MNCH CASE STUDIES DECEMBER 2016

BEING THE CHANGE...
Communities Leading Health Transformation for Mothers and Children

World Vision

EVERY CHILD FREE FROM FEAR

Acknowledgements

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Acronyms

ANC	Ante-natal care
ART	Anti-retroviral therapy
CHPs	Community Health Promoters (Somaliland)
CHVs	Community Health Volunteers (Kenya)
CHWs	Community Health Workers (DRC)
CSOs	Civil society organisations
CVA	Citizen Voice & Action
DFID	Department for International Development
DHS	Demographic and Health Survey
DPT	Diptheria, Pertussis and Tetanus vaccination
DRC	Democratic Republic of Congo
FGM	Female genital mutilation
HIV	Human immunodeficiency virus
IEC	Information, education and communication
LQAS	Lot Quality Assurance Sampling
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MPs	Members of Parliament
NGOs	Non-Government Organisations
ORT	Oral rehydration therapy
PPA	Programme Partnership Arrangement
PSGs	Parent Support Groups
PMTCT	Prevention of mother-to-child transmission
STI	Sexually transmitted infection
TB	Tuberculosis
ttC	Timed & Targeted Counselling programme model
UK	United Kingdom
VHTs	Village Health Teams (teams of CHWs in Uganda)
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WVI	World Vision International
WVUK	World Vision UK

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Introduction

This compendium of case studies showcases some of the core health programming World Vision is carrying out in more than 20 countries around the world. The projects represented here are maternal, newborn and child health (MNCH) projects funded by the UK's Department for International Development through the Programme Partnership Arrangement (PPA), implemented in partnership with Ministries of Health.

The World Vision partnership has established a number of health and nutrition programme models which aim to influence change at three levels: the individual/household level, the community, and the wider environment. The Timed & Targeted Counselling (ttC) model, which was strongly supported through the PPA projects, aims to provide an integrated platform for the 7-11 strategy (see Table 1) at household level by increasing demand for services and strengthening the links between households and the formal health system. Community Health Workers (CHWs) - also known as Community Health Promoters (CHPs), Community Health Volunteers (CHVs) or Village Health Teams (VHTs) in different contexts – are a key stakeholder, and the model builds on capacity-strengthening provided through the national curriculum established by the Ministry of Health in each country. It is not a stand-alone model, but is used together with interventions that strengthen the supply side of community health systems. World Vision's ttC model was developed in 2009 and endorsed by the World Health Organization (WHO), with the first phase of implementation from 2011 to 2013. Revisions have included development of a new monitoring and supervision system and a mobile application, as well as alignment to new WHO recommendations. The latest revision of the ttC model in 2015 has strengthened the focus on early childhood development (cognitive, physical and emotional), male involvement, and supportive counselling of women experiencing perinatal mental health or psychosocial support needs.

Enhanced community-based programming was enabled through this grant with the aims of decreased disease burden, improved nutritional status and increased skilled birth attendant utilisation rates in the following countries: Afghanistan, Democratic Republic of Congo, India, Kenya, Pakistan, Sierra Leone, Somalia (Somaliland), Uganda, Zambia and Zimbabwe. The PPA programming has been instrumental in enabling better access to quality health services, increased protection of vulnerable children and improved maternal and child health outcomes across a range of indicators that lead to reduced mortality and morbidity. In a number of the projects this was complemented by our social accountability programmes, which serve to empower citizens and civil society organisations (CSOs) to increase their influence on the delivery of basic services, influence policies, and strengthen the capacity of duty bearers to respond positively to citizen participation in service delivery decision-making and monitoring processes.

Through these projects there have been some outstanding achievements in the communities in which we work and the scalability of the curriculum is evident. Strategic decision-making is taking place in several countries at Ministry of Health level toward the scale up of the 7-11 strategy nationally, hand-in-hand with strengthening the capacity of health services to respond with quality care for mothers and their children.

Table 1. World Vision's 7-11 Strategy for Health and Nutrition

	PREGNANT WOMEN: 9 MONTHS OF PREGNANCY	CHILDREN: AGED 0-24 MONTHS
CORE INTERVENTIONS	1. Adequate diet 2. Iron/folate supplements & deworming 3. Infectious diseases prevention: Tetanus toxoid immunization, PMTCT of HIV, STI and TB screening 4. Malaria prevention, treatment access and intermittent preventive treatment 5. Healthy timing and spacing of pregnancy 6. Birth preparedness (includes preventing postpartum haemorrhage using misoprostol) 7. Access to quality maternal health services: antenatal and postnatal care; skilled birth attendants	1. Appropriate breastfeeding 2. Essential newborn care (includes chlorhexidine for umbilical cord care) 3. Adequate diet (includes appropriate complementary feeding and Vitamin A supplementation) 4. Adequate iron 5. Full immunisation for age 6. Hand washing with soap 7. Oral rehydration therapy (ORT)/zinc 8. Prevention, care seeking and treatment for acute respiratory infection and malaria 9. Prevention, care seeking and treatment for acute malnutrition 10. Prevention, care seeking and treatment for paediatric HIV (includes ART and Cotrimoxazole prophylaxis) 11. Deworming (12+ months)

UGANDA

An integrated approach: health behaviour change and local level advocacy

Mothers registered in ttC gather for nutrition education session

COUNTRY
Uganda

DISTRICT
Kyankwanzi District

KEY STAKEHOLDERS
Women and children under five
Community Health Workers
CVA committees
Public service providers

PROGRAMME MODELS
Timed & Targeted Counselling (ttC)
Citizen Voice & Action (CVA)

HOW ARE TTC AND CVA INTEGRATED?
CVA committees represent the voices of the community regarding health services, in particular addressing barriers to quality care for women and children in the local context. This leads to strengthened health structures and systems through social accountability, while ttC promotes the same through increased capacity of CHWs to bring about behaviour change in their communities and strengthening the links between CHWs, health facilities and local health authorities.

The Context

Nalinya Ndagire Health Centre, located in the sub-county of Mulagi, Kyankwanzi District, is the only health facility serving a population of 17,500. Historically, the Health Centre was understaffed and lacked basic resources and maternity facilities, affecting provision of effective healthcare. Hard to reach households were particularly vulnerable, with poor access to the facility because families lacked the resources to travel the long distances or found the facility closed on arrival due to lack of staffing. This affected the ability of mothers to give birth at a health facility with a skilled birth attendant. Low rates of exclusive breastfeeding and antenatal care (ANC) visits were also reported by Village Health Teams.

Approach

Through an MNCH project combining individual health behaviour change with local level advocacy in Kyankwanzi and Kiboga Districts, World Vision has made a difference by building the capacity of 236 Community Health Workers (CHWs) and empowering communities, including those in Mulagi sub-county, to advocate for strengthened service delivery.

What is ttC?
World Vision's Timed & Targeted Counselling (ttC) takes a life cycle approach to behaviour change, training CHWs to support pregnant women and children up to two years of age through health messaging, counselling and referrals. Household visits by CHWs are timed at critical stages – four visits during pregnancy, three in the first week of life and a further six in the first two years of life. The visits target households in a family-inclusive way, in particular inclusive of male partners, mothers-in-law and grandmothers who influence key health decision making in the home. Supervision and monitoring of CHWs by health facility staff is also strengthened.

What is CVA?
Citizen Voice & Action, World Vision's social accountability model, serves to empower citizens and civil society organisations to increase their influence on the delivery of basic services, influence policies, and strengthen the capacity of duty bearers to respond positively to citizen participation in service delivery decision-making and monitoring processes (see diagram opposite). The approach has three key stages:

1. Enabling citizen engagement through capacity building
2. Engagement via community gathering
3. Improving services and influencing policy

> "You can even see that VHT functionality is higher in the sub-counties where World Vision is working and lower in the others. Our appeal to World Vision is to expand this project to other sub-counties."
>
> **District Health Officer, Kyankwanzi District.**

CitizenVoice AND ACTION

World Vision

The CVA process: simple and effective

What should my school, clinic, or other facility have according to local law?

What does it actually have?

How happy am I with this service?

Townhall meeting to discuss what community has found with government reps

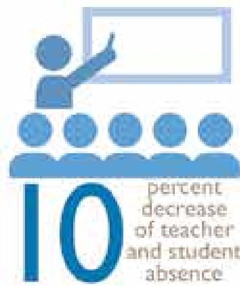
Citizens and government decide on an action plan

Citizens and government improve service

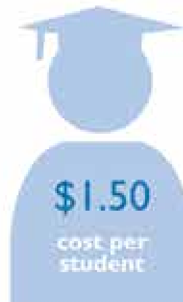
Citizens work with high level government to ensure commitments are met

RESULTS

9 percent increase of test scores in 1 year



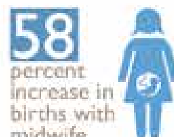
10 percent decrease of teacher and student absence



$1.50 cost per student

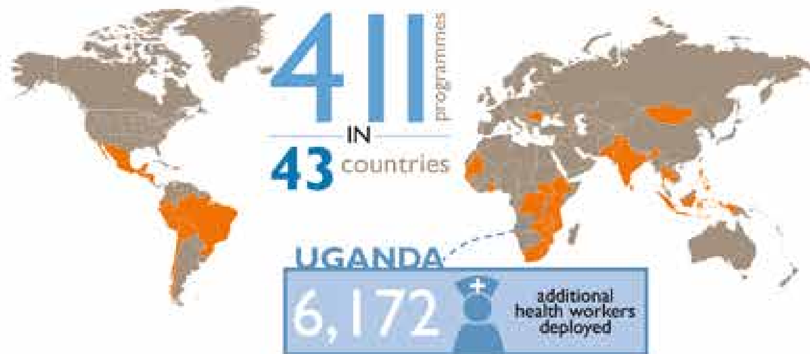
Study of a similar approach found:

33 percent drop in child mortality



58 percent increase in births with midwife

19 percent increase in patients seeking prenatal care



DONOR PARTNERS

RESEARCH PARTNERS

Mothers wait outside a clinic with improved maternity services, established as a result of CVA advocacy

Outcomes

The functionality of the Village Health Teams (teams of CHWs), which are the backbone of the ttC programming, was strengthened in five core components of recruitment, ongoing training, equipment and supplies, supervision and referral systems. The end of project VHT functionality assessment indicated an improvement from 50.7% to 81.9% functionality in Kyankwanzi district. Improved health seeking behaviours were also noted by these populations, particularly in immunisation rates, skilled birth attendance, and continued breastfeeding during illness.

Further to the impacts on VHT functionality and community health behaviours, the CVA approach has helped to enable the following marked achievements at Nalinya Ndagire Health Centre through community-led engagement at facility and district levels:

- Staffing levels have improved, from two staff to 12, through provision of district health funds, with medical clinical officers, enrolled nurses, midwives and laboratory staff now employed.
- Community members contributed local materials for the construction of a maternity ward.
- Quarterly review meetings are now conducted on health service delivery and ANC.
- Nalinya Ndagire Health Centre now carries out outreaches aimed at improving access to essential health services in the hard to reach areas.

"I used to get traditional medicines in place of immunisation, but now I get the ones from the hospital. My first three children died and I didn't immunise them. The VHTs have encouraged me to immunise my other children and I think they are now better protected."

Mother, Kyankwanzi District

"Educating the community about advocacy has created a linkage between the health facility and the community which also benefits the health facility. The activities will continue without World Vision's support because many stakeholders are involved and we decide together on strategies to maintain new activities that are implemented"

Ruth (Clinical Officer in charge)

Lessons learned

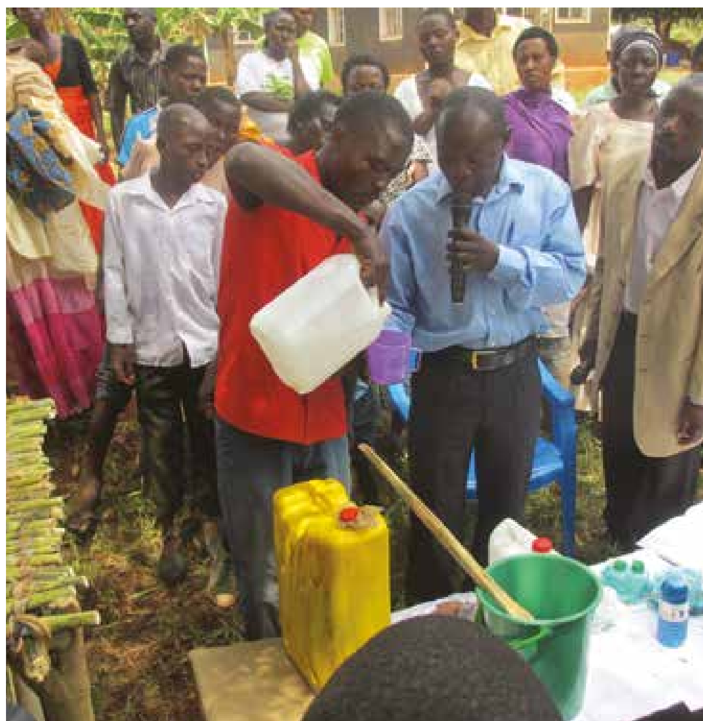
Integration of these two models improves the sustainability of health system strengthening through improved linkages between the various health structures combined with increased demand for services through capacity building and behaviour change counselling.

Recommendations

- Opportunities for scale up of the evidence-based ttC and CVA programming to other sub-counties and districts should be enabled and supported, especially for hard-to-reach communities.
- Lessons learned from the application of the ttC approach should be shared with governments in order to influence their strategy on evidence-based approaches to improve health for the hardest to reach populations.
- Given the increasing expectations of the role of VHTs, coordination, capacity building and supervision should be strengthened to a greater degree at facility, district and national levels and communities should be strongly involved and informed regarding CHW linkages to health facility level.

UGANDA

Enabling innovative piloting of community-led health initiatives



Parent Support Groups demonstrating the local production of liquid soap to promote sanitation in the community

COUNTRY
Uganda

DISTRICT
Kiboga District

KEY STAKEHOLDERS
Households
Parent Support Groups (PSGs)

THEMES
Model Household Approach

HOW DOES THE MODEL HOUSEHOLD APPROACH WORK?
World Vision's Model Household approach is a collective community process that involves parent support groups and households in learning about best practice for improving environmental hygiene in and around the home. The communities themselves work together to identify the best-managed households in terms of environmental health. The addition of incentives for winning households leads to healthier environments for all.

Context for piloting a new approach

During the implementation of the MNCH project, poor environmental hygiene was thought to be contributing negatively to the achievement of indicators related to decreased burden of diarrhoeal illness. In addition to the core health programming carried out throughout the project, new initiatives were able to be piloted in Kiboga District. The following example demonstrates the motivation driving project staff and the community toward improved health at household level, and the innovative problem-solving which was enabled through the project.

Model Household Approach

Living conditions in Kibiga Sub-county, Kiboga District, were characterised by poor environmental hygiene. Contributing factors included poor access to latrines, poor health seeking behaviours related to diarrhoeal illness and fever, and infrequent attendance by mothers and children under five at growth monitoring and health promotion sessions.

The new Model Household approach was adopted in Kibiga Sub County following its success in Rakai District, Uganda, where it has been implemented successfully by World Vision for several years with evidence of improvements in environmental hygiene and improved health outcomes related to diarrhoeal illness. The approach uses a participative process that allows the community to lead in learning about best practice for improving environmental hygiene in and around the home, and together build solutions to sanitation issues using readily available or low-cost materials. Households work together to identify which homes provide the healthiest environment and these are marked as model households from which other community members can learn. The model household process can be incentivised with prizes such as water tanks, soap, lamps and basins which are awarded to the best performing households, however sustainable local sources need to be established as has been done in other parts of Uganda where the approach was first piloted. This can create a sense of healthy competition which leads to better community hygiene and sanitation, and ultimately improved child health.

Steps in WV's Model Household Approach

1. Village Health Teams (VHTs) & members of Parent Support Groups (PSGs) are clustered into small groups.
2. Preliminary assessment of hygiene & sanitation standards of households is carried out to determine mean group performance.
3. Groups are sensitised on the minimum acceptable hygiene standards (e.g. ownership of latrines, drying racks, rubbish pits)
4. Inter-group competitions are launched with members in each group tasked to support each other to ensure all group members meet the set standards in their households.
5. Optionally, prizes can then be awarded to the best performing group after final assessments are concluded.

A tippy tap, which is an improvised handwashing facility to encourage regular handwashing after latrine usage. The rope acts as a fulcrum about which the jerry can turns. A long cord attached to the handle is fastened at the other end to a stick which rests on the ground. When the stick is stepped on by foot, the jerry can tips and water flows. Hand washing soap is suspended beside it

The model can be linked with any community group that is focused on promotion of community health. In the Kiboga project, PSGs were chosen because women play a very key role in decision-making about their children and are the primary caretakers of the home regarding sanitation and hygiene.

Outcomes

While the intervention was not formally monitored for evidence of change, the Model Household intervention was a small component of project programming, which allowed the community to address a barrier to health which they themselves had identified.

VHTs and community members reported the following benefits of the model household approach:

- Increased awareness of the importance of better hygiene and sanitation, and increased social capital - households are learning from each other.
- Household members are empowered to take responsibility for better hygiene and sanitation for their family members.

While the approach seems promising from the pilot in this community, more rigorous evaluation is needed as World Vision implements this in various settings.

Lessons learned

The Model Household approach:

- Is highly cost effective because communities mobilise their own local resources.
- Requires limited technical expertise and is therefore relatively easy to implement.
- Promotes genuine community participation and ownership which makes improvements in hygiene more sustainable.
- Strengthens community structures and relationships, such as the VHTs and PSGs.
- Requires adaptations to local contexts.

"PSGs conduct peer to peer counselling with fellow mothers through dramas and also serving as role models in the community. They have carried out community sensitisation and health education which has greatly reinforced key messages delivered by VHTs under the ttC strategy, thereby promoting positive behaviour change."

Project end-term evaluation

UGANDA

Outreaches and drama to improve ANC attendance in remote communities

A mother and child attend an outreach clinic for education and follow up

COUNTRY
Uganda

DISTRICT
Kiboga and Mityana Districts

KEY STAKEHOLDERS
Mothers, newborns and their families

THEMES
Outreaches to increase ante-natal care (ANC) attendance

WHY IS COMMUNITY OUTREACH NEEDED?

- Word Vision is working in Uganda with community health volunteers (VHTs) to encourage more mothers in remote communities to access antenatal services in order to reduce complications during pregnancy and following birth, such as low birth weight, post-partum haemorrhage and infection.
- The VHTs are testing the use of culturally sensitive and inclusive stories and drama to get the message across to whole families and communities.
- Working this way encourages peer to peer learning which in turn can make health seeking behaviours more sustainable.

The challenge

Mothers in the more remote villages of Kiboga and Mityana Districts are less likely to access health services for the recommended four ANC visits during pregnancy, according to health facility data for these areas. This increases the risk of complications during pregnancy, labour and the post natal period, including increased risk of infection or poor feeding. Some of the reasons for the poor access to services are:

- A small number of health facilities serve large populations. Kambuga Health Centre serves both Kiboga and Mityana districts. This means that women have to travel long distances to receive antenatal care, and some women are obliged to stay at a health facility for several nights. Absence from the home has a negative impact on the welfare of both children and other family members.
- At times health facilities run out of medical supplies, including life-saving drugs. This means that women have even less incentive to access ANC services.

Village Health Teams (VHTs) encourage mothers to attend ANC health facilities at least four times before giving birth. These visits include:

- Weighing mothers and monitoring the weight of their baby to ensure adequate growth and wellbeing of the unborn baby.
- Testing for sexually transmitted diseases.
- Giving mothers information about the benefits of health seeking behaviours, including family planning.
- Increasing mothers' awareness of feeding practices, basic hygiene, and sanitation practices prior to birth.

The impact of outreaches on health seeking behaviours

In order to encourage health seeking behaviours in communities, World Vision is supporting VHTs to do outreach work in outlying villages. They are pioneering the use of culturally sensitive and inclusive stories and drama to get the message across to whole families and communities. Working this way in Kiboga and Mityana has empowered women to share their experiences of seeking health services and to talk about ANC from their own perspectives. Doing this encourages peer-to-peer learning which can support the behaviour change process.

Community members enact a health drama to address barriers to care

Co-creating stories and drama to get the message about ANC across

At a World Vision workshop in 2015 project participants co-created a mini community drama about barriers to ANC and how to overcome them. Making a drama allowed participants to draw on their own experience of ANC challenges and benefits using their own words. The story that emerged was powerful because it allowed the voices of different stakeholders to be heard: mothers, fathers, children, and health centre workers. The story has a ring of authenticity.

The co-creation process highlighted a number of needs and perspectives that might not have been so evident if presented as a traditional case study, including:

- Health workers need to be able to monitor the progress of a mother regularly throughout her pregnancy. Health facilities are often not staffed adequately enough to be able to provide regular outreach services.
- Children and fathers are impacted upon by the absence of mothers when they have to stay overnight at health facilities.
- Mothers value health checks once they understand the benefits and then will spread the word to their peers.
- Mothers can have difficulty breast feeding an underweight baby and need support.
- Bringing outreach services closer to communities enables more mothers to access services.
- Offering small incentives to mothers to attend community outreach meetings is a way of increasing attendance.
- Increased health seeking behaviours are a good thing for mothers, babies, families, and health centre workers, as it reduces length of stay in health facilities, increases the likelihood of a growing and healthy baby, and health centre workers are less overloaded.

SOMALIA (SOMALILAND)

Adaptive programming in the fragile context: addressing barriers to care

A ttC registered mother in Baki is visited by her Community Health Promoter following the birth of her healthy twins

COUNTRY
Somalia (Somaliland)

DISTRICTS
Gabiley, Arabsiyo, Baki and Baligubadle

KEY STAKEHOLDERS
Women and children under five
Community Health Promoters (CHPs)

PROGRAMME APPROACH
Timed & Targeted Counselling (ttC) model

WHY IS THE TTC APPROACH EFFECTIVE IN FRAGILE SETTINGS?
The ttC model is World Vision's core model for MNCH programming. It is designed to promote health behaviour change at individual and household level through home visits, using storytelling, negotiation and dialogue counselling methods which go beyond a health promotion approach. It attempts to identify and explore with household members the multiple social, economic, access and gender-related barriers that prevent individuals from adopting healthy practices. Evidence shows consistently high impact even in very different country settings.

Barriers to care in Somaliland

Effective strengthening of health systems in fragile contexts requires adaptation of programming approaches to fit the context, as barriers to accessing health services are numerous. Poor staffing and lack of supplies due to limited health infrastructure can contribute to poor access to health facilities for antenatal care (ANC) and deliveries, meaning that many women still rely on traditional birth attendants for advice. Before the project started in four districts of Somaliland, baseline surveys showed that only 58.2% of women attended at least four ANC visits, and only 48.5% of children had received their third dose of Diptheria, Pertussis and Tetanus (DPT) vaccination. Some mothers held the belief that vaccination is harmful and will make their child unwell. Other concerns such as cost sharing charges prevented mothers from seeking help, and in some areas women were further deterred from accessing services by their semi-nomadic lifestyle or the need to travel long distances to a health facility.

Adaptive approach

Through a five year MNCH project World Vision has partnered with the Ministry of Health to address the barriers to utilisation of existing health services through:

- Capacity building of Community Health Promoters (CHPs) to use the Timed & Targeted Counselling (ttC) model with adaptations to reflect the realities of the local context, as identified by local health facility staff, CHPs and the wider community: One of the most important tasks a CHP has to do is to visit families in their homes, so she needs to develop good relationships with the family, listen to them, provide relevant information and encourage them to make their own informed decisions. Counselling is a process of working with people in which the CHPs try to understand how the mothers feel and help them to identify barriers to preferred health practices.
- Ensuring culturally acceptable modes of working by providing male counterparts to accompany female CHPs for a greater effectiveness in targeting husbands as decision makers: This reinforces their positive contribution to improved health outcomes for their families.
- Provision of allowances for CHPs, which is mandated by the Ministry of Health in Somaliland: While more sustainable sources for remuneration need to be established, it was strongly evident that motivation levels of CHPs and consistency of their visits to households were higher in this project than those in other countries where CHWs were not remunerated.

"The counselling method of health promotion has been effective in my community as it increases trust. One mother who did not breastfeed her first two children decided to breastfeed her third, following my visits to the household. She saw the benefits and is now convinced." **CHP from Arabsiyo**

Outcomes

Improvements were seen across a number of health indicators, including delivery with a skilled birth attendant, use of long-lasting insecticide nets, and initiation of breastfeeding within one hour of birth. Evidence shows that World Vision's ttC model has brought about change in the way mothers perceive health services, with a corresponding improvement in access to care. Focus group discussions with mothers reflect increased recognition and integration of CHPs by their communities and a perception of improved quality of health services, leading to mothers accessing these services more readily. At the close of the project, 98.1% of mothers had attended at least four ANC visits during pregnancy and 84.6% of eligible children had received their third dose of DPT. There was a 51.4% increase in seeking treatment for diarrhoea.

Health indicator	Baseline (2011)[1]	End term evaluation (2016)[1]
Percentage of women who attended at least four ANC visits during pregnancy	58.2%	98.1%
Percentage of children who have completed third dose of DPT immunisation	48.5%	84.6%
Percentage of caregivers of children aged 0-59 months who had diarrhoea in the past two weeks who sought treatment	24.8%	76.2%

The project also created strong linkages between the health facilities and the community, as the CHPs played a pivotal role in the referrals of mothers and their children. By involving local implementing partners and regional health management teams right from the start of the project, duplication was reduced and resources were more effectively utilised.

Lessons Learned

- There remain gaps in this context in addressing the health and protection of women, especially those between the ages of 12 to 18 years. In some such contexts like Sierra Leone and Sudan we have lowered the target age range for ttC to 12 years, and have begun to include sessions on the delay of fertility and prevention of early marriage through an increased number of household visits.
- Contextualisation of support systems for CHWs working in fragile settings requires consideration of security and movement limitations, access to technology and transport. Moving forward we've learned lessons about how we can work within these challenging settings, including:
  - the importance of security considerations and logistics for CHW meetings and supervision
  - the need to strengthen remote support systems for CHWs e.g. through mobile technology
- In fragile settings, prevention of violence against children and integration of psychosocial interventions for the child are also of high importance. Early engagement with parents for promoting child development and resilience, prevention of child abuse including child marriage and female genital mutilation (FGM), as we are beginning to explore with ttC in Sudan and Mauritania, are priority areas for MNCH programmes in fragile settings.
- When reaching out to women and households it is essential to use culturally appropriate media (videos, radio, songs) and IEC materials that appeal to local rural communities. This enhances community support for behaviour change.

[1] Cross-sectional surveys using representative sampling methods

Recommendations

- CHWs working in fragile settings are frequently the first line responders in stressful situations related both to political and economic fragility and to psychosocial issues such as gender-based violence. In such settings there is a stronger need for training in methods for supporting individuals in distress, such as the evidence-based model Psychological First Aid. We have learned about the importance of increasing community resilience (and surge capacity) by enhancing capacity for dealing with traumatic, post-traumatic, psychosocial, and mental health conditions of women in fragile settings. This needs to be carefully contextualised in partnership with governments.
- Future projects should pay special attention to health behaviour change targeting men where they hold the locus of decision making power in target communities.
- An integrated health approach should be utilised where possible in fragile contexts, comprehensively addressing needs in water, sanitation and hygiene (WASH), nutrition and mental health/psychosocial support in addition to MNCH.

Community Health Promoters meet together in Arabsiyo District

"Before World Vision came here a lot of women were delivering at home, but after the counselling and education we received, many of us now understand that it is better to go to the hospital. Some of the CHPs even accompany us to the health facilities. The project is slowly changing the way we used to do things and we are now more enlightened about seeking health care services both for ourselves and for our children."

Feedback from a mother during the project evaluation

DEMOCRATIC REPUBLIC OF CONGO

Influencing the national health budget: a journey to zero preventable deaths of mothers and children

Mrs Eve Bazaiba, Member of Parliament, committing to "0 deaths due to preventable disease" for women and children.

COUNTRY
Democratic Republic of Congo

DISTRICT
Kinshasa

STAKEHOLDERS
Members of Parliament (MPs)
Ministries of Health and Finance
Civil society organisations (CSOs)
Communities

THEMES
National budget for MNCH
National and local level advocacy

HOW IS AN ADVOCACY APPROACH EFFECTIVE IN DRC?
Multi-stakeholder engagement links the voices of the community with decision makers, including MPs, by collecting information on the change that communities want to see. In addition, community representatives have engaged with MPs to demand better quality services. In parallel, CSOs have also sought to target a wider base of decision makers at national level.

The Challenge

The under-five mortality rate in DRC is one of the highest in the world, estimated at 98 per 1,000 live births.[1] The maternal mortality ratio is 693 per 100,000 live births[2], reflecting a health system with poor infrastructure and chronic underfunding.

In 2001, the DRC government committed to Millennium Development Goals (MDGs) 4 and 5. Despite ongoing commitments to allocate 15% of the government budget to health in order to reduce maternal and child mortality, the health budget remained at 3.9% of government spending in 2013. The country has experienced ongoing fragility and little progress has been made in strengthening maternal, newborn and child health (MNCH) specifically. This has resulted in poor levels of access to quality health services for many in DRC.

Advocacy Approach

As part of World Vision's Child Health Now campaign, a two-pronged approach to advocacy was adopted: engaging with communities at local level, as well as holding regional and national level duty bearers accountable for commitments to maternal and child health.

During the 2014 government budget-making process, World Vision lobbied 146 Members of Parliament using official child and maternal mortality figures as well as evidence from local communities to seek their commitment to secure a greater budget for MNCH. An assessment carried out early in this project highlighted health financing in DRC as a key issue to be addressed in order to improve health systems. In addition, engagement with various stakeholders, including government representatives, provided clear evidence that they supported such an approach. At the national level, the campaign sought to directly influence identified decision makers, and to support advocacy work by other civil society organisations (CSOs) and faith based organisations (FBOs). At provincial level, efforts were made to engage communities in order to increase their understanding of both relevant policies and their role in holding authorities accountable through social accountability.

> "Our government has no choice but to focus on the post-2015 agenda, and they are now clear that they can't achieve this without the civil society coalition. World Vision is very involved in the civil society Health Commission, whose key role is to identify the needs of communities and present them to decision-makers."
>
> Madame Andeka, Coordinator of the civil society coalition

[1] http://data.unicef.org/maternal-health/maternal-mortality.html
[2] http://data.unicef.org/child-mortality/under-five.html

World Vision's 'Global Week of Action' for the Child Health Now campaign, 2012

Steps in the journey toward zero preventable deaths

Key steps in the Child Health Now campaign included:

1. Regular engagement by World Vision with civil society partners and MPs, in particular the Economic and Finance Commission and the Socio-cultural Commission
2. Sharing child and maternal statistics with MPs and lobbying them as national duty-bearers
3. Research into the national budget process
4. Engagement by Child Parliamentarians with national MPs to push the government into action
5. Popular mobilization around child health (Global Week of Action) in partnership with celebrities
6. Training of 25 journalists to improve their understanding of the issues
7. A campaign for improved MNCH budget allocation by involving Ministry of Health officials in relevant publications, radio and television programmes, and posters.

Outcomes

Notably, through national level advocacy, in 2014 the government of DRC declared a commitment to increase the health budget from 3.9% to 7.8% annually. While challenges remain, MPs have committed to ensuring that the allocated budget for health is disbursed appropriately, and civil society organisations continue to hold them to account. The project has also enabled improved relations between civil society and MPs, in particular the Minister of Health and the Minister of Finance.

Through local level advocacy using the Citizen Voice & Action (CVA) model, communities have strengthened the commitment of local government to improving the health system at community level. One example from Kikula, Katanga Province, is that the number of health personnel staffing the local health facility increased from two to six as a result of community advocacy. In Kinkole, the community now has access to drinking water through the actions of the CVA committee.

Lessons Learned

Government officials were willing to endorse the campaign, helping to increase the momentum for addressing high MNCH needs in DRC. Some of the key lessons learned in the process of achieving this were:

- Working strategically together with other CSOs and FBOs resulted in a combined and more effective advocacy campaign.
- Reinforcing the capacity of communities to follow up on health budget expenditure at community and provincial levels leads to greater transparency and accountability.

Next steps

The following recommendations were made from the closure workshop for the project, reflecting the need for sustained advocacy for MNCH by World Vision and other partners:

- Further mechanisms are needed in parliament to ensure upstream budgeting that reflects the commitments made through various agreements, and also to monitor the disbursement of the health budget at community level.
- The creation of an advocacy network composed of MPs, civil society and NGOs is recommended, with the role of investigating how allocated budget is being disbursed and pushing decision makers to increase the health budget to 15% as per the Abuja Declaration.
- Commitments should be made to linking local and national level advocacy by engaging communities through popular mobilisation, sensitisation and awareness raising using social accountability programmes.

KENYA

Sustainable advocacy by communities toward improved health service delivery

Nyamuka CVA committee in Nyatike District

COUNTRY
Kenya

COUNTIES
Homa Bay and Migori Counties

STAKEHOLDERS
Citizen Voice & Action (CVA) committees
Women and children under five
Health authorities and community stakeholders

THEMES
Citizen Voice & Action (CVA)

WHAT MAKES ADVOCACY SUSTAINABLE?
World Vision Kenya has strengthened community-led advocacy widely across its programming through the Citizen Voice & Action (CVA) approach. In Homa Bay and Migori Counties, the committees have remained active beyond the life of the four-year project. What is likely to have contributed significantly to this is that the groups were registered as independent community groups at local sub-county level and were self-governing. Over the course of the project some committees established income generating activities to sustain their action long-term.

Establishing an advocacy approach

Making motherhood safer and improving child survival is at the core of World Vision's mandate. World Vision Kenya is actively involved in a number of initiatives to address maternal, newborn and child health (MNCH), including the Pala area programme in Homa Bay County and Nyatike area programme in Migori County. World Vision's CVA approach was utilised to address weaknesses in health service delivery locally, with the following aims:

- Increase knowledge of community members on their rights for effective and sustained maternal and child health services.
- Increase uptake of positive health practices, especially among pregnant women and children under five years.
- Strengthen health delivery systems and infrastructure to support maternal and child health service delivery.

CVA committees were established as independent community groups, registered locally at sub-county level, with a mandate to promote transparency, equity and accountability in the way local government funds and delivers services to its people. CVA activities are geared toward increasing local and national level advocacy for sustained maternal and child health service delivery. To improve access and uptake of maternal and child health services, CVA groups have also engaged health workers to identify gaps that may hinder health service delivery.

> "Our capacity has been built to the level where we are now able to participate in county budget forums"
> **CVA committee member**

Health dialogue in Homa Bay with various community stakeholders

Outcomes

The end-term evaluation of the project revealed that the CVA approach was used to influence the sustainability and quality of maternal and child health services, as seen in the following examples of change:

- Homa Bay County authorities proposed a revision of the 2014/2015 budget through advocacy at local level.
- Health workers in 10 health facilities now provide on call services to their communities.
- The county government has budgeted for the construction and equipping of a paediatric ward at Kandiege level 4 Hospital, which is the only hospital in the sub-county.
- The CVA committees have engaged the Constituency Development Fund Committee (CDFC) and county government to allocate funds to improve the road networks to help facilitate easy access to various health facilities.
- Partnership between CVA committees and CHVs in 30 communities has strengthened mobilization and sensitization in the community through health dialogues and action days.
- Social audits were conducted on 24 out of 33 health facilities and the reports were shared with key stakeholders, leading to key improvements being undertaken in those facilities.

Recommendations

- The CVA model should take a county-wide approach in implementation because this will accelerate health system strengthening. When people are aware of their rights, responsibilities, and policy entitlements they will advocate the government to improve quality, access, coverage and efficiency of service delivery county- or district-wide, especially in sectors such as health and education that impact children daily.
- CSOs must invest more in facilitating community groups and partners based at the local level to participate in policy formulation and legislation processes. This integration gives credence and legitimacy to the advocacy efforts of the CSOs.

"CVA committees met with facilities whose charges were beyond the ability of mothers to pay, to see how these costs could be reduced or supplemented by local government. Mothers can now have their delivery at a health facility at a subsidised cost."

Shaban, Public Health Officer

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