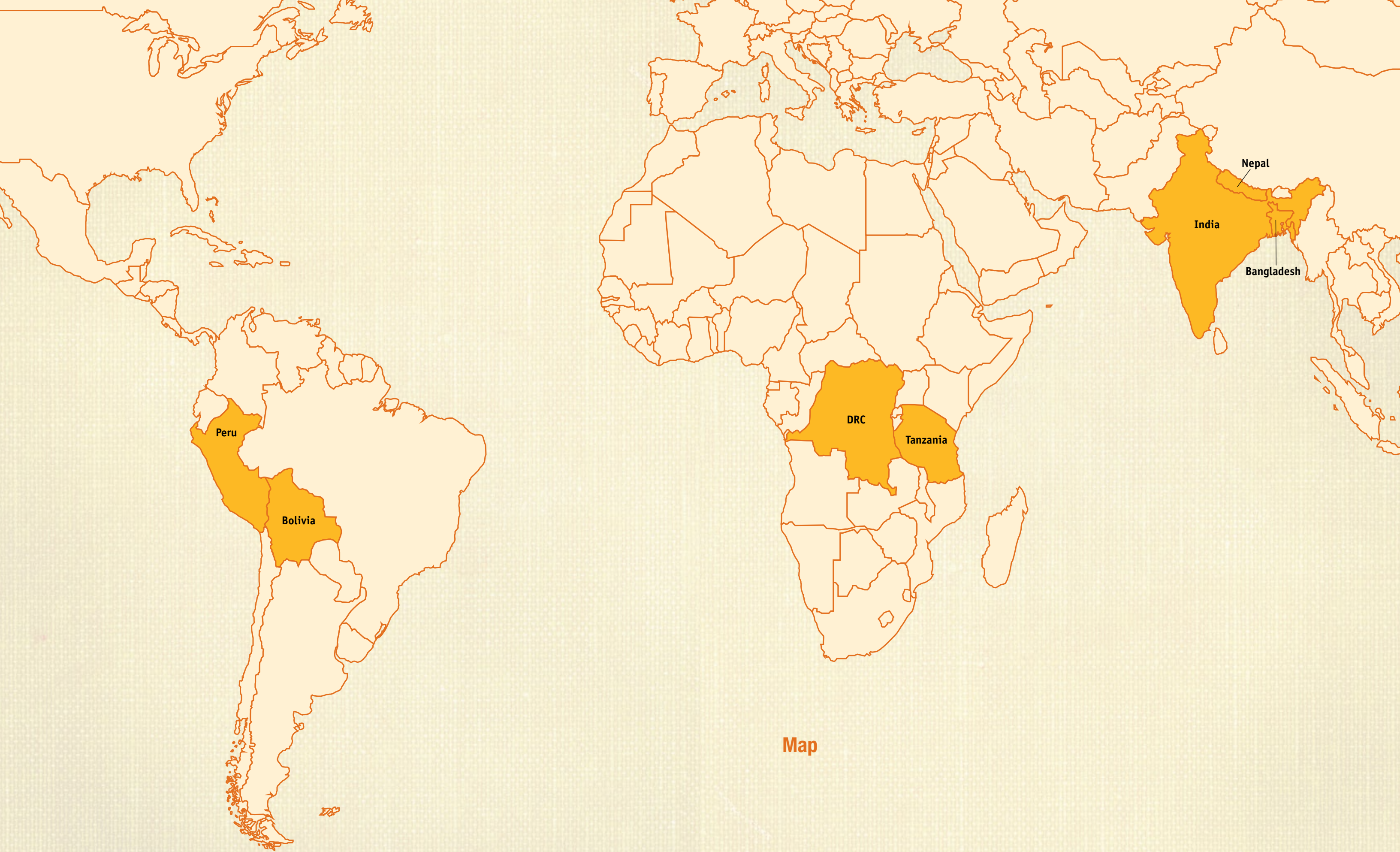
chapter illustrates the potential for scale and leverage that advocacy efforts offer to health programming and CARE's goal to bring long term change. The chapter also offers a potential fifth delay is receiving care and makes the case that effective, community-led advocacy can positively influence all four delays.

How to use this guide

This reference guide is a user-friendly collection of successful CARE strategies and approaches to maternal health programming that can serve as guidance for future program design and development. It is designed to assist program managers and others to plan, design, implement, or build upon maternal health, or broader sexual and reproductive health projects, for improved impact.

While each chapter and program example can be read separately together they offer rich opportunities for comprehensive program design. Although the reference guide is structured into chapters, there is tremendous overlap across the chapters and program examples.





Peru

Bolivia

India

Nepal

Bangladesh

DRC

Tanzania

Map

CHAPTER 1

EMPOWERING COMMUNITIES

Why Empower Communities?

CARE believes that community empowerment and mobilization are critical strategies for changing health care seeking norms and behaviors. An empowered and mobilized community can provide a deeper understanding of individual and social barriers to services, including latent inequities and harmful cultural and gender norms. This understanding is invaluable for efforts to work to improve health care quality and access across an entire health system. When communities are empowered, they are their own best advocates for high quality, affordable and culturally appropriate care — and are best-equipped to hold local governments accountable for the provision of that care.

What is an Empowered Community?

While there is no standard definition of an empowered community, the examples presented in this chapter offer some insights on characteristics of an empowered community. An empowered community is one that is supported and successful in participatory analyses to uncover previously unrecognized or non-prioritized sexual, reproductive, and maternal health (SRMH) problems and their underlying, root causes and develop their own solutions and implementation plans. For example, empowered communities can analyze not only which pregnant women lack access to health care, but also uncover the barriers to accessing that care. These can include basic barriers such as lack of transport, lack of money to pay for services or women's limited mobility and constrained decision-making ability. With this information, communities can mobilize to address these underlying barriers to improved health. An empowered community can also put in place mechanisms to hold governments and service providers accountable for the provision of quality care. In short, an empowered community can generate the human capital necessary to demand and ensure systems change.

Empowered Communities: Three Cases

This chapter highlights three CARE projects that incorporated successful strategies for community empowerment to address barriers to seeking and accessing life-saving treatment. While the three examples are quite different in terms of project strategies and context, their experiences and those of others show a trio of innovative approaches to reduce maternal mortality and morbidity described in detail below.

Critical reflection and social analysis to identify underlying causes of maternal and newborn mortality and morbidity, including gender inequity. Underlying causes include such things as lack of available transport; restrictions on women's mobility; constraints on women and men acknowledging, much less discussing, sexual desire and the right to initiate or refuse sexual relations with a spouse; and norms that stigmatize men who help with "women's work," such as caring for children.

Community mobilization to eliminate underlying causes of maternal and newborn mortality and morbidity. Community efforts can include such things as increasing awareness about danger signs associated with pregnancy and the importance of timely referral; increasing availability of and access to resources for ensuring safe pregnancies; and transforming harmful gender-related norms and inequalities by enabling women and men to discuss sexual relations, by increasing women's mobility and autonomy, and by shifting the division of labor to increase men's involvement in the household.

Citizen oversight and social accountability to hold service providers and government officials accountable for providing quality care and increasing constructive dialogue between communities and providers. Oversight and accountability strategies can include regular feedback sessions linking community members and local government health officials; implementing community watch-dog processes, such as community scorecards; and community monitoring of care provided at local health care facilities.

What is in this chapter?

This chapter provides an overview of three innovative CARE strategies designed to help communities work collectively to improve sexual, reproductive and maternal health. Specifically, it details CARE’s community-based efforts to uncover and address underlying, root causes of poor maternal health.

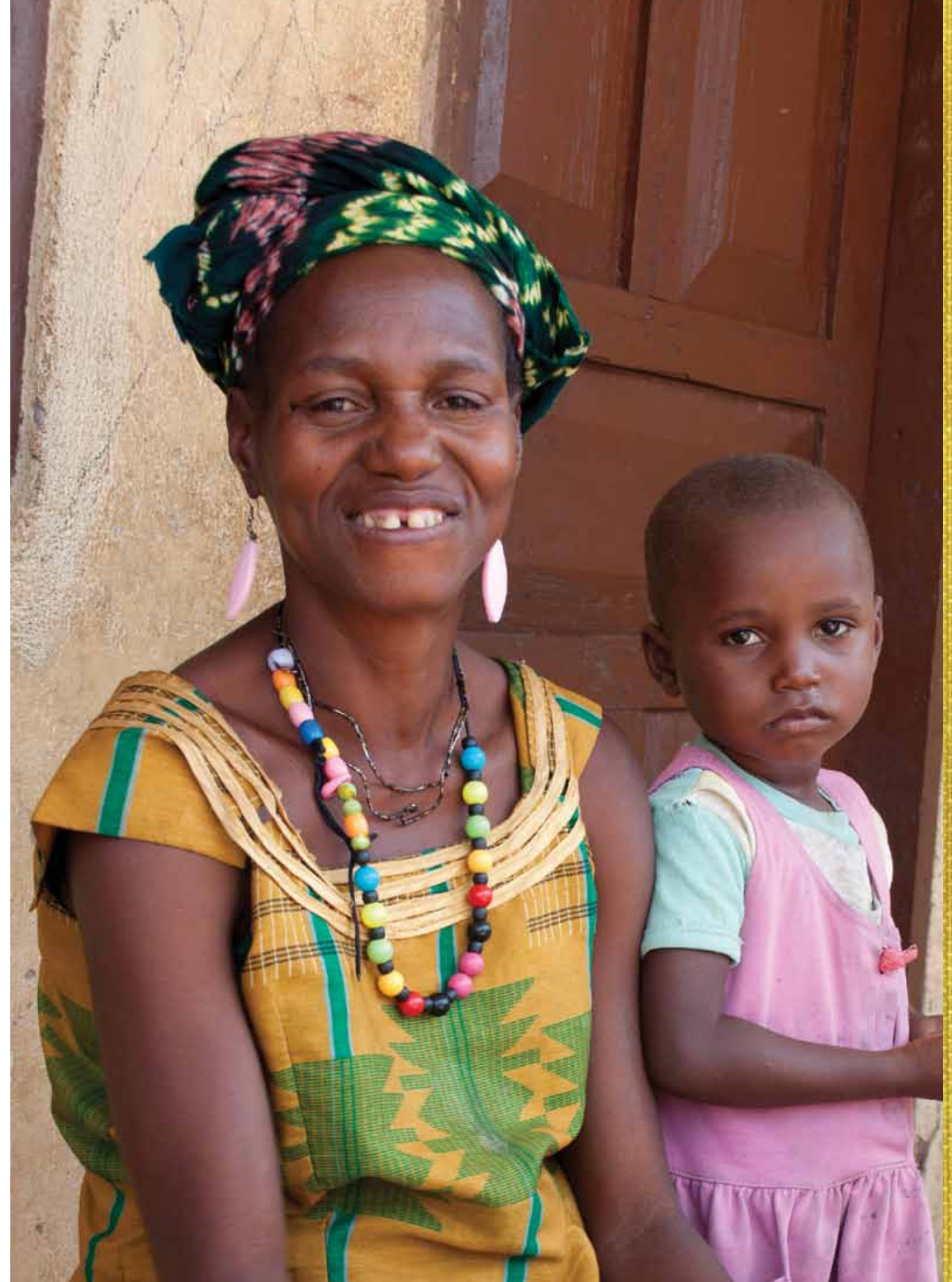
- ▶ In **Bangladesh**, CARE helped establish a community-level system to support pregnant women, especially poor and marginalized women, during obstetric emergencies.
- ▶ In **India**, in collaboration with partners, CARE integrated gender and sexuality components into a traditional maternal and newborn health program to address underlying gender norms and inequalities that negatively impact health care.
- ▶ In **Bolivia**, CARE helped establish a participatory community-management structure that brought together communities, municipalities and health centers for meaningful dialogue on maternal health services.

Together, the experiences, strategies and tools described in this chapter can help stimulate ideas on how to empower communities for improved maternal health. While these projects are presented as examples of empowering communities, they also include elements related to health systems strengthening and policy action. Please refer to those chapters for more ideas on how to build comprehensive maternal health programs.

PROJECT EXAMPLE	KEY STRATEGIES FOR EMPOWERING COMMUNITIES		
	Critical reflection and social analysis	Community mobilization	Citizen oversight and accountability
Community Support System (CmSS) in Bangladesh		■	■
Inner Spaces, Outer Faces (ISOFI) in India	■	■	
Participatory Community Management in Southern Bolivia		■	■

■ Indicates which strategies are present in each program example.

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COMMUNITY SUPPORT SYSTEMS (CMSS) IN BANGLADESH



PROJECT EXAMPLE	KEY STRATEGIES FOR EMPOWERING COMMUNITIES		
	Critical reflection and social analysis	Community mobilization	Citizen oversight and accountability
Community Support System (CmSS), Bangladesh		■	■

Overview

What is a Community Support System?

The Community Support System (CmSS) is a mechanism for establishing a structure at the community level, through collective efforts of the people, which tracks all pregnant women, and provides need-based support for making their pregnancy safer including timely use of life-saving emergency obstetric care services. The purpose of creating a CmSS is to accomplish the following:

- Facilitate timely referral of women with obstetric complications to an appropriate EmOC facility
- Foster an enabling environment in the community, and ultimately at the household level to support women in accessing EmOC services in a timely manner, and
- Create awareness among the community about the danger signs of obstetric complications and available services at different facilities.

What is the Context of the Community Support Systems (CmSS) Intervention in Bangladesh?

Maternal mortality in Bangladesh is still very high (320 per 100,000 live births). Seventy-five percent of women who die from pregnancy-related complications do so at home, without ever having received professional medical attention.¹

In an effort to improve maternal and newborn health (MNH) services, the country's Ministry of Health and Family Welfare (MOHFW), with support from the Japan International Cooperation Agency (JICA), launched the Safe Motherhood Promotion Project (SMPP) in Narsingi district in 2006. From 2006-2010, CARE Bangladesh served as a partner on this project, facilitating community mobilization in two of the project's six sub-districts.²

¹ Annual Government of Bangladesh Ministry of Health Program Review, 2009.

² Bangladesh is composed of 21 regions (or districts), which are the country's key administrative units. Under a 1997 law, rural regions are organized into a four-tier local government system: gram (village), union (collection of villages), upazila (subdistrict) and zila (district) councils. Other legislation made the upazila the most important tier in local government, giving its council the power to collect revenue, prepare its own budget and hire its own employees. The elected body of the union council is also referred to as the union parishad.

What Did CARE Bangladesh Set Out to Do, and Why?

When the project started, efforts in Bangladesh to improve health care utilization had largely focused on upgrading health facilities. CARE saw a need to mobilize women and their families so that they could more effectively access health care services. In addition, the quality of these services needed to be addressed to enhance utilization.

CARE Bangladesh sought to carry out community mobilization strategies that would build community capacity to demand, negotiate and use quality MNH services, and also enhance community participation in the management of reproductive health service delivery.

To do so, CARE implemented a community-based support and governance mechanism that had been effective in an earlier pilot project in Bangladesh.³

CARE's mobilization strategies often focus on reducing three important delays that result in negative maternal health outcomes: 1) recognizing a pregnancy-related complication, 2) deciding to seek care, and 3) reaching a health care facility. A fourth delay, in receiving quality care, was also addressed by CARE, and was the MOHFW's primary intervention.

The Four Delays

- 1) Delay in recognizing a pregnancy-related complication.
- 2) Delay in deciding to seek care.
- 3) Delay in reaching a health care facility.
- 4) Delay in receiving appropriate treatment and quality care.

³ Community support systems (CmSS) were first piloted in Bangladesh by a CARE demonstration project from 1999-2001. Given its promising outcomes and the continued gap in community engagement interventions for safe motherhood in Bangladesh, the CmSS was developed further in the SMPP project. For further details, see Shahnewaz Khan and A. S. M. Jaheedul Islam. Final Draft Report for Review of the Dinajpur Safe Mother Initiative (DSI).

What is innovative about CmSS?

At the village level, CmSS provided a practical way to pool community resources to overcome key barriers (e.g., information, funds, transport, and accompaniment to health facilities) to women, especially poor and marginalized women, getting timely access to health facilities. In the process, CmSS made safe motherhood not just a family responsibility but a community responsibility, including community pledges of “zero tolerance” for maternal and newborn deaths.

The project also established two-way coordination and accountability mechanisms between communities (at the village level), health care providers and policy makers (at the sub-district level) through regular meetings. The result: a greater voice for women and other community members with regard to the **governance** of local health systems, and greater accountability of service providers and local government to community members for ensuring quality, timely care. By integrating community-led efforts with existing decision-making and health services infrastructures at all levels, this approach increased the sustainability of CmSS beyond the project period.

Governance

CARE defines “good governance” as the “effective, participatory, transparent, equitable and accountable management of public affairs guided by agreed procedures and principles, to achieve the goals of sustainable poverty reduction and social justice ... By empowering citizens, by promoting more accountable and effective public authorities and service providers, and by expanding spaces for negotiation between citizens and authorities, we can achieve desirable and positive health outcomes and goals. Change needs to happen in all three domains in order to achieve this impact.

Snapshot of CmSS

From 2006-2010, the project’s structured process enabled 133 target communities to:

- Create a local, village-level CmSS.
- Develop multi-village and sub-district CmSS linkages within local health-system infrastructure.
- Facilitate ongoing coordination and accountability between the community, local health service providers and policy makers to improve health care quality and access.

Five core principles of CmSS:

- 1) CmSS is initiated and established by the community.
- 2) CmSS is led by the community (i.e., community makes decisions).
- 3) Regular meetings are held at the village level and are led by community members.
- 4) CmSS is implemented and monitored by the community.
- 5) CmSS develops linkages with existing community structures and institutions.

Village-level CmSS Activities

Through a participatory process, CARE helped community members — usually members of the local village committee — decide if they wanted to prioritize elimination of maternal death and morbidity. If they did, the community then formed a dedicated community support system within the village committee structure, which allocated resources and both coordinated and monitored actions to ensure safe motherhood. It also functioned as a neighborhood-based forum, which local households were encouraged to join.

Village-level CmSS activities included the following:

- **Establishing pooled community resources for women to use in case of obstetric emergency, including** a common fund; timely, affordable transportation to the nearest health center; blood donation; volunteer to accompany the patient to the health facility, if desired.
- **Creating awareness in the community and, ultimately, at the household level** about pregnancy danger signs, the availability of both district EmOC services and CmSS supports; and birth planning (e.g., how the mother would like her labor to be carried and how she will pay for services), including emergency preparedness.
- **Maintaining a registry of each pregnancy in a village**, including data about CmSS program participation, antenatal and postnatal care visits, status and place of delivery, birth complications, access to services and the health of both mother and newborn.

Multi-village and sub-district-level activities:

The CmSS structure also linked to multi-village decision-making structures as well as government health infrastructure on the sub-district level. Key activities included the following:⁴

- **Building the capacity of existing Health and Family Planning Standing Committees** (at the level of the local government multi-village or district health infrastructure) to support and monitor implementation of CmSS community mobilization activities at the village level.
- **Formalizing a governance system in which village-level CmSS members elect representatives** to the Standing Committee, who, in turn, were able to represent the interests of their villages.
- **Helping the Standing Committee monitor the quality of health care services** — and relevant local government performance. CmSS pregnancy registration data documented successes and failures in the efforts of ensuring safe motherhood; this evidence was used to back up community advocacy for needed health-system changes.

Working across the village-level and sub-district level, the CmSS structure strengthened local-level coordination and linkages with all relevant stakeholders in planning, implementation and performance evaluation. As a key part of this process, the CmSS provided a structure through which women and communities could channel their voices to identify key barriers to safe motherhood that needed overcome – and to hold health facilities and local governments accountable for high-quality, timely care.

⁴ In Bangladesh, the union and upazilla health and family-planning infrastructure included the upazilla health complex, family welfare center (FWC) and satellite clinic.

Outcomes

Project **outcomes** show that CmSS was an effective way to:

- Create a supportive environment to promote safe motherhood in the community.
- Help women — especially those who were poor and marginalized — get timely emergency obstetric care.
- Begin building community dialogue around broader harmful social norms, including violence against women, early marriage and dowry.

Data from monitoring and impact evaluation indicate the following outcomes:⁵

Maternal and Newborn Health

- Reduced maternal and neonatal deaths: 68% and 78% reduction of maternal and newborn death, respectively, in project areas within three years (shown in project monitoring data).⁶
- Increased service utilization rate, especially among the poorest women. The rate at which women made antenatal care visits to a trained health care provider was significantly higher in project areas (57.7%) than non-project areas (48.7%). The difference was most striking among the poorest women (70.9% versus 29.7%).⁷
- Increased skilled birth attendance among lowest quintile of pregnant women: Delivery by skilled birth attendance (SBA) among the lowest quintile of women was 21.7% in project areas, compared to 12.9% in the comparison area showing an elimination of health disparities between highest and lowest quintiles in the project area.⁸
- Increased maternal health knowledge and practices: Compared to non-project areas, women in project areas were more likely to:⁹
 - Know three dangers signs of pregnancy, labor and postnatal period (OR 3.42).
 - Have a say in the decision to seek prenatal care (OR 3.97).
 - Have made a birth plan (OR 5.36).

Reach of CmSS Interventions

- **Local CmSS reached almost all women — and many household members.**¹⁰ Almost all women in CmSS areas (97.2%) were aware of CmSS in their communities. About 81.4% reported registering with CmSS, and almost the same percentage were visited by health workers/CmSS members and volunteers during their last pregnancy. Other family members, such as mothers-in-laws (46.1%), sisters-in-laws (37.8%) and husbands (33.5%) also met CmSS members or their volunteers.

⁵ At the same time CmSS was being implemented, the Government of Bangladesh was also implementing a voucher scheme in one of the two sub-districts. This allowed poor, pregnant women to receive pregnancy-related services such as antenatal care (ANC), delivery care, treatment of complication and postnatal care (PNC) at health facilities. Qualitative analysis showed that the CmSS program had a synergistic impact on service uptake through the voucher system.

⁶ Excerpted from the two-page CARE summary about the Safe Motherhood Promotion Project (SMPP) prepared for JICA, August 2010.

⁷ Excerpted from CARE Briefing Paper: CARE Perspectives on the MDGs ~ MDG Goal 5 Improve Maternal Health, September 2010.

⁸ Excerpted from the two-page CARE summary about the Safe Motherhood Promotion Project (SMPP) prepared for JICA, August 2010.

⁹ R. Stephenson (n.d.). Community Support System Improve Maternal Health Behaviors and Increase Equity, Narshingdi District, Bangladesh. Prepared for CARE International, 2010.

¹⁰ These data are excerpted from M. Sekander Hayat Khan, APM Shafiqur Rahman, and Tauhid Nasrin. Evaluation of the Impact of the Community Support System (CmSS). Prepared by Associates for Community and Population Research (ASPR) for Japan International Cooperation Agency (JICA), 2009

- **Women accessed pooled community resources and valued information.**¹¹ With regard to accessing specific CmSS pooled resources during their last delivery: 8.5% of women reported using CmSS services and 7.4% reported receiving financial assistance for transportation and medical cost; given that approximately 15% of all pregnancies require EmOC, these pooled resources provided good coverage. In addition, almost two-thirds (64.3%) of women reported that they received help from the CmSS during their last delivery, including: verbal advice (62.7%), birth-planning sessions (26.3%) and someone to accompany them to a health facility (5.9%).
- **Some gender-related barriers that limit women's rights to safe motherhood were identified and addressed.** Ongoing CmSS analysis of barriers to safe motherhood (especially among longer-established systems) identified specific gender norms and inequities that undermine safe motherhood. In addition to targeting specific barriers (e.g., lack of funds, transport and accompaniment), the project used peer pressure to prevent harmful practices by traditional healers and addressed broader social and women's issues, including violence against women, early marriage and dowry. CARE staff observed that when community members tackled gender-based issues, they also become more interested in sustaining their CmSS.

Commitment by Government

- **Promising outcomes prompted plans to replicate CmSS intervention in Bangladesh.** Based on these outcomes, the Government of Bangladesh is replicating the CmSS model throughout the country, and JICA committed to expand the CmSS model in 10 districts within five years.

Lessons Learned, Implications and Insights

The CmSS model increased SRMH demand by establishing an effective, community-led process for overcoming key barriers to accessing maternal health services, especially among poor and marginalized women. The following lessons learned can be useful for future implementation:

- **Strong CmSS governance requires dedicated resources and capacity building — and a belief in community capacity to lead.** This project promoted community ownership and action to ensure safe motherhood. It demonstrated the importance of investing in the creation of a community-led process. As efforts are scaled-up, it is also important to ensure that principles and practices needed to ensure community ownership remain central to CmSS replication.
- **An effective governance structure requires local government involvement from the start.** Building on lessons learned from prior CmSS implementation in Bangladesh, this project involved local government early on, and established its role as a mentor to local support systems. A concrete role in the CmSS process, coupled with dedicated capacity-building, can help local governments work with communities to monitor and improve maternal health.
- Meaningful involvement of marginalized community members requires explicit strategies. The CmSS Standing Committee (see the description of the CmSS Standing Committee in step 5) created an important space for community members to voice their experiences and make demands for change. From the start, a deliberate strategy was needed to ensure that the voices of the poor and most disadvantaged were heard. Key tools to develop such a strategy include community analysis and power mapping, identification and involvement of champions from among the most poor and marginalized, and tailored capacity-building and accompaniment to support this population's full participation.

¹¹Ibid.

- **Greater opportunities exist to address underlying gender relations and inequalities.** Women and their families valued the birth-planning sessions for new information on proper nutrition and rest for pregnant women. However, some CmSS groups also identified and developed strategies to address harmful gender norms and inequities, including dowry and violence against women, which often limit a pregnant woman’s access to critical resources and her ability to make decisions. Although most CmSS groups did not explicitly seek to address these issues, future CmSS efforts could use social analysis and action approaches to identify and transform underlying gender inequalities. (For example, guidance from the ISOFI approach on addressing underlying gender barriers could be integrated with the CmSS model).
- **Assessing local governance structures and other existing community accountability systems for future CmSS implementation.** For the project approach to be successful, local (village, sub-district, and district level) decision-making structures must be functioning well. If conflicts within local community structures impede their smooth functioning, or if community members feel that these structures do not represent their best interests, then linking CmSS to local governance structures does not add value. In this case, linking to other structures and systems of representation should be considered. It will also be important to assess other successful community structures (e.g., village savings and loans groups and/or community scorecard processes) to identify how the CmSS can best enhance, and not duplicate, these structures.

How to Replicate/Step-By-Step

To foster a supportive community environment in which women can access skilled birth attendance and emergency obstetric services, efforts should include building broad support for CmSS implementation as well as carrying out specific activities to establish the CmSS, including:

- Communication efforts at the larger community level, such as facilitating discussions between local and religious leaders and health service providers.
- Community diagnosis, community mobilization meeting, formation of executive committee, orientation to and implementation of operational guidelines, and monitoring visits to support CmSS.

Establishing a CmSS includes eight key steps that cut across all levels of governance, from the village to the district. (See the section below for a list of resources on implementation).

- 1) Carry out a community diagnosis or situational analysis at multiple levels (village and higher administrative levels)** to identify gaps/problems related to maternal health — and resources available for addressing them. This process requires the support and participation of local committees, and forms the basis for the community meeting in which participants decide whether to prioritize safe motherhood — and form a CmSS. As part of the community diagnosis process, CARE staff and involved community members also need to identify existing community structures at multiple levels (i.e., not just in the community) and assess which ones could help further strengthen community mobilization and governance systems.
- 2) Formalize the multilevel governance structure that connects local CmSS to district-level health and family planning systems.** A critical part of this step is developing a community mobilization action plan for the village-level CmSS, with leadership coming from concerned district health officials. It is important to identify a structure, such as a Standing Committee, that is charged with this coordination.

- 3) Design and implement village birth-planning sessions** to guide community-awareness activities. This includes developing both support materials and a cadre of change agents to carry out these sessions. Birth planning aims primarily to delays in recognizing pregnancy-related complications (i.e., the “first delay”). There are three targets to consider for these awareness-raising activities: 1) woman-centered at household level, 2) community-level, and 3) facility level. The guidelines include mapping tools for each level to help identify potential change agents, and information on how to develop awareness-raising sessions and materials.
- 4) Establish a local support system, such as community-pooled resources,** to address barriers to quality MNH. This includes affirming CmSS principles, identifying areas of villages and community facilitators for local CmSS, forming the CmSS and providing follow-up and monitoring of pregnancies and CmSS activities. Guidelines also include recommended capacity-building sessions for CmSS, and how to elect and support community member representatives from the local CmSS to participate in district meetings/fora.
- 5) Build the capacity of local government health services and the district-level entity charged with their coordination (e.g., a Standing Committee)** to lead, monitor and support district-wide MNH activities and ensure that appropriate accountability measures for service providers are in place. This includes a terms of reference for the committee or other coordinating group as well as facilitation guidelines on building committee capacity. The coordinating group includes community CmSS members as well as health service officials and policy makers.
- 6) Establish a mechanism to ensure responsive and accountable MNH services linking the local and district levels** to institutionalize regular sharing information between facility and community. This includes facilitation guidelines on capacity building for regular review of pregnancy maintenance and quality of care data, accountability sessions with providers, and proposed activities to increase provider sensitivity to local realities and priorities of village women and families for maternal health services. Of note: CARE experience in other projects with maternal death reviews/audits and community score card processes are other community surveillance approaches that would also support this step.
- 7) Develop a plan** for a formal phase-out process, and to ensure ongoing CmSS sustainability within local government.
- 8) Develop a plan** for replicating the CmSS model in other geographic areas.

Recommended Resources

Unless otherwise noted, these resources are available at <http://familyplanning.care2share.wikispaces.net/MHguidance>

Key Elements for Scaling up the Community Support System in Bangladesh. CARE Bangladesh, 2011.

Operational Guidelines documented by Naba Krishna Muni, Community Facilitation Consultant. Ministry of Health and Family Welfare, Government of Bangladesh, supported by CARE and JICA, 2008.

- Operational guidelines on Community Support System
- Operational guidelines on birth planning
- Operational guidelines on process to introduce safe motherhood model to other districts of Bangladesh
- Operational guidelines on phase out and sustainability of safe motherhood programs

PARTICIPATORY COMMUNITY MANAGEMENT IN SOUTHERN BOLIVIA



PROJECT EXAMPLE	KEY STRATEGIES FOR EMPOWERING COMMUNITIES		
	Critical reflection and social analysis	Community mobilization	Citizen oversight and accountability
Participatory Community Management in Southern Bolivia		■	■

Overview

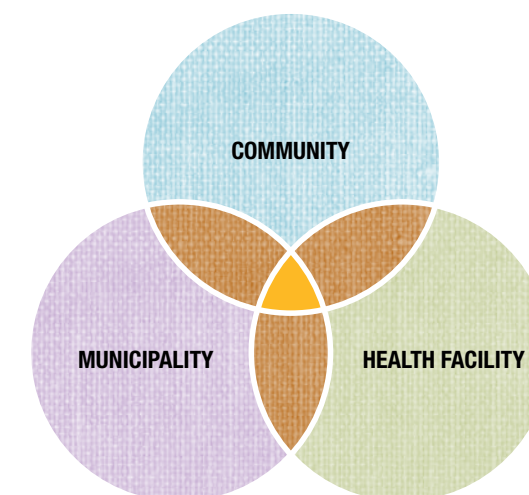
What is the Context of Participatory Community Management in Southern Bolivia?

In recent years, Bolivia has made important gains in sexual, reproductive, and maternal health (SRMH), especially increased access to and use of family planning services – a key pillar of improving SRMH. In 2003, only 57.6% of women had ever used a contraceptive method, modern or traditional; by 2008, the percentage had increased to 63.1%. During that time, however, Bolivia’s maternal mortality rate increased from 229 deaths per 100,000 births (1998–2003) to an estimated 310 deaths. This might be the result of a large margin of error as well as better reporting. Process indicators have markedly improved: from 2003 to 2008, the percentage of women receiving antenatal care by trained personnel increased from 79.1% to 90%, and the percentage of women who had at least four antenatal care visits, the number recommended by WHO, increased from 58% to 72%.¹

Within this overall context of improving maternal health, there are areas of Bolivia where the quality of and access to SRMH services remain weak. In response, CARE Bolivia implemented the ENLACE EN SALUD (Networks in Health) project for approximately one year to strengthen maternal and newborn health, family planning, and post-abortion care in four of the country’s rural and peri-urban departments—the remainder of this program example focuses on one department, Tarija in southern Bolivia.

ENLACE focused on strengthening the quality and functionality of emergency obstetric and neonatal care (EmONC) services and referral networks among different levels of health facilities. ENLACE was based on the FEMME model² used by CARE Peru, which had developed several successful approaches to strengthening health services. In Bermejo, one municipality of Tarija department, ENLACE was able to work with a consortium of government, communities, and other NGOs to strengthen the local governance of those services through a set of participatory and interlinked activities.

CARE approached community mobilization and participatory management through a recently enacted Bolivian national policy called Family and Community Intercultural Health (or SAFCI, by its Spanish acronym).³ SAFCI mandated community participation in decisions concerning municipal health expenditures. This legal framework set the stage for CARE’s activities, allowing municipal and health facility staff and management to engage communities in a meaningful way. CARE’s work also operationalized in very concrete ways the principles and goals of SAFCI policy. While the national government mandated community participation in decision making, the state administration was dominated by a party that was opposed to the national government, and therefore not eager to enforce its policies. However, through CARE’s efforts community participation was depoliticized in the project area.



What Did CARE Bolivia Set Out to Do and Why?

Because ENLACE’s central objective was to decrease maternal and newborn mortality, the project could have focused exclusively on increasing the technical capacity of health facilities to respond to obstetric emergencies by providing equipment, training medical staff, and ensuring implementation of evidence-based interventions. So why engage the community?

The ENLACE team recognized that the community has the most to gain from well-functioning health services. Health workers often come and go, but an informed and empowered community can follow up on the needs and

¹ All data is from Ramiro Coa and Luis Ochoa. 2009. Encuesta Nacional de Demografía y Salud: ENDSA 2008. Ministry of Health, Bolivia and MEASURE DHS, Calverton, MD USA. www.sns.gov.bo

² Foundations to Enhance Management of Maternal Emergencies (FEMME) was a CARE project implemented in multiple locations worldwide, including Ayacucho, Peru. It was part of Averting Maternal Death and Disability (AMDD), a global program developed by Columbia University and funded by the Bill and Melinda Gates Foundation that focuses on emergency obstetric care and promoting a rights-based approach to health.

³ SAFCI (in Spanish, Salud Familiar Comunitaria Intercultural) was the new national health policy in Bolivia that mandated community participation in decisions about municipal health expenditures.

responsibilities of its health center, keep the processes of health promotion going long-term and give feedback on facility and provider performance. Community participation is also key to identifying factors outside the health system that contribute to maternal and newborn mortality, such as lack of transportation or communication in obstetric emergencies. This approach also moves beyond a focus on technical interventions to broader, underlying social determinants of health. Finally, the involvement of communities corresponds to two human rights: the right to health and the right to participate in public affairs.

During project implementation, the CARE team continued previous efforts — training providers, improving the quality of care, and procuring equipment — to strengthen the capacity of the public-health system to respond to obstetric and neonatal emergencies. CARE also continued to provide training and support to community health agents (CHA), who are the link between health centers and pregnant women and their families. In addition, the project sought to increase the capacity of municipal management to work with civil society to solve health problems.

A major achievement in Bermejo — and the reason for highlighting ENLACE efforts here — was the integration of activities in the project's functional areas: health services, municipal and community. This participatory approach to governance, described below, increased coordination, co-management and mutual support across all three.

What is Innovative About the Participatory Community Management Project?

The project's approach to community engagement entailed linking communities, municipalities and health centers to create meaningful dialogue on improving health services. As a result, communities were able to effectively voice their opinions to health authorities and policymakers, and were able to hold them accountable for providing resources needed for reducing maternal mortality. This gave communities an important sense of ownership of local health services. For example, the project created simple checklists that community representatives could use to evaluate whether health centers had adequate human and other resources (e.g., supplies and equipment) for obstetric emergencies. Once needs were identified, community leaders figured out what additional resources were needed.⁴

Communities played an integral role in finding solutions to gaps in services and resources. For example, in one community, members identified a lack of health services, prioritized construction of health facilities and allocation of health personnel, and identified municipal funds that could be budgeted for these efforts, with monthly monitoring. This strengthened link between communities, municipalities and health centers helped create a sense of mutual commitment to improving health.

The project used a pictorial checklist to help both men and women in the community better understand pregnancy, potential complications and how to prepare for them. The checklist included important information on the following: pregnancy danger signs, birthing options (such as home, health center or hospital), necessary preparations for going to a health facility to give birth (e.g., planning for transport, saving money, and identifying community health workers who can provide assistance), and what to have ready for a home birth, (e.g., a clean container for boiling water).

Another innovative project feature was the creation of a local epidemiological tracking tool that included pictures to help identify health problems. This allowed the community to monitor the number of pregnant women, the number of antenatal care visits, family planning visits, referrals due to danger signals, and ultimately the number of births and maternal deaths.

⁴ For example, one community identified the following needs: physicians on call 24 hour call seven days a week, instead of five; a licensed nurse; lab facilities available 24 hours a day, seven days a week; a maternity waiting home; ongoing review of obstetric emergencies; need for local hospitals to return completed referral forms; a designated bed for obstetric emergencies; sheets for beds to be used in post-partum care; IV fluids; oxygen; medications for obstetric emergencies; and caps and gowns.

Snapshot

The Government of Bolivia established a legal mandate for community involvement through SAFCI; the project aimed to operationalize this policy in Bermejo municipality. CARE facilitated the training of administrative and medical MOH staff and municipal staff in participatory planning and management. CARE also provided community members and the municipality with an orientation on the new national policy.

The project then helped create new structures of community organization — i.e., a local health authority⁵ (LHA) and a municipal association of existing community health agents⁶ (CHA). With help from CARE technical staff with expertise in community mobilization, these groups engaged with local health centers to assess health problems, plan solutions, follow up on decisions, provide social accountability and ensure that the municipal government's operating plan to provide EmONC had adequate resources.

CARE also promoted community-level dialogue on the underlying social causes of poor health, working with community members to analyze problems and develop solutions that would ultimately help reduce maternal mortality and morbidity. Facility-based health personnel also contributed to this process by identifying key health problems reported by patients and providing this information to their local health committee, which included LHAs, health personnel and members of the general community.

Outcomes

Despite its short timeframe, this project successfully implemented a process of facilitation and mentorship to help target communities define their goals and understand how to achieve results. An important part of this process was the ability of CARE staff to listen to community concerns and work with community members to address these concerns. CARE also helped create and institutionalize linkages between communities and both their municipalities and health centers, which encouraged and sustained collaborative efforts to improve the quality of maternal health services in Bermejo. Below are the results of this project.

Through community tracking and collaboration with health centers, Bermejo's health clinic acquired needed laboratory facilities and laboratory personnel. Community mobilization resulted in a health center certified to provide basic EmONC and another center certified to provide comprehensive EmONC, including Cesarean sections.

Health system is functioning at the municipal level to prevent maternal deaths. For several years no cases of maternal or infant mortality have been reported in this municipality. This is due at least in part to the cumulative efforts of the NGOs, and MoH staff. From the health promoters who identify and refer high risk cases in their communities, to the doctors in the municipal hospital who provide the necessary attention or refer emergencies to the departmental hospital in Tarija in time, it is possible to say that the system is functioning at the municipal level. However, it is important to note that women from this municipality have died in recent years from obstetric causes, but they have died in Tarija where the primary departmental hospital does not have the adequate capacity to attend such a large population, and emergency cases sometimes cannot be attended immediately. In order to be able to say that the emergency obstetric network functions properly, cases referred from the municipal level must be well attended at the departmental level and that will require the expansion of the hospital both in terms of infrastructure and medical personnel.

⁵ Local health authorities (LHAs) are elected community officials (not volunteers) who represents the interests of the community to municipal and health authorities.

⁶ Community health agents (CHAs) are volunteers who provide local health services, such as home visits and birth plans.

Community mobilization increased government accountability with respect to community health needs and led to the renewal of health worker contracts. In late 2010, when the MOH advised health workers that their contracts would not be renewed, local health authorities, local health committees and health workers in Bermejo demanded that government not cancel the contracts.⁷ Community members wanted continuity of care; they had established strong relationships with their health providers. On their third visit to the departmental capital, community members took over MOH administrative offices until the contracts were renewed. This action, an example of participatory management and oversight having gone beyond the usual administrative methods, showed that residents of Bermejo have truly taken an active role in deciding how their health system functions. In contrast, other municipalities, continued to suffer constant medical and nursing personnel turnover.



“As doctors, we would never have achieved this alone... without the participation of the local health authorities.”

Clearly, the ENLACE project owes its success to greater community participation in decisions about health services. Through their elected authorities, community members became involved in municipal administrative activities as well as with local health centers — not as patients, but as defenders of their community’s collective right to good health.

Lessons Learned, Implication and Insights

ENLACE fostered greater community participation and ownership of local health services as well as an improved collaboration between multiple health care stakeholders, ultimately leading to improved service quality and access. CARE learned several valuable lessons from this project:

Creating mechanisms that bring community representatives into the public sphere is an important first step.

Health center tours and service-evaluation checklists are important ways for community representatives to discover how these institutions function, without feeling intimidated or uncomfortable. (Some representatives may have never interacted with a health center before this project.) These representatives were able to evaluate the center’s capacity and respond to obstetric and neonatal emergencies. They also learned what additional resources were needed, and worked with health center staff to develop a plan for obtaining them. In addition, community representatives helped field-test the checklist tool, which had been created for larger facilities, such as hospitals or polyclinics.

The introduction of new public figures may be perceived as an external imposition. The project encouraged each community to elect a LHA to advocate for that community’s health needs. This person’s role was different from that of the existing volunteer health promoters, but the two worked together successfully to strengthen the link between the community and health services. However, there was initial confusion about (and resistance to) the role of the LHA because of the word “authority,” and the perception that



community roles were being changed. Project staff learned that it was important to work closely with communities to ensure that new structures are incorporated into the existing political organization in a complementary manner.

National political context is an important factor in efforts to improve maternal health. National policies that mandate community participation in municipal-budget decisions can provide an effective platform for community mobilization. If replicating this effort in other countries, it will be necessary to explore what legal framework exists for real community participation in the municipal management of health resources. Without laws that mandate community involvement in the planning and social oversight of health services, it will be difficult to replicate the experience of ENLACE. If an adequate legal framework exists, the first step should be to educate administrators and supervisors in the MOH and municipal government about why promoting community participation is important. Accompanying these individuals into the field in the initial stages of a project will lend legitimacy and support for their activities. It is particularly important that local health providers understand that coordinating with community leadership is not “extra NGO work” but rather a part of their professional duties within the public health system.

Lastly, CARE learned about the importance of being a facilitator and catalyst for change. CARE did not create community mobilization per se, but rather facilitated collaborative efforts at different levels in the health system to achieve project objectives. Exchange between communities, municipalities and health systems should lead to a greater degree of mutual respect and collaboration. Because of historic differences in power dynamics, education, etc., this interaction should be carefully facilitated in its initial stages. It is also important to recognize that many health center staff have never learned about facilitating community processes and health education, and thus need to receive basic instruction in the use of participatory methodologies.

⁷ Health worker contracts can be either short-term (through the municipality or state) or permanent (through the MOH).

How to Replicate/Step-By-Step

If government backing for community involvement is a given, as it is in a number of countries, the following steps can be used to replicate this innovation.

- 1) Inform, educate and motivate administrators and supervisors to promote community participation in health planning and oversight.** Even when legally mandated to promote community involvement, administrators and supervisors may not understand how community participation can be operationalized, nor what value it adds. CARE knows the benefits of community mobilization and has the know-how to facilitate community participation in health planning and oversight.
- 2) Ensure that the community chooses a representative.** For community mobilization to work, representatives must be chosen by the community, not an external body. CARE staff can facilitate this selection process.
- 3) Train health providers in participatory methodologies.** Since most medical schools teach a very hierarchical doctor-patient model of medical care, health facility staff might not have the skills to effectively partner with communities. CARE staff can help local health providers understand that planning with communities is part of their professional duties.
- 4) Train health providers to help patients and communities better understand their health situation.** Conventional health care often leaves health providers ill-equipped to explain medical problems in a language that patients can easily understand. CARE staff can facilitate this process.
- 5) Facilitate the entry by community representatives into the health system.** As mentioned earlier, some community members might not have had exposure to a hospital or other formal health settings. Clinic tours, or open houses, gives them a chance to learn about the services available to them.
- 6) Create opportunities for community representatives, health providers and municipal authorities to plan and communicate together.** CARE staff can facilitate the process whereby community representatives, health providers and municipal authorities work together for the benefit of the community.

Recommended Resources

Unless otherwise noted, these resources are available at <http://familyplanning.care2share.wikispaces.net/MHguidance>

CARE Governance Resource Centre: www.careinternational.org.uk/research-centre/governance

Governance Programming Framework. CARE, 2011.

Maternal Health and Governance Discussion Paper. CARE, June 2011.

National Guidelines for Salud Familiar, Comunitaria, Intercultural (SAFCI). Developed by the Ministry of Health and Sport of Bolivia.



INNER SPACES/OUTER FACES INITIATIVE (ISOFI) IN INDIA



PROJECT EXAMPLE	KEY STRATEGIES FOR EMPOWERING COMMUNITIES		
	Critical reflection and social analysis	Community mobilization	Citizen oversight and accountability
Inner Spaces, Outer Faces (ISOFI) in India	■	■	

What is the ISOFI model?¹

CARE’s Inner Spaces Outer Faces Initiative (ISOFI) was designed to share a simple lesson: Every person has both an “internal space” and an “outer face.” Their internal space includes their perceptions of issues such as gender, sexuality, family and identity. Their outer face represents the way they communicate ideas with others. Although these two concepts are very connected and can be mutually reinforcing, they can also conflict.

The guiding principle of the ISOFI model is that in order to enhance organizational effectiveness, we first must explore and understand our own values, attitudes, beliefs and experiences of gender and sexuality and how they shape ourselves and influence our work.

Overview

What is the context of the Inner Spaces, Outer Faces Initiative (ISOFI) in India? ISOFI was carried out in the Indian state of Uttar Pradesh, which accounts for a large percentage of the country’s maternal and newborn mortality. The state also ranks below the national average in many gender equity indicators, such as women’s mobility, decision-making autonomy and control over household resources. From 2007-2010, CARE implemented ISOFI in two districts of Uttar Pradesh as part of a larger maternal and newborn health (MNH) initiative.

What did CARE India set out to do, and why? Many norms related to gender and sexuality present critical, yet often unacknowledged or unaddressed, barriers to MNH.

Women’s autonomy, mobility and control over resources have long been shown to be important predictors of maternal health outcomes. Studies also show that men’s gender attitudes and behaviors can significantly

Sex refers to the biological distinction between women and men.

Gender concerns social differences between women and men.

influence reproductive health outcomes.² As a result, many researchers and advocates are now calling for “gender-transformative” approaches to health interventions — strategies that aim to transform gender attitudes, behaviors and norms, along with conventional interventions for improved health status. Yet, there are relatively few implementation models to guide such transformation.

In response, CARE India decided to integrate the ISOFI approach within an existing MNH project. The resulting intervention aimed to further enhance maternal health outcomes by building the capacity of project staff and community members to address social as well as medical issues related to MNH. In particular, the project sought to transform key underlying gender norms and inequities related to MNH, such as women’s mobility, division of labor within the household (and especially during pregnancy) and male involvement in caring for their pregnant wives and newborns.

What is innovative about ISOFI? This unique approach combines a cutting-edge methodology that is powerful enough to transform underlying gender norms and inequalities, yet practical and flexible enough to be layered into traditional MNH project activities and timelines. ISOFI’s innovative methodology includes:

- Engaging staff (before reaching out to the broader community) to help them recognize and reconsider gender norms and inequities that impact their own lives as well as those in the community.
- Supporting a structured, ongoing cycle of reflection/learning, action/experimentation and analysis/dissemination; this aims to build the confidence and capacity of women and men to identify, challenge and change key barriers to MNH.
- Developing participatory social and behavior change communication (SBCC) methods that move away from “passing messages” or “sensitization” approaches (aimed at transmitting pre-packaged knowledge) to encouraging critical personal examination of previously unquestioned norms as well as creative, visible support for more equitable behaviors.

¹ This description and selected text in the sections that follow are drawn from Meeting Challenges, Seeding Change (CARE and ICRW, 2010); this document synthesizes evaluation findings and includes citations for health and gender statistics in Uttar Pradesh. In addition, description of the ISOFI innovation and selected text are drawn from Challenge and Change: Integrating the Challenge of Gender Norms and Sexuality in a Maternal Health Program (CARE and ICRW, 2010).

² Meeting Challenges, Seeding Change (CARE and ICRW, 2010) includes citations demonstrating the link between gender norms/inequalities and reproductive health outcomes.

Creative Community Approaches to Foster Gender Norm ‘Challenge and Change’

- The bead game, which demonstrates how the sex of a baby is determined.
- Songs and stories to celebrate the birth of a daughter, as opposed to traditional laments.
- Community couples meetings, which not only reinforce behaviors they promote, but also reinforce a shift in social norms simply by bringing husbands and wives together in public.
- Baby washing by fathers in public to model new ways of men caring for newborns.

The ISOFI approach was effectively layered into traditional MNH project activities at the couple, household and community levels. Most community members found the ISOFI activities fun and engaging; in many instances, their popularity enhanced the existing project’s reach. Evaluation data indicate that the ISOFI approach improved gender equality and MNH outcomes above and beyond the increases achieved through the MNH intervention alone.

Snapshot ISOFI

CARE staff provided technical assistance to integrate the ISOFI approach into existing SBCC efforts at the individual, household and community levels. Key elements of this assistance included support to:

- First transform staff capacity to address gender and sexuality through critical personal reflection, and then facilitate similar processes with community members
- Develop complementary activities and materials for integrating ISOFI approaches into ongoing MNH SBCC, and helping staff facilitate public dialogue on sensitive social and gender norms.
- Identify, design and implement additional community-level activities to create a broader enabling environment for challenging and changing community gender norms.

Details of these elements included the following:

Ongoing, iterative, critical reflection for staff and partners was central to building capacity to address gender and sexuality. Through this process, ISOFI focused on building staff and organizational capacity to critically analyze the social construction of gender, how gender influences personal values and beliefs, and how values and beliefs on gender affect program designs and implementation. In turn, ISOFI staff helped community health providers and other stakeholders carry out the same process of critical reflection, analysis and action. Together, staff and community members were able to develop their ability to question gender roles and assumptions that were key barriers to MNH, to challenge themselves and others to consider more equitable alternatives, and to catalyze actions to transform harmful gender norms and inequalities.

Knowing that one-off training is not sufficient, ISOFI’s capacity building efforts used multiple opportunities to support iterative processes for staff to consider how gender and sexuality affects their personal and professional lives. These opportunities included activities such as training workshops, monthly project meetings, quarterly all-staff meetings, qualitative and participatory assessment with community members, cross-visits to other field sites, an off-site retreat that included spouses and children, and ongoing mentoring and modeling with community health workers.



ISOFI layered a process of reflection and ‘challenge’ into a standard maternal and newborn health project, at multiple levels. This project was not designed as a standalone model, but rather as a collection of integrated and embedded components within a MNH project. All SBCC efforts in the MNH project were opportunities for exploring values and challenging assumptions related to gender and sexuality norms.

ISOFI INTERVENTIONS LAYERED INTO EXISTING MNH PROJECT

Level	MNH Interventions	Plus ISOFI Interventions
Policy	MNH advocacy at the district level.	Includes advocacy on issues related to gender and sexuality.
Community	MNH behavior change through meetings as well as training and support of community-level groups, such as village health and sanitation committees (VHSC) and mothers’ group meetings.	Includes training, coaching and BCC activities (e.g., newer, more question-oriented approaches) related to gender and sexuality.
Household	Household-level counseling on MNH (15% of households).	Includes training, mentoring and support of community-based workers, who, in turn, provide social support and referrals with regard to gender roles and sexuality issues during pregnancy and postpartum.
	Intensive household-level interventions, such as home visits (15% of households).	
Additional Interventions		Includes additional community-wide activities and gatherings such as “couples meets” and “new parents meets,” film discussions, puppet and magic shows, community theater to challenge social assumptions around gender and sexuality, improve couple communication and promote male involvement in RH and newborn care (see below)

The project used an ecological model (see diagram) to identify multilevel opportunities for transforming social norms — and create new social spaces for this process in the community. Working across different levels (e.g., household, couple, community, district and health services) creates synergy for initiating and sustaining changes in social norms.

THE ECOLOGICAL MODEL

This model holds that health behaviors and social norms are formed, negotiated and transformed through the interplay of individual-level circumstances, interpersonal-level interactions, and community- and societal-level norms, organizations and policies.



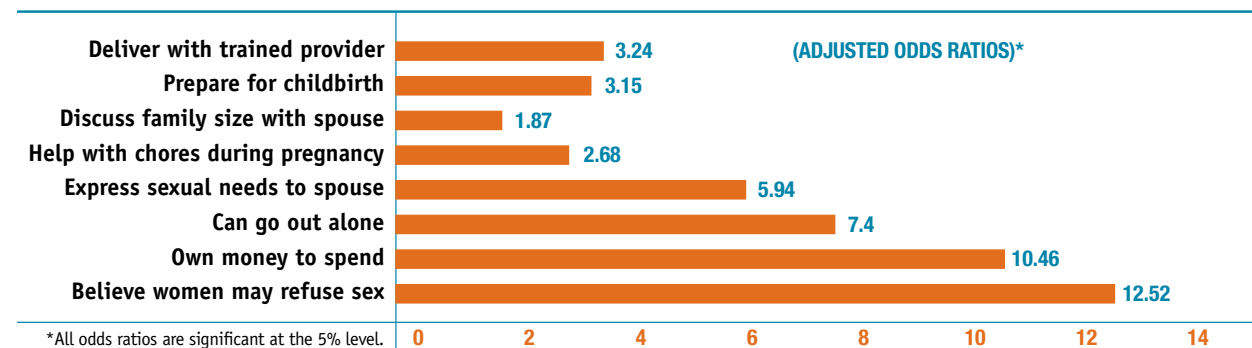
Using this model, ISOFI identified additional community-level interventions that could help change gender norms. For instance, through ISOFI-supported “couples meets” and “new parents meets,” new gender norms between husbands and wives interacting publicly could be realized, and where further critical reflection, dialogue and transformation in practices could be enacted. In the process, community members often discovered that they and their peers were more open to discussing previously unquestioned topics than they thought.

Outcomes

Enhanced health and gender outcomes — above and beyond MNH interventions alone. Evaluation findings³ indicated that communities with the ISOFI intervention received more benefits than those with the MNH intervention alone, including significantly greater:

- MNH outcomes, especially related to delivery with a trained attendant, and preparation for childbirth; and Gender equality outcomes across a number of areas, including women’s mobility, their attitudes toward refusing sex with their husbands, their ability to express their sexual needs to their husbands, and their partners’ willingness to help with chores during pregnancy.

ASSOCIATIONS BETWEEN LIVING IN THE INTERVENTION DISTRICT AT ENDLINE AND SELECTED FACTORS



Increased capacity of health care providers. ISOFI also provided training, mentoring and support to the Government of India’s community-based health providers,⁴ so they could begin thinking critically about gender and sexuality, and address discrimination as part of their work. In endline interviews, these workers (mostly female) reported greater confidence in discussing issues like sex during pregnancy and encouraging men to become more knowledgeable and involved.

“We prefer the boy child (over the girl child), even though the men drink and treat us badly while the girls take care of us. We need to appreciate our daughter.”

Auxiliary Nurse Midwife (ANM), community-based health provider

“Rashmi (the CARE staff) gave status to the community providers. She gave an example on how to discuss things and they (Rashmi and the community providers) did joint home visits for counseling.”

Village Health and Sanitation Committee (VHSC) member

“I am now visiting other ASHAs in my neighboring villages to discuss the themes I learned through ISOFI. I am now speaking with husbands, comfortably talking with women at home and in groups, and role modeling women’s rights.”

Accredited Social Health Activist (ASHA) community-based health provider

Inequitable attitudes and practices transformed in a relatively short time period. The ISOFI intervention showed that it is possible to transform gender attitudes and practices in a relatively short period of time. It also showed that such transformation can produce health outcomes above and beyond MNH interventions that do not explicitly tackle these barriers.

Lessons Learned, Implications and Insights

Future initiatives⁵ that build on this success might consider the following lessons learned from the ISOFI experience:

Sufficient time and resources to build staff capacity is critical. This project followed the three-year ISOFI Phase One, which focused on building staff capacity to look inward and closely examine the norms and practices related to gender and sexuality that shape their lives and those of fellow community members. To replicate ISOFI, CARE staff and their project partners must also have time and space to do this — prior to starting any activities in the community.

Shifting from “passing information” to a process of self-reflection and transformation requires ongoing support. This is a major shift for community facilitators, who will need to start using provocative, open-ended questions and other methods to promote dialogue and debate.

⁴ Accredited Social Health Activists (ASHAs), anganwadi workers (AWWs), and auxiliary nurse midwives (ANMs).

⁵ Building on the experiences in India, CARE developed the ISOFI toolkit and the Social Analysis and Action (SAA) manual. Both are being used by a number of country offices and can be found at www.care.org/reprohealth.

³ These outcomes are drawn from Meeting Challenges, Seeding Change (CARE and ICRW, 2010). Evaluation findings are based on a quasi-experimental operations research design, with some communities receiving just the MNH intervention and others receiving both MNH and ISOFI interventions.



“ISOFI is a dialogue approach, with questions rather than mechanical message transmission, and it is more effective.”

A playful tone can open up a productive space to examine and challenge deeply rooted gender and social norms.

This approach was used at various levels and promoted a sense of fun and relevance among individuals and community groups. Staff noticed that this light hearted approach resulted in higher numbers of participants coming to activities, and greater numbers of women participating and sharing opinions.

Health workers are part of the community, and also need structured opportunities for both critical reflection and overcoming gender-related barriers to carrying out their work.

Another core element of the project was creating space and guidance for health workers to reflect on — and change — some of their own attitudes and values, and to address gender-related barriers that they (especially women) face every day. This process can play an important part in transforming deep-seated gender biases in health systems, services and policies.

It is important to examine whether potential community structures fit ISOFI. While ISOFI approaches can be layered in existing MNH interventions, not all potential entry points may be equally productive. For instance, if some pre-existing activities are predominantly for “passing information” rather than being open to methods of question and reflection – the ISOFI interventions are not as easily integrated. Also, groups that have irregular attendance are not the best fit for ISOFI activities – as the process of dialogue and reflection works best in an ongoing, iterative process.

Sustainability can be enhanced by identifying how best to embed ISOFI in existing structures. Project staff and community members alike reported that ISOFI fundamentally changed how they see and act in the world, and that these changes will endure. Yet, this intervention did not necessarily find an existing structure to link to more permanently. Future interventions might consider where such a sustainable institutional home might exist to embed ISOFI, or core pieces of ISOFI.

Carefully considering staffing structures fosters staff ownership. The MNH staff were originally supposed to incorporate ISOFI methodologies to strengthen integration of MNH and ISOFI approaches. But with tight project timelines and new skills to learn, staff members felt overburdened. In response, ISOFI hired new staff members to accompany, and integrate with, current MNH staff. Eventually, both teams were able to help with each other’s primary activities, and introduce new staff members to a fully integrated platform of interventions. The result was better synergy and coordination in the field; ongoing senior management support for ISOFI approaches can help sustain and build on this synergy.

How to Replicate/Step-By-Step

1. Identify potential entry points

How and where to link and layer ISOFI into MNH interventions. The ISOFI approach can be layered into MNH projects that are already implemented or still in the design phase. A preliminary assessment will determine which

MNH interventions ISOFI might best link to (this assessment will be further refined based on steps 3 and 4). This step also includes ensuring buy-in from MNH senior management and determining staffing needs, specific terms of references for all staff, and ISOFI interventions to be integrated.

2. Transform staff capacity

Carry-out foundational training(s) for critical reflection and dialogue. It is useful to plan for at least two foundational trainings. First, an orientation workshop of community-based health providers and other staff that focuses on comparing personal values and beliefs with social norms related to gender and sexuality, and examining how they might impact health. Second, a workshop with the same staff that focuses on specific pregnancy-related issues such as mobility, access to food, rest during pregnancy, male involvement, son preference and consensual sex. This second training can also discuss how to use ISOFI tools and exercises (see resources below). Given that one-off training is not sufficient, it is important to identify multiple opportunities for staff to think critically about gender and sexuality in their personal and professional lives.

Provide accompaniment and mentorship. The ISOFI approach calls for community health workers to counsel on topics such as gender and sexuality. CARE staff can help build their capacity to do so through on-the-job-support in joint home visits and community discussions —as opposed to relying on classroom training. As a result, health workers (most of whom were women) can gain additional community status and direct experience talking about sexuality and reproductive health in public — and with men.

3. Plan for action based on analysis with community

Review existing primary and secondary data sources to surface already identified gender-related barriers. Most MNH projects conduct assessments at the planning stage. This assessment can be designed or (if it’s already been conducted) reviewed to identify gender-related barriers to MNH. In the ISOFI project, these barriers included issues such as restrictions on pregnant women’s mobility, expectations that they will do household and agricultural work throughout their pregnancy, and the tradition in Indian families that females eat last.

Carry-out deeper, qualitative examinations of how gender and sexuality influence maternal and newborn health. For instance, ISOFI staff, in conjunction with the ISOFI research partner ICRW, used in-depth interviews to get a better understanding of women’s agency and autonomy in the context of marriage and the nuclear family —and their impact on safe motherhood. Participatory learning and action (PLA) approaches, such as body mapping, fishbowl discussions and problem ranking used in the first phase of ISOFI (see the Resources section below), might also be useful.

“Some of the factors were realized during the rapid assessment, but we did not choose them for intervention. But now I can see that how important it is for the woman to have agency and to decide and access health services. We definitely need to look at power dynamics at the household level while we plan our (MNH) interventions.”

Project staff member

4. Design and implement interventions to address underlying MNH barriers

Based on the results of a community assessment, a project team can identify key gender and sexuality issues linked to MNH, and opportunities to layer discussions about these topics in existing project structures. In the ISOFI project, this meant integrating **gender and sexuality issues in existing project strategies at multiple levels, including** home visits, mothers' committees, and other meetings.

To support these interventions, it is often important to develop **creative, easy-to-use materials and methods that spark critical dialogue and reflection** about the issues at hand.

The ISOFI interventions, for instance, worked with a local NGO to develop a set of flashcards that showed scenes from the lives of pregnant women and their families. The cards prompted discussions that included the role of men as supporters for women's rights, the role of nutrition and rest during pregnancy, the importance of a supportive home environment where division of labor is shared, and preventing violence in the home.

The ISOFI flash cards were modeled on the cards typically used in clinical settings as job aids; yet, in the place of messages to be transmitted, the cards included questions for health workers to ask to spark dialogue. In this way, ISOFI participatory-questioning approaches to gender and sexuality were incorporated as job aids into routine care provided by government-paid community workers.

Recommended Resources

Challenge and Change: Integrating the Challenge of Gender Norms and Sexuality in a Maternal Health Program. CARE and ICRW, 2010. Available at www.care.org/reprohealth

Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health. CARE, 2007. Available at www.care.org/reprohealth

ISOFI Toolkit: Tools for learning and action on gender and sexuality. Developed by CARE and ICRW, 2007. Available at www.careacademy.org/ISOFI

Meeting Challenges, Seeding Change: Integrating Gender and Sexuality into Maternal and Newborn Health Programming. CARE and ICRW, 2010. Available at www.care.org/reprohealth

Social Analysis and Action Training Guidelines. CARE, 2012. Available at www.careacademy.org/SAA



CHAPTER 2

STRENGTHENING HEALTH SYSTEMS

Why Strengthen Health Systems?

The stronger a health system is, the better it can deliver services equitably and sustainably, resulting in better health outcomes for individuals and entire populations. CARE's strengths lie in building communities' capacity to participate fully in their own development, as well as advocating for just and equitable social and economic policy. Within this view, health systems strengthening remains an important and legitimate field of action for CARE—often in projects that also contain community engagement and/or policy action elements. By assessing health systems, CARE staff can identify gaps, develop strategic partnerships and pinpoint specific interventions to ensure access to and quality of services for underserved populations.

What is a Health System?

A health system can be thought of like a pipeline for delivering health-related services, materials and information to individuals and groups. The World Health Organization (WHO) offers this comprehensive definition:

- All the activities whose primary purpose is to promote, restore and/or maintain health; and
- The people, institutions and resources, arranged together in accordance with established policies to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health, through a variety of activities whose primary intent is to improve health.¹

Building Blocks

WHO identifies six building blocks² that comprise well-functioning health systems. The building block concept is important because it helps promote a common, global understanding of:

- What an ideal health system is and does,
- How an ideal health system should function, and
- How to identify and discuss gaps and weaknesses in a specific health system.

LEARNING
SHARING
ADAPTING

¹ WHO Health Systems Strengthening Glossary (http://www.who.int/healthsystems/hss_glossary/en/index5.html)

² "Everybody's Business: Strengthening Health Systems to Improve Health Outcomes." 2007, WHO.

BUILDING BLOCKS	ITS FUNCTION IN A HEALTH SYSTEM
Health Services	Safe, effective, quality health interventions to those who need them, when and where needed, with minimum waste of resources. Services include those that are technical or informational, curative or promotional.
Health Workforce	To be responsive, fair and efficient in achieving the best health outcomes possible, given available resources and circumstances. This includes ensuring that staff are competent, responsive, productive and fairly distributed.
Information System	Production, analysis, dissemination and use of reliable and timely information on health determinants, health-system performance and health status.
Medical Products	Essential medical products, vaccines and technologies, which are high-quality, safe, efficacious, cost-effectiveness and accessible to all. This also includes ensuring that their use is scientifically sound and cost-effective.
Health Financing	Adequate funds for health care and ensure that people are not further impoverished as a result of receiving this care. Also, this includes providing incentives for the efficient provision and use of health services.
Leadership/ Governance	Strategic policy frameworks combined with effective oversight, coalition-building, regulation, attention to system-design, and accountability.

Levels

Building blocks describe the functions of a health system. The levels of a health system refer to people and places, from a national ministry of health (MoH) to the women, men and children in distant villages who are health service users. Specific levels can vary from country to country; the list below shows typical levels in a typical health system. An analysis of local partners will help to determine which one is most strategically positioned to address each level.

Integrated Functions and Levels

To best serve health service users, all building blocks exist at all levels and they all must work together; that is, they must be integrated. The Health Workforce function, for example, is important to a MoH, which approves service-provider training curricula and enforces performance standards, among other activities. This function is of equal concern to a health post administrator, who supervises community health volunteers.

Strengthening a health system refers to any initiative or activity that aims to improve the system and/or manage interactions between the system's functions, levels and actors in ways that promote service delivery. In other words, it means ensuring the right services, supplies and information, at the right quality and right price, in the right place, for the right people and at the right time.

Typical Levels of a Health System

- Ministry of Health
- Provincial Department of Health
- District Health Office
- Central Hospital
- Health Center
- Health Post
- Health Management Committee
- Outreach Worker
- Community Health Volunteer
- Community Group
- Household
- Individual

Strengthening Health Systems: Two Cases

This chapter examines two CARE projects that successfully strengthened health systems. In the DRC, CARE's Uzazi Bora project improved health services — specifically, the provision of emergency obstetric care (EmOC) in an isolated, neglected district. In Nepal, CARE worked at both the district and national level to implement community-based distribution (CBD) of misoprostol to prevent post-partum hemorrhage (PPH).

Both projects aimed to serve hard-to-reach populations. That said, an important difference between the two was the condition of their respective health systems: The Nepal example shows what can be accomplished within a stable and well-defined (though underfunded) system. The DRC example, by contrast, shows what can be done within a weak system, damaged by neglect and war.

In both projects, CARE worked with multiple actors at multiple levels to improve several building blocks of the health system. Interventions were identified and prioritized based on an analysis of gaps and weaknesses in the particular system they addressed.

What is in this chapter?

This chapter provides an overview of two different approaches to strengthening health systems in order to improve sexual, reproductive, and maternal health (SRMH). Specifically, it details CARE's multifaceted, multilevel efforts to help extend quality services to underserved or remote populations in the Democratic Republic of Congo (DRC) and Nepal.

- ▶ In **DRC**, CARE collaborated with local partners to help a weak, poorly functioning health system in a remote, war-affected district offer high-quality SRMH services.
- ▶ In **Nepal**, CARE worked within the local health system to address the most common cause of maternal death — post-partum hemorrhage (PPH) — through community-based distribution of misoprostol.

Together, the experiences, strategies and tools described in this chapter can help stimulate ideas for future SRMH efforts focused on strengthening health systems. While these projects are presented as examples of health systems strengthening, they also include elements related to empowering communities and policy action. Please refer to those chapters for more ideas on how to build comprehensive maternal health programs.

PROJECT EXAMPLE	KEY STRATEGIES FOR HEALTH SYSTEM STRENGTHENING (BUILDING BLOCKS)					
	Health Services	Health Workforce	Information System	Medical Products	Health Financing	Leadership & Governance
DRC Uzazi Bora	■	■	■	■		
Nepal CBD of Misoprostol	■	■	■	■		■

■ Indicates which strategies are present in each program example.

UZAZI BORA IN THE DEMOCRATIC REPUBLIC OF CONGO



KEY STRATEGIES FOR HEALTH SYSTEM STRENGTHENING (BUILDING BLOCKS)

PROJECT EXAMPLE	Health Services	Health Workforce	Information System	Medical Products	Health Financing	Leadership & Governance
DRC Uzazi Bora	■	■	■	■		

Overview

What Was the Context of the Uzazi Bora Project in DRC?

When CARE implemented the Uzazi Bora project in Kasongo district in 2007, the area was still recovering from the war that ended five years earlier. It was also characterized by severe geographic isolation — there are no roads linking the district to the rest of Maniema province, or the country as a whole — and chronic neglect and underinvestment. The health system certainly reflected this: Most health centers in the district did not meet even minimal standards for care. Staff were underpaid and had little support or supervision. Turnover was high, especially in the most remote villages. Drugs, supplies and materials were grossly insufficient, and logistics systems were broken. Even the most motivated workers in Kasongo’s Bureau Central de Zone (BCZ), the local representation of the Ministry of Health, and its 22 health facilities¹ faced enormous obstacles. Maternal and newborn health indicators in Kasongo were among the worst in the Democratic Republic of Congo (DRC).

Uzazi Bora was the third and most comprehensive health intervention² that CARE had implemented in the district since 2002. Earlier projects laid some groundwork, especially in family planning (FP) services and the Minimum Initial Services Package (MISP),³ and made it possible for Uzazi Bora to strengthen health systems with a specific focus on sexual, reproductive and maternal health (SRMH).

What Did CARE DRC Set Out to Do, and Why?

The overall goal of Uzazi Bora was to reduce maternal mortality in the Kasongo health zone by ensuring sustainable access to quality, comprehensive SRMH services. From mid-2007 to mid-2011, CARE and its partner, the BCZ, implemented a range of activities that strengthened several building blocks of the district health system, engaging it on multiple levels.

¹ All facilities in Kasongo were government-managed; no private providers were present during the project’s lifetime.

² Uzazi Bora was part of the RAISE (Reproductive Health Access, Information, and Services in Emergencies) Initiative funded by a private foundation and coordinated by Columbia University’s Mailman School of Public Health and Marie Stopes International. The initiative aimed to catalyze changes in how SRMH is addressed by all sectors involved in emergency response, from field services to advocacy and local aid providers to global relief movements.

³ The Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations is a set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; and plan for comprehensive reproductive health services in humanitarian crisis. The MISP is implemented through the coordinated efforts of humanitarian agencies, ministries of health, and local partners.

What is Innovative About Uzazi Bora?

Uzazi Bora shows how a weak health system can be strengthened within a challenging operating environment. While the project’s largest (and costliest) component was building technical capacity of district administration and health workers, CARE ensured that communities, local groups and individuals also played a central role. In short, CARE integrated community mobilization efforts into a largely technical project.

First, CARE **partnered with both upper and lower levels of the health system** — notably, CODESA members⁴ and BCZ staff — and built the capacity of each to fulfill their mandates. Quarterly meetings— Uzazi Bora held one meeting with community-level actors and another with health administrators and selected health workers — were an especially useful way for these entities to share, analyze and act on one another’s monitoring data. The meetings promoted engagement and mutual responsibility, and reinforced the idea that different levels of the health system had to work in harmony to achieve good SRMH outcomes.

Second, the project included a rich **social and behavior change communication (SBCC) package** to educate and motivate individuals, and to help communities define and enact new SRMH –related social norms. Though Uzazi Bora was heavily oriented toward technical services, CARE and the BCZ worked with a wide array of non-technical actors — radio journalists, entertainers, CODESA members and relais⁵ — to engage communities. CARE also tapped into traditional authority structures, such as village chiefs, village councils and influential women, to set and reinforce expectations that new SRMH behaviors would be adopted.

Uzazi Bora also offers insights into issues of sustainability, an issue central to CARE’s evolving approaches to comprehensive programming. Globally, CARE is stepping away from a direct delivery approach in non-emergency programming. But in Kasongo’s post-crisis environment, Uzazi Bora included some direct delivery of materials, supplies and training. Throughout the project, CARE and the BCZ had to weigh the need for each project intervention against the likelihood it could be sustained.

⁴ The Comité de Santé, or health committee, is a government-mandated citizen group that serves as a conduit for information and representation between citizens and their nearest health facility.

⁵ Relais are health educators and social mobilizers. The position is mandated by the government; individuals are selected by their communities.

Snapshot of Uzazi Bora

This section offers a brief overview of the project’s activities and approaches, categorized by health system building block.

Health Services

Technical Services

CARE and the BCZ promoted a technical package of five crucial SRMH services:

- Standard and Emergency Obstetric Care (EmOC), including Post-Abortion Care (PAC): Uzazi Bora used the United Nations’ standards⁶ for basic and comprehensive EmOC, including PAC, at three and one facilities, respectively. Eighteen health centers offered standard (nonemergency) obstetric care and referrals as needed. Perinatal services — a minimum of four antenatal visits, attended delivery and postnatal follow-up — were available in all 22 health facilities.
- Family Planning (FP): All health facilities in Kasongo offered short-term methods (male and female condoms, oral contraceptives and injectables) and, as needed, referrals to the four facilities that offered long-term and permanent methods — implants, IUDs, tubal ligation and vasectomy. Emergency contraception was available, most often dispensed in post-gender-based violence (GBV) care.
- Post-GBV care: Services included emergency contraception and provision of or referral for post-exposure prophylaxis (PEP) to prevent HIV transmission. In reality, relatively few women used these services, likely due to the stigma still attached to the survivors of these crimes, and to the normalization of male domination over women, including violence.
- Syndromic Management of Sexually Transmitted Infections (STIs): Because Kasongo lacks adequate laboratory facilities the BCZ adopted a syndromic approach to diagnosing and treating STIs.
- Prevention of Maternal to Child Transmission (PTMCT) of HIV: CARE and the BCZ extended voluntary counseling and testing (VCT) for HIV from the central hospital to several health centers and, toward the end of the project, expanded PTMCT to a total of six health facilities in Kasongo.

STANDARDS FOR BASIC AND COMPREHENSIVE EmOC

For a facility to meet these standards, all six or eight functions must be performed regularly and assessed every three to six months

Basic EmOC Functions	Comprehensive EmOC Functions
Performed in a health center and do not require an operating theater	Usually performed in a central hospital and require an operating theater
<ul style="list-style-type: none"> • IV/IM Antibiotics • IV/IM Oxytoxics • IV/IM Anticonvulsants • Manual removal of placenta • Assisted vaginal delivery • Removal of retained products 	<p>All six Basic EmOC functions plus:</p> <ul style="list-style-type: none"> • Caesarean section • Blood transfusion <p>UNFPA recommends at least four facilities offering Basic EmOC and one facility offering Comprehensive EmOC for every 500,000 people.</p>

LEVEL OF CARE	NUMBER	TECHNICAL SERVICES	REFERRALS
Central Hospital	1	<ul style="list-style-type: none"> • Comprehensive EmOC, including PAC • FP (long- and short-term methods) • Syndromic STI management • VCT, ARV and PMTCT • Post-GBV care, including PEP 	
Referral Health Centers	3	<ul style="list-style-type: none"> • Basic EmOC, including PAC • FP (long- and short-term methods) • Syndromic STI management • VCT and PMTCT • Post-GBV care, including PEP 	For: <ul style="list-style-type: none"> • Comprehensive EmOC • ARV
Health Centers	18	<ul style="list-style-type: none"> • Normal deliveries • FP (short-term methods) • Syndromic STI management • VCT and PMTCT (2 centers only) • Post-GBV care, including PEP in 2 centers only 	For: <ul style="list-style-type: none"> • Basic EmOC • FP long-term methods • VCT and PMTCT • ARV, PEP

Appropriate Distribution of Technical Services

As part of its baseline research, CARE undertook a detailed assessment of the 22 existing health facilities (e.g., physical conditions, materials, supplies, staffing), the services they offered and the population’s use of those services. The results helped CARE and the BCZ determine what SRMH services to offer and where to offer each type of service.

United Nations’ EmOC standards guide the distribution of services according to the size of the population. Uzazi Bora supported three basic EmOC facilities and one comprehensive EmOC facility to serve approximately 200,000 district residents — a ratio somewhat higher than UN recommendations. The table above summarizes SRMH technical services across all levels of the formal health system in Kasongo district near the end of the project.

Social and Behavior-Change Communication (SBCC) Services

Health system levels include individuals and community groups that can help link the right services and information to the right people. Uzazi Bora’s technical support was matched by an extensive SBCC package that not only educated and motivated individuals, but also helped communities define and enact new SRMH-related social norms.

CARE and the BCZ researched and tested health messages and collaborated with a wide array of actors — local NGOs, radio journalists, musicians, dancers, theater troupes and even Kasongo’s most popular comedian — to deliver information and challenge norms. Uzazi Bora also built knowledge and communication skills among some 360 relais, who kept the topic of SRMH alive in their communities. The relais and others, including service providers, used the project’s educational materials to support their work.⁷

Finally, CARE tapped into traditional power-holders such as the lubunga (village chief and his council), whose members learned to not only relay information and persuade others to adopt new health behaviors, but also to set and enforce new health-related social expectations. These groups were especially useful for encouraging men to understand the importance of good SRMH — in their own lives and those of family members.

⁶ “Emergency Obstetric Care Checklist for Planners.” 2003. UNFPA.

⁷ Uzazi Bora’s illustrated “Family Planning Dialogue Guide” was later adopted by the DRC’s national initiative to reposition family planning and reproductive health.



Health Workforce

In the DRC's weak health system, service providers had little opportunity for in-service training. So Uzazi Bora invested in competency-based training for service providers. The highest-level health workers traveled to the Institut Africain de la Santé de la Reproduction in Burkina Faso for EmOC and PAC refresher training; most other training occurred in major DRC cities. The BCZ and CARE followed newly trained service providers with supportive supervision and used project generated data (see the next section) to tailor their monthly supervision plans to meet the needs of each facility and service provider.

TRAINING TOPIC	NUMBER OF SERVICE PROVIDERS
EmOC	38
PAC	15
FP	25
Infection Prevention	17
Syndrome STI Management	24
Care of GBV Survivors	22+
Drugs Management	25
Anesthesia and Recovery	10
Lab Analysis	24
PMTCT	24

Information System

Uzazi Bora used “data for decision-making” to strengthen service provision as well as the analytic, planning and management skills of service providers and BCZ staff. The first steps were to analyze and modify each health facility's record-keeping, and to train service providers to routinely record key data that would allow both services (supply and demand) and outcomes to be tracked. The project used EmOC process and output indicators (box below) to guide data collection, and to detect progress and problems over time.

The quarterly meetings with senior health facility staff involved discussions on service use and outcome data, positive and negative. Participants identified actions needed to be taken as well as drivers of positive change — and ways to replicate them. In the quarterly meeting of non-technical actors, CODESA members learned to

promote and track use of services, including perinatal care, in their catchment area. Participants discussed their own indicators and data, as well as service-use and outcome data from throughout the health zone. These two types of meetings were closely linked, and the two groups used each other's observations to improve their own performances.

Process, Output and Outcome Indicators

Population-based maternal mortality ratios are the gold standard for measuring women's risk of death in the perinatal period. Yet in a short timeframe, and/or a small geographic area, measuring change is not realistic or cost-effective, nor is it sensitive enough to detect change.

WHO and other global health experts promote an alternative to the maternal mortality ratio: measuring the actions that prevent mortality and morbidity via a series of process, output and outcome indicators “... designed to monitor interventions that reduce maternal mortality by improving the availability, accessibility, use and quality of services for the treatment of complications during pregnancy and childbirth. The indicators are based on information from health facilities with data on population and birth rates.

“There are several advantages to this approach. First, the indicators can be measured repeatedly at short intervals. Second, the(y) ... provide information that is directly useful for guiding policies and programs and making program adjustments.”

The indicators address these questions:

- Are there enough facilities providing EmOC?
- Are the facilities well-distributed?
- Are enough women using the facilities?
- Are the right women (those with obstetric complications) using the facilities?
- Are enough critical services being provided?
- Is the quality of the services adequate?

Adapted from introduction to “Monitoring Emergency Obstetric Care: A Handbook”
WHO, UNFPA, UNICEF, AMDD (2009)

During the course of the project, the MOH adopted maternal death audits at the national level; CARE worked with the BCZ to conduct them in Kasongo.

Medical Products

All 22 health facilities were supplied with equipment and initial stocks of consumables. At least one person from each site was trained in drug and supply management. But equipment maintenance and re-supply of consumables were a chronic challenge. For example, stockouts of FP supplies were so frequent that contraceptive security was difficult to guarantee. CARE and the BCZ devoted enormous time and effort to meeting the logistics challenge, but were unable to resolve it in a sustainable way. Simply put, a single project could not fully overcome Kasongo's isolation within a poorly functioning national system.

For three important items, no supply system existed in DRC at all: manual vacuum aspirators (MVA) for PAC, contraceptive implants, and emergency contraception. CARE and the BCZ chose to directly source these items.

Outcomes⁸

Facilities Improvements: In addition to building/rehabilitating, equipping and supplying health centers and the central hospital, Uzazi Bora fostered other improvements, as shown in table.

Assisted Births: When Uzazi Bora began, only 40 percent of women in the project area reported that their most recent birth had been attended by a trained service provider. Two and a half years later, the figure had nearly doubled, to 78 percent. Data from health facilities show this evolution month by month, and compare the number of assisted births to the number of expected births. This population-based calculation⁹ is an important planning tool in a place like Kasongo, where not all births are necessarily recorded by the health system.

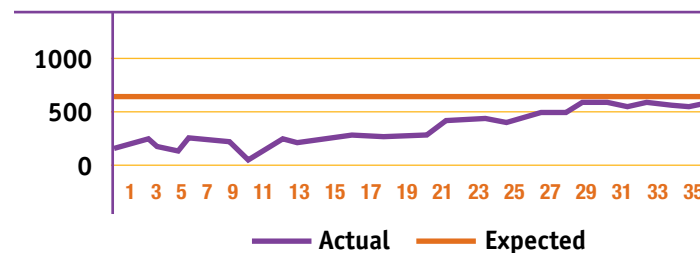
Emergency Obstetric Care: CARE and the BCZ used EmOC indicators to measure the effect of Uzazi Bora on women's well being, including:

- 1) Caesarean section as proportion of expected births. At baseline, 0 percent of women reported having had a caesarean section; at endline, 2 percent did. This shift was in the right direction but remained dangerously low compared to the acceptable range of 5–15 percent.¹⁰
- 2) Met need for EmOC. Met need is the proportion of all women with major, direct obstetric complications who are treated in EmOC health facilities. The proportion of such women increased threefold over the course of

OF 22 FACILITIES, NUMBER WITH...

	2008	2010
Means of Transport	4	18
Means of Communication	0	16
Infection-Prevention Measures	0	13
Waste Disposal System	0	10

ACTUAL V. EXPECTED BIRTHS AT FACILITIES PER MONTH



Uzazi Bora, from 11 to 30 percent. (The minimum acceptable standard for met need for EmOC, however, is 100 percent).

- 3) Proportion of PAC. When Uzazi Bora began, PAC represented only 2 percent of all obstetric cases that were presented at health facilities. Thirty months later, PAC had risen to 8 percent. Globally, about 13 percent of maternal deaths are due to unsafe abortions.

Family planning: The contraceptive prevalence rate for all modern methods rose from 2.8 percent baseline to 5.9 percent 20 months later. This was a significant gain in a relatively short time, given the chronic difficulty of ensuring supplies in Kasongo.

Lessons Learned, Implications, and Insights

Uzazi Bora achieved important outcomes within a weak health system and difficult operating environment. The project yielded several important insights for future efforts aiming to strengthen health systems, especially as CARE more fully adopts integrated and partner-oriented approaches.¹¹

Typical Levels of a Health System

There is not always a linear transition from the MISP to comprehensive SRMH services. A crisis can often hit a country where previously comprehensive SRMH services have been provided. In this case, the challenge lies in sustaining these services. (But) in settings such as Darfur or DRC, the lack of SRMH services and the inadequacy of the health system reflect a chronic situation. (I)n a protracted crisis, one needs to assure the minimum services first.

Adapted from: "Sexual and Reproductive Health Care in Protracted Post Crises and Recovery", 2011, WHO et al

Balance immediate needs and long-term sustainability.

Overall, CARE's role in Uzazi Bora was more directive than in most of the organization's current, global health portfolio. CARE did not undertake direct delivery in the conventional sense in that CARE did not set up, equip and staff health centers outside the government system. It did, however, sponsor service provider training, pay for materials and equipment, and support some construction and rehabilitation of health facilities. As mentioned earlier, Kasongo's particularly difficult environment necessitated this approach: SRMH services would not have been possible without buildings, drugs and skilled staff.

Like many CARE projects, then and now, Uzazi Bora had to make hard choices between what was needed and what was ideal in an imperfect operating environment. Investment in health-worker training, for example, played a crucial role in meeting the immediate SRMH needs of women in Kasongo. But returns on this investment may be limited if the BCZ cannot sustain supportive supervision. In addition, the drug-supply system in DRC is broken. Uzazi Bora alone could not fix this national problem, nor could it help the BCZ provide quality SRMH care without supplies such as FP methods. Therefore, CARE chose to directly source supplies from United Nations Population Fund (UNFPA) and a neighboring province, while joining others to advocate for improvements to the national system.

⁸ CARE carried out endline surveys approximately nine months before Uzazi Bora officially ended. It is likely that outcomes continued to improve in the project's final months.

⁹ WHO recommends using 4 percent of the population as the proportion expected to give birth in any year, divided by 12 months.

¹⁰ "Monitoring Emergency Obstetric Care: A Handbook" 2009, UNFPA et al.

¹¹ Building on the successful experiences of Uzazi Bora, CARE began implementation of the Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAF-PAC) initiative. SAF-PAC aims to reduce both unintended pregnancies and deaths from unsafe abortion during emergencies in DRC, Chad, and Pakistan.

Strengthening a health system is slow work. CARE partnered with the BCZ to strengthen the existing health system, and to do so in ways that built the BCZ's ability to fulfill its mandate. By choosing to work across Kasongo's the entire health system, including all 22 facilities, CARE and the BCZ increased the likelihood that the system could sustain its collective gains over time. This type of partnership, however, demands enormous amounts of time and patience. For example, CARE and the BCZ carefully examined each project element, choosing the best balance of quality, speed, sustainability and effectiveness that they could foresee. Each choice required some compromise.

Intervening at Several Levels of the System. In the context of a project like Uzazi Bora, marginalized people are only partially served by better health care and health knowledge. They must also be able to control what happens to their bodies, gain access (financial, physical, decision-making) to health care, and live within family and community structures that support their rights to both.

CARE's partnership with the BCZ was one way to increase intervention sustainability. Another way was to work with lower levels of the health system to increase the supply of services (e.g., by strengthening CODESA capacity and building the skills of community relais) as well as demand for those services (through the SBCC package). At these lower levels, especially, CARE went beyond technical services and introduced notions of rights, gender, and social change — and how socially constructed norms help or hinder good health outcomes.

Promote Mutual Accountability Using Data for Decision-Making. As noted, CARE and the BCZ held two types of quarterly meetings: one with service providers and health administrators, and one with SBCC actors, CODESA and influential community members. In each case, participants reviewed project monitoring data such as service use, EmOC indicators and community activity numbers. They compared actual and planned progress. They determined how to replicate good results and improve poor results. Community and technical actors took responsibility for suggesting and making changes, and publicly scrutinizing outcomes in subsequent meetings. CARE DRC's Health Advisor noted that "Uzazi Bora is the first time CARE has done this kind of review in the DRC, and it has been exceptionally useful. In fact, it's the very definition of primary health care: the full participation of society at each stage of development."

How to Replicate/Step-By-Step

This section summarizes some of the general steps (described in greater detail above) for determining how to help a health system deliver services, with the understanding that every health system is different.

1. Assess the health system and its environment. A thorough analysis of the existing health system, including its functions (building blocks) and levels, will identify gaps and opportunities for improvement. Future CARE initiatives will need to understand how a particular system operates nationally and locally, and what barriers exist to SRMH service quality, access and use. A project should plan to carry out a detailed assessment as part of its baseline survey. Uzazi Bora's extensive health facility assessments¹² provided a detailed view before and after of all 22 facilities' conditions, as well as the availability, use and quality of SRMH services. Baseline results formed the foundation for trainings and provision of equipment, drugs and materials; they also helped project staff select the facilities that would offer basic EmOC.



Likewise, map all other relevant players nationally and locally: other ministries whose mandate overlaps with health; non-professionals who collaborate with the health system (such as the relais and CODESA); traditional providers (birth attendants, healers); private practitioners; and peripheral service providers such as pharmacies. Trace logistics systems and supply routes, communication systems, power and water supplies. In remote and difficult environments such as Kasongo, all these elements affected SRMH service delivery, and many were legitimate targets of strengthening.

2. Carefully determine staff qualifications. In Kasongo, CARE hired high-level professionals (doctors, nurses and even an attorney) to implement Uzazi Bora. While this may not be the right decision in all instances, in the DRC it was an important way to gain the trust and cooperation of the health system on several levels.

3. Balance direct interventions and long-term sustainability. Projects should plan interventions with the overarching aim of supporting sustainable solutions, but accept that some direct delivery may be required. Direct delivery might be chosen, for example, if a certain life-saving service is needed — but not just because it is easier to implement than indirect delivery. As a targeted health system becomes stronger and more capable, a project can change its approach. For example, rather than continue to send doctors and nurses to Burkina Faso for medical training, Uzazi Bora used the first wave of trained workers to train their peers on site in Kasongo.

4. Be prepared to advocate. Weaknesses in local health systems are often reflections of weaknesses in the national system. CARE should be prepared to address countrywide issues, such as norms and standards, systems for delivering essential medicines, and health worker training and turnover. In the DRC, for example, the MOH did not include manual vacuum aspiration (MVA) in its norms for PAC. Rather than train service providers in the existing normative procedure, dilation and curettage, CARE joined others to advocate that MVA become the new norm, in line with international best practices.

¹² CARE used an EmOC assessment tool that RAISE adapted from the Averting Maternal Death and Disability Programme. Uzazi Bora also surveyed women of reproductive age and other community members at baseline and endline to gather information on practices, knowledge and attitudes vis-à-vis SRMH.

5. Consider using UN process indicators. Strengthening weak health systems in remote areas requires better data collection and information systems. In Uzazi Bora, CARE adopted UN process indicators as one of several tools to gather health service data. Together with health providers and engaged non-professionals, project staff analyzed the information, identified changes in indicator data and made programmatic decisions based on shared knowledge.

6. Remember that non-professionals are part of the health system. Even though Uzazi Bora had a strong technical component, CARE's work with communities was extensive. Community groups and individuals are part of the health system and thus legitimate targets of a system-strengthening project. They can play an important role in building demand, while holding health workers and administrators accountable for quality SRMH services. Community members, carefully chosen, are also well-positioned to help transform social norms that affect the use of health services.

Recommended Resources

Emergency Obstetric Care Checklist for Planners. UNFPA, 2003. Available at http://www.unfpa.org/upload/lib_pub_file/150_filename_checklist_MMU.pdf

Family Planning: A Key to Prosperity and Health for Your Family / Family Planning Dialogue Guide for Community Relays in the DRC. 2010, USAID, CARE et al. Available at http://c-changeprogram.org/sites/default/files/Community_Relay_FP_Tool_English_Version_June2010.pdf

Maternal Death Audits as a Tool for Reducing Maternal Mortality. 2011, World Bank. Available at <http://siteresources.worldbank.org/INTPRH/Resources/376374-1278599377733/MaternalDeathAuditMarch22011.pdf>

Minimum Initial Service Package for Reproductive Health in Crisis Situations / an E-learning module. 2011, Reproductive Health Response in Crisis Consortium. Available at <http://misp.rhrc.org/>

Monitoring Emergency Obstetric Care: A Handbook. 2009, UNFPA et al. Available at <http://www.unfpa.org/public/publications/pid/3073>

Needs Assessment of Emergency Obstetric and Newborn Care. 2010, Averting Maternal Death and Disability. This and several related resources available at <http://www.amddprogram.org/d/content/technical-resources>

Using the U.N. Indicators of Emergency Obstetric Services: Questions and Answers. 2003, Averting Maternal Death and Disability. This and several related resources available at <http://www.amddprogram.org/d/content/technical-resources>

Uzazi Bora: Meeting the Maternal Health Needs of Post-Conflict Kasongo District, Democratic Republic of Congo. Voices from the Village: Improving Lives through CARE's Sexual and Reproductive Health Programs. CARE (No. 6, June 2011). Available at www.care.org/reprohealth



COMMUNITY-BASED DISTRIBUTION (CBD) OF MISOPROSTOL IN NEPAL



KEY STRATEGIES FOR HEALTH SYSTEM STRENGTHENING (BUILDING BLOCKS)

PROJECT EXAMPLE	Health Services	Health Workforce	Information System	Medical Products	Health Financing	Leadership & Governance
Nepal CBD of Misoprostol	■	■	■	■		■

Overview

What is the Context of Community-Based Distribution of Misoprostol in Nepal?

Nepal’s maternal mortality ratio is estimated at 281 deaths per 100,000 live births,¹ a significant decrease from 539 per 100,000 live births in 1996. Still, a Nepali woman’s lifetime risk of dying from maternal causes is one in 80,² and the single biggest cause of maternal death, accounting for up to 46 percent, according to one study,³ is postpartum hemorrhage (PPH).

Almost all cases of PPH can be prevented or treated in health facilities and with appropriate, active management of the third stage of labor. But in Nepal, about 81 percent of all women—and 90.8 percent of women in the Far West hill area, where CARE first implemented community-based distribution (CBD) of misoprostol—delivered at home as recently as 2006.⁴ Despite intense government efforts to increase the proportion of births in health facilities, home births remain the norm, and women remain at high risk of PPH.

This prevalence of (and preference for) home births in rural Nepal can be partly attributed to issues of poor quality infrastructure and services.⁵ Persistent gender discrimination is an equally important factor in the high proportion of home births; rural women can seldom make autonomous decisions, even about their own bodies, or travel without permission of husbands and in-laws.

Though imperfect and underfunded, at least Nepal’s health system is stable. Each of Its levels is clearly defined and can reach deep into communities. All of these qualities were essential for CBD of misoprostol.

¹ Nepal Demographic and Health Survey. Measure DHS, 2006. The 2011 DHS Preliminary Report does not include revised maternal mortality ratio.

² Lifetime Risk of Maternal Death. World Bank. Available at <http://data.worldbank.org/indicator/SH.MMR.RISK>

³ CARE et al (2011). Study on Utilization and Feasibility of Misoprostol in Doti District.

⁴ DHS 2006.

⁵ WHO cites, "... (p)oor quality of infrastructure and services ... unsatisfactory access to reproductive health information and services; low level of access to and quality of antenatal and postnatal care, and non-affordability of delivery in hospitals and primary institutions." World Health Organization Regional Office for Southeast Asia, Country Health System Profile/Nepal. Available at http://www.searo.who.int/en/Section313/Section1523_10656.htm

What did CARE Nepal Set Out to Do, and Why?

For years, the focus of Nepal’s Ministry of Health and Population (MoHP) had been on increasing the percentage of births at health facilities. Yet a decade of effort produced only modest results: About 19 percent of women delivered in a facility in 2007, up from 8 percent in 1996. Nepal’s experience with CBD of misoprostol, including the significant role played by CARE, offers an model that can be replicated in countries with the following characteristics:

- PPH is an important cause of maternal mortality and morbidity.
- Women do not have access to or use health facilities and skilled birth attendance.
- There is a stable, defined health system that reaches deep into communities.

Misoprostol: Its Actions and Indications

Misoprostol is a common, stable, cost-effective drug that can be used to prevent and treat PPH. It stimulates uterine contractions and thus slows bleeding after birth.

Misoprostol is generally seen as a second-line defense against PPH, to be used where injectable uterotonics (e.g., oxytocin) are not available or cannot be safely administered. (See the Resources section for WHO guidelines and positions).

The use of misoprostol is controversial at several levels. First, because the drug causes uterine contractions, it can be used to terminate pregnancies. Second, the dosages and indications for misoprostol’s various actions (inducing abortion, inducing labor, and both treating and preventing PPH) are very different, and mistakes can be fatal. Third, research is still inconclusive on the optimal minimum dosage and modes of administration for the drug’s various uses.

CARE's CRADLE Project

CARE's misoprostol interventions took place within its larger CRADLE (Community Responsive Antenatal, Delivery and Life Essential) project, which was the third in a series of child survival grants that CARE managed in Nepal's Far West Region. From 2007 to 2011, CRADLE concentrated, more narrowly than previous projects, on maternal and neonatal survival.

CARE's goal was to achieve sustained and equitable improvements in maternal and newborn health in Doti and Kailali districts, especially among marginalized populations. Activities and partnerships were designed to improve:

- Maternal and newborn outcomes.
- Quality and viability of maternal and newborn services.
- Capacity of MoHP, district public health offices and others in maternal and newborn care.
- Community commitment to maternal and newborn care.
- Social environment for maternal and newborn care.



After agreeing that FCHVs could distribute and track misoprostol, the MoHP initially backtracked and limited the drug's use to health facilities, before finally approving national expansion of CBD. CARE's participation in the decision-making process about who was qualified to distribute the drug, and what training they should receive, was essential for success in Nepal.⁷

Snapshot of CBD of Misoprostol

This section includes a brief overview of activities and approaches, categorized by health system building block.

Health Services

The most important health system issue was ensuring appropriate use of misoprostol: that the right dosage (three 200 µg tablets) and information (when to take the tablets and how to recognize complications) reached the right individuals (all pregnant women) at the right time (fourth and final antenatal care [ANC] session during eighth month of pregnancy) and at the right place (at home, if the woman cannot deliver at a health facility).

MISOPROSTOL REACHES WOMEN AT HOME THROUGH FCHVS. THIS ENSURES ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR, REGARDLESS OF WHERE A PREGNANT WOMAN DELIVERS.

MHO	District	Health Facility	1			
▶	▶	▶	▶	Women delivering in a health facility receive oxytocin injections as part of third stage labor management.		
			▶	Dispensed by health facility to FCHV for distribution in communities.	Dispensed by FCHV to pregnant woman during 4th home visit.	Taken by woman during home delivery.
			▶	Dispensed by health facility to FCHV for distribution in communities.	Dispensed by FCHV during delivery.	Taken by woman during home delivery.

Misoprostol distribution was first piloted in the country's Banke district by the USAID-funded Nepal Family Health Program, both through the health facilities and the community. Within the framework of the CRADLE project (see sidebar), CARE next introduced misoprostol CBD in Doti district, in mountainous Western Nepal. From 2008 to 2010, CARE replicated this original misoprostol pilot,⁶ emphasizing research on the feasibility, safety and acceptability of community-based distribution as a way to reach women who delivered at home. Both pilots clearly showed that female community health volunteers (FCHVs) were capable of counseling women correctly, and that women were capable of using the drug correctly — resulting in a significant reduction in PPH events. This allowed CARE staff to advocate, alongside partner organizations, that the MoHP adopt CBD as the national norm for misoprostol delivery.

In 2010, a grant from CARE's global Mothers Matter program supported the development and testing of national guidelines and protocols as well as the development of training and social and behavior change communication (SBCC) materials — efforts critical for national scale-up of CBD of misoprostol. As the initiative got underway, CARE used these standardized tools to introduce CBD of misoprostol in Kailali and Doti districts. The national health system and other NGOs were actively involved in the development process and the materials to scale up elsewhere in Nepal.

FCHVs played an important role in the success of the project. As official members of the health system, FCHVs monitored the health of pregnant women and newborns and linked with service providers at health posts and sub-health posts, as well as Village Development Committees (VDCs), the lowest administrative unit in the national health system.

⁶ CBD of misoprostol was piloted in Nepal from 2005-2008 in Banke district. The pilot took place within the large-scale Nepal Family Health Program, managed by John Snow, Inc., and funded by USAID.

⁷ CARE also procured misoprostol tablets, covering almost 50,000 pregnant mothers.

Most women in Nepal deliver at home, and almost all obtain health education and get referred via FCHVs, as part of national efforts to link ANC and deliveries with health facilities and professional health workers. In the diagram above, the first “pathway” represents the national ideal; the second and third pathways ensure that misoprostol reaches all women who need it. (The Leadership & Governance section below examines the MOH’s decision-making process on misoprostol delivery).

Health Workforce

In 2010, CARE guided national standardization of misoprostol use in Nepal. Based on previous experience, CARE’s own pilot project in Doti, and the work of several other implementing organizations in other districts, these standards explained who could distribute the drug, under what conditions, and with what training. Now health workers (down to the sub-post level) and FCHVs can dispense misoprostol if they have successfully completed birth preparedness planning (BPP) training. National FCHV training curriculum now includes standardized misoprostol information (see top box).

Nepal’s health system includes regular technical-support visits from health workers at all levels. Misoprostol use is now integrated into the support-visit format that district health officials use when supervising health facilities, and that health facility staff use when supervising FCHVs.

Information System

Use of misoprostol is also integrated into nationally used information systems. At the lowest level, FCHVs uses a ward (village) register to record information on individual counseling and mothers’ group meetings, and a BPP/misoprostol register to track pregnancies and misoprostol use. The FCHV protocol required early postnatal home visits to follow up on misoprostol use and birth outcomes. FCHVs were thus able to systematically detect cases of PPH (and other events) and report them via the health information system. In addition, mortality due to hemorrhage is captured through a maternal death review process.

FCHVs are trained to:

1. **Introduce misoprostol information to Mothers’ Groups.**
2. **Identify pregnant women.**
3. **Provide antenatal health education over four home visits.**
4. **Encourage use of a health center for ANC and birth (but prepare for safe home delivery).**
5. **Dispense misoprostol at fourth home visit/during eighth month of pregnancy, with correct counseling and instructions.**
6. **Make early postnatal home visit.**
7. **Document pregnancy outcomes, misoprostol use and complications.**
8. **Return unused misoprostol to health facility for repackaging.**

Counseling should include information on:

- **Benefits of facility delivery, skilled birth attendance and oxytocin injection.**
- **Misoprostol, including benefits and warnings (i.e., do not use during pregnancy or before giving birth).**
- **Misoprostol as an option when delivery occurs at home and without skilled birth attendance.**
- **Proper time of use (i.e., within one hour of birth).**
- **Possible side effects and simple management instructions.**
- **Seeking prompt care in case of heavy bleeding, even after using misoprostol.**



Following national protocols, the sub-health post is responsible for compiling data from FCHV registers and feeding it to health facilities, where it is, in turn, shared at the district level. The information is then used to track progress and guide decision-making at the facility and village levels. In effect, elements that CARE built into monitoring and data collection for CBD of misoprostol helped close several information gaps that are common in Nepal and wherever else women typically give birth outside the formal health system. As a result, there is now a better understanding of how to extend the health system to this population.

The CBD initiative went beyond ensuring routine monitoring: CARE also undertook a district-wide study on the safety, feasibility and acceptability of CBD of misoprostol in Doti district (see Outcomes section). There already had been a misoprostol study in conjunction with the original Banke district pilot, but it was important to replicate the study to find out the following information:

- Determine safety, feasibility and acceptability, not only of the drug itself, but of CBD of misoprostol along pathways that the government approved in 2010 (See bottom box on page 58.)
- Detect differences, if any, in the drug’s use and effects in Doti, which is quite different culturally, socioeconomically and topographically from Banke district.

CARE also looked for disparities in Doti district, such as the socioeconomic characteristics of women who did and did not use misoprostol. Finally, CARE designed its research to capture information on PPH events in the year prior to the study, thus creating a baseline for tracking project progress.

Medical Products

Following the advocacy efforts of stakeholders including CARE, the Government of Nepal added misoprostol to its national essential drugs list in 2009. In 2010, CARE assured standardized drug packaging with the label Matri Surakcha Chakki (“mother’s safety tablet” in Nepali) and information on drug use and precautions. Standardized stock registers at district, health-post and sub-health-post levels all were modified to include misoprostol.

Leadership and Governance

MoHP approved CBD of misoprostol in 2010, after shifting its position several times on which group should be allowed to deliver uterotonics, what types should be delivered, and where. The government remained committed to increasing the proportion of births in health facilities and was initially concerned that misoprostol distribution by FCHVs would work against this objective. (The government argued that it is better for women come to facilities where injectable oxytocin can be administered by a health worker.) On the other hand, the MoHP recognized that years of efforts to increase facility-based births had yielded only modest results, and women who deliver at home need realistic options to prevent PPH. In the end, the government approved national expansion of misoprostol distribution via FCHVs, with several caveats: Only FCHVs can distribute the drug, distribution must be accompanied by standardized counseling, the drug can only be used for PPH, and health facilities should use injectable oxytocin instead of misoprostol.

CARE sponsored the development and testing (and publication, where applicable) of:

- National misoprostol implementation guidelines,
- Monitoring and evaluation guidelines,
- A package of BPP training, SBCC and counseling,
- A misoprostol information sheet to accompany the tablets, and
- Misoprostol procurement and distribution in line with government protocol.

CARE formed a technical working group and held several workshops to draft and finalize the documents, with full participation and buy-in from important government ministries and programs, the private sector, and various development NGOs and multilateral organizations. The involvement of national-level partners, both in developing materials and in piloting the interventions, was essential to scaling up CBD of misoprostol efforts.

Outcomes⁸

Within Nepal’s health system, CARE played an important supporting role in preventing the leading cause of maternal mortality: PPH. The following outcomes are from CARE’s research in Doti district, which investigated the acceptability, feasibility and safety of CBD of misoprostol via a retrospective study of women who had given birth at home in the previous year.

CBD of misoprostol was acceptable. A full 99.4 percent of study respondents would advise other women to use the drug if delivering at home, indicating a high degree of acceptability among the target population. Focus-group discussions revealed that husbands and mothers-in-laws, influential figures with regard to birthing, also found misoprostol acceptable.

CBD of misoprostol was feasible. The purpose of CBD is, of course, to reach the considerable proportion of women who give birth at home and risk PPH. The study found that 95 percent of respondents lived less than 30 minutes’ walk from their FCHV, 49 percent of all women who had correctly used misoprostol were illiterate and 40 percent were members of the lowest caste. These results suggest that FCHVs were reaching the most remote and disadvantaged women, and these women are capable of using misoprostol correctly.

CBD of misoprostol was safe. No woman reported taking misoprostol before delivery, and 96 percent reported taking the tablets between delivery of infant and delivery of placenta. Only 2 percent said they did not take all three tablets. Reported side effects (faintness, convulsions, excessive bleeding) were within expected limits and were tolerated by respondents. In focus group discussions, health workers reported that no women had appeared at a health facility with complications from misoprostol, and that they saw no evidence suggesting misuse of the drug.

Among the women who experienced excessive bleeding within 24 hours after delivery, 63.5 percent had not taken misoprostol and 36.4 percent had.

The retrospective study showed that coverage with a preventive dose of uterotonic can be achieved at the community level, and that a significant proportion of poor, vulnerable and marginalized women benefitted from its use.

Lessons Learned, Implications and Insights

The study found that CBD of misoprostol safe, acceptable and feasible join similar studies from other countries, including Indonesia and Guinea-Bissau.⁹ In short, there is a growing body of literature suggesting that this is a safe, cost-effective way for resource-poor countries to address PPH.

In Nepal, CARE collaborated with the government and other stakeholders to create and test a package of materials for scaling up and ensuring the quality of CBD of misoprostol; this package included training manuals, stock registers, SBCC and counseling tools, technical support visit guidelines and much more. Other countries can take these and similar materials and adapt them to their own local health systems, cultures and languages.

The lowest levels of the health system require the most negotiation and strongest evidence. Going forward, other national ministries of health will need to determine how best to deliver misoprostol to the women who need it. In Nepal, the MoHP was torn between its commitment to increase the proportion of births in facilities, and the reality that most women give birth at home. In the end, it agreed to allow CBD of misoprostol via FCHVs; CARE (and others) helped influence this decision with evidence that CBD was safe, accepted and feasible within Nepal’s well-defined health system. Countries with weaker systems, especially weaker community health volunteer systems, might need to test different pathways for distributing the drug and counseling on its use.

A pilot project is strongly advised. By definition, a pilot project is a small-scale test of logistics, interventions and outcomes. It is a context specific opportunity to test each element of the health system, from Ministry to health post, and from FCHV (or its equivalent) to community end-users. During a pilot, problems can be detected and corrected before large-scale and costly implementation. In Nepal, the original misoprostol pilot was implemented in Banke district. When CARE introduced CBD of misoprostol in Doti district, it did so as a second pilot to determine if results could be replicated

⁸ CARE et al. (2011). Study on Utilization and Feasibility of Misoprostol in Doti District.

⁹ Rajbhandari S, et al. (2009). Expanding uterotonic protection following childbirth through community-based distribution of misoprostol: Operations research study in Nepal. Int J Gynecol Obstet.

Minimum standards of implementation

In Nepal, misoprostol will only be distributed where:

- Community health workers are available at the Village Development Committee level,
- All FCHVs are fully trained on the proper use of the drug,
- Appropriate recording of each pregnant woman has been completed,
- Records of stock/use/return are maintained, and
- Adequate counseling is provided to pregnant woman and their family members.

in Doti's very different socioeconomic and geographic profile. The Doti replication provided the MoHP with further data illustrating how CBD could be accomplished, and with what results.

Between pilot and scale-up, integrate CBD into the health system. Successful, sustainable scale-up is a multifaceted systems issue: The innovation must be built comprehensively and coherently into numerous health system building blocks and levels. It must be integrated into, among other things, norms and procedures, training curricula, supportive supervision, information systems, procurement and logistics lines, budgets and BCC materials. (See the Resources section for further guidance).

CBD information systems can capture PPH and other events. A carefully planned information gathering system can detect and record cases of PPH and other events. In Nepal, even where women gave birth at home without assistance, FCHVs made postnatal home visits and recorded information about PPH, misoprostol use and any side effects, and birth outcomes. Systematic collection of data on PPH events means that Nepal's MoHP will be able to track this important cause of maternal morbidity and mortality, and how misoprostol affects it.

How to Replicate/Step-By-Step

1. Research maternal health. Gather as much information as possible about causes of maternal death in the particular country and/or target area, the proportion of births that occur in facilities and/or with skilled attendance, and the skill levels of those who attend births. Coordinate with local partners to prioritize problems and develop appropriate solutions. Investigate the national government's current policies and guidelines on the use of uterotonics, and their inclusion on the national essential drugs list.
2. Determine the strength of the health system at all levels. Trace the route that a drug such as misoprostol would take through the health system, from importation to end user, and determine strengths and blockages along the way. Trace a similar route in the opposite direction for data and information on the drug's use, safety and effects. What are the weakest links, and how could they be strengthened? Develop strategies to address gaps in the health system and identify strategic allies that can help.
3. Consider piloting misoprostol distribution — in partnership with the ministry of health, if necessary. Build solid research and monitoring activities into the pilot, as CARE did in Nepal. The research and monitoring results will help support strong national policy, and will guide the creation of norms, standards, training modules, SBCC materials and information-collection tools that can help promote misoprostol use, safety and effectiveness. In Nepal, the government was at first reluctant to act on some CBD recommendations from CARE and its partners. It took close collaboration and friendly negotiation to eventually pilot distribution in the most resourceful and efficient way.



4. Build coalitions and advocate with appropriate government authorities to allow a pilot distribution project (if needed) or to include misoprostol in national norms. Seek data from other countries and use it to support advocacy. At the community level, educate key stakeholders about the intervention and discuss their expected support, including local support for regular monitoring and review meetings. Talk to local support groups, such as mothers' groups, about the intervention during their group meetings and home visits.
5. Contribute to national minimum standards of implementation and scale-up. Use pilot data from CARE and/or others to support and inform national standards and norms, training and BCC materials, record-keeping and monitoring, and procurement and logistics management. Gather, examine and modify (as needed) these materials, including those from Nepal. Research how to bring an innovation, like CBD of misoprostol, to national scale and how to ensure that the innovation is both embedded and tested in all building blocks and levels of the health system. Determine how CARE can logistically support workshops, conferences, and testing and revisions of materials.

Recommended Resources

Clarifying WHO Position on Misoprostol Use in the Community to Reduce Maternal Death. WHO, 2010. Includes brief history of CBD of misoprostol and several additional references. Available at http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.11_eng.pdf

Post-Partum Hemorrhage Prevention and Treatment. Numerous resources available at <http://www.pphprevention.org/resources.php>; <http://www.k4health.org/toolkits/postpartumhemorrhage>

Practical Guidance for Scaling Up Health Service Innovations. WHO and ExpandNet, 2009. Available, with other resources on scaling up health innovations at http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf

Study on Utilization and Feasibility of Misoprostol in Doti District, CARE et al, 2011. Available at <http://familyplanning.care-2share.wikispaces.net/MHguidance>

WHO Guidelines for the Management of Post-Partum Haemorrhage and Retained Placenta. WHO, 2009. http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/9789241598514/en/index.html

CHAPTER 3

POLICY ACTION

Why Engage in Policy Action?

Maternal mortality and morbidity stem not just from decisions made in households, communities and health facilities, but are also the result of decisions or action (and inaction) by local leadership, national governments and international bodies. Therefore, advocacy or “policy action” is a critical strategy for CARE to achieve long term improvements in maternal health and to achieve CARE’s broader goals of poverty reduction and social justice.

By strategically engaging in policy action– alone, in coalition or through capacity building of civil society organizations – CARE can dramatically expand the impact of programs. Policy action can be a key factor in scaling up successful program work, assuring prioritization and funding to support maternal health, ensuring appropriate policies are in place and being implemented and holding governments accountable to their commitments.

In line with CARE’s rights based approach, engaging women and communities in advocacy empowers them to know and claim their rights and actively engage in their own health. CARE’s breadth of experience with the most marginalized populations brings an important voice to the policy debate – the voice of marginalized women and girls – and ensures that policies and programs are responsive to their needs.

CARE’s definition of a rights-based approach

A rights-based approach deliberately and explicitly focuses on people achieving the minimum conditions for living with dignity (i.e. achieving their human rights). It does so by exposing the roots of vulnerability and marginalization and expanding the range of responses. It empowers people to claim and exercise their rights and fulfill their responsibilities. A rights-based approach recognizes poor, displaced, and war-affected people as having inherent rights essential to livelihood security – rights that are validated by international law.

If CARE is to have a significant impact in the fight against global poverty, then changing policies or ensuring the implementation of policies already in place at the local, national, and global levels is critical. In the case of maternal health, this means improving the lives of millions of women and providing benefits to their families for generations to come.

What is Policy Action?

A **policy** is a plan, course of action, or set of regulations adopted by a government, business or an institution, designed to influence and determine decisions or procedures.

Advocacy or “policy action” is the deliberate process of influencing those who make policy decisions. Advocacy aims to create constructive policies, reform detrimental policies and ensure that policies are effectively implemented and enforced.

In line with the four delay framework (see introduction), the examples in this chapter highlight what has been referred to as a potential “fifth delay”– inadequate government response. Like the other delays, this delay can have significant repercussions on the lives of women. These examples demonstrate how CARE uses policy action to

influence government action related to maternal health,¹ which contributes to progress overcoming the other delays. Effective policies and adequate public funding will help ensure that families recognize that a woman needs help, decides to seek help and that she gets to a well-equipped facility with well-trained staff that are respectful of her needs in time to save her life and the life of her child.

How CARE Engages in Policy Action?

There are many excellent resources for developing advocacy strategies, including the CARE Advocacy Manual, so this chapter will touch only briefly on key elements. For more details, including worksheets and other tools, please refer to the resources listed at the end of this chapter.

It is not always necessary to develop an extensive written advocacy strategy; however, investing time for proper analysis and planning at the outset, as with the development of any program, will lead to more successful results. Planning in advance will ensure that advocacy work is deliberate and targeted, that it leverages limited resources and that it results in the outcome being sought. The following steps are meant to guide development of an advocacy strategy. Given the time and budget constraints that often accompany advocacy work, going through each step in great detail may not be feasible:

1. Prepare for policy action - Gather policy and political information; assess risk; build strategic relationships; establish CARE's credibility as an advocate; link advocacy to country office priorities; maintain focus
2. Analyze policies - Examine plans and regulations and how these policies, or lack of policies, affect specific groups
3. Outline an advocacy strategy - Select policy issue; select target audience; set policy goal; identify allies and opponents
4. Finalize an advocacy strategy - Select role for CARE; identify key messages; define advocacy activities
5. Frame a plan - Set a timeline; prepare a budget; prepare a logical framework; develop a plan for monitoring and evaluation

Policy Action: Two Cases

In many countries around the world, CARE has proven to be a legitimate and effective advocate for stronger maternal health policies and has contributed to global efforts to improve maternal health and broader sexual and reproductive health. This chapter draws from programs in Peru and Tanzania that successfully used policy action to address key barriers to improving maternal health. While the two programs' respective goals and approaches were different, their experiences and those of others reveal "common denominators" of successful efforts to influence policy action. These include:

Grounding advocacy in field work; and using evidence to inform policy action

CARE has more than 50 years of experience in maternal health programming and is currently working on sexual, reproductive and maternal health programs in over 30 countries. By sharing evidence and insights with decision makers, CARE helps ensure that maternal health policies and programs are grounded in solid experience. When governments base policies on practices that have been shown to be successful or that respond to the expressed needs of communities, they can positively improve health outcomes. CARE's evidence provides a solid basis for government officials to increase spending on maternal health and implement large-scale policies and intervention strategies.

Engaging citizens and health care providers as fellow advocates

Health care users and providers can be the strongest and most credible advocates for better maternal health policies. By engaging communities and health providers, CARE can amplify the voices of these allies and help them demand action from their policymakers. In one example, CARE's collaborative approach led to health care staff enthusiastically embracing new practices and training approaches, and lobbying for their adoption as government policy. Other cases provide evidence of the clout of civil society groups, such as networks of women's and youth organizations, using their collective power to obtain new government funding for contraceptive supplies.

Partnering for change

As with all its programming strategies, CARE is extremely effective in working with partners on advocacy. In such cases, partners often include agencies working on maternal health at the local, regional, national or international level, as well as opinion leaders such as religious, community, civil society and business leaders who can help identify community needs and shepherd resources toward meeting those needs. These partnerships can both influence governments (i.e. putting maternal health on the agenda and allocating adequate resources) and provide them technical assistance to strengthen their capacity to ensure access to and utilization of quality maternal health services.

Appealing to, and influencing, the agenda of policymakers

Maternal health goals must compete for policymaker attention and resources against other policy goals. By considering the agendas of policymakers, CARE can help push an issue forward and catalyze action. For example, governments who have pledged to reach the Millennium Development Goals may be more receptive to programs and policies proven to reduce maternal mortality. Likewise, providing a clear "ask," such as a specific amount of funding and showing how a government's budget can accommodate it will make it easier for them to act. Identifying supportive elected officials, "champions", and strengthening their ability to mobilize political will with their colleagues (i.e., by providing compelling data and linking to the desires of their constituents) is another important way to generate results. CARE can also highlight aspects of maternal health that may not be on their agenda, such as framing maternal health as a human rights issue, or showcasing the influence of social and cultural norms on maternal health.

What Is in This Chapter?

This chapter discusses CARE's use of advocacy to influence and bolster policies that promote optimal maternal health. Specifically, the examples highlight how to deliberately integrate policy action as a core program strategy to help shape MH-positive policies and increase CARE's impact.

- ▶ In **Peru**, CARE collaborated with government and civil society partners and health care providers to scale-up a project that reduced maternal mortality by 50% and to replicate the approach elsewhere in the country. CARE helped policymakers incorporate the successful methodology into national guidelines and provided technical assistance to support geographical extension of the project.
- ▶ In **Tanzania**, CARE and partner NGOs engaged citizens and civil society to advocate for policies and public funding at the district and national levels to improve maternal and newborn health, as part of a popular movement to ensure equitable access to quality health services for all people.

Together, these approaches suggest possible entry points for policy action, regardless of the political climate in your respective country. While these projects are presented as examples of policy action, they have strong elements of empowering communities and health system strengthening. Please refer to those chapters for more ideas on how to build comprehensive maternal health programs.

¹ Although the information in this chapter is focused on maternal health, the elements of policy action described here can be applied to other issues and sectors.

NATIONAL LEVEL SCALE-UP OF FOUNDATION FOR ENHANCING MANAGEMENT OF MATERNAL EMERGENCIES (FEMME)

Overview

What Is the Context for FEMME?¹

Due to sustained economic progress in the past 20 years, Peru is ranked a middle-income country. However, the interior of the country displays major inequities and poverty. The mountainous and isolated Ayacucho region was the base of the bloody guerrilla war of the 1980s, which devastated an already fragile health care system, and Ayacucho remains one of the country's poorest regions. Most people in Ayacucho are part of an indigenous cultural minority who speak Quechua as their primary language. Women in this group indicate they have often felt culturally and emotionally mistreated by health center staff, so have been reluctant to seek emergency obstetric care.

These factors contributed to a maternal death ratio in Ayacucho much higher than the national average, 240 versus 185² per 100,000 live births, respectively, and the third highest in the country. The country's maternal mortality rate is among the highest in Latin America, despite efforts in recent decades by the Peruvian government to reduce maternal deaths. Peru has committed to reducing maternal deaths to 66 for every 100,000 live births by 2015, in line with Millennium Development Goal 5. During this period of government reform and decentralization, the government enacted universal healthcare, including a strategic plan for maternal and newborn health, and regions took on greater responsibility for health policies.

What Did CARE Set Out to Do and Why?

In the initial FEMME program, CARE sought to reduce maternal mortality in Ayacucho by improving the availability, usage and quality of emergency obstetric care, using a rights-based approach that emphasized the right to a safe and healthy motherhood. The strategy was to promote the strengthening and organization of rural health services to reduce potential deaths among pregnant women experiencing complications.

The FEMME program was a partnership with the Peruvian Ministry of Health (MINSA using its Spanish acronym), involving the Ayacucho Regional Health Directorate, the Ayacucho Regional Hospital, and the National Maternal-Perinatal Institute in the capital, Lima. From 2000-2005, the program specifically targeted the Ayacucho Regional Hospital and four rural satellite clinics with the aim to improve the technical capacity of health personnel to provide basic and comprehensive emergency obstetric care, strengthen management of health care services, and help health teams incorporate rights-based approaches into their medical practices. FEMME proved to be extraordinarily successful, reducing maternal deaths by 50%.

¹ Foundations to Enhance Management of Maternal Emergencies (FEMME) was a CARE project implemented in Ayacucho. It was part of Averting Maternal Death and Disability, a global program developed by Columbia University and funded by the Bill and Melinda Gates Foundation that focuses on emergency obstetric care.

² Demographic and Family Health Survey, 2000.



Recognizing that despite its success, FEMME in Ayacucho reached only 2% of Peruvian women of reproductive age, CARE made a strategic decision to engage in policy action, partnering with the government and others to facilitate national level scale-up. CARE worked with MINSA to evaluate and validate the core FEMME strategies, then to systematize and document these strategies to show how other regions could implement this approach. Through this process, which engaged national, regional and municipal governments and international agencies, eight replicable modules were developed. The modules, known as FEMME+, integrated other effective interventions into the initial FEMME strategies (see Box 2). A costing study was also conducted to guide decision-makers in budgeting for these approaches. The FEMME+ model was incorporated into public policy and guidelines at the regional and national levels and in 2010, the FEMME+ modules were published by MINSA, with support of international and local partners. They are currently being used to guide geographical extension and build capacity in other regions to implement the FEMME+ model.

FEMME+ modules being replicated throughout Peru

1. Standardized management of emergency obstetric and neonatal care (EmONC)
2. Regional management of training on EmONC
3. Audit of the standardized management of EmONC
4. Quality standards for EmONC facilities and UN Process Indicators and standardized records
5. EmONC referral and counter-referral system
6. Prevention of infections in maternal and neonatal care
7. Gender equity and Interculturality in the frame of human rights on health
8. Implementation, monitoring and evaluation of the intervention model

What Is Innovative about FEMME?

FEMME's achievement of halving maternal mortality in Ayacucho has been highly publicized and the methodology well-documented (see Recommend Resources). While that accomplishment itself is significant, it is the subsequent national-level scale-up of the program that makes FEMME a particularly compelling study of how policy action can greatly increase CARE's impact on maternal health.

The following four elements of CARE's approach in Peru are particularly noteworthy, and will be useful to other country offices seeking to scale-up a successful intervention that integrates policy action into their maternal health program.

Grounding advocacy in field work; and using evidence to inform policy action

The FEMME program offered validated solutions to maternal mortality that could be packaged for replication elsewhere. The strategic decision to conduct the FEMME impact assessment study in partnership with MINSA led to their increased buy-in and ownership of the work and commitment to scale-up. The costing tools also helped regional offices to determine the costs of actually implementing the strategies. This technical support reinforced CARE's credibility and leadership and provided critical information and tools needed by policymakers and officials to take FEMME+ to scale.

Engaging health care providers as fellow advocates

During implementation of FEMME, CARE worked with health care providers and policymakers in Ayacucho to develop an emergency obstetric protocol that became the basis for the FEMME+ model and for regional and national policies. The collaborative process of developing the guidelines led to the buy-in of health care providers and their becoming advocates for the approach. The support of health providers was critical to paving the way for regional and national officials to adopt FEMME+ as national health guidance.

Partnering for change

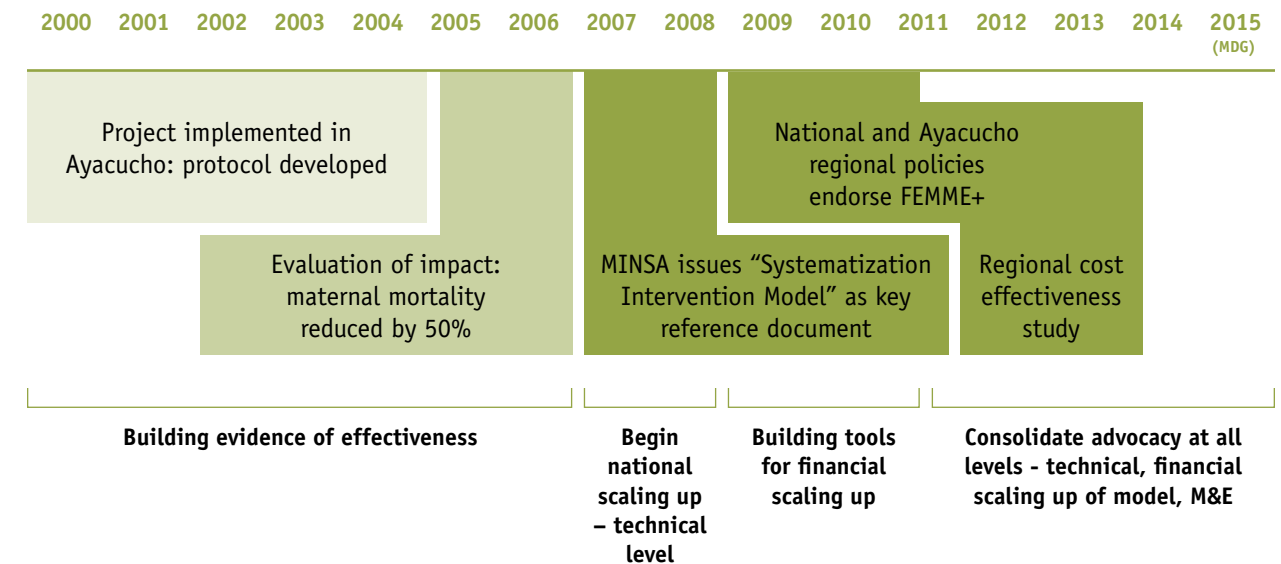
CARE joined with other institutions whose experience, ability to mobilize and presence in other regions could play a strategic role in scaling-up FEMME+ and contributing more broadly to progress toward Millennium Development Goal 5. For example, CARE worked as part of the "National Alliance for Safe and Healthy Motherhood in Peru"³ to provide technical assistance to regional and local governments to design, develop and implement programs and policies focused on improving maternal and newborn health. This alliance also worked with civil society to build political will, and ensure prioritization of maternal and newborn health care and the fulfillment of commitments by policymakers at the regional and national level.

Appealing to, and influencing, the agenda of policymakers

CARE worked closely with MINSA, keeping in mind the aims of the ministry and elected officials. CARE made a strategic decision to include key MINSA officers in the development of the FEMME impact assessment study, which led to MINSA "appropriating" the core FEMME strategic interventions and promoting their scale-up throughout Peru. CARE and MINSA shared a common purpose of linking the political will of regional governments with the allocation of public resources for maternal health. In addition, the Government of Peru had made global and national commitments to improving maternal health, which implementation of FEMME+ would help them to meet.

Snapshot of the FEMME Program

As mentioned previously, from 2000-2005, CARE implemented technical interventions at the regional hospital in Ayacucho and four satellite health clinics, working closely with government partners and health providers to develop guidelines to improve maternal health. Then from 2006 onwards, CARE and MINSA incorporated the lessons learned from Ayacucho into national policies and created programs and tools to be used at the regional and national level. The evidence generated from 2000-2005 informed the work done from 2006 onwards. Figure below shows the timeline of activities.



Technical Interventions, 2000-2005

The work in Ayacucho from 2000-2005 consisted of technical interventions involving four integrated components which included the following: 1) building staff capacity and competence, 2) strengthening management systems at facilities, 3) encouraging a rights-based approach during obstetric care, and 4) developing partnerships and policies that promote emergency obstetric care.⁴

Though advocating for scale-up was not an initial part of the program strategy, many elements of the FEMME approach – similar to the approach and partnership model used by many country offices— laid the foundation for policy action at the regional level and later at the national level. For example, FEMME staff engaged in awareness-raising efforts with Ayacucho authorities and community leaders to incite collective consciousness on the importance of working together to improve maternal health. This led to the formation of a Multi-Sectoral Committee for Prevention and Reduction of Maternal Mortality that included all main regional government bodies (i.e., health, education, attorney general, etc.), the health care system, municipal government and civil society, as well as the military, police, media, mayor's office, drivers' union, universities and the Red Cross. The committee developed a multi-sectoral plan to reduce maternal and newborn mortality, for which members provided financing.

³ The Alliance includes Pan American Health Organization/World Health Organization, UNICEF, UNFPA, USAID, Pathfinder International, Mesa de Concertación de Lucha Contra la Pobreza and PRISMA.

⁴ Described in detail in Ministry of Health's Impact of the FEMME Project in Reducing Maternal Mortality and its Significance for Health Policy in Peru, 2006. and M. Kayongo article in International Journal of Gynaecology and Obstetrics.

These efforts led to the development of the abovementioned emergency obstetric protocols in partnership with the Ayacucho regional health directorate. These protocols took into account World Health Organization recommendations and the local operational environment. Again, this provided the basis for the FEMME+ model and policies later enacted at the regional and national level.

The project's 2006 evaluation noted that these collaborative efforts were especially valuable in creating a favorable context for FEMME, as they contributed to "the support provided by local hospital management and the [regional health directorate], which acted as facilitation agents in the process."⁵ This work laid the foundation for subsequent widespread adoption of the intervention model.

Scaling up FEMME, 2006 and Beyond

The extraordinary results in Ayacucho and CARE's strategic engagement with the government positioned CARE well for scaling-up the work. The close relationship with MINSA included joint research and creating tools to support systemization and implementation throughout the country.

After the impact assessment study, CARE and MINSA conducted two additional studies⁶ to develop tools to guide regional and local governments on how to implement the strategies and how to determine the cost. With support from other agencies, CARE and MINSA structured the original interventions into eight modules, integrating lessons learned from the work of others, such as promoting rights-based approaches and culturally appropriate health care, especially for rural women. This resulted in the FEMME + model.

In 2009, the Ayacucho regional government passed resolution that recognized the FEMME+ model as the official EmONC protocol, and promoted the model as a critical component of any safe motherhood intervention in the region. At the national level, MINSA issued a resolution, declaring the FEMME+ intervention model as National Reference Guidelines⁷ to improve nationwide availability, quality and use of health facilities providing emergency obstetric and neonatal care.

CARE and MINSA then collaborated with agencies working on maternal health to strengthen capacity for emergency obstetric care in target regions. This alliance provided technical assistance to regional and local governments to design, develop and implement programs and policies to reduce maternal deaths. CARE also worked with MINSA to build cost estimation tools and to ensure that more accurate, regionally-grounded costs for maternal health programs were included in the 2011 national and regional budgets.

Throughout the scale-up, CARE worked closely with various partners to generate political support for maternal health care and to provide technical assistance to MINSA and regional and local governments on programs and policies to reduce maternal deaths. In 2007, CARE joined with other international agencies in the "National Alliance for Safe and Healthy Motherhood in Peru," which collaborated on several activities such as: 1) publishing a position paper that was endorsed by the Congress of the Republic's Commission on Health, Family and People Living with Disabilities, 2) sponsoring workshops with MINSA in five priority regions to develop multi-sectoral regional plans

to reduce maternal and newborn mortality, and 3) ensuring political commitments of regional governments and presidential candidates who pledged to prioritize maternal and newborn health care (e.g., candidates for president signed commitments⁸ and regional governments established goals to reduce maternal mortality by 35%).

CARE continues to help MINSA implement the FEMME+ intervention model in target regions, as well as monitor political commitments and encourage public funding for sexual and reproductive health. Further, CARE Peru has engaged with colleagues in Latin America to identify regional applications of the FEMME+ methodology, particularly as policymakers in Andean countries (Bolivia, Ecuador and Peru) have shown interest in formulating culturally relevant strategies and policies like those of FEMME.

Outcomes⁹

The FEMME project had several notable outcomes from 2000-2005, and the subsequent scale-up from 2006 onward has resulted in additional achievements on a broader scale.

FEMME led to a 50% drop in maternal mortality in Ayacucho in the first five years¹⁰ and there was a dramatic increase in the "met need" for emergency obstetric services.¹¹ All health centers in the project area, as well as the regional hospital, offered Quechua-speaking staff, bilingual information for patients and visitors, a warm and friendly environment, and multiple options for childbirth, like vertical birthing chairs, often preferred by indigenous women.

The 2006 project evaluation cited additional "unexpected positive side-effects," including:

- Effective relations between different levels of care, and improvement in the referral system
- Designation of the Ayacucho Regional Hospital as a regional emergency obstetric care training center
- Appropriation of the FEMME+ model by MINSA for adaptation and nationwide application

These accomplishments laid the foundation for scaling-up FEMME. Below are some additional achievements since 2006:

- Joint CARE-MINSA impact assessment study that led to the development of eight modules based on FEMME core strategies.
- A national resolution issued making the FEMME+ intervention into national reference guidelines to inform maternal health policies nation-wide and promoting the intervention strategies to regional and local governments
- Regional political decision made to implement the FEMME + intervention strategies amongst key regions, sharing public resources from national and regional governments
- Tools developed to facilitate the incorporation of financing for intervention strategies within the public investment system
- Institutional allies allocating their own resources to promote and support the implementation process
- Joint learning - both for CARE and MINSA - coming from the actual implementation process of the FEMME + national reference guidelines within the regions sometimes referred to as scaling-down.

⁸ This was a joint effort by CARE Peru's Health Rights Project (2006) and as part of a wider coalition led by the MCLCP (Mesa de Concertación de Lucha Contra la Pobreza) in 2011.

⁹ Impact of the FEMME Project in Reducing Maternal Mortality and its Significance for Health Policy in Peru. Ministry of Health, Peru, 2006. The project evaluation was co-funded by AMARES, Columbia University Mailman School of Public Health, and CARE PERU's Health Rights Program.

¹⁰ The maternal death rate dropped from nearly 240 for every 100,000 live births in 1999 to approximately 120 in 2005.

¹¹ The percentage of women who needed emergency obstetric services and actually accessed those services more than doubled, from 30 percent to 75 percent.

⁵ Impact of the FEMME Project in Reducing Maternal Mortality and its Significance for Health Policy in Peru. Ministry of Health, Peru, 2006.

⁶ Both studies were supported by the CARE USA "LIFT UP" Initiative, particularly the construction of a financial model to insert local costs and get the adapted local costs for the different strategic interventions. The process of cost validation within 5 regions in 2010-2011 contributed to strengthening the cost structure of the national maternal and newborn public health care program.

⁷ National reference guidelines are recommendations rather than mandatory national technical norms to be implemented by every health facility nationwide.



Lessons Learned, Implications, and Insights

The FEMME experience provides valuable lessons for others seeking to scale-up maternal health programs.

- When interventions involve a high degree of change and new trends for public institutions, scaling-up will require a considerable amount of time and technical support to partners and government, including the design of a flexible program that can adapt to changing contexts, and the allocation of public financial resources. Therefore, it is likely that scaling-up processes will need longer time frames than those of typical project cycles and will require partnerships with other organizations and the government to leverage funding.
- Scaling-up FEMME required: 1) identifying and planning for targeted events and opportunities to leverage advocacy processes at different levels, 2) designing a clear map of stakeholders, 3) working together with an institutional group (MINSA) willing to take on new innovations and mobilize support from other partners and allies, and 4) counting on the support of key actors – such as international researchers or other “champions” – who could play a key role in supporting technical assistance and advocacy.
- CARE’s internal drivers of success included: 1) retaining key staff who had knowledge of the project and the practical “know-how” of how to address the diverse key actors, 2) flexible funding to take advantage of “windows of opportunity,” which are vital in any advocacy process, and 3) resource mobilization for new interventions to keep the scaling-up process going.
- Working at both the national and regional levels and facilitating the linkage between them helped to support continuity of national health policies as the country underwent decentralization of its health system and regional gained increasing autonomy in health.

The FEMME scaling-up process also faced challenges, many of which may arise in other contexts:

- Difficulty keeping political will alive as political actors change: To accommodate changing political actors with varying agendas and degrees of commitment to maternal health, it is helpful to ensure institutionalization of norms and policies.

- High turn-over within the health system, particularly in the poorest regions: Given the difficulty of finding and retaining qualified health staff to work in remote, underserved areas, having intervention “modules” that can be easily taught and that build on well-established protocols will facilitate implementation and increase the likelihood of continuity of program approaches as health staff members change.
- Working together with citizens (i.e., rights-holders) and governments (i.e., duty-bearers): Citizen participation is important, yet is still not well understood or accepted as critical to improving the health of women and communities. An example is the emphasis regional health authorities place on strengthening technical clinical skills rather than training on rights-based approaches and promoting cultural appropriateness in health services, despite the fact that indigenous women have identified disrespect and lack of cultural sensitivity as major barriers to their seeking care at health facilities. Establishing local accountability mechanisms that promote dialogue and mutual understanding between citizens and governments can provide a platform to raise and address these issues.

Moving forward, CARE has identified additional elements to be incorporated as a complement to the FEMME+ model. These center on the expansion of rights-based approaches and innovative interventions, such as the good-governance approaches used in the Participatory Voices Project (see Box 3), that increase respect for health services users’ rights and helps create a “culture of accountability” among public authorities and health providers.

Citizen Monitoring to Promote the Right to Health Care and Accountability

CARE Peru continues to pursue innovative approaches to ensure the right to health, recognizing that in countries with a high level of inequality, the achievement of the MDGs in health will not be possible with simply more resources and technical interventions. Significant and sustainable change will only be achieved if people have a greater involvement in the design and adjustment of social policies and programs and in their implementation. The Participatory Voices Project of 2008-2011 aimed to strengthen the capacities of civil society networks to improve policies and programs for health care and social development.

The work is spearheaded by indigenous women trained to be “social monitors”, who visit and observe health posts, hospitals, and pharmacies, and discuss with women their experiences in receiving care. On the basis of their findings, the social monitors produce reports for monthly analysis with the regional Ombudsman’s office, CARE Peru and ForoSalud members (a national network of civil society representatives). The findings – both positive and negative– are then prioritized and shared for discussion with health care facility staff. An action plan is developed to outline commitments to address and any concerns raised.

Through advocacy and technical assistance, this initiative is contributing to the acceptance of citizen surveillance as part of Peru’s national health policy and the launch in 2010 of national policy guidelines to promote it throughout the country.



How to Replicate/Step-By-Step

The following are strategies CARE followed for scaling-up the FEMME project, which may be useful as guidance for others. These strategies include the following:

Generate evidence of results

The initial FEMME project offered validated solutions to maternal mortality that formed the basis for scaling-up. Evidence of program effectiveness and feasibility of implementation help establish CARE's credibility and provide critical information needed by policymakers and officials.

Systematize and cost the model so it can be easily replicated

CARE formed a strategic alliance with MINSA to package the FEMME+ strategies into modules and help regional officers plan for the costs of implementing them. Partnering with government stakeholders to systematize successful interventions and help them budget the costs will facilitate broader replication.

Engage in advocacy and coalition building

Allying with others working on maternal health strengthens CARE's "voice" and advocacy capacity. As evidenced such collaboration has multiple benefits, such as reinforcing the efforts of individual organizations, leveraging limited resources and capacity, learning from one another and drawing from the respective strengths of the members, and mobilizing political will on a larger scale.

Provide technical assistance and capacity building for geographical extension

CARE's expertise in building the capacity of health care providers and working with communities and local governments

is particularly valuable to government partners, who may lack the resources or ability to do so themselves. Through the development of targeted tools and training which support implementation and facilitating multi-sectoral partnerships, CARE bolsters the efforts of policymakers, so that scale-up happens more efficiently. This is also an area where partner agencies working in other geographical regions can be of assistance.

Convert the model into public investment projects, with budget

It is vital to understand the public budgeting process, and anticipate and respond to the concerns and expectations of planners and policy makers. CARE put a strong emphasis on developing tools to help policymakers determine the cost and feasibility of incorporating the FEMME+ model. Policymakers want to know: What needs to be done? How does it need to be done? How much does implementation cost?"¹²

Incorporate complementary and additional components

In scaling-up the successful approach from Ayacucho and expanding the work nationally, CARE integrated new components, drawing from the work of others. This requires staying engaged with public officers and agencies working on maternal health, and being aware of new, innovative approaches. Doing so will not only strengthen CARE's programming, but will improve its sustainability.

Establish accountability mechanisms

Establishing mechanisms to ensure accountability is key to ensuring the legitimacy and sustainability of new policies and programs. MINSA officers and stakeholders analyze together how the program is being implemented, whether financial resources are being appropriately allocated, and the advances and barriers faced in the process. Community empowerment and civil society engagement are also important components of fostering accountability by decision-makers.

Recommended Resources

Advocacy Guidelines and Tools, CARE 2000. Available at www.care.org/getinvolved/advocacy/tools/english_01.pdf

The FEMME Project in Peru: Partnerships for Improved Health. Voices from the Village: Improving Lives through CARE's Sexual and Reproductive Health Programs. CARE, May 2007. Available at www.care.org/reprohealth

From Project to Public Policy: The Experience of the FEMME Project in Peru. Developed by CARE Peru, 2011. Available at <http://familyplanning.care2share.wikispaces.net/MHguidance>

Impact of the FEMME Project in Reducing Maternal Mortality and its Significance for Health Policy in Peru. Ministry of Health, Peru, 2006. Available at <http://familyplanning.care2share.wikispaces.net/MHguidance>

The Impact of Maternal Health in Peru. CARE, 2010. Available at www.care.org/campaigns/mothersmatter/downloads/Peru-Case-Study.pdf

Kayongo, M., E. Esquiche, M.R. Luna, G. Frias, L. Vega-Centeno, P. Bailey. (2006). Strengthening emergency obstetric care in Ayacucho, Peru. *International Journal of Gynecology & Obstetrics*, Volume 92, Issue 3, pp.299-307. Available at <http://www2.ohchr.org/english/issues/women/docs/WRGS/Other%20Entities/FamilyHealthInternational.pdf>

¹² Esquiche, E. and Frisnacho, A. March 2011. From Project to Public Policy: The Experience of the FEMME Project in Peru. p. 12.

HEALTH EQUITY PROJECT IN TANZANIA



Overview

What Is the Context for the Health Equity Project?

The Health Equity Project (HEqP), which ran from 2007-2011, was an initiative of the Health Equity Group, a network of four NGOs (CARE, Tanzania Gender Networking Programme,¹ Women's Dignity² and Sikika³) who came together in 2004. The goal of the Health Equity Group was to generate a popular health movement to advocate for the right to health for all Tanzanians and commitments to equity in health as a priority for citizens and their elected representatives. The initiative prioritized the situation of maternal health⁴ as an entry point to advocate for policies, plans, budget allocations and utilization of resources to ensure equitable access to quality health services.

Tanzania has a strong platform of policies aimed at creating equitable access to health services and improving health outcomes. The country has committed to achieving its the Millennium Development Goals and government strategies, including health sector reform processes begun in the early 1990s, aim to improve access to quality maternal health services and ensure reproductive health rights.

Despite such commitments, maternal mortality remains high, at 578 deaths per 100,000 live births in 2004-2005.⁵ In a 2006 rank of 162 countries on the state of women's reproductive health, Tanzania was 125th.⁶ The data also revealed a sharp urban-rural divide and a marked difference in access to key maternal health services, such as skilled care at delivery, between rich and poor, reflecting persistent inequities across the country.

Significant challenges persist in the implementation of government policies and in the roll-out and institutionalization of reforms to address health inequities and poor maternal health. One of the most significant gaps identified by CARE and its allies was the lack of an organized and effective public demand for better quality health services. There was limited involvement of civil society organizations in health sector policy and governance, and a need for community leaders and groups to develop a shared idea of what they should demand with respect to better service provision and stronger maternal health policies. There was also limited connection between the information and evidence being gathered from communities and the actions being taken by decision-makers at the national level.

What did CARE Set Out to Do and Why?

Health equity means quality access to health services for all, regardless of geographic location, education level, socio-economic status or gender. When health inequity exists, membership in one group is associated with lower health outcomes as compared to other groups. A group can be disadvantaged on account of ethnicity, religion, poverty, geographic area, gender or some other shared trait. Rural and poor women are particularly susceptible to socioeconomic inequities due to prevailing gender and cultural norms, lack of education and lack of decision-making ability.

To address the inequitable health situation in Tanzania, the HEqP increase public participation in health planning, financing and governance, and increase national-level political commitment and leadership in ensuring health equity as a national priority and investing in equitable access to quality health services. This would be achieved through the strengthening of community-based initiatives to empower women and young people so as to demand their rights and entitlements in health and increasing the capacity of decision-makers at local, regional and national levels for evidence-based planning and resource allocation.

¹ Tanzania Gender Networking Programme advocates for gender equality/equity, women's empowerment, social justice and social transformation.

² Women's Dignity works to enable citizens -- particularly marginalized girls and women -- to realize their basic rights to health, with a particular focus on obstetric fistula.

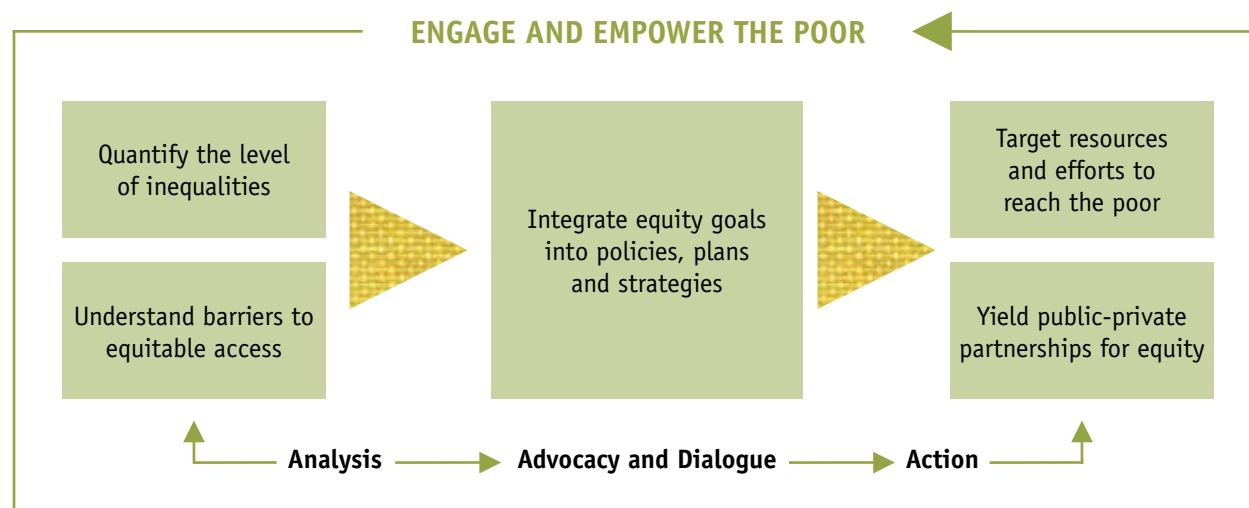
³ Sikika aims to ensure that citizens are empowered to participate in the national development process in order to realize Tanzania's development vision for 2025.

⁴ High levels of maternal, newborn and child mortality and morbidity are often used as effective proxy measures of levels of inequity in societies.

⁵ As of the 2010 DHS, the maternal mortality ratio had dropped to 454 deaths per 100,000 live births.

⁶ Social Watch Report, 2006.

The following image provides a framework to understand the stages of the HEqP. This “Equity Framework for Health,”⁷ developed by the USAID-funded Health Policy Initiative,⁸ shows the continuum from analysis to advocacy and dialogue to action.



In-line with the framework, the Health Equity Group engaged communities -- including members of disadvantaged groups, local health service providers and other local stakeholders -- to identify health inequities and barriers to equitable access throughout the process.

Key target groups for HEqP included civil society, government and elected leaders at the local, regional and national levels. The HEqP focused especially on enhancing the participation of civil society by actively linking with civil society coalitions and organizations and engaging the public through media and public events. These served as platforms to share information and advocacy tools, to further strengthen and build coalitions, and to promote policy action by civil society (e.g., lobbying, monitoring, etc). Government officials targeted included members of various ministries and departments at the national level and the Local Government Authority at the district and local levels. Elected officials, from Members of Parliament to District Councilors to elected village and ward representatives (part of the LGA) were also targeted. This focus on all levels of government and the health system was critical, as significant decision-making authority in Tanzania has been decentralized to the local levels.

In addition, Health Equity Group members used this collective effort to build on their programming in different areas of the country. For CARE, HEqP was used to strengthen the Community Scorecard process, a participatory governance⁹ process being implemented in the in Magu and Misungwi districts in the Mwanza region. The CSC process was used to expand the space for citizen engagement in planning, financing and monitoring for improved quality health services at the district level. The CSC process allowed community members and service providers to assess maternal health services, identify problems and develop action plans to address them. Information gathered through the CSC process, informed HEqP advocacy efforts at all levels.

⁷ These are discussed in the Health Equity Project final evaluation (April 2011), which drew from the following document: United States Agency for International Development (USAID), 2010. Considerations for Incorporating Health Equity into Project Designs: A Guide for Community-Oriented Maternal, Neonatal, and Child Health Projects.

⁸ The USAID Health Policy Initiative provides field-level programming in health policy development and implementation so that people may obtain the information and services they need for better health, especially in the areas of family planning and reproductive health, HIV/AIDS, and maternal health.

⁹ For more information about CARE’s work on governance, visit www.careinternational.org.uk/research-centre/governance.

What Is Innovative About the HEqP?

The HEqP provides a particularly strong example of how CARE can link local-level programming and accountability strategies with national-level advocacy efforts and how evidence can drive advocacy at all levels. The following four elements of CARE’s approach are especially noteworthy.

Grounding advocacy in field work; and using evidence to inform policy action

HEqP advocacy efforts were grounded in evidence from programming, from additional research and analysis and from gathering the voices of communities themselves, and this information informed all aspects of the advocacy work. For example, the Community Scorecard process CARE implemented in Mwanza highlighted gaps in maternal health services, such as lack of transportation to health facilities for pregnant women, and potential solutions (such as tricycle for emergency transport). It also provided an important example of how citizens (and health providers and government) could be engaged in maternal health decision-making at the local level.¹⁰ Supplemental research was also conducted, including a barrier study, in partnership with Women’s Dignity, which uncovered critical factors or “barriers” such as cost, distance to the facility, and informal charges incurred for delivery to name a few, which were preventing women from accessing maternal health care. CARE also conducted budget analyses to assess the national budget and its allocations to different sectors. This information, compiled with information from other partners, informed the focus of the advocacy efforts, specifically what the “ask” was. The information was compiled into various formats, such as policy briefs and packets, depending on the audience, to inform their actions.

Engaging citizens and health care providers as fellow advocates

The HEqP enhanced the participation of citizens in decision-making processes pertaining to health policy and resources through several different strategies including the CSC process at the local level, documentation of the voices of communities through video and testimonials to share with policy makers, targeted campaigns and the use of media, such as television and radio spots, newspaper articles and billboards. Together, these raised public awareness on the right to health, highlighted the inequitable maternal health situation in Tanzania and promoted citizen action. By giving citizens the information they needed to understand their rights and responsibilities regarding the health system, how budgets and plans are developed, as well as providing a platform for them to share their concerns, citizens were able to play a more active role in advocating for increased resources for maternal health at different levels. At the local level, the CSC process strengthened the relationship between health service providers and users by creating opportunities for them to discuss issues of health inequity and jointly identify solutions. The information generated by the process enabled decision-makers to make informed decisions and policy choices that responded to citizens’ rights, needs and preferences, while also helping communities understand the systemic challenges being faced by health service providers.

Working with and through partners

Acting in concert with three other NGOs enabled them to leverage limited resources, generate more evidence (from regions where the other NGOs worked), reach a broader audience, and have a stronger, united “voice” when engaging with policymakers. Each member organization contributed a core body of experience and capabilities. The fact that the NGOs had different but complementary missions increased the impact of their individual reach and signaled to policymakers a broad-based interest in improving health equity, particularly maternal health. In addition, the HEqP reached out to other civil society coalitions and organizations to promote collaborative action and to strengthen the voice of civil society.

¹⁰ In 2007, CARE documented its experience, and the experience of others in citizen mobilization, in a report entitled: Developing user-friendly process tools to enable villages and Districts to make evidence-based plans for improving maternal and newborn health.

Appealing to, and influencing, the agenda of policymakers

The Government of Tanzania has made a global commitment to improving maternal health, yet maternal mortality figures have been stagnant for 20 years and improvements were still not reaching the poorest communities in Tanzania. The work of the HEqP provided decision-makers with useful information, such as situational and budget analysis, as well as community feedback on health services, that could guide their decision-making and help them meet their goals. CARE and its partners also engaged in dialogue with policymakers to increase their capacity for evidence-based planning and greater resource allocation for health. For example, CARE worked with District Councils to build their capacity to include maternal health in district level budgets, in line with national level budget guidelines. Finally, HEqP used important political moments, such as elections, to promote public action on these issues and to influence decision-makers. For example, three political parties changed their election manifestos to include commitments around maternal health, as the result of HEqP's advocacy efforts.

Snapshot of the HEqP

The HEqP activities were implemented to generate evidence of inequitable differences in health access and outcomes and to use this evidence to inform advocacy approaches at different levels of the Tanzanian health and political systems.

The Health Equity Group engaged in several advocacy approaches all of which reinforced one another and aimed to promote citizen engagement and to increase capacity at the local and national levels for evidence-based planning and resource allocation and utilization. Some of these approaches include the following:

- 1. National and local policy engagement and consultation:** The purpose was to influence the commitment of national leaders and policy makers to improving maternal health. This was done through “policy dialogue” with key officials, such as members of the Social Services Committee of Parliament or District Councilors (based on policy analysis to identify gaps and advocate for solutions); research and documentation (e.g., budget policy briefs, barrier analysis, testimonies of health service users; participation in national level consultations or working groups, such as the Safe Motherhood Working Group, that inform government health policies, and reaching out to elected officials to have them sign commitments to improve health services, particularly the areas identified by the communities.
- 2. Public engagement:** Created awareness by highlighting key messages through media (billboards, TV and radio spots); posters (using information gathered from the CSC process and research); fliers; and conferences, advocacy events and key international days (i.e. International Women's Day)
- 3. National campaigns:** The campaigns aimed to build a popular movement around a specific issue, such as a campaign for free maternal health services for all pregnant women, and to highlight any issues that surfaced during the CSC process (i.e., the need for maternity beds, as three women in labor were sharing one bed). Campaigns such as those organized by the Health Equity Group provided highly visible advocacy opportunities in the capital and in Mwanza.
- 4. Community engagement:** CARE used the CSC process to gather community input and to increase capacity for grassroots organizing and networking to influence the prioritization of health resource allocation at the district level. Please see box on CSC.
- 5. Policy and accountability monitoring:** The aim was to monitor the implementation and effectiveness of existing policies and hold governments accountability to their commitments. At the local level, the CSC process was used to monitor both policy and accountability to maternal health. At the national level, budget analysis and other tools were used to bring to the attention of decision-makers and the public the lack of progress being made on maternal health and promote action.

Box 1: The Community Scorecard Process

The Community Scorecard (CSC) process involves citizen representatives and health service providers in a mutual process of identifying problems, generating solutions, and working in partnership to improve coverage, quality and equity of services. Each group (citizens and health providers) separately defines indicators of coverage, quality and equity of services; join together in an interface meeting to agree on a common set of indicators; and then independently score how well the indicators are being met. Where deficiencies exist, community members and providers work together to identify and implement solutions, and then through re-scoring the indicators, assessing whether improvement occurred. The Community Scorecard process has been used in CARE's family planning and maternal health programs in Malawi, Rwanda, Tanzania, and Honduras, and in many other sectors such as girls' education, water management and agriculture in Burundi, Congo, Liberia, Ghana, Papua New Guinea and Kenya.

Outcomes

Given the inherent complexities of advocacy processes, it is often more credible to show how efforts contributed to a specific impact, rather than resulted in such an impact.¹¹ The HEqP evaluation identified several significant project contributions, both in funding for maternal health and greater support for maternal health efforts by policymakers and the public. These included:

Increased resource allocation for maternal health

Through the collective efforts of the HEqP to ensure a 15 percent allocation of the national budget to health, public leaders and government representatives realized the importance of adequate budgeting for health. This was demonstrated through notable, albeit unpredictable, increases in the proportion of Tanzania's national budget allocated to the health sector. The most noteworthy outcomes were resource allocations in the Ministry of Health and Social Welfare budget for maternal health (the Ministry's budgets for 2006/07 and 2007/08 included a budget line for maternal health). The national government also purchased and distributed tricycles to help pregnant mothers in rural areas, which was a key advocacy focus area for CARE. Advocacy on clean delivery kits resulted in the government budgeting for these supplies in the national budget. Budget priority was also given to ensuring availability of skilled birth attendants.

Increased awareness on maternal health

The national level dialogue on maternal health and health issues in general gained intensity. Prior to the HEqP, policymakers were generally not aware of equity issues in health. Following the advocacy interventions, there was a notable increase in the level of awareness of Members of Parliament on equity and maternal health issues. Meeting minutes show more open discussions of maternal health and equity issues by Members of Parliament.

¹¹ See Steven Teles and Matt Schmitt article in the recommended resources section for a discussion on evaluating advocacy efforts.



on the part of health service providers, and provided the basis for policy action with government officials. While difficult to measure, the data indicated that there were improvements in transparency, accountability and quality of service provision. The process resulted in several tangible outcomes, including the district medical officer's providing a midwife in N'gombe community following his participation in an interface meeting. Other outcomes include:

- Improved knowledge of the policy structure guiding health service delivery
- Improved understanding of rights and responsibilities
- Increased public participation in public service provision
- Strengthened relations between service users and service providers
- Strengthened commitment of service providers to fulfill responsibilities
- A better understanding of the constraints faced by service providers in performing their jobs and impede the provision of quality services (i.e., weak supply chain systems and lack of funding)

Lessons Learned, Implications and Insights

The HEqP demonstrates how community empowerment can provide a solid foundation upon which to engage policymakers at the district level and provide data for national level advocacy efforts to address structural and social barriers to maternal health. In addition, HEqPs experience speaks to the need to have strategic, targeted advocacy efforts at all levels. The experience provided several valuable lessons, such as:

With policy action, timing is critical

CARE and its partners worked to leverage specific opportunities to influence decision-makers, such as during elections and at different stages of the budget cycle. For example, HEqP used election campaigns to push the agenda for equity in health which brought noticeable results like re-organizing the election manifestoes of the three most popular political parties to reflect prioritization of maternal health. Posters were also displayed encouraging citizens to vote and to look carefully which political parties were in support of maternal health. Political events are important opportunities for bringing attention to issues.

Importance of having monitoring and evaluation plan

The lack of a monitoring and evaluation plan weakened CARE's ability to demonstrate measurable progress and evidence toward achieving the goal of improved health equity. Advocacy is a long and oftentimes challenging process. Some HEqP stakeholders expressed frustration that Tanzania does not yet have sufficient political will to realize the changes envisioned by the Health Equity Group. A monitoring and evaluation plan with tightly defined outcome and impact indicators provides an opportunity to recognize and celebrate incremental achievements toward the overall advocacy goal. In addition, a strong monitoring and evaluation plan can help the group to assess advocacy efforts in an ongoing way, making any adjustments as needed.

High expectations of Community Scorecard participants

Some CSC participants expressed disappointment in lack of results for the plans they had developed. It is important to offer honest communication and a clear set of expectations about what the process can deliver. This is particularly important given systemic problems in the health systems of poor countries. The CSC process alone will not fix the overall system so it is important that commitments and solutions emerging from the process are feasible, cost effective, measurable and time-bound. Ideally, community empowerment would be coupled with health systems strengthening so that both the "demand" and the "supply" sides of quality health care are addressed.

Evidence-based decision making

The project fostered increased capacity for evidence-based planning, resource allocation and utilization at the local and national levels. For example, a 2008 budget analysis was disseminated to 15 Members of Parliament from both the Social Service Committee and the Finance and Economic Affairs Committee; this sparked a lively debate and helped members realize gaps in the budgeting processes and levels of resource allocations to health in general and maternal health specifically.

Linkages to national and international advocacy movements

The Health Equity Group (and HEqP) provided support and information to the White Ribbon Alliance,¹² a global advocacy alliance on maternal health. The Health Equity Group was also on the board of the International Initiative on Maternal Mortality and Human Rights¹³ and shared learning and experience to inform the global dialogue on rights-based approaches to health. The Health Equity Group also used advocacy forums (e.g., the Gender Festival) to establish linkages between national and local level advocacy movements and advance the cause of maternal health.

Improved maternal health seeking behavior

At the local level, the CSC process revealed improved relationships between service providers and community members (users of services) in areas where the CSC was implemented—an indicator monitored by the CSC process. As a result, more community members were accessing health care services.

Effective community engagement tools

Overall, citizens felt that the CSC process was effective in empowering communities to claim their health rights and overwhelmingly held a positive view of the CSC process.¹⁴ The CSC process was successful in improving community and civil society participation in planning and budgeting for health at the local level and improving the relationship between health service providers and service users. The process acted as a catalyst for ensuring accountability

¹² The White Ribbon Alliance for Safe Motherhood is a global movement advocating so that all women and newborns in every country have the life-saving healthcare which is their right. Visit at: www.whiteribbonalliance.org

¹³ The International Initiative on Maternal Mortality and Human Rights (IIMMHR) is a civil society human rights effort aimed at reducing maternal mortality. Visit at: <http://righttomaternalhealth.org>

¹⁴ The Community Score Card in Tanzania: Process, Successes, Challenges, Lessons Learned, CARE, 2011.

Including policymakers in the CSC process leads to better results

In addition to engaging health care users and providers in the community scorecard process, it is important to include elected officials, as they can garner the political will and resources needed to deliver upon commitments made by participants, as well as to take issues, like supply chain management, to a higher level of government as needed. A thorough stakeholder analysis should be conducted at the outset to understand the community's perspective on who best to engage to ensure that commitments are realized. Also, the buy-in of local officials can be critical when undertaking a participatory process, like CSCs.

Importance of linking advocacy work at national and local levels

Linking local level realities with government officials making decisions is critical to ensuring that the appropriate items are acted upon and in a manner that responds to the needs of the community. Also, because national-level commitments (and resources) do not always cascade down to local levels, it is important to bring this information to decision-makers. It is also important to create stronger feedback loops between community-level advocacy, national-level advocacy and equity activities, to ensure that the activities are successful in achieving the intended equity aims at the community level.

Partnerships require clearly defined plans, processes and support

Advocacy involves working with partners, often in coalitions such as the Health Equity Group. These partnerships require the same attention to detail as do all programming partnerships. In the case of the HEqP, some challenges arose from delayed decision-making, shifting priorities and inconsistent staffing. These problems can be mitigated by developing a memorandum of understanding to guide project direction and build consensus on areas of focus and specific activities; establishing routine and systematic monitoring and evaluation systems; harmonizing management activities through a dedicated focal person for each organization; and ensuring consistent staffing.

Advocacy requires patience and time

As noted earlier, advocacy is a long and complex process, with periods of progress and stagnation; it might even involve backwards movement. This project had significant successes particularly in generating engaged dialogue and meaningful discussions about health equity and maternal health issues; however, it was less successful in realizing concrete actions, political commitments, and improved health outcomes as a direct result of this project. It is important to both recognize the incremental achievements towards the overall goal of improved health equity in Tanzania, while at the same time, build on the progress moving forward.

How to Replicate/Step-By-Step

While these are presented as a linear process, policy action often does not happen linearly, nor require completion of all steps. A strong policy analysis¹⁵ can help determine where you are in the process and what steps need to be undertaken.

1. Adopt a framework to address health inequities.

The "Equity Framework for Health" adopted by the HEqP provides a helpful model of the continuum from analysis to advocacy and dialogue for action. Because maternal health status often reveals inequity, discrimination and denial of rights, the "equity framework" is particularly appropriate and may be useful to others seeking to increase public participation and political commitment for improved maternal health policies and funding. It can also be used as a framework for monitoring progress.



2. Choose partners strategically and establish clear operating guidelines

Given the benefits and necessity of engaging in policy action with allies, it is important to identify partners who can bolster CARE's advocacy efforts with their unique capabilities, constituencies and resources. If it is a formal collaboration, it is helpful to, develop a memorandum of understanding to guide project direction and build consensus on areas of focus and specific activities; establish guidelines for processes such as funding, coordinating campaigns and developing joint positions; harmonize management activities through a dedicated focal person from each organization; and establish monitoring and evaluation systems.

3. Conduct analysis – quantify level of inequities and understand the barriers

Programs that aim to have health equity outcomes need to identify the inequities, the magnitude of the problem, who is affected, underlying socioeconomic issues and barriers that lead to inequity, and how gender relationships affect inequities in health outcomes. Communities themselves should be involved in providing this information. The Community Scorecard process, situational analysis, gender gap analysis, and review of utilization data offer ways to gather these data, which then provides evidence for policy action. The HEqP adopted the Community Score Card process.¹⁶

4. Engage in advocacy and dialogue for action

The information gathered during the initial analysis period will help inform the strategies and activities, which may include the following:

- **Identify advocacy issues, goals and objective:** Clearly articulate and define how equity is defined within the context of your program. It is important to develop and maintain a project-specific definition of equity; one that prioritizes a specific situation of health inequity and concentrates its efforts on addressing that situation.

¹⁵ See the CARE Advocacy Manual for more information on conducting a policy analysis.

¹⁶ For details, please see 1) Community Score Card in Tanzania: Process, Successes, Challenges, Lessons Learned; 2) CARE Health Equity Project Community Score Card Implementation Process 2; and 3) CSC implementation Phase II Process detailed.

- **Determine target audiences:** Identify who must be engaged to contribute to improved health outcomes. This should include policymakers at all levels of government and both elected officials and civil servants (i.e. health officers, budget planners, etc.)
- **Develop and implement strategies:** Project strategies need to align with the barriers identified in the analysis stage and the baseline information about the situation of health inequity. Be clear about which specific actions are aimed at improving equity. Strategies may address underlying conditions and barriers directly or indirectly, and communication channels will be selected accordingly. For example, a targeted ask of key policymakers supported by evidence and budget analysis can lead to a policy change that removes a barrier (i.e. free maternal health services for pregnant women), while a simultaneous media campaign can raise public awareness of the importance of pregnant women receiving the care.
- **Develop materials and tactics to help policymakers endorse favorable maternal health policies:** Providing concise, evidence-based materials with clear action steps will make it easier for policymakers to act. These can include policy briefs, budget analyses, examples of effective programming and legislative recommendations. Likewise, helping their constituents voice their desires and expectations will demonstrate public demand for equitable health services, which will help build political will.
- **Monitor progress and outcomes:** Develop a plan to monitor progress and outcomes along the way. If successful in improving health equity outcomes, the project should articulate how these actions can be sustained and scaled up. Building support for sustaining and scaling up successes is paramount. Use the monitoring and evaluation process to identify changing circumstances which may require a change in strategy, as well as a way to celebrate the shared victories towards the achievement of a long term goal of improved health equity

Recommended Resources

Advocacy Guidelines and Tools, CARE 2000. Available at www.care.org/getinvolved/advocacy/tools/english_01.pdf

Community Scorecard and Citizen Report Card available at <http://go.worldbank.org/QFAVL64790>

Community Scorecard in Tanzania: Process, Successes, Challenges, Lessons Learned, CARE, 2011. Available at <http://familyplanning.care2share.wikispaces.net/MHguidance>

Health Equity Project final evaluation, CARE, April 2011. Available at <http://familyplanning.care2share.wikispaces.net/MHguidance>



