



Working with Individuals, Families and Communities to Improve Maternal and Newborn Health

Programmes in Bangladesh, Burkina Faso, El Salvador, Guatemala and Haiti

1. Background

In 2003 the World Health Organization (WHO) published a strategic framework entitled *Working with individuals, families and communities to improve maternal and newborn health* (WHO, 2003), herein referred to as the IFC framework.

Based on the Health Promotion approach of the Ottawa Charter (WHO, 1986), the framework asserts that working with individuals, families and communities is a critical link in ensuring the recommended continuum of care throughout pregnancy, childbirth and the postnatal periods for women and newborn.

The Secretary General of Enfants du Monde (EdM),¹ Carlo Santarelli, under a mandate by WHO, was responsible for the elaboration of the framework. EdM subsequently adopted the IFC framework to orient its support to maternal, newborn and child health programmes.

1.1. The IFC Strategic Framework

The IFC framework is proposed by WHO as *a key component of maternal and newborn health (MNH) strategies in developing countries*, recognizing that these programmes cannot achieve the desired reductions in maternal and neonatal morbidity and mortality if women and their families have no possibility to be healthy, to make healthy decisions, and to act on these decisions.

The framework emphasizes the positive and active role that individuals and groups can play to improve health, as well as the wide array of influences on health, including social, cultural and economic influences. It is designed to be integrated into national MNH strategies, *to compliment the health service and policy components*.

The integration of the IFC framework within national health programmes has two principal objectives. First, the component aims to contribute to the *empowerment of women, men, families and communities to improve and increase their control over maternal and newborn health*. Empowerment for MNH is a means and an end, and occurs both at the individual level, and also at the collective level, through a process that actively involves people in analysing their situation and in finding solutions.

The second aim of the IFC framework is to *increase access to and utilization of quality health services, particularly those of the skilled attendant at birth*.

¹ EdM is a Swiss NGO, based in Geneva, with regional offices in Bangladesh, Burkina Faso, Guatemala, and Haiti.

The framework identifies key interventions and strategies (based on expert opinion and a review of experiences in different countries) to achieve these aims. These interventions are presented in Table 1 below.

The interventions are categorized into four priority areas, namely:

- (1) **developing capacities** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies;
- (2) **increasing awareness** of the rights, needs and potential problems related to maternal and newborn health;
- (3) **strengthening linkages** for social support between women, men, families and communities and with the health-care delivery system; and
- (4) **improving the quality of care** of health services and their interactions with women, men, families and communities.

The multiple determinants of maternal and newborn health and the proposed objectives of the IFC component require an integrated approach, with consideration to interventions from each of the four priority areas.

An intersectoral approach is also needed, in particular looking to collaboration with education, transport, sanitation and income-generating programmes.

Table 1 : IFC Interventions within the priority areas

Priority Areas	Developing CAPACITIES to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies	Increasing AWARENESS of the rights, needs and potential problems related to maternal and newborn health	Strengthening LINKAGES for social support between women, families and communities and with the health delivery system	Improving QUALITY of care, health services and interactions with women, families and communities
Interventions	<ul style="list-style-type: none"> • Self-care/care in the household • Care-seeking behaviour • Birth and emergency preparedness 	<ul style="list-style-type: none"> • Human and Reproductive Rights • The role of men and other “influentials” • Community epidemiological surveillance and maternal-perinatal death audits 	<ul style="list-style-type: none"> • Community financing and transport schemes • Maternity waiting homes • Roles of traditional birth attendants within the health system 	<ul style="list-style-type: none"> • Community involvement in the quality of care • Social support during childbirth • Interpersonal and intercultural competence of health-care providers

Source: WHO, 2003.

1.2. EdM experience in implementing the “IFC” framework

EdM is working with partners in the following countries, where maternal and neonatal mortality rates remain high, to implement the IFC framework, including: Bangladesh, Burkina Faso, El Salvador, Guatemala, and Haiti. Initial contacts have been made in Niger and Rwanda.

To start the implementation process in each country, discussions were held with different partners, including the Ministry of Health (MoH), NGO counterparts, WHO and other international organizations. An introductory workshop was held in each case to present the framework to partners and discuss its appropriateness and feasibility within the national context and strategy. Details of implementation for each country are outlined further below.

EdM recognizes that in order to have broader impact and sustainability, it is important to assure that its programmes correspond to larger regional and national processes, and in particular with the MoH. EdM encourages local partners to engage in dialogue and efforts to assure insertion into national strategies. Common programmes with different partners (including MoH, other Ministries, local and international NGOs, international agencies) is embraced by EdM as the way forward.

A general model of IFC implementation, inspired by the experience developed by WHO, the Pan American Health Organization (PAHO) and EdM, is being proposed in the selected countries (see Figure 1 in 2.4. Implementation process).

Each country has been encouraged to select, based on agreed criteria, one or two municipality to begin implementation.

Activities at the local or municipal level include preparatory activities, a participatory community assessment (PCA), a joint planning process, implementation of the IFC interventions, and finally evaluation.

Implementation at the local level is supported by the national and district levels, where ongoing activities ensure the integration of the IFC framework into regular health planning processes. (WHO, PAHO, EdM, 2007, in preparation)

Overview of the current situation (as of October 2006) and perspectives

Country	Preparation	PCA	Planning	Implementation	Evaluation
El Salvador	Done	National committee	Beginning 2007	2007-09	2009
Guatemala	Done	Done	Beginning 2007	2007-09	2009
Haiti	Workshop in October 2005	Request received for an orientation workshop	2007	2007-09	2009
Burkina Faso	Workshop in March and June 2006	Agreement with MoH and national committee organized	2007	2007-09	2009
Bangladesh	Done	Done	End of 2006	2007-09	2009

2. The Programme

This section provides more detail of objectives, strategies, implementation process, monitoring and evaluation, and country implementation by region:

- a) **Latin America and Caribbean:** El Salvador, Guatemala, and Haiti
- b) **Africa:** Burkina Faso and initial contacts in Niger and Rwanda
- c) **South Asia:** Bangladesh

Globally, the programme aim to strengthen the capacities of NGO partners, MoHs and other key actors to implement the IFC framework.

2.1. Objectives of the first phase (2007-2009), for all the countries

- Examine the feasibility of implementing the IFC strategy in national health programmes.
- Consider the effectiveness of the framework on health and social development indicators within a broader MNH strategy.
- Promote the adaptation of generic processes and instruments to national and local context.
- Encourage the incremental implementation of the IFC strategy, while planning for long-term national scale-up, based on lessons learned.
- Promote exchanges and networking activities

2.2. Expected results in each country

- Strengthened national and local technical committees
- Strengthened communication mechanisms between local and district/national levels
- Lessons learned shared
- A team trained in the application of participatory assessment methodologies and planning
- A completed participatory community assessment (PCA) in selected localities
- An intervention plan for the selected localities developed and implemented
- A validation of IFC strategic framework by 2009, based on local experiences and evaluations
- The IFC component expanded to other districts by 2009, including adaptation of generic processes and instruments
- Strengthened national capacities in the implementation of the IFC strategic framework

2.3. Programme strategies

The main strategies adopted to achieve the programme objectives are the followings:

Operational strategies:

- Support for health education processes.
- Support to community action for health that refers to the involvement of communities in needs identification, selection of priorities, planning, implementation and evaluation of activities.

Institutional strategies:

- Establishing close collaboration between key actors including health services, education sector, other sectors, NGOs and other local groups, and international organizations at international, regional and local levels.
- Institutional strengthening in terms of planning, implementation and evaluation as well as skills needed for working with communities and for community-health service collaboration.
- Linking different country programmes to offer an opportunity for interaction between national teams, promoting dialogue, collaboration and sharing of lessons learned.
- Give technical assistance and financial support in the application of the framework, and for the development of strategies and interventions; offer tools like for the PCA process.

2.4. Implementation process

The following process is based largely on the experience developed by PAHO, WHO and EdM in El Salvador to begin integration of the IFC component into the current MNH strategy, to allow for country participants to gain experience in participatory methods and approach, and to assure the future scaling-up of activities.

National level

Firstly, it is important to obtain the commitment and involvement of the national MoH. The MoH should ideally be the lead partner in the process in order to ensure integration into ongoing health planning processes, in partnership with other organizations and actors working in MNH.

The IFC strategic framework is intended to be implemented as part of a broader national MNH strategy: actions at the community level must be undertaken in conjunction with both policy and health service actions, to ensure a synergistic effect and that the demand for services created can be met effectively by the health services. As expressed above, a common programme with all the partners involved is the way to move IFC forward at the national level.

In order to coordinate IFC at the national level and to conduct the common programme of actions, it is advisable to form a **national coordination committee**. This committee can be a sub-committee of an existing national MNH committee. Coordination of IFC work includes development of a programme of work, management of national budgets and human resources, selection of implementation sites, support to local committees, documentation of lessons learned, and monitoring and evaluation.

District Level

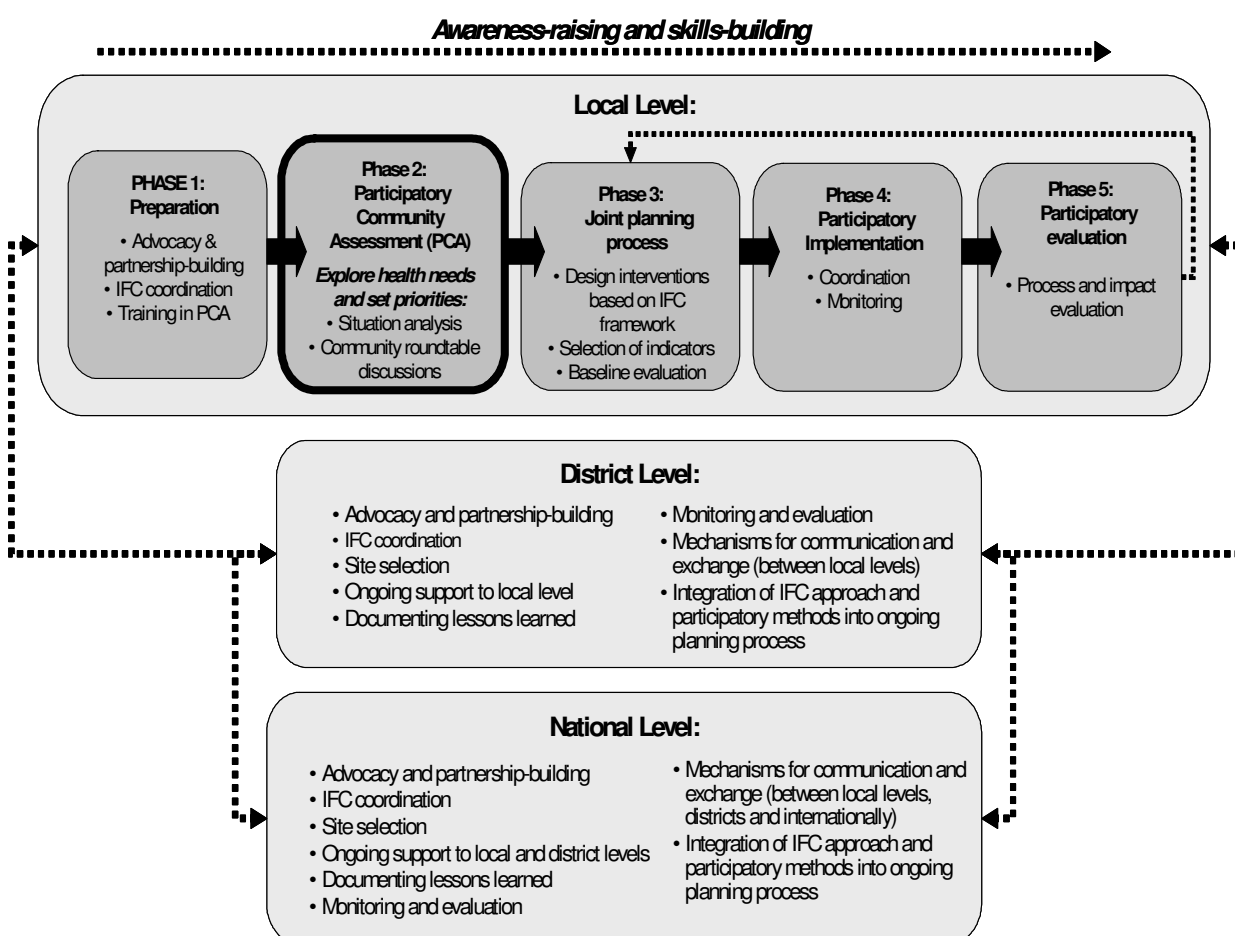
Many of the activities ongoing at national level will be supported by similar activities at the district level. Depending on the size of the country and the configuration of the health system, the national level may have little or more involvement in IFC activities. As with the national level, it is recommended to integrate IFC work into existing MNH committees, and may be necessary to create a subcommittee responsible for IFC. MoH at district level has a responsibility to lead the process and coordination between actors and .

The district level may also be responsible for site selection within their area in coordination with national level committee. They should also usually have representation on the local committees in their area. It will usually be necessary to reallocate resources within the district health sector in support of IFC, both at the local levels and the district level, and it may be important to assign a district coordinator responsible for the IFC component.

Local level

The definition of local level will depend on the geography and health systems of the country, but is understood to mean small towns, suburbs or municipalities (ideally 50'000 to 100'000 people). The various phases of an IFC programme at the local level include: preparation, participatory community assessment, joint planning process, implementation, evaluation. The participatory community assessments are proposed as a step while countries gain experience in participatory planning process and it is intended that these will become part of an *ongoing process*. The health services network, together with the social network, should conduct regular assessments, planning processes and evaluation.

Figure 1: Phased Implementation of the IFC framework



2.5. Monitoring and evaluation

At the country level once interventions have been determined, input, process, output and outcomes indicators are selected. Community participation in monitoring the programme will also be emphasized. No more than 10 indicators should be prioritized (some indicators should be common to all the national programmes), assuring that the information is and will be available. Once indicators have been selected, the programme will need to conduct a baseline evaluation.

Self-evaluation processes will be held annually in each programme and an external evaluation will be carried out in 2009 for all the programmes. The results of all the evaluations (of each country programme) will be presented in a workshop with representation of national and international partners.

Programme monitoring is also assured by the EdM coordination offices of each of the regions (EdM offices in Guatemala, Haiti, Burkina Faso and Bangladesh) and regularly by the head office in Geneva. Each national programme will have a specific planning and contract of collaboration signed by the different actors. A local audit firm will revise the financial reports.

2.6. Country implementation, by region

a) Latin America and Caribbean (LAC) region

One of the first regions to begin implementation was the LAC region. In the region, every year approximately 23'000 women in the region die from complications of pregnancy and childbirth (PAHO, 2003), and 180'000 babies die during their first month of life (PAHO, 2004). The vast majority of these deaths are preventable. Since the late 1980s LAC countries have made important achievements in improving maternal and newborn health, yet significant challenges remain, both in improving the quality of services and in increasing access to them. PAHO's "Regional Strategy for the Reduction of Maternal Morbidity and Mortality" (PAHO, 2002) is designed to address these challenges. The strategy embraces a Health Promotion approach and identifies empowerment of women, families and communities as one of six key areas of intervention. The strategy was adopted by the national ministries of health in 2002.

The Secretary General of EdM (through mandates) participated in three WHO-PAHO regional meetings in the last three years to present the IFC approach and to collaborate in the implementation of the regional PAHO programme for IFC. EdM maintains close communication with PAHO Washington and WHO Geneva.

El Salvador

During the preparation phase in late 2005, the Ministry of Health (MoH) began collaboration with a network of local NGOs, Concertación Educativa de El Salvador (CEES), a long time partner of EdM, to implement the IFC strategy, with support from WHO, PAHO and EdM. A national steering committee was formed comprised of representatives from the MoH, CEES and the national PAHO/WHO office. Two municipalities, Izalco and Nahuizalco, of Sonsonate department were selected as initial implementation sites. Contacts with the departmental health authorities SIBASI and with local authorities were established.

The first stage of implementation, a *Participatory Community Assessment (PCA)*, was finalized in July 2006. A workshop to design the next phase of the programme is planned for early February 2007. Based on this experience, EdM is participating with PAHO and WHO in the development of a generic guide to support countries in initiating IFC implementation and in conducting the PCA.

Guatemala

A local partner, Fundación EcuMénica Guatemalteca (ESFRA), which is a member of the Instancia Nacional de Salud (INS), a network of health NGO's, conducted a PCA process in the southern health area of Guatemala city in two districts, San Miguel Petapa and Villa Canales. A workshop to design the next phase of the programme is planned beginning of 2007.

ESFRA has provided regular updates to the MoH and is also in contact with the PAHO/Guatemala office. Discussions are under way between PAHO and WHO to begin national discussions on implementing IFC and the EdM experience will serve as a model.

Haiti

EdM provides support to the UCS² of the Artibonite district. The different partners in the UCS, including MoH, Service Oecuménique d'Entraide (SOE), l'Hôpital Albert Schweitzer (HAS), Médecins sans frontières (MSF) expressed interest in strengthening their work at the community level.

In October 2005, a workshop was organized by EdM to discuss the IFC approach to the UCS. The MoH (central and district level), the Inter-American Development Bank (IDB), and PAHO/Haiti also participated. The participants expressed interest in moving forward with the approach, however plans have been interrupted due to the political and socio-economic situation.

The IDB supports a programme within the MoH and has expressed a strong interest in adapting the IFC approach within support to the reorganization of the health system. A second workshop is planned for early 2007 to present the implementation process and in particular the PCA phase.

b) Africa region

The average maternal mortality ratio in sub-Saharan Africa is estimated at 940/100'000 live births. The greater proportion of these deaths occurs in rural and disadvantaged communities. It is estimated that nearly two thirds of the eight million infant deaths that occur every year result largely from poor maternal health and hygiene, inadequate care, inefficient management of delivery, and lack of essential care of the newborn (WHO, 1999). Though the clinical causes of maternal deaths are well known and are preventable and amenable to treatment, the unfavourable socio-economic status of women that engender vulnerability to poverty and their lack of participation in decision-making in the communities lead to delay in recognizing the need for care, reaching care and obtaining appropriate care (WHO, 2002).

These problem call for improved health systems and referral as well as action to address socio-economic, cultural and behavioural determinants and gender issues, including power dynamics at the household and community levels. In this spirit, strengthening the capacity of individuals, families and communities to improve MNH has been identified as one of the two objectives of the Road Map for the attainment of the MDG's related to maternal and newborn health in Africa. As in the LAC region, EdM maintains communication and collaboration with the WHO regional office and with the country offices in the countries where programmes are supported. EdM supported the WHO Africa regional Office by presenting the IFC approach in the Inter-country Workshop for Strengthening Newborn Care Into Maternal and Child Health Programmes, recently held for francophone countries in Burkina Faso.

Burkina Faso

² The UCS in Haiti are Municipal Health Units that are decentralized administrative units responsible for carrying out coordinated health activities with the participation of local actors including the community, NGOs and the private sector.

In March and June 2006, two workshops on the IFC approach were organized by EdM in collaboration with the MoH, in particular the Directorate of Family Health. The participants, representing nearly 30 different institutions including WHO, the United Nations Fund for Children (UNICEF) and the United Nations Population Fund (UNFPA), identified existing programmes, partners, supporting national policies, and possible actions.

The MoH has subsequently integrated the IFC approach into the Burkina Faso Road Map for Maternal and Newborn Mortality Reduction. An inter-agency committee has been established with representatives of the MoH, WHO, UNFPA and Family Care International (FCI) to develop an intervention plan. A guide is under development to lay out the process at the national and district level. An agreement has been signed between the MoH and EdM for collaboration in the implementation of the IFC programme and to support the country process.

Niger

The MoH of Niger participated in the first workshop held in March 2006 in Burkina Faso and has expressed interest to go further in analysing its applicability and eventual implementation. Conversations and next steps with MoH Niger and WHO AFRO are pending.

Rwanda

Initial contacts were made with the Swiss Tropical Institute (STI) and the Swiss Development Cooperation (SDC) to discuss the applicability of the IFC approach in an on-going STI-supported programme. Subsequently discussions were held with the MoH and WHO/AFRO and Rwanda in the above AFRO workshop held in Ouagadougou, mentioned above. The Rwanda team expressed interest in learning more about the IFC approach and in holding an introductory workshop in the country.

c) South Asia region

In the South-East Asia Region, pregnancy-related deaths constitute the leading cause of loss of healthy lives among women of reproductive age. This Region alone accounts for 40% of the over 500'000 annual maternal deaths occurring worldwide. Of the 38 million babies born every year in the South-Asia region 1,4 million lose their lives in the first month after life. An additional 1 million are still-born (SEARO 2006).

A large proportion of women each year deliver with no skilled birth attendants, and many more mothers and newborns go without any post-natal care during the most vulnerable days and weeks after birth. Children born to unhealthy mothers are also more likely to be under weight and to have difficulty combating illness. They face an environment that is less able to provide safe and nurturing conditions that are necessary for their healthy growth and development.

The Member States of the South-East Asia Region expressed their concern and adopted a resolution at the 53rd Session of the Regional Committee for South-East Asia held in New Delhi in September 2000. The resolution emphasizes among others, the need to incorporate the national strategy for reduction of maternal mortality and morbidity as an important element of health sector reform.

Bangladesh

An initial workshop was held in October 2004 to introduce the IFC approach to NGO's and the representatives of the MoH (central level). One local EdM partner, PARI (Participatory Action for Rural Innovation) has since then worked closely with health authorities to develop an IFC programme in the Netrokona district.

A situational analysis was carried out with support from EdM in 2005, using qualitative methods to explore individual and community perceptions and practices as well as the availability of MNH services and the perceptions of services providers. The results were shared with district stakeholders in January 2006 during dissemination and consultation workshops. Based on these discussions, a Concept Paper was developed by an EdM consultant, proposing the way forward including the approach, a list of key interventions and steps for implementation. The Paper was shared with local health and family planning authorities during a meeting held in July 2006.

A workshop was organized at the end of August 2006 to develop a common programme for the Netrokona district. In the meeting, partners prioritized the key interventions identified in the Concept Paper. A coordination group with participation of the local health authorities is proposed, and PARI will assume the role for coordinating and implementation of the programme, and will organize regular meetings for planning, monitoring and evaluation. The IFC programme is to begin in 2007 and will continue through 2009. EdM continues to promote discussions on the Programme and on the IFC approach with the MOH and other partners at the national level.

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