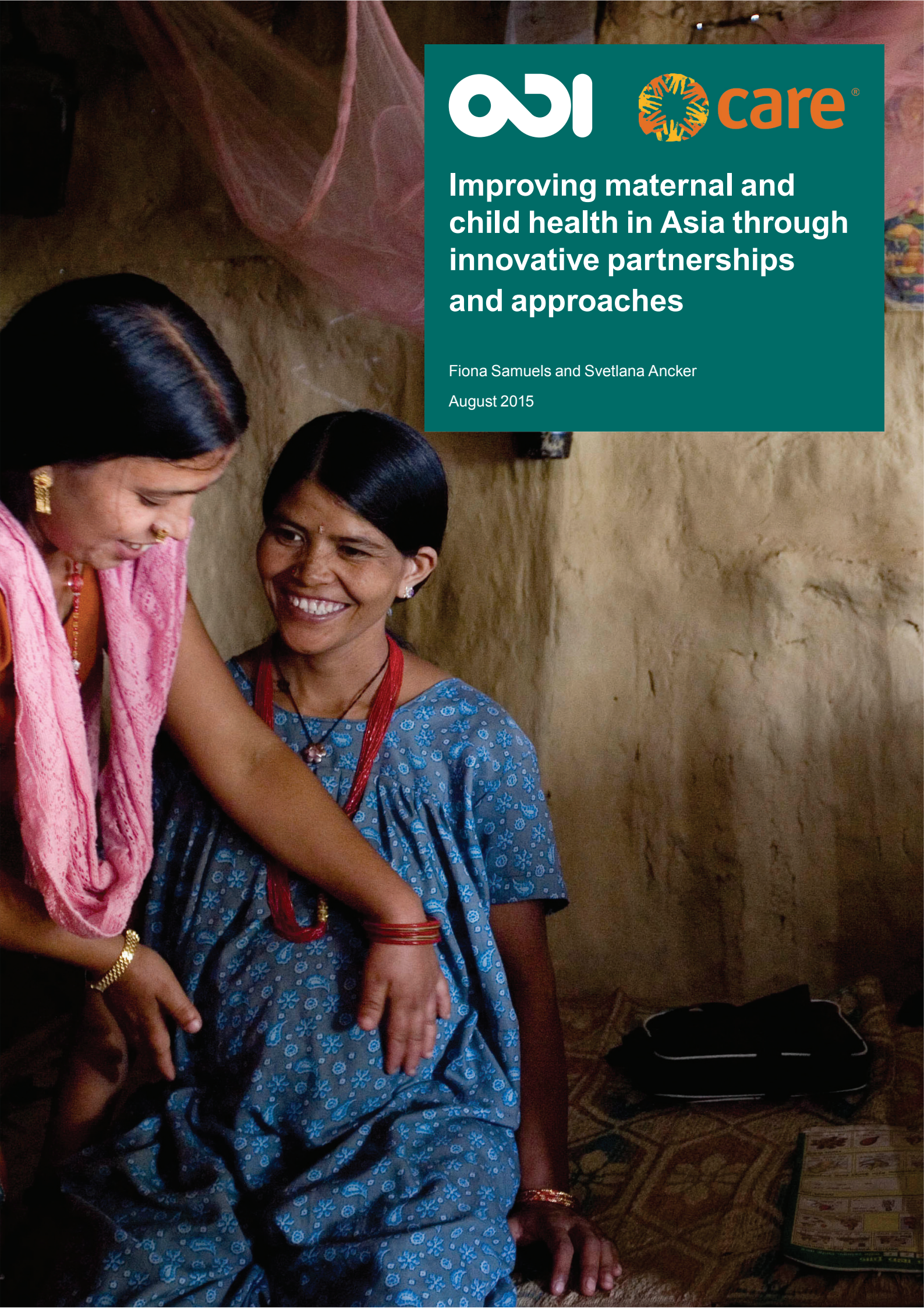

Improving maternal and child health in Asia through innovative partnerships and approaches

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Abbreviations

AMW	Auxiliary midwife
ANC	Ante-natal care
ANM	Auxiliary nurse midwife
BPHS	Basic package of health services
CBE	Community based educator
CBSS	Community based surveillance system
CEmOC	Comprehensive emergency obstetric care
CHV	Community health volunteer
CHW	Community health worker
CmSS	Community support system
CMW	Community midwife
CSP	Community support programme
DOH	Department of health
ENC	Essential newborn care
FCHV	Female community health volunteer
FHAG	Family health action group
FWDR	Far west development region
GoB	Government of Bangladesh
GSK	GlaxoSmithKline
HA	Health assistant
HFOMC	Health facility operations and management committee
HW	Health worker
IMCI	Integrated management of childhood illnesses
MCAT	Midwife coordination alliance team
MMR	Maternal mortality ratio
MNCH	Maternal and neonatal child health
MoH	Ministry of health
MoHFW	Ministry of health and family welfare
MOHP	Ministry of health and population
MoPH	Ministry of public health
OMID	Opportunities for mother and infant development
P-CSBA	Private community based skilled birth attendant
PMR	Peri-natal mortality rate
PNC	Post-natal care
RGoC	Royal Government of Cambodia
SAMMAN	Strengthening approaches for maximizing maternal, neonatal and reproductive health
SATH	Self-applied technique for quality health
SBA	Skilled birth attendant
TOT	Training of trainers
UNICEF	United nations children's fund
UNFPA	United nations population fund
VDC	Village development committee
VERS	Village emergency referral system
VHSG	Village health support group
WHO	World health organization

To help respond to a shortage of 7 million health workers worldwide and a growing overall burden of disease, CARE International UK has entered into partnership with GlaxoSmithKline (GSK) as the implementing partner of GSK's 20% Reinvestment Initiative in Asia. This corporate community investment initiative aims to reinvest 20% of the company's profits into strengthening of community health systems in six of the least developed countries in which GSK operates. This strategic partnership between CARE and GSK focuses on improving maternal and neonatal child health by improving the quantity and quality of frontline community health workers in the most remote and marginalised communities in Afghanistan, Bangladesh, Cambodia, Laos, Myanmar and Nepal. Through a mix of programming, lesson-learning and advocacy efforts, the initiative hopes to galvanise further national and international action on the health workforce issue. The CARE-GSK partnership is about to complete its first phase (2011-2015) and plans to continue and scale up its projects in 2015-2020.

This briefing provides highlights from the six country projects. First, it presents the key indicators and context for each of the countries, followed by the goals and objectives of each project, and then outlines their achievements and impact. The briefing ends with a discussion of the key approaches and models that the projects have developed also providing some broad conclusions and recommendations for strengthening community health systems with a particular focus on maternal and child health.

Afghanistan

Key health indicators and context

Afghanistan has the second highest maternal mortality rate in the world. Despite the fact that contraceptive prevalence has increased from 16% in 2005 to 21.2% in 2010, Afghanistan continues to observe the highest birth rates in the world. Although there has been an increase in the number of functioning health facilities across the country from 496 in 2002 to over 2,324 in 2014 (MOPH 2014), utilisation remains low especially with regard to maternal and infant health. In 2010, even though 51.2% of pregnant women received antenatal care and the use of Skilled Birth Attendants (SBAs) increased from 16% in 2005 to 39.9% in 2010, most women still delivered at home (USAID 2013). One of the main reasons for low use of birth attendants is that the vast majority of health care workers are male, and stringent cultural practices prevent many women from approaching male health care providers. Two out of five children suffer from malnutrition, and child mortality in Afghanistan is one of the highest in the world – the probability of dying among children under the age of five is 102 per 1,000 (CSO/UNICEF 2012). Most causes of mortality are preventable and treatable, such as diarrhoea and acute respiratory infections, chronic malnutrition among all under-five children is still very high (39%) and micro-nutrient deficiency is widespread (MOPH 2012).

The Ministry of Public Health (MOPH) has identified the improvement of maternal and child health as a high priority, as evidenced by the National Reproductive Health Strategy, where a Basic Package of Health Services (BPHS) is being rolled out across rural Afghanistan. CARE is committed to supporting the MOPH's mission by working in areas not covered by the BPHS to overcome the barriers to accessing maternal and newborn health care and facilitating the holistic chain of service delivery.

Project goal and objectives

In 2012-2015, CARE Afghanistan, together with GSK, has implemented the Opportunities for Mother and Infant Development (OMID) project in 23 targeted communities in District-1 of Kabul City. District 1 was identified by the MOPH as a priority district due to the inadequacy of services currently in place to cover the estimated 3,435,000 population (although the actual figure is likely to be double this), as well as the poor living conditions, low incomes, and increasing vulnerability of the population.

The overall goal of the project was to contribute to the reduction of maternal and infant mortality and morbidity through community-based intervention by Community-based Educators (CBEs) and Community Midwives (CMWs) in these 23 communities of District 1 of Kabul city. Specific objectives are to:

- establish a community-based surveillance system (CBSS) in 23 communities in District 1 of Kabul city, to assess perinatal health outcomes for improved maternal and child health indicators
- enhance community mobilisation and participation of influential community members in community-based health services and strengthen local networks (e.g. shuras) as preventive maternal and child health care centres
- intensify the community outreach program to expand project intervention in urban and semi-urban setting communities of Kabul sub-districts, through review of data on maternal and child health indicators and an assessment of one Kabul sub-district

Table 1: Key health indicators

Maternal mortality ratio (per 100,000 live births)*	327
Coverage of antenatal care (%)**	At least one visit – 51.2% At least four visits – 9.9%
Births attended by SBAs (%)**	39.9%
Coverage of tetanus vaccination (% of pregnant women)**	35%
Total fertility rate (per woman)*	5.2
Contraceptive prevalence (% of women 15-49)***	21.2
Crude birth rate****	34

*Source: * APHI et al., 2011; ** CSO, 2014; *** CSO/UNICEF, 2012; **** World Bank, 2015*

Key achievements and impacts in 2012-2015

Project achievements	Project impacts[1]

• A total of 414 frontline health workers, including 4 CMWs, 12 CBEs, 264 members of the Family Health Action Groups (FHAGs) and 134 members of the male health shuras (committees) have been trained.
• 2 maternal health centres were opened and staffed with 4 community midwives.
• 12,176 women of reproductive age, including their infants and toddlers, have directly benefitted from the project.
• A total of 46,650 visits have been conducted to 3,204 households in targeted communities by CBEs and CMWs.
• 37,235 members of the families of direct project beneficiaries and other community members benefitted from the project through education and awareness raising activities.
• 22 FHAGs and 10 male health shuras have been established and are now functioning.
• 2,038 pregnant women have received 4 recommended ante-natal care (ANC) services and 1,325 postpartum women have received post-natal care (PNC) services.
• 16,679 cases have been referred by CBEs to OMID health centres and 879 cases were referred by OMID health centres to higher level government health facilities and hospitals.
• The following supplies and medication have been distributed:
  • 1,922 pregnant women received 1,922 safe delivery kits.
  • 3,164 women received 64,771 condoms and 1,369 women received 4,378 packs of contraceptive pills.
  • 3,414 women have received 134,004 tablets containing iron and folic acid to treat anaemia.
	• The maternal mortality ratio (MMR) has reduced from 309.6 to 121.5 per 100,000 live births.
	• The perinatal mortality rate (PMR) has reduced from 18.3 to 12.2 per 1,000 live births.
	• The infant mortality rate has reduced from 15.5 to 10.2 per 1,000 live births.
	• Exclusive breastfeeding of infants (0-6 months of age) has increased from 46.7% to 70.9%.
	• Coverage of ANC visits has increased from 46% to 98%.
	• Contraceptive use has increased from 25.7% to 76%.
	• Institutional delivery rates have increased from 87.5% to 98.5%.
	• Knowledge of danger signs of pregnancy (3 or more signs) of the pregnant women has increased from 7.4% to 99.5%.

Bangladesh

Key health indicators and context

Bangladesh has been able to reduce its MMR from 340 to 170 maternal deaths for every 100,000 live births from 2000 to 2014 (world Bank 2015). Despite this achievement, only 37.4% of deliveries occur in health facilities, only 42.1% of births are attended by a medically trained provider, and only 23% of women with complications receive Comprehensive Emergency Obstetric Care (CEmOC) services, with large discrepancies in the use of these services between the urban (38%) and rural areas (18%) (BDHS 2014). Table 2 summarises key health indicators.

Sunamganj was selected as the project district for the CARE-GSK Community Health Worker (CHW) Initiative for three reasons: it is an underserved remote *haor*[2] area that has poor maternal, newborn, and child health indicators when compared to the national averages; it is a priority district for the Government of Bangladesh (GoB); and it has the potential for collaboration and synergies with other development projects.

1 Data was obtained from the CBSS.

2 A *haor* is a wetland ecosystem in the north eastern part of Bangladesh which is a bowl- or saucer-shaped shallow depression, also known as a backswamp.

Box 1. Case study of a P-CSBA

Nishad* lives in Dowarabazaar Upazila. A widow and a mother of two children, she was trained as a P-CSBA in November 2013. Although her catchment area is big (three wards of Mannargaon Union with 1,673 women of reproductive age), her average monthly income was stagnant, at around BDT 1,133. As a part of internal and external assessment of P-CSBA, JITA identified the reasons for the lack of growth in her income to the desired benchmark of BDT 5,000. These included a lack of support from her extended family, her own feelings of insecurity when visiting new areas and a lack of awareness about the services she provides in the community. To address these, JITA developed an action plan that focused on engaging her family members and getting their support for child care while she goes to work, engaging local decision-makers and community leaders to ensure her security in the areas where she works, and introducing her to community members and building her credibility through yard meetings. JITA also helped her to develop a list of health, hygiene and nutritional products that she can sell in addition to her skilled maternal and neonatal child health services. As a result of these efforts, her monthly income increased to BDT 7,500 by February 2015.

*Name changed for the purpose of anonymity.

Project goal and objectives

To address the shortage of qualified health workers in remote communities, the project is strengthening community health systems in 50 unions of Sunamganj district through a public–private partnership. The goal of the project is to improve the health of women and children in these remote communities by enabling increased access to health services. The project is targeting 1.4 million people and its original aims were to:

- train 150 skilled CHWs
- build the capacity of community groups
- establish community-led accountability mechanisms
- leverage lessons learned to improve maternal, neonatal and child health (MNCH) outcomes in remote, under-served and poor communities
- strengthen relationships with local government at the union and Upazila levels, as well as with the overall health system.

Table 2: Key maternal, neonatal and child health indicators in Bangladesh

Indicators	National	Rural
Family planning*		
Total fertility rate	2.3	2.4
Contraceptive prevalence rate (modern methods)	54.1%	53.2
Unmet need for family planning	12%	12.9%
Maternal health**		
Maternal mortality ratio (per 100,000 live births)**	170	N/A
Deliveries by medically trained personnel	42.1%	35.6%
Deliveries in health facility	37.4%	30.6%
Deliveries by untrained traditional birth attendants	37.5%	41.8%
Women who get four antenatal care visits	31.2%	26.1%
Women who get a post-natal care visit by a qualified provider within 48 hours of delivery	34%	N/A
Child health**		
Under-five mortality ratio (per 1,000 live births)	46	N/A
Infant mortality ratio (per 1,000 live births)	38	N/A
Neonatal mortality ratio (per 1,000 live births)	28	N/A
Newborns breastfed within the first hour	57.2%	57.7%
Newborns bathing delayed to 72 hours after birth	34.4%	35.3%
Children with acute respiratory infection for whom treatment is sought from a qualified health provider	42%	39.3%

*Source: *Bangladesh Demographic and Health Survey, 2014; ** World Bank, 2014.*

The specific objectives were to:

- enhance community efforts to create local solutions that improve MNCH outcomes
- create sustainable health providers that offer affordable and high-quality MNCH services in remote communities
- enhance the effectiveness of community-led support and accountability mechanisms
- leverage lessons learned to improve MNCH health outcomes for remote communities in Bangladesh

Project achievements in 2012-2015

Training of CHWs

- 168 P-CSBAs (Private Community Based Skilled Birth Attendants) have been trained, have graduated and are now providing maternal and child health services in 150 remote wards of Sunamganj.
    - Services provided have included: 8,918 deliveries, 79,552 ANC visits, 38,785, PNC visits, 11,691 services related to children; and referrals of 2,560 women and children to different health facilities.
- 2,112 CHWs were trained in pregnancy registration, birth preparedness, essential newborn care, family planning, essential health service promotion and referral.
- 1,050 public health-service providers and workers were trained in community-based birth attendance, training of trainers (TOT) on (integrated management of childhood illnesses) IMCI, supportive supervision of P-CSBAs, performance monitoring and data-based decision-making.
- 185 Community Support Systems (CmSS) were established and are now functioning, and the capacity of their 3,100 Community Health Volunteers (CHVs) has been enhanced.
- There has been engagement with 50 Union Parishads (local government bodies), and 700 local-government elected members have been trained on their roles and responsibilities in improving maternal and child health in their respective constituencies.

Infrastructure

- 10 skill labs have been established in the government hospitals of Sunamganj, where P-CSBAs are provided with hands-on and needs-based refresher training by Ministry of Health and Family Welfare (MoHFW) health providers and medical doctors.

Awareness-raising

- 181 folk-song sessions have been organised to introduce and promote P-CSBA services and to address MNCH issues in the project communities.
- 7,250 courtyard sessions were held to promote P-CSBAs and their services, and raise awareness of the services offered by skilled MNCH services.
- 25,616 birth planning sessions have been conducted.

Advocacy

- A biannual Technical Advisory Group was established and two meetings were held.
- Five issues of a bi-annual newsletter were published, outlining project progress, findings and learning.
- The baseline study was published and disseminated through workshops at national and district level.
- A national round table entitled 'Human Resources for Health: Foundation for Universal Health Coverage and the post-2015 development agenda' was organised.
- Together with government, health-related informational and advocacy activities were organised (e.g. rallies, health education sessions, health camps, and key days campaigns – World Health Day, Safe Motherhood Day, the Measles-Rubella Campaign and 21 National Immunisation Days).

Beneficiaries

- A total of 367,186 direct beneficiaries were reached, including mothers and children.
- A total of 1,101,558 family members and community members have benefitted indirectly.

Cambodia

Key health indicators and context

Cambodia's MMR has shown a remarkable decline in the past decades, from 472 per 100,000 live births in 2005 to 170 per 100,000 live births in 2014 (CDHS 2014). This is largely due to improvements at the health facility level, with access to skilled birth attendants and facility-based deliveries increasing: the percentage of babies delivered by a health professional has increased from 44% in 2005 to 89% in 2014 (CDHS 2014). Similarly, the proportion of babies delivered at a health facility nearly quadrupled between 2005 and 2014 (22% in 2005 versus 83% in 2014). There are significant variations according to whether a woman resides in an urban or rural area (96% of births to urban women were delivered in a health facility compared to 81% of births to rural women), and whether she is educated (68% of women with no education delivered in a health facility, compared to 81% with at least some primary education, 92% with some secondary schooling, and practically all women with more than secondary education). Overall, 56.3% of women are using some method of contraception; the majority rely on a modern method which has increased over the past 10 years, from 27% in 2005 to 39% in 2014. Childhood mortality has also seen remarkable progress and rapidly declined between the 2000 and 2014 CDHS, see Figure 1.

Despite this progress, there is still great unmet need among populations in the lowest wealth quintile, in households where the mother has not attended school and in rural areas, indicating that further improvements are required to community health services. The Health Strategic Plan for 2008 to 2015, developed by the Royal Government of Cambodia (RGoC), aims to address these gaps and CARE has been working in collaboration with the Ministry of Health (MoH) to support programming priorities focusing on improvements in maternal, neonatal and child health, particularly for populations in remote and marginalised communities.

CARE Cambodia identified Koh Kong province for project interventions. The total population of the province is 117,481 people, with 81,428 residing in rural areas. There are two operational districts, Sre Ambel and Smach Mean Chey, supporting 62 villages with 12 health centres and three health posts. Primary barriers to health services in Koh Kong province are the inability of households to secure funds for treatment, including user fees and transport costs, and the distance between health facilities and communities (CDHS 2014). Additional barriers include:

- a poor model of integrated postpartum coverage for women and children
- lack of regular outreach activities that enable communities to access health services
- lack of an integrated approach for prevention and treatment services
- poor community and health-centre-level management of comprehensive diagnosis and treatment of illnesses
- a mobile and transient population.

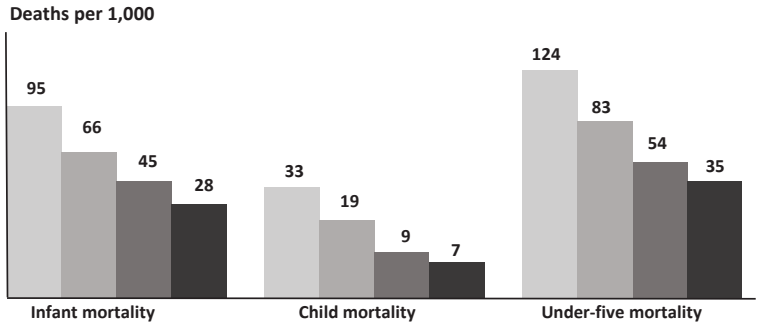
Project goal and objectives

The overall goal of the project is to contribute to the reduction of maternal and neonatal mortality through increasing access to and the quality of sexual, reproductive, maternal, neonatal and child health services.

Specific project objectives include:

- improving the effectiveness and quality of health services by enhancing the capacity and motivation of health workers to facilitate more comprehensive and integrated services
- enhancing health centre outreach mechanisms to improve access and utilisation of health services, including prevention services such as vaccination
- improving the capacity and motivation of Village Health Support Groups (VHSGs) to provide key health messages to communities and households
- advocating with key MoH partners and stakeholders to inform future MoH protocols, guidelines and policies by leveraging the visibility and successes of project activities.

Figure 1: Trends in childhood mortality 2000-2014



Project achievements and impacts in 2011-2015

Project achievements	Project impacts
• 489 midwives and medical doctors from 12 health centres and two hospitals in remote rural areas have been trained through Midwife Coordination Alliance Team (MCAT) meetings in 2012-2015. • 14 MCAT meetings have been held and provided midwives with the opportunity to practice their skills and share experiences with one another. • 452 health staff have received on the job training and supervision from the 12 health centres. • 135 spot checks on outreach services have been carried out to ensure these were regular, consistent and offered full supplies of vaccines and medications. • 56 meetings have been conducted with key stakeholders to share project successes and advocate for increased support and resources towards maternal and child health. • 245 Village Health Support Group (VHSG) members have been trained to share health information and hold monthly education sessions in their communities. • The project has reached 97,183 direct beneficiaries, including 22,111 community members reached through monthly educational sessions and 75,072 mothers and children through outreach service delivery (e.g. vaccinations) by health centre staff. • A total of 58,614 people (indirect beneficiaries) have been reached through health education sessions since the beginning of the project. • 12 health centres have been supported with safe delivery kits and other supplies.	• The percentage of pregnant women who attended all four recommended ANC visits increased from 33% in 2012 to 49% in first six months of 2015. • 56% of mothers/newborns attended postnatal care at the health facility within 24 hours in 2014 compared to 48% in 2012. • 97% of under-1 year olds received all vaccinations within the national health program for Cambodia in 2014. • All children under 5 years of age received vitamin A supplementation in 2014 • 50% of reproductive-aged women were using modern contraception in 2014, compared to 42% in 2012. • Delivery at health facilities by skilled heath providers rose from 54% in 2012 to 57% in 2014.

Laos

Key health indicators and context

Since 2012, CARE and GSK implemented two projects in Laos: a project in 2012-2013 focused on supporting improved access to basic health care and sanitation for remote ethnic communities; and a project in 2014-2015 trained health educators and assisted female garment factory employees to better manage their health, pregnancy and wellbeing through a combined approach of health training and mobile clinic access.

Over 80% of people in Laos live in remote rural areas without access to basic health services and sanitation facilities, while the capacity of community health workers in remote areas of Laos is quite low as training has been sporadic and they receive very little follow up and support. In the meantime, Laos has been experiencing high levels of migration from rural areas to Vientiane. Out of an estimated 30,000 people employed by the Laos garment industry approximately 85% of workers are female, and 50% of these women come from rural areas of the country with the aim of supporting their families back at home. Many garment factory workers suffer from chronic health problems due to a lack of nutritious food intake and poor ventilation in the factories. Additionally, their knowledge of sexual and reproductive health is inadequate, while access to health services is limited largely because government health centres opening times are not convenient for them. As such, they seek health services from unregulated private health service providers or through pharmacies. These service providers frequently do not meet the women's needs nor do they maintain confidentiality; furthermore, because of the low social standing of many of these women as well as their limited knowledge of the Lao language, they are often discriminated against.

Project goal and objectives

2012-2013 project goal: to increase community access to health services and sanitation in remote and marginalised villages of Laos. Key objectives were:

- providing training and supportive supervision to 43 village health volunteers in order to improve their ability to deliver quality health services for communities
- increasing the visibility and motivation of these village health volunteers by training them and supporting with educational materials .
- installing 200 latrines in selected project villages to mitigate the health risks of open defecation.

2014-2015 project goal: to improve the quality of services and the promotion of good health by increasing the skills of health workers. Specific project objectives included:

- improving the health and livelihood of migrant girls and young women working in the garment and entertainment industries located in Vientiane Capital, by supporting and promoting access to skilled health workers (mobile clinics), access to information and training on nutrition and sexual and reproductive health and life skills
- establishing a well-qualified pool of health educators to deliver training, outreach and awareness raising campaigns on health and life skills for marginalised urban women. By organising and facilitating monthly meetings the project promotes learning and exchange and increases the evidence base for future interventions and projects. Evidence and case studies can also inform decision-making processes that affect the target population (labour law, sexual and reproductive health (SRH) policy, advocacy efforts to end violence against women).

Project achievements in 2011-2015

Project achievements

2012-2013 project

- Constructed a total of 197 latrines in Samphan, Mai and Khua districts of northern Laos.
- Trained 43 village health volunteers in 43 villages (one in each village).
- Restocked the medicine box of the village health volunteer in each of these 43 villages, enabling 11,563 community members to have access to basic care and medicines at the community level.
- 1,116 community members benefitted from improved sanitation facilities in 5 villages.**2014-2015 project**

- 8 health workers (doctors and nurses) have been trained in SRH and counselling.
- 20 staff from the implementing NGOs – Laopha and Vientiane Youth Centre – have received capacity-building training.
- 20 heath educators (Laopha volunteers and factory peer educators) have received 12 training sessions which have included modules on decision-making, women's rights and violence, reproductive health and family planning (including condom use and negotiation), assertive communication, and healthy eating and nutrition.
- 20 health educators have provided 79 outreach activities in 13 garment factories, including education on nutrition and healthy eating, family planning and condom use negotiation, and reached 890 female garment workers.
- 2,208 people have received counselling and information about STIs/HIV prevention, and family planning services at the Vientiane Youth Centre (VYC) Clinic.
- 3,767 people (including 2,707 females) have been reached as direct beneficiaries.
- 7,534 indirect beneficiaries have been reached through their friends and partners.
- 80 mobile clinics have provided health services at 72 garment factories in 3 districts in Vientiane.
- 1,788 factory workers have received health services from mobile clinics.

Box 2: The impact of mobile health clinics

"It is very good that garment factory workers get an opportunity to check their health and get counselling and right information. It is not only me that has health problem and I think there are many girls who also have problems. They have limited time to see a doctor. Many girls come from remote areas and don't know how to get to the clinic or hospital. They are very shy to talk about personal issues to other people or afraid they will not keep confidentiality. So when they have menstrual issues, discharge and STD or other issues they buy medicine at the pharmacy to treat it themselves."

Maile,* garment factory worker, Vientiane

*Name changed for the purpose of anonymity.

Myanmar

Key health indicators and context

Despite political commitment and continuous efforts by multiple partners, the status of reproductive health in Myanmar remains a challenge, marked by the high, though albeit declining, MMR. In 2013, it stood at 200 per 100,000 live births (World Bank 2015). Although use of skilled birth attendants has increased over time, around one-third of women still continue to have unsafe deliveries (MOH/UNICEF 2013). The infant mortality rate is 62 per 1,000 live births, while the under-five mortality rate is 72 per 1,000 (MIP 2015). Prematurity, low birth weight, sepsis and birth asphyxia are the leading causes of neonatal deaths, and malnutrition continues to be a major public health concern (MOH 2009). In response to these health challenges, the Government of the Republic of the Union of Myanmar committed to meeting Millennium Development Goals 4 and 5 and aimed to improve maternal and child health outcomes by setting various targets and developing national plans and guidelines. For example, the National Health Plan (2011-2016) identifies maternal and child health services as a national priority.

However, meeting these national and international goals and targets has been challenging due to the remoteness and limited availability of health services in rural areas, out-of-pocket health expenditure, shortages of supplies and essential medicines, inadequate quality and availability of human resources, and poor infrastructure and logistics.

CARE's project focused on the Lashio and Kayah townships, which are home to ethnic minorities and where development indicators are much lower than the national level averages. The limited availability and access to comprehensive sexual and reproductive health services, such as birth spacing and maternal and neonatal health services, lack of information and awareness in communities on sexual and reproductive health issues, adverse effects of some traditional practices, and low literacy rates are all factors contributing to a significantly higher maternal mortality ratio in remote areas (UNFPA 2010).

Project goal and objectives

The overall project goal is to contribute to the reduction of maternal and neonatal mortality through increasing access to and the quality of SRH and maternal and child health services.

Specific project objectives include:

- increasing the capacity of Auxiliary Midwives (AMWs) at the community level
- formalising the position of AMWs as general health service providers at the community level
- strengthening the effectiveness of health systems
- enhancing the effectiveness of community mobilisation
- increasing reflection and learning in order to have a greater impact on maternal, neonatal and child health
- creating a supportive environment that enables maternal, newborn and child health.

Project achievements and impacts in 2011-2015

Project achievements	Project impacts
• 2,289 health workers have been trained, including 811 AMWs, 1,077 government basic health staff, 56 traditional birth attendants and 345 Village Health Volunteers (VHVs). • AMWs have provided health services to 13,109 mothers and children and promoted health messages among 24,350 community members. • 115 Mothers' Groups/Couples' Groups have been established with 2,566 members and received SRH awareness training from AMWs. • 345 VHVs have been trained and conducted 1,183 educational sessions in their villages. • 115 Village Emergency Referral Systems (VERS) have been established and supported 590 mothers and children for emergency health, ANC and PNC care. • 2,042 members of Mothers' Groups and 524 members of Couples' Groups have received birth-spacing and pregnancy training and counselling. • 9,229 children and mothers have been immunised. • 115 village development committees have been organised with 911 members. • 4,489 young people have been mobilised by AMWs and received education encouraging them to seek available health services. • 823 patients have been referred by health workers to health facilities and 590 of them benefitted from VERS funding. • 29,819 beneficiaries have been reached directly through health training, awareness sessions and health care services. • 362,362 indirect beneficiaries have been reached through peer-to-peer education and health care services. • 6 sub-rural health centres and 1 rural health centre have been renovated, and medical equipment has been supplied to 9 rural and sub-rural centres, 2 hospitals and 2 station hospitals. • 2 Community Learning Centres (CLCs) have been built, as well as 17 ANC rooms in various CLCs. • Water, sanitation and health (WASH) facilities have been constructed in 2 schools, 1 rural health centre and 3 sub-rural centres.	**In Kayah:** • the number of babies delivered by AMWs increased from 28% to 44.85% • the abortion rate reduced from 24% to 5.7% • immunisation coverage increased from 85% to 90.68% • the number of men accompanying their wives to ANC increased from 16% to 62.48%. **According to Kayah Department of Health (DOH), in 2013-2015 the project contributed to:** • a decline in the under-5 mortality rate from 27.5 to 16 per 1,000 live births • a decline in the infant mortality rate from 23.8 to 16 per 1,000 live births • an increase in recommended 4 ANC visits from 33.1% to 51%. **In Lashio:** • 247 pregnant mothers received at least 4 ANC visits from AMWs • 102 deliveries were facilitated by trained AMWs • 92% of targeted children and 85% of mothers received immunisation • 449 under-5 children received health services • 761 clients received family planning services **According to Lashio DOH, in 2013-2015 project contributed to:** • a decline in under-5 mortality from 14.7 to 11 per 1,000 live births • a decline in infant mortality rate from 12.6 to 9.1 per 1,000 live births • an increase in recommended 4 ANC visits from 36.4% to 52.7%.

Nepal

Key health indicators and context

Despite progress in MNCH, Nepal still has a high rate of maternal mortality (with 281 women dying from pregnancy-related causes per 100,000 live births) and neonatal mortality (with 33 infants dying within the first month of life for every 1,000 live births). There is a high (25%) unmet need for contraception and more than 80% of women give birth at home without the help of a skilled birth attendant. In addition, only 10% of health-posts, the second-lowest government health facility at district level, are able to provide labour and delivery services. There are also large disparities in access to quality MNCH services. For example, a 2009 survey of 40 districts showed that, although the share of deliveries attended by a skilled provider nearly doubled between 2006 and 2009, wealthy

women were 12 times more likely to be attended by a skilled health worker during delivery than women in the lowest wealth quintile (Suvedi et al. 2009).

The Far West Development Region (FWDR), where CARE's Strengthening Approaches for Maximizing Maternal, Neonatal and Reproductive Health (SAMMAN) project is being implemented, and specifically the districts of Doti, Kailali, and Dadeldhura, is one of the least developed regions in Nepal: only 29% of births take place at a health facility, more than 25% of women do not go for ANC check-ups, more than half of mothers (51.6%) do not go for or receive PNC services and about 63% of newborns are not taken to health facilities for a PNC check. About 12% (11.8%) of the region's people have migrated to other countries for employment and other opportunities (GON 2011) and migration has fuelled the HIV epidemic in the region (Vaidya and Wu 2011). The FWDR is also characterised by gender discrimination. This includes limited investment in female children, the persistence of child marriage and specific traditions like *Chhaupadi*[3] and *Badi*[4].

Project goal and objectives

The overall goal of the 2012-2015 SAMMAN project is to improve MNCH by strengthening and increasing the effectiveness of frontline health workers to have a positive impact on MNCH goals.

Specific objectives include:

- increasing the capacity of health workers at a community level
- enhancing the effectiveness of community health systems
- enhancing the effectiveness of community mobilisation
- leveraging lessons learned on how to improve the effectiveness of health workers to increase their impact on maternal, neonatal and child health.

Box 3: The impact of a Peer Educator

"Becoming the mother of five children has not been easy for me. I used to have vaginal discharge which I usually ignored and never shared with others. As a matter of fact, I limited my movements outside of my house. In the meantime, my sister-in-law started working as a peer educator and thanks to her information and support I decided to visit the health facility. After receiving treatment from Mahakali Zonal Hospital, I was able to address my problem, prevent future complications and improve my quality of life."

Mother, Jogbuda-4, Dadedhura

The SAMMAN project works in close collaboration with Nepal's Ministry of Health and Population (MoHP) and its regional and district offices, community health centres (CHCs), local NGOs, frontline Health Workers (HWs) and communities. It does so by enhancing the skills of frontline HWs, including government-backed Community Midwives (CMWs), other auxiliary health workers in health facilities and Female Community Health Volunteers (FCHVs), by providing equipment and supplies to health centres, and by facilitating effective supervision, coordination and support between HWs, FCHVs, government health centres and communities. The project has a used a number of innovative tools developed by CARE Nepal, such the Self-Applied Technique for Quality Health (SATH), where community members and frontline HWs participate in the mapping/identification of pregnant women, new mothers and newborn babies, track their use of health care services and discuss in Mothers' Groups (MGs) the services, check-ups and care each mother needs and why.

3 *Chhaupadi* relates to a range of restrictions placed on menstruating girls and women, including isolating them from other members of the household during menstruation, not allowing them to enter the kitchen or to touch water and food, and preventing them from eating milk products.

4 *Badi* refers to the so-called untouchable caste in Hindu religion. For decades, poverty has led Badi women to support their impoverished families through sex work, often from puberty. While for some this ends at marriage, the majority work as sex workers until they are can no longer attract customers.

Key achievements in 2012-2015

Project achievements:

- reached 254,430 direct beneficiaries, including women of reproductive age, pregnant and post-natal women and their babies
- reached 373,320 indirect beneficiaries, such as relatives and other members of the community
- trained 1,472 Community Health Workers (CHWs) and 1,977 Female Community Health Volunteers (FCHVs)
- trained 593 peer educators who in turn have reached 191,078 beneficiaries across the three districts
- worked with 102 Village Development Committees (VDCs) and 8 municipalities to strengthen their Health Facility Operations and Management Committees (HFOMCs)
- supported 84 of the 108 birthing centres across the three districts to upgrade their services through the provision of essential medical equipment
- constructed four birthing centres buildings and three placenta pits in collaboration with the DFID-funded Community Support Programme (CSP)
- supported the Seti Zonal Hospital in Kailali district to renovate its neonatal intensive care unit and construct its training hall for skilled birth attendants (SAMMAN together with CSP)
- supported 94 health facilities in Doti and Kailali districts with infection prevention training and supplies
- supported the MoHP/Family Health Division at the central level in piloting the distribution of calcium to 35,000 pregnant women
- supported the MoHP/Family Health Division through the distribution of misoprostol for the prevention of post-partum haemorrhage to 33,300 pregnant women in Doti and Dadedlhura districts
- supported the MoHP/CHD with the distribution of chlorhexidine to prevent infection among 7,000 newborns in Doti and Dadedlhura districts
- supported the set-up of 177 SATH processes by MGs
- supported the implementation of the CHSB in 54 health facilities
- supported the set up an Emergency Fund in 167 MGs; a total of 3,612 mothers have access to them; a total of NRS 412,000 ($4,130) has been pooled with an average of NRS 2,467 ($24.7) per group; a total of 349 mothers in 95 MGs have used the funds for emergency maternal and child health services.

Key project approaches and models

Despite large variations in country contexts and progress in key health indicators, all six countries in this partnership face similar challenges and barriers to improving maternal and child health care. On the supply side, quality health service provision in rural, usually remote areas and areas where ethnic minority populations often reside, remains patchy. Not only may the country have a relatively limited supply of formal health workers, but limited resources and inadequate incentive structures mean health workers are often reluctant to work in rural and remote areas. Additionally, capacity to carry out outreach activities, even if health workers are located in rural areas, is often limited. A further supply side constraint relates to the fact that in some countries (e.g. Afghanistan) the majority of formal health service providers are men which, due to cultural barriers and social norms around interaction with the opposite sex, also limits the uptake of services by women and girls.

Barriers in terms of demand for maternal and child-related health services include: large distances to health centres; the costs incurred for travelling to these health centres; limited awareness of the services on offer; the perceived quality of those services; the limited mobility of women; and the relatively disempowered role of women in household decision-making processes including with respect to health-seeking behaviour.

With these contexts in mind, the individual country projects designed their approaches and models accordingly. Despite the differing contexts, the policies and priorities of the ministries of health in these countries, ongoing governmental and non-governmental programming around maternal and child health, the resource parameters and capacities of the in-country CARE teams, and the approaches and models adopted and developed, share similarities and complementarities. These similarities also stem from the overall goal of the partnership which, as stated at the onset, focused on strengthening formal and community health systems. Thus, all country programmes had the community level and community involvement and engagement as a key focus and adopted and developed

differing processes and mechanisms to facilitate/enable this; all the programmes also focused on strengthening the formal health systems through a range of strategies and approaches; and for each programme, partnerships and advocacy at different levels were critical to success. These dimensions clearly build on and complement each other, with one dimension often being dependent on the effectiveness of the other. Additionally, the method and degree of implementation of these approaches and models varied across the different countries, again depending on the context, key governmental stakeholder priorities, existing capacities and resource parameters, amongst other things. Nevertheless, drawing also on best practice and evidence-based learning on ways to improve maternal and child health outcomes, arguably all countries did take on board these broad parameters in their programmes. We now explore briefly each of these broad approaches in turn, highlighting key aspects across the six country programmes.

Community involvement and mobilisation

In all countries, community involvement was a critical if not the most critical component of the approach. Involving community members offers a range of potential benefits including: ensuring projects and programmes are both needs based and based on local priorities; creating ownership which can also lead to sustainability and empowerment; and awareness-raising and capacity building which can also lead to empowerment and ultimately change behaviours and attitudes. These CARE-GSK partnership programmes used various approaches to involve and engage community members, as outlined below.

Training and capacity building of community health groups

In all countries, education, training and capacity building of community-based individuals, groups and informal and/or community-based health workers was critical to increasing engagement.

In **Nepal**, the capacity of the existing cadre of FCHVs, essential for providing services to women in remote rural areas, was further developed to also work alongside and facilitate Mothers' Groups (MGs) and the SATH process (see below). In addition, a group of peer educators, both female and male, were identified and trained to provide MNCH-related information particularly to their peers at community level. In **Afghanistan**, community engagement and mobilisation were carried out through facilitating the development of FHAGs as well as male shuras (committees) – both already existing structures – and raising their awareness around maternal health and family planning. Engaging men and boys is also a key tenant of CARE's programming worldwide, which emphasises the importance of gender equality and women's empowerment to both health and development. Engaging men is particularly critical in a society such as Afghanistan where the majority of decisions at household level, including those related to health-seeking behaviours, are taken by men.

In **Cambodia**, VHSG members' health knowledge and facilitation skills have been strengthened so they can in turn educate fellow villagers about health and act as a link between the community and local health facilities. These monthly community education sessions have focused on key health messages, such as importance of immunisation, symptoms of diseases such as malaria, nutrition and vitamins, hygiene, breastfeeding and child health care. VHSG members also coordinate vaccination sessions with visiting health workers to ensure those villagers that are in need get their vaccinations. Such close collaboration between formal and informal community health workers means that health facilities and their staff are better informed about the health status of communities, any potential disease outbreaks, and the health needs and concerns that need attention.

In **Bangladesh**, as part of the CmSSs, capacity of CHVs has been enhanced so that they can identify and address barriers to health-service access, especially for poor families, and create and enabling environment for P-CSBAs to perform effectively. CHVs have been trained on pregnancy registration, birth preparedness, essential newborn care (ENC), family planning, essential health service promotion and referral. In **Laos**, the urban project trained health educators (volunteers) from local NGOs and garment factories' peer educators on SRH, communication and decision-making skills, violence prevention and women's rights. This enabled peer educators to deliver training and implement outreach activities for female workers in various garment factories in Vientiane, covering topics such as such as nutrition and family planning.

Finally, in **Myanmar**, the capacity of VHVs and MGs has been built in sanitation, prevention of infectious diseases, reproductive health and safe motherhood, family planning and nutrition. Both groups conduct regular health education activities for villagers, mobilise them to seek care at health facilities, track community members' health status and report to health workers on ANC, PNC, birth planning or immunisation service needs.

Innovative processes and systems

Innovative processes for engaging with community members have also been a key feature of many of the six country programmes. These processes have ranged from members of the community collecting, monitoring and tracking data through house-to-house visits, to more participatory, inclusive and visual techniques which include the use of community maps and community dialogues.

In **Afghanistan**, a community-based surveillance system (CBSS) has been set-up whereby CBEs (part of the formal system, see below) collect key indicators on

pregnant and post-partum women and their newborns on a regular basis during their monthly house-to-house visits. This not only allows the project to measure progress, but ensures the identification of high-risk populations or geographic areas where interventions should be targeted. Similar to Afghanistan, in **Bangladesh** the CmSS, which consists of a group of at least 17 members, both men and women, identifies and tracks pregnant women, provides information on MNCH good practices and available services, and raises funds for emergency transport as part of the referral of complicated pregnancies to formal health services.

In **Nepal**, a number of participatory tools have been developed and adapted which not only help in identifying local needs and priorities, but also in empowering women and girls to practice their reproductive and maternal health rights. The Self Applied Technique for Quality Health (SATH) (CARE Nepal 2015b), used by MGs, is a type of participatory mapping tool to monitor maternal health and particularly pregnant women in the community. This approach not only allows women to apply peer pressure to ensure that appropriate health-seeking behaviour occurs, but also to identify gaps in service provision. Another participatory tool used to empower women and ultimately improve maternal health service provision in Nepal is the Community Health Score Board (CHSB) (CARE Nepal 2015a). This tool brings together beneficiaries (the demand side) and service providers (the supply side) at the local health facility to jointly analyse priority concerns and barriers in service delivery, find shared ways to address them and monitor progress in services and health system performance using a community grading system.

Strengthening health systems

In order for the above mentioned community-based processes and actors to be effective, the public health system also needs to be strengthened through the availability of a number of elements, including: appropriately capacitated staff; the necessary infrastructure and equipment; and medication and other supplies.

Community health workers training

Since one of the main objectives of the CARE-GSK partnership is improving the quality and quantity of health human resources, over 16,500 CHWs have been trained in all six countries since 2011.

In **Nepal**, cadres of staff trained have included CHWs, Auxiliary Nurse Midwives (ANMs), Health Assistants (HAs) and staff nurses. Topics of training have ranged from neonatal intensive care training, training on use of chlorhexidine and Birth Preparedness Package refresher training. In **Afghanistan**, CBEs and CMWs have been trained following guidelines from the MOPH. At the end of the first phase (2012-2015) of the CARE project, they became part of the formal health system with their salaries being taken over by the MOPH. In **Bangladesh**, in addition to already mentioned P-CSBAs, the project has trained public health-service providers and workers in community-based birth attendance, training of trainers (TOT) on IMCI, supportive supervision of P-CSBAs, performance monitoring and data-based decision-making. It has also established skill laboratories in sub-district hospitals of Sunamganj to provide hands-on and needs-based refresher training for P-CSBAs and other health providers.

In **Myanmar**, Auxiliary Midwives (AMWs) have been selected from communities and have undergone intensive 6-months' midwifery training and now provide ANC, delivery, PNC, family planning and child health care and support in remote communities in Myanmar which are hard to reach by formal health system. In **Cambodia**, midwives and medical doctors have been trained through their participation in Midwife Coordination Alliance Team (MCAT) meetings which focus on various ANC, PNC, newborn care, nutrition, breastfeeding and family planning related issues. These meetings have then followed up with impromptu spot checks and quarterly supervision visits, which are similar to skills laboratories in the Bangladesh project and ensure that AMWs in health centers are able to apply new skills and knowledge and that quality of their service remains high. In **Laos**, medical doctors and nurses from the Vientiane Youth Center received a range of training that enabled them to understand and identify specific challenges and problems experienced by female garment factory workers, such as stigma and violence, and provide necessary support.

Development of infrastructure and distribution of supplies

Support in this area has also been a key feature in all country programmes. Thus, new infrastructure has been built and local health centres have been upgraded and renovated, including the provision of essential medical equipment (e.g. Nepal, Bangladesh, Myanmar); training supplies have been distributed (e.g. Nepal, Cambodia); and the distribution of drugs and/or vitamin/mineral tablets, safe delivery kits, and family planning supplies, such contraceptives (e.g. Afghanistan, Nepal, Laos, Cambodia) has been supported.

Partnerships and advocacy

In order for project interventions to have a long-term impact and partnership models to be scaled up and adopted by wider public health systems in all countries, partnerships and advocacy with key stakeholders and decision-makers are critical.

Joint project design

In all country programmes, partnerships with government at different levels have been key. The approach has varied between projects but has included working alongside and

in-line with government priorities in maternal and child health; and/or complementing, supporting or filling a gap in service provision.

In **Afghanistan**, the project focused on District 1 in Kabul, a priority area identified by the government as lacking sufficient health services to cover the urban population. Additionally, at the design phase of the project and where any decisions were made going forward, the government and other key country level stakeholders working on maternal and child health were involved. Similarly, for the design of the P-CSBA model in **Bangladesh**, the CARE project team met the Government of Bangladesh (GoB), WHO, UNICEF, the United Nations Population Fund (UNFPA), other donor agencies and international and national NGOs to present and discuss the feasibility of the proposed P-CSBA model. The Bangladesh programme has continued to work closely with different stakeholders, including carrying out a joint health mapping exercise, undertaking joint (CARE, GSK, MOHFW) monitoring and performance reviews and setting up a Technical Advisory Group (TAG).

Partnerships at the project implementation stage

In order for partnerships to be effective, they also need to take place at the implementation stage. As mentioned above, one means of developing and strengthening these partnerships around project implementation was through building the capacity of government health staff to either support the community-based processes or to support and supervise the community-based actors.

In **Bangladesh**, government health staff have been trained to support the functioning of the P-CSBAs; members of Union Parishads (local government bodies) and local-government elected members have also been trained on their roles and responsibilities in improving maternal and child health in their respective constituencies. Similarly, in **Afghanistan** the CBEs and CMWs in District 1 have become part of the formal health after the completion of the project activities in this district.

In **Nepal**, in addition to building the capacity of government health staff, the capacity of the lowest administrative levels of the Ministry of Federal Affairs (the Village Development Committees and their Health Facility Operations Managing Committees (HFOMCs) was also built in order for them to ensure that community level processes and people (FCHVs, SATH, CHSB) were functioning effectively. In **Myanmar**, Village Development Committees have been trained to manage village emergency referral systems that provide financial support for emergency care and referrals more efficiently.

Technical input

Another means of developing and strengthening partnerships is ensuring the involvement and contribution of the project teams to already existing relevant government-run meetings, technical groups and task forces.

In **Afghanistan**, for instance, the project team participated in monthly Community-based Health Care (CBHC) and Reproductive Health (RH) Taskforce meetings and at the provincial level, in the Kabul Provincial Health Directorate (KPHD) meetings. Similarly, in **Cambodia**, at national level, project staff participated in the MOH Sub Technical Working Group for Reproductive, Maternal, Neonatal and Child Health meetings; they also participated regularly in Provincial Technical Working Group meetings, the Annual Operating Plan review workshop with the Provincial Health Department, and health information system meetings at the OD level. CARE Cambodia staff also held monthly coordination meetings with Provincial and OD health staff to review monthly progress, identify challenges, and develop next month's joint work-plan.

In **Myanmar**, CARE held regular health coordination meetings with state, district and township health authorities, UN, international NGOs and other partners to share project learning and advocate for its replication in other areas of the country. The model developed in **Bangladesh** in particular demonstrates how partnerships have been developed and function at different levels: CARE International and GSK support the training of P-CSBAs and other community health workers, build community capacity through CmSSs, and facilitate linkages between P-CSBAs, community, local government and the broader health system; the MOHFW issues accreditation and supervises P-CSBAs, provides supplies and other logistical support such as family planning commodities and vitamins, and provides MNCH referral services; community and local government identify and select P-CSBAs, advocate for the use of their services, negotiate their fees and provide access support to poor families, monitor P-CSBAs performance and provide support when necessary; and P-CSBAs provide basic maternal and child health services and issue referrals to health facilities, report to MOHFW on the supplies they receive, link with traditional birth attendants (TBAs) for joint deliveries and report on their services to the formal health systems.

National and international advocacy

In addition to participation in government-led meetings, project teams in all countries have used both local and international fora to showcase the CARE-GSK partnership, sharing key findings and best practices. For example, in **Cambodia** a promotional brochure (in both English and Khmer) and video documentary were produced and shared with key health providers. Both **Bangladesh** and **Nepal** teams produced project newsletters, as well as research studies, which were disseminated across wide audiences of national stakeholders.

The project teams have also participated in national and international health observance days: in **Afghanistan**, for instance, the team participated in the Community Health Workers Day, International Women's Day and Mothers'

Day; and in **Myanmar** the project participated in the World AIDS Day activities organised by the Township health department and also took part, as part of the Shan New Year Festival, in the 16 days activism against gender-based violence (from 25 November, the International Day for the Elimination of Violence against Women, to 10 December, Human Rights Day). Project teams have also presented at various regional and international conferences, such as the International Family Planning Conference (Indonesia), the International Conference on Public Health (Sri Lanka), International Forum on Quality and Safety in Healthcare: Asia (Hong Kong) and Global Health and Innovation Conference (USA).

As a result of all these national and international advocacy efforts, local allocation of governmental funding towards maternal and child health in project countries has been increasing while some of the project innovations and interventions have influenced national approaches. For example, in **Afghanistan**, MOPH has adopted Pregnancy, Post-Partum and Birth weight and Age-at-death for an Intervention and Evaluation System (BABIES) data collection tool, which has been developed by CARE International and the US Centers for Disease Control and Prevention (CDC) and has been widely used by the project. In **Nepal**, as a result of CHSB community discussions, 25 health facilities arranged a separate room for maternal health services and VDCs or District Health Offices allocated funding for these. In **Bangladesh**, as a result of CmSS advocacy and participation, 50 Union Parishads allocated an annual budget of BDT 2,715,000 (£23,205) and spent BDT 1,097,700 (£9,382) on: providing health services for the poor, TBA orientation to reduce harmful practices, organising blood donations at health camps and referrals, and constructing labour rooms for P-CSBAs at their homes.

Conclusion and recommendations

Although each country has a set of country-specific lessons that can be drawn from their experiences on the CARE-GSK partnership, a number of cross-cutting issues also emerge:

Continued commitment from the highest levels is necessary, including appropriate policies and measures, to both strengthen community health systems, and to replicate and scale-up the particular models and approaches. Amongst other things, this support and commitment requires:

- involvement of key government and other stakeholders in the development of the model from the initial stages and their ongoing support, insights and approval
- commitment to take on board the approach, the trained staff, and/or more generally, to continue the work by government once the project ceases
- ongoing advocacy, including documenting and sharing of existing evidence (at local, national and international fora) on the effectiveness of the approach to ensure support, uptake and replication.

In addition, to continue to raise awareness and share information on maternal and child health, different and innovative ways are necessary, ranging from peer-to-peer approaches and mass media campaigns to the use of alternative information channels (e.g. mobile phones).

Strong, effective, sustainable and accountable community health systems are only achievable with the involvement of (and linkages between) different levels of the health system (including private sector providers). Mechanisms and processes to allow for linkages and involvement include:

- joint monitoring and data collection processes to ensure transparent and inclusive decision-making, accountability and planning
- regular visits by national and district levels public health officials to monitor project performance and provide support
- monthly coordination meetings with relevant district authorities
- setting up a steering or technical advisory group/s made up of key stakeholders from government, donors and NGO, maternal and child health experts and the corporate sector (where appropriate) to provide overall guidance and review strategies and approaches, as well as to increase local ownership and responsibility.

Partnerships between government and the community are critical to address geographical, social and financial barriers to accessing health services (especially for poor and marginalised communities) and to leverage and mobilise resources. These barriers can only be addressed through:

- the operationalisation of these partnerships at lower levels through, among other processes, referrals between the community and health service provider level
- the effective functioning of referrals, with secondary and tertiary health facilities that are both responsive to cases referred from lower levels and able to provide high-quality services.

Investment in continued capacity building for health service providers is crucial for improving the access to and quality of health care, which has a direct effect on overall maternal and child health outcomes. However, given the context of political instability and a challenging socio-economic situation in many of the countries in

this partnership, frontline health workers' incentives and remuneration need to be addressed. For example, they may require longer-term financial support from international NGOs as the state may not yet be prepared to take full responsibility and ownership. Nevertheless, projects in Bangladesh and Afghanistan provide alternative solutions and examples of how these issues may be successfully addressed.

Given that gendered social norms as well as socio-cultural practices continue to negatively impact on women and girls in many of these countries (e.g. chhaupadi in Nepal, where women and girls are kept in isolation during menstruation; the fact that women are often not allowed to participate in activities outside of their homes/communities in Afghanistan; and the gendered identities and socio-cultural taboos in Myanmar that prevent women from discussing and addressing sexual and reproductive health issues), there is a need, therefore, not only to continue to provide information on these issues, but also to think creatively about how to engage the community in reflective dialogue or other activities that will challenge norms, so that they can develop their own solutions. The engagement of political and social leaders at community level, including importantly men, through community mobilisation and local-level governance processes, is critical in order to empower and support women and ultimately have a positive impact on maternal and child health.

Overall the CARE-GSK partnership has been remarkably successful in all six countries in both mobilising and strengthening community-based processes and institutions, as well as in supporting the strengthening of broader health systems. Much of these activities have been carried out through building the capacity of a range of stakeholders at different levels of the health system as well as through developing mechanisms and approaches at the community level for raising awareness about maternal and child health. This has given rise to both the improved supply of maternal and child health services, and to increased demand for and utilisation of these services. There has already been a positive impact on direct beneficiaries of the projects, as witnessed through improvements in health indicators for women and children in some of the countries. Success has also been seen in the commitment of governments to support these projects in the different countries, through ongoing advocacy, partnerships and collaboration, and in willingness to incorporate both the trained health staff and community-based processes and approaches into the public health sector once the CARE-GSK partnership projects cease.

References

APHI et al. (2011). Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India], and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt].

BDHS (2014). Bangladesh Demographic and Health Survey: Key Indicators. Dhaka/Rockville, MD: Ministry of Health and Family Welfare/National Institute of Population Research and Training. Available at: http://www.dhsprogram.com/pubs/pdf/PR56/PR56.pdf.

CARE Nepal (2015a). Strengthening Approaches for Maximizing Maternal, Neonatal and Reproductive Health (SAMMAN): Community Health Score Board (CHSB). Kathmandu: CARE Nepal. Retrieved from: http://www.carenepal.org/publicationdetail.php?id=47.

CARE Nepal (2015b) Strengthening Approaches for Maximizing Maternal, Neonatal and Reproductive Health (SAMMAN)/: Self Applied Technique for Quality Health (SATH). Kathmandu: CARE Nepal. Retrieved from: http://www.carenepal.org/publicationdetail.php?id=49.

CDHS (2014). Cambodia Demographic and Health Survey. MEASURE DHS/ICF Macro: Calverton, Maryland, USA.

CSO/UNICEF (2012). Afghanistan Multiple Indicator Cluster Survey 2010-2011: Final Report. Kabul: Central Statistics Organisation (CSO) and UNICEF.http://cso.gov.af/Content/files/AMICS.pdf.

CSO (2014). National Risk and Vulnerability Assessment 2011-12. Afghanistan Living Condition Survey. Kabul: Central Statistics Organization (http://moph.gov.af/Content/Media/Documents/AMS2010FinalFullReport14122011142624269553325.pdf).

GON (2011). National Census, Preliminary Report. Kathmandu: National Planning Commission Secretariat and Central Bureau of Statistics, Government of Nepal.

MIP (2015). The 2014 Myanmar Population and Housing Census. Census Report Volume 2. Yangon: Ministry of Immigration and Population.

MOH (2009). Five-year Strategic Plan for Reproductive Health (2009-2013). Yangon: Ministry of Health/Department of Health of Myanmar.

MOH/UNICEF (2013). Assessment of Newborn Health in Myanmar: August-September 2013. Yangon: Ministry of Health and UNICEF (http://www.unicef.org/myanmar/Newborn_Health_Assessment_Report.pdf).

MOPH (2012). National Reproductive Health Strategy (2012-2016). Kabul: Ministry of Public Health (http://moph.gov.af/Content/Media/Documents/FinalRHStrategy109201222265744255332532 5.pdf).

MOPH (2014). Health Management Information System. Kabul: Ministry of Public Health, Afghanistan (http://moph.gov.af/en/documents/category/hmis).

Suvedi, Krishna B., Pradhan, A., Barnett, S., Puri, M., Chitrakar, S.R., Poudel, P., Sharma, S., and Hulton, L. (2009) Nepal Maternal Mortality and Morbidity Study 2008/2009: Summary of Preliminary Findings. Kathmandu: Family Health Division; Department of Health Services; Ministry of Health; Government of Nepal.

UNFPA (2010). Report on Situational Analysis of Population and Development, Reproductive Health and Gender in Myanmar. Yangon: United Nations Population Fund.

USAID (2013) Demographic and Health Survey (DHS). United States Agency for International Development (USAID): Rockville, MD.

Vaidya, N.K. and J. Wu (2011) 'HIV epidemic in Far-Western Nepal: effect of seasonal labor migration to India', BMC Public Health 11(1): 310.

World Bank (2015). Key maternal and child health indicators. Online database. Geneva: The World Bank Group, 2015 (http://data.worldbank.org/indicator/SH.STA.MMRT).

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