Introduction

This paper represents a quick review of selected examples of Child Survival and Health Grants Program/Family Planning (CSHGP/FP) integration with observations from the MCHIP PVO/NGO support team. Intended originally to provide reference and discussion points for MCHIP’s technical support team, the document is posted because it provides useful insights about practical and operational aspects of family planning integration in child survival projects, particularly with nutrition activities. The CSHGP has funded integrated community-based projects for over 25 years—meaning, grantees use platforms at multiple levels, including community and facility, to deliver services in various intervention areas (child spacing, nutrition, malaria, immunization, etc.) simultaneously. For example, a project may train community health workers to provide nutrition counseling along with family planning counseling and ITNs to their communities. Some projects work with Ministries of Health to scale-up recognized integrated packages of interventions like Integrated Management of Childhood Illness (IMCI). For that reason, this portfolio of projects, totaling over 450, provides a trove of learning about experiences with programmatic integration in different settings.

This collection contains one project each from Africa, Southeast Asia, and Latin America and two projects from Central Asia. The descriptions are lifted directly from final evaluation reports with minimal editing for coherence. There are references in the footnotes and these reports can be found at www.mchipngo.net. MCHIP added this Introduction, Key Aspects of Integration for each project and Concluding Thoughts to this summary. MCHIP also underlined details in the project descriptions that particularly illustrate how and why certain interventions were delivered through integrated programming, and what resulted in the areas of family planning and nutrition. Some parts of the descriptions may appear disjointed due to the effort to capture the most relevant features of integration from a structured reporting format. In this document, MCHIP has endeavored to reduce redundancy while allowing the rich details of the reports to tell context-specific stories that may inspire further investigation or even replication. The subheadings for each project description are slightly different to maintain fidelity to the evaluation reports and reflect what the evaluator deemed important. An acronym list is not provided, but each report can be accessed for context-specific acronyms.

Finally, the quantitative data reported are derived from Knowledge, Practice, and Coverage (KPC) Surveys conducted at the beginning and end of each project. These are accompanied by qualitative data from focus groups and key informant interviews.
Adventist Development and Relief Agency CAMBODIA - 2001 - 2006

Summary

The Adventist Development and Relief Agency’s (ADRA) Cambodia Child Survival XVII Project was implemented in ten health center catchment areas (113 villages) of the Baray-Santuk Operational District (BSOD) of Kampong Thom Province, Kingdom of Cambodia. The major project partner for this project is the BSOD through the staff of the local Health Centers (HC) under the management and direction of the District Manager and MCH Manager. Child Survival interventions were provided to an estimated 17,477 children less than 5 years-old and 22,575 women of reproductive age within a population of 126,658 in these 113 villages.

The project goal and objectives were to improve the quality of health and reduce the morbidity and mortality of local women of reproductive age and local children under five through activities addressing maternal and newborn care, child spacing, nutrition and immunization in a sustainable manner.

The key implementation strategies to reach these objectives were:

- Use of village-level volunteers, Traditional Birth Attendants (TBAs) and existing care structures in multiple capacities to do promotion and perform surveillance;
- To mobilize community leaders and resources through village-level organizations and initiatives (Mothers Clubs, Village Health Days, community-based nutrition promotion groups, home gardening, Child Friendly Village Initiatives);
- To strengthen the capacity of the local Health Centers and BSOD system to deliver quality maternal and child health services;
- Partnerships with the BSOD, PHD, CMA, RACHA, GTZ and other PVO and local associations. Key community health organizations developed integrated Health Center staff, community leaders, village-level volunteers and TBAs.

Examination of the baseline and final surveys found that the project had produced excellent measurable results in relationship to nearly all components of the project. For example, the proportion of mothers with children less than two years old who had received at least two antenatal visits has increased from 10.3% to 47.1%; the proportion of similar mothers who initiated modern birth spacing methods within the three months following pregnancy increased from 24.6% to 60.5%; and the proportion of similar mothers who breastfeed exclusively for up to 6 months after delivery increased from 19.3% to 97.5%. Similarly, the proportion of children less than 2 years who are underweight decreased from 41.6% to 25.5% and the proportion of children less than 2 who had complete immunization coverage increased from 27.8% to 60%.

Key accomplishments included: upgrading all aspects of clinical obstetric care available through the Health Centers and TBAs; development of a community-based approach to nutrition and the establishment of a network of CBDs of contraceptives supervised by the HC staff. Further integration and strengthening of services was established by bringing community health volunteers and TBAs under the supervision of HC staff. ADRA also introduced best practices for emulation with regards to training, health information management and dissemination of lessons learned.

Of the interventions, the project’s general approach of using community health volunteers in association with integrated community organizations to mobilize and educate the community stands out as an approach suitable for scaling-up, especially as it is applied in its Child Friendly Village Initiative.

**Selected Results-Family Planning**

The indicators in the final cluster survey, relevant to birth spacing, indicated that mothers’ knowledge about and use of birth spacing has greatly increased. The number of women receiving birth spacing methods and counseling had increased (68.4% final compared with 33.3% in the baseline survey). In WRA with children less than 2 years of age, expressed desire to have no children in the next two years had more than doubled (67.8% compared with a baseline 31.7%). In the same group, initiation of birth spacing within the first 3 months after pregnancy has increased by a similar margin.

The factors involved with these changes were: making contraceptives readily available and affordable through Community-Based Distributors; promoting the availability of a mix of contraceptives through strengthening the availability of injectable contraceptives, contraceptive pills and condoms available through local Health Centers and Community-Based distributors; and promoting birth spacing multifocally. Birth spacing was promoted before, and soon after birth by the village-level volunteers, TBAs and Health Center Midwives (HCMs). Village-level volunteers and TBAs promoted birth spacing through one-on-one counseling of mothers in their areas. Village-level volunteers also led Mothers Clubs. Through these Clubs, group discussion and support would also encourage use of birth spacing. HCMs promoted birth spacing during antenatal visits and at time of birth. Community communication--drama, dance, posters and video--were also used at Village Health Days.

Access to contraceptives increased due to the presence of CBDs at the community level, and the overcoming of incorrect beliefs and financial barriers to accessing contraceptives. Retraining of Health Center staff through the project and promotion of birth spacing at the community level worked to overcome psychological barriers to accessing birth-spacing methods (especially injections) at the Health Center level. Access was also increased in financial terms as the prices for contraceptive services were set and posted at all Health Centers and those who were deemed unable to pay were given contraceptives free of charge.

The lesson learned is that promotion of birth spacing through the use of Community-Based Distributors in combination with its promotion by village-level volunteers and TBAs in partnership with local Health Center staff can lead to increased availability, quality and use of birth spacing methods. An important part of the involvement of the community volunteers is their practice as one-on-one counselors, leaders of Mothers Clubs and community educators through community events such as the Village Health Days.

**Selected Results-Nutrition**

The increase in early initiation of breast feeding, exclusive breastfeeding in the first 6 months of life, increased fluids and feeding of infants during illness—as evident in the final survey—all exceeded project targets. These increases can all be attributed to the community mobilization and communication strategy of the project especially the activities of village-level volunteers. In the last year of the project, local monks also promoted breastfeeding and messages were introduced in a national media by the MOH and partners as well as ADRA. All those
interviewed and most participants in focus groups saw increased breastfeeding as a sustained legacy of the project.

Vitamin A and iron are supplied by the local Health Center staff, when mothers attend for antenatal or postnatal care. TBAs, and village-level volunteers not only promote attendance of mothers for these purposes, but also announce when community outreach patrols are coming, and follow up with mothers to encourage them to attend with their babies. In cases when mothers do not attend, village-level volunteers will take these supplements to them.

The final survey showed that the prevalence of children under two years of age who are underweight decreased compared with baseline (from 41.6% to 25.5%). The project used three different approaches to promotion of good nutrition for malnourished children, these were modified-Hearth, Hearth and what has been designated as Community-Based Nutrition.

Key Features of Integration:

- Streamlined service delivery by bringing community health volunteers and TBAs under the supervision of HC staff.
- Multiple agents (TBAs, volunteers, HCMs) promoted birth spacing and nutrition at multiple times, including before and after birth and as part of ANC.

Mercy Corps AZERBAIJAN 2001 - 2006

Summary

The goal of Mercy Corps’ (MC) Azerbaijan Child Survival Project, Building Partnerships, Saving Lives, is to work through its partners, the Ministry of Health (MOH) and International Relief and Development (IRD), to reduce maternal and child morbidity and mortality in the remote mountainous Yardimli and Lerik districts, and the mountainous quarter of the Masally district, in southern Azerbaijan along the border with Iran.

The major objectives are: 1) sustained changes in care-giving and health-seeking behavior; 2) improved quality of health services; 3) increased number of community health initiatives; 4) improved support of primary health care (PHC) by the District Health Authority (DHA) and; 5) increased health programming capacity within Mercy Corps itself. The project’s technical mix includes: Pneumonia Case Management (PCM) at 20% level of effort (LOE); Control of Diarrheal Disease (CDD) at 20% LOE; Maternal and Newborn Care (MNC) at 25% LOE; Breastfeeding at 20% LOE; and Child Spacing at 15% LOE. The introduction of IMCI is included as the integrating strategy for facility and community level intervention.

MC and its partners put primary focus on strengthening the ability of caretakers (primarily grandmothers and mothers, together with male family decision makers) and communities to increase their responsibility for the health of mothers and children. The project focuses on creating new community-level mechanisms and networks which facilitate health information transfer and promote preventive behaviors. Actions are based on community-collected health information. Community-based preventive actions are coupled with improvement in the quality

---

and utilization of primary health care through training and mentoring of feldshers, midwives, and physicians as first level health care providers in communities.

According to the project health information system, the project has achieved a significant reduction of child and infant mortality in the project villages. Over the life of the project, child mortality has decreased by almost 80% and infant mortality by 70%. There was an increase in the infant mortality rate (IMR) during the last year of the project (2005-2006) over the previous year, but overall, the IMR was still lower than the rates for the three prior years. Project staff believes that the higher rate was due to the addition of many remote and difficult to reach smaller villages during the last year, where access to care seems to be more difficult particularly during the winter season. Nevertheless, these figures indicate important improvements in health status.

The final KPC survey captured important improvements in knowledge and behavior in project villages. The project met or surpassed most of its target indicators in focus as well as non-focus villages. For example, 100% of mothers sought treatment for children experiencing cough and rapid breathing (baseline: 40%), 69% of women continued to increase the amount of breastfeeding when children had diarrhea (baseline: 52%), 87% of women recognized two or more signs of childhood illness that indicate a need for treatment (baseline: 55%) and 70% of women made at least two prenatal visits to a health facility during pregnancy (baseline: 32%).

Child Spacing - Results
The final survey found that 83% of women knew of one natural family planning method. In addition, the proportion of women using modern contraceptives, among those not desiring children in the next two years, increased from 4.6% at baseline to 24% at the final. Likewise, the proportion of children aged zero to 23 months who were born at least 24 months after the previous surviving child increased from 37.6% to 43%. Between 2004 and 2006, 12,524 women have received education about child spacing, primarily LAM and the Standard Days Method, from project staff. The final KPC also documented that the percentage of health professionals providing appropriate family planning services to clients at health facilities increased from 0% at baseline to 100% during the final evaluation.

Nutrition - Results
The final KPC found that 83% of women in the project area immediately breastfed their infants after delivery, compared with 15% at baseline. The proportion of infants zero to five months old who were exclusively breastfed within the previous 24 hours also increased from 14.5% at baseline to 53% at final. By May 2006, 10,291 women were educated through women’s group discussions about the importance of early initiation of breastfeeding and exclusive breastfeeding.

Although the project did not focus on complementary feeding or other aspects of child nutrition, it is interesting to note that KPC data shows a drop in percentage of children zero to 23 months of age who were underweight from 11.2% at baseline to 8% at the final. The evaluation team attributes this decrease to improved exclusive breastfeeding rates.

Reaching Women through Male Mobilizers and Educators
Among the major accomplishments of this grant is the creation of a pool of trained local professionals, Mentors and Mobilizers (M/M), living in the three CSP target districts in southern Azerbaijan. All M/Ms are local men, working in the communities in which they also live; all were raised in this regional conservative and predominately Muslim society; all have
university degrees; none had any previous experience working with communities on MCH issues.

All 18 M/Ms were selected by the project’s senior staff and tasked with raising community awareness about key health issues including breastfeeding, child spacing, pregnancy danger signs and home management of common childhood illness such as pneumonia and diarrhea. In this area, it is not common for women to work outside their homes, both because of tradition and because of a lack of employment opportunities; thus, men were the logical next “best bet” to take on community education responsibilities within the CSP. The project’s M/Ms are a diverse group ranging in age from 26 to 48, and coming from a wide range of professional backgrounds including doctors, economists, an engineer, a lawyer, and even a poet and singer.

After intensive training provided by the project senior staff, M/Ms traveled to remote villages in teams of two (one Mentor and one Mobilizer). The M/M division of labor was that the Mentors (who are medical doctors) coach and upgrade training of the local health care professionals, and the Mobilizers (who are university educated professionals in other fields) work with and educate the Village Health Councils (VHCs), Community Health Educators (CHEs) and community members. The goal was to empower community members to take responsibility for their own and their children’s health, with mothers stepping into a community leadership role around these issues.

For the M/M teams, it has not been an easy road to success. They faced a number of barriers, and were confronted daily by the poverty of the region, poor infrastructure, severe weather conditions, unreliable vehicles and treacherous road conditions. All the Mentors and Mobilizers underwent a long training process with extensive emphasis on role plays, interactive techniques and other adult learning principals.

One of the biggest challenges for M/Ms to overcome was the cultural barriers between men and women. In the southeastern region of Azerbaijan, cultural values and diametric gender roles prevail to create distance between men and women, with women largely only interacting with men from within their families – husbands, brothers and fathers. Initially, the M/Ms were uncomfortable speaking with women, and even found it difficult to make eye contact with the project’s senior staff. They found it particularly difficult to teach women about their health needs and discuss sensitive or private topics such as breastfeeding and family planning. At first, it was difficult to get women to participate in training or to find meeting spaces in the communities. Now, not only do the community women enjoy the health education but also the social interactions, which they were never able to have before. Eye contact is plentiful, and questions are frequent.

Over the last four and half years of the project, the M/M teams have overcome communication barriers that were both internal to them, and external within the communities the project targeted. They worked tirelessly to create a strong community health program, and their success is revealed in the dramatic decrease in infant and child mortality and morbidity rates document by the final KPC. M/Ms developed an incredible amount of love and respect for one another. They have overcome their anxiety and embarrassment of discussing sensitive health issues with women, and they confidently educate them about breastfeeding (including demonstrating good placement and attachment!), family planning and safe motherhood practices. They are not only welcomed but are viewed as experts in their communities.
Key Features of Integration

- Mentors and Mobilizers provided health information to communities on breastfeeding, child spacing, and several other topics. They trained other cadres of community-based agents to provide information on these topics.
- Mentors worked with health care providers to improve quality of primary health care in a range of services.
- IMCI was the integrating strategy for facility and community interventions. LAM unites both family planning and exclusive breastfeeding interventions.

Medical Care Development International MADAGASCAR – 1998 – 2002; 2003 - 2006³

Summary

The Toliara Province Child Survival Project (TPCSP, 2003-2006) is a cost-extension of the Betioky Child Survival Project (BSCSP, 1998-2002), which itself built on a Planning Grant project (1996-1998) awarded to MCDI to prepare its application for a first CSHGP grant. In 2006, USAID awarded MCDI an Expanded Impact grant for the Toliara Region Expanded Impact Project (TREIP, 2007-2011), which will extend the successful results achieved in Betioky and Toliara II to the nine districts of the South West Region. The Final Evaluation (FE) of TPCSP is conducted with this 10-year perspective to contribute to the planning and evaluation of TREIP.

The goal of TPCSP is: “To reduce morbidity and mortality among children under 5 and to improve the health status of women of reproductive age (WRA) in the Betioky-Sud and Toliara II Districts.” Its three main strategies are to (1) strengthen capacity at the community level; (2) strengthen case management, BCC, and management/supervision at the facility and district levels; and (3) facilitate synergies with other donor partners.”

TPCSP focuses on five technical interventions with similar level of effort. Four of these interventions--Control of Diarrheal Diseases, Immunization, Breastfeeding, and Child Spacing--were already implemented during BSCSP, although complementary feeding and vitamin A supplementation were added to Breastfeeding, and HIV prevention was added to Child Spacing during TPCSP. In addition, two new interventions were added during TPCSP: Pneumonia Case Management and Malaria Control.

TPCSP is implemented in the two districts of Toliara II and Betioky, with a total beneficiary population 63,791 under five years-old and 81,510 women of reproductive age. In Betioky, TPCSP continued supporting activities implemented under BSCSP through the local NGO VEMIMA, with the primary goal of building local capacity to maintain or improve the results previously achieved and achieving the same results as in Toliara II for the new interventions. In Toliara II, TPCSP implemented the same approaches and activities as in the previous project in Betioky, with the primary goal of achieving the same or better results for the BSCSP interventions and specific new objectives for the two new interventions.

The TPCSP primary partners are the Ministry of Health and Family Planning (MOHFP) at the Region (Regional Office of Health and Family Planning-ROHFP), District (District Office of Health and Family Planning-DOHFP) and Commune (Basic Health Center-BHC) levels, the Ministry of Communication and Youth, and three local NGOS (VEMIMA, Mampifoha and Miainga).

**Selected Results**

The main TPCSP accomplishments are:

**Behavioral change and community health**
- 548 CHVs trained in communication skills, VISA approach, and TPCSP interventions
- 6 Field Agents trained as CHV trainers
- Modules for training CHVs in TPCSP interventions developed
- BCC tools for TPCSP interventions developed and used
- Implementation of the VISA approach regarding TPCSP interventions
- Implementation of community-based distribution of key social marketing health products
- Development and broadcasting of radio programs on TPCSP interventions
- Relay of project activities to NGOs VEMIMA Mampifoha et Miainga
- Support to BHC for supervision of CHVs
- Support to implementation of health campaigns
- Support to implementation of Kôminina Mendrika in 8 communes

**Quality of Care in Basic Health Centers**
- 11 Trainers trained in clinical IMCI
- 55 HWs trained in IMCI, TPCSP interventions, supervision and training
- Support to DOHFP for supervision of BHCs and HWs

Contraceptive prevalence among mothers of children under two who are not pregnant and do not want another child in the next two years or are not sure increased from 9% at baseline to 24% at the end of the project. In 2006, the Field Agents (FA) reported that 88% of CBDs trained and supervised had stocks of condoms in the last 6 months.

Although breastfeeding practices improved during the project period, only 4% of mothers of children under two know of exclusive breastfeeding as a child spacing method; the objective to increase this percentage to 40% is not met.

The FE Team identified these among other constraints and lessons learned:

**Constraints:**
- Some cultural traditions and habits, often reinforced by grandmothers, do not favor Child Spacing (for instance, delay of 3 months or more for first postpartum visit)
- Poor understanding of the key BCC message by mothers
- There is only one song on Lactational Amenorrhea Method among the 123 radio products developed by MCDI

**Lessons Learned:**
- Community mobilization and quality services are effective in increasing contraceptive prevalence
- Grandmothers need to be taken into account in the BCC approaches to child spacing
- Well-trained and motivated NGO staff can effectively implement the community health and mobilization approaches developed under BSCSP and TPCSP
CHVs and VISA Community Mobilization

Local leaders interviewed in the four communities visited by the evaluation team listed among activities of CHVs the promotion of health in general (antenatal care, nutritional surveillance, breastfeeding, family planning, malaria and ITN, utilization of BHC, immunization and tuberculosis), the distribution of health booklets and mass campaigns.

Local Leaders found that TPCSP community mobilization approaches were effective because:

- CHVs are motivated and determined to conduct their activities; they know their subjects; and they are skilled in communication techniques
- Mothers who have successfully practiced key behaviors can effectively encourage other mothers in adopting these practices
- Key messages are well received and practiced in the communities
- Local authorities, HWs and Field Agents participate in community health and mobilization, and often directly assist CHVs and other community members involved in these activities

Local leaders also pointed out that CHVs would benefit from some transportation means like bikes and even some compensation to improve their motivation and effectiveness.

Mothers interviewed in the four communities visited by the FE Team know the various activities of the CHVs, including their transfer of knowledge to VISA mothers. They acknowledge that CHVs have helped them change their life and ensure that their children are healthy and that practices of exclusive breastfeeding and family planning have increased in their communities.

TPCSP trained a total of 185 CBDs in Toliara II, as proposed in the DIP. A first group of 20 CBDs were identified and trained in Q4 FY04 and the others in Q3 and Q4 of FY05. The training included home-based management of malaria with chloroquine (PaluStop) the use of ITNs (Supermoustiquaire), counseling on oral contraceptives (PilPlan) and condoms (Protector), the use of safe water (Sur’Eau), and use of the various tools for the management of the social marketing of these products.

The VISA Approach

The VISA Approach is the unique aspect of the community health volunteers program of TPCSP. The approach was further developed based on the experience gained under the previous child survival project in Betioky. It provides a way to sustain the number of motivated CHVs by continuously recruiting new CHVs among mothers, called VISA mothers or Remy Limy in Malagasy, who have successfully adopted healthy behaviors for their own child. VISA refers to the main role played by the mothers enrolled in the program and stands for Visit, Identify, Sensitize and Accompany: visit new mothers, identify with them inadequate behaviors, sensitize them on how to adopt optimal behaviors, and accompany them during the process of behavioral change.

CHVs trained in the VISA approach are asked to identify 5 new mothers in their communities who showed particular interest in the health of their child and have successfully adopted healthy behaviors. These mothers are then encouraged to share their experience with others and those who get involved and motivated by this volunteer work are invited to become CHV
and receive the appropriate training. This continuing enrollment of new and motivated mothers allows for the replacement of CHVs who lose interest in or stop this work for various reasons.

**Key Features of Integration**

- CHVs promoted various health behaviors including breastfeeding and family planning.
- Mothers who successfully practice health behaviors become advocates for them through the VISA program.
- CBDs marketed a variety of products including condoms and oral contraceptives, water guard, and malaria treatment.
- A widened pool of trained health agents to include local authorities, CHVs, FAs, HWs, and mothers to increase the reach of health messages.

**CURAMERICAS GUATEMALA – 2002 - 2007**

**Summary**

This project served three very isolated districts or municipalities in the Department of Huehuetenango in northwest Guatemala. Within these municipalities, Curamericas chose the most isolated communities with the highest mortality rates. The terrain is very rugged, and although new roads are being built at this time, there are still communities that cannot be reached by vehicle. The rainy season and consequent mudslides make most roads impassable.

In addition to infrastructure challenges, each district has different cultural backgrounds and uses different languages. Akateko is spoken in San Miguel Acatan and San Rafael La Independencia, and Chuj is spoken in San Sebastian Coatan. The health facilities network and the degree of development of community-based services were very different in each district. The three districts have also suffered from the long tradition of distrust of community development activities, a remnant of a 30-year civil war, which ended only one decade ago. Language and culture differences posed various implementation challenges that the project addressed by hiring staff and engaging community workers from those communities that spoke the local language, and by developing communication materials in Spanish and the local language.

The target population has decreased over the life of the project due to outward migration. At the time of the final evaluation, there were 11,134 children and 11,123 WRA. The total population of the project area at the time of the final evaluation was 62,428 in 118 villages (*aldeas*) of which 49 are in San Sebastian Coatan, 21 in San Rafael La Independencia and 48 in San Miguel Acatan.

In this context, the project partnered with the Ministry of Health (MOH) and the communities to provide well-known and effective child survival interventions and assigned a level of effort according to the magnitude of the problems: Nutrition (including breastfeeding promotion) had 30% of the level of effort (LOE); Maternal and Newborn Care, 25%; Childhood Pneumonia, 15%; Control of Childhood Diarrhea, 10%; Child Spacing, 10%; and Immunizations had 10%.

---

Objectives

- Improve the scope and the quality of preventive and curative care provided to children and pregnant women through household visits, outreach, and improved facility-based care; and,
- Improve the prevention of childhood illness in the home, as well as improve the home recognition, treatment and care-seeking for illness when it occurs.

Overall Technical Approach

To reach these objectives, the project combined the Census-Based, Impact-Oriented (CBIO) Methodology with the Care Group Model. The Care Group Model included the training and support of a network of village health volunteers, which included 321 Health Communicators (Comunicadoras en Salud), who were each responsible for 10-15 surrounding households. It was projected the number of Comunicadoras would reach over 400 but resistance from husbands and family prevented involvement of a number of mothers who had expressed interest to join the project at the beginning. At first, the Comunicadoras hardly reached 200 but resistance has decreased and now more mothers want to join. The Health Communicator held mothers' group meetings, called Self-Care groups (Grupos de Autocuidado) with those living in households in her jurisdiction and made home visits, according to the health needs of each family. By the end of the project, there were over 300 active Self-Care Groups, each lead by one Health Communicator.

The network of community workers also included 62 project-paid Community Facilitators (CFs, or Facilitadores Comunitarios), who had additional training to support the work of the Health Communicators. Community Facilitators were paid an average of 500 quetzales (about US$80) depending on the number of communities they served. These facilitators also provided services at preventive care facilities called “Centros de Convergencia.” Groups of ten Health Communicators form a Care Group (Grupo de Cuidado), which met monthly with a Community Facilitator for continuing education and reporting of project activities, including reporting of births and deaths; the Community Facilitators were trained and supported by three Health Educators, one in each municipality. The Health Educator was also in charge of observing and supervising the CFs to ensure the quality and consistency of their work and of the health messages.

To improve facility-based care, the project trained and supported 15 Institutional Facilitators (IFs, or Facilitadoras Institucionales), who staffed equal number of minimum health facilities (Unidades Minimas). The IF, usually an auxiliary nurse, was responsible for all the health activities in the jurisdiction. The IF planned, implemented and monitored all the project’s child survival (CS) indicators in his/her jurisdiction according to the project work plan. He or she also built the capacity, supervised the CFs in his/her jurisdiction and accompanied the CFs in selected home visits that the CF had identified. The IF also gathered the vital events information provided by the CFs in his/her jurisdiction.

The CBIO Methodology was one of the most important reasons -- if not the main reason -- for the success of this project. It involved determining local health priorities as defined both by locally acquired epidemiological information and by the local people themselves. The CBIO approach was strongly community-based because of the community partnerships, which emerged in the process of gathering vital information and defining health priorities as well as in the process of program implementation and evaluation. The mid-term evaluation revealed that
the CBIO Child Survival project had made strong progress towards meeting End-of-Project objectives. Then, the project had also made remarkable progress in building partnerships with the communities, mapping the communities to identify all households and conducting a census of all the identified households. This was a major effort, particularly in light of the isolation and difficult terrain of the Project area and the initial distrust and suspicion encountered in the communities. In the final evaluation, the CBIO Methodology also demonstrated to be a simple, and at the same time, effective approach to improve CS indicators based on reliable census information. Including the registration of vital events and monitoring of mortality rates allowed the continuous assessment of project impact.

**Selected Results**

The project improved nutrition practices, including exclusive breastfeeding, in all three municipalities, and the percentage of malnourished children decreased from 43% to 33%. It was also reported that improvements in nutrition were related to improvements in newborn care. Immediate and exclusive breastfeeding increased from 54% in the MTE to 73% in the final KPC. However, this was exceeded in all three jurisdictions of San Miguel, in some cases reaching 90% and 87%. The operational research conducted by the project team showed that the baseline survey had probably overestimated the prevalence of exclusive breastfeeding and mothers were afraid to say they preferred the use of baby bottles. Consequently, the practice of providing other liquids was underestimated. Mothers also reported they discarded colostrum because they believed this first milk was “weak” and was just the result of breast impurities collected during the pregnancy. Educational materials were adjusted to address this belief and the number of mothers that gave exclusive breastfeeding in the first 24 hours of life has increased. Another important lesson learned was that by linking a tangible benefit to postpartum care (such as receiving vitamin A), mothers had an incentive to report births and to increase postpartum care.

Birth spacing practices using a modern method have greatly increased, reaching 47% of the mothers who do not want to have a child in the next two years. The number of mothers that know where to obtain child spacing methods has reached 80%. The Project had an integrated approach to family planning that focused on child spacing and worked collaboratively with the MOH for the supply of commodities. This lead to improved quality, increased access, and greater use of family planning options, and complied with the Tiahrt Amendment and Mexico Policy. Among the lessons learned were the focus on child spacing, women’s empowerment and the participation component that enabled women to discuss their sexual behaviors and choices of when to have children with men. Additional lessons were learned about home visits and care group support received by users. There is still need to address the reproductive health needs of all women, as well as the need to develop community-based distribution of commodities. Male involvement should be emphasized in future activities. The majority of CFs are men, which should aid Curamericas in expanding the acceptability of family planning by husbands.
The following table explains the activities directed toward child spacing, as they were implemented at different levels.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Household</th>
<th>Community</th>
<th>Health Facility</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate Child Spacing</td>
<td>• Maintenance of a women's registry with family planning data to identify women who are and are not using family planning methods</td>
<td>• Promotion of child spacing during Care Groups</td>
<td>• Retraining of clinical staff in child spacing methods and counseling skills</td>
<td>• Provide family planning methods to health facilities</td>
</tr>
<tr>
<td></td>
<td>• Education of WRA and their partners on child spacing</td>
<td>• Training of CFs and FIs in child spacing methods and counseling</td>
<td>• Provision of family planning methods</td>
<td>• Provision of IEC materials</td>
</tr>
<tr>
<td></td>
<td>• Promotion of child spacing among WRA and their partners</td>
<td>• Promotion of child spacing during Care Groups</td>
<td>• Strategically place family planning educational materials (e.g. posters, brochures) in the health facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Development and implementation of child spacing education materials for Comunicadoras</td>
<td>• Develop education materials on child spacing for use with Care Groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Features of Integration

- CBIO encourages community monitoring of health in multiple areas (child spacing, exclusive breastfeeding, etc.).
- Care Groups promote mothers’ involvement in community health and increase coverage of health messages.
- An Institutional Facilitator supervised all facility and community health activities in his/her jurisdiction.
- Local prioritizing can facilitate integrated service delivery.
Summary

Project HOPE’s child survival (CS) project in the Navoi Oblast of Uzbekistan is an extension of a child survival project that began in 1999. The current project, Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan, is the second phase of the original project and was extended from October 2003 to September 2007.

The purpose of the Project HOPE’s CS project in Uzbekistan was to: (a) reduce the mortality and morbidity in children under five years-old and women of reproductive ages and (b) increase adolescents’ knowledge about reproductive and sexual health. The CS project directly targets an estimated 36,716 children ages 0-5 years; 77,479 women of reproductive age (15-49 years old), and 25,505 adolescents (16-18 years of age). The project has introduced and expanded the use of standard case management protocols in: IMCI, Making Pregnancy Safer and Family Planning interventions, through which the project intervened in the following areas: ARI/Pneumonia Control (10%), Control of Diarrheal Diseases (10%), Child Nutrition (10%), Breastfeeding Promotion (10%), Maternal/Newborn Care (30%), and Family Planning (30%).

Select Results

The project has successfully influenced the Oblast Health Department (OHD) and Rayon Health Departments (RHD) to adopt such strategies as IMCI and the Making Pregnancy Safer program, as their own and are implementing those programs in other parts of the country. In addition, some of the materials developed by the project are now being used by UNICEF and other INGOs in other areas of the nation. The partnership between the project staff, the OHD and the RHDs is very strong and the project has made tremendous strides in building the capacity of the health department staff.

Other noteworthy achievements include the organization and implementation of a community health promotion strategy by training local makhalla and other informal leaders who are then supervised by the Rayon Women leaders. These leaders have the responsibility of organizing and overseeing family health promotion at the community level. The project has successfully coordinated the leaders’ community awareness work with that of the patronage nurses who have also received updated training by the CS project to deliver MCH and FP home care services.

Project HOPE began to introduce the New Parents’ Schools in 2004. The purpose of the New Parents’ Schools is to educate expectant parents about pregnancy, delivery, postpartum and newborn care, breastfeeding, family planning, and use of mother home cards. Currently, Project HOPE has supported the formation of 75 parents’ schools at primary health care facilities, which is 91.46% of all PHC facilities.

The following achievements are most noteworthy (selected):

- Organization and support of 32 types of training courses: 4-IMCI, 4-BF, 7-Safe Motherhood, 3 FP, and 4 ARH; 1 MPS +RH; 3 BF+ c-IMCI; 2 Community Health Promotion; 1 Database Management.

---

• Training of 2,215 of health professionals – 493 - Safe Motherhood; 709 – IMCI and BF-C-IMCI; 538 – Breastfeeding; 475 – Family Planning.
• Development, production, and distribution of health education materials including a Mothers Home Card (added to Prikaz 425) and 32-page pocket guide including the IMCI 16 key practices.
• Development of protocols at local and national levels in support of IMCI, maternal and neonatal health care and family planning.
• Streamlined Quality Improvement program that includes participation from the MOH counterparts.
• Seven hospitals and two PHCs Certified as “Baby-Friendly,” each with mothers’ support groups, private room for counseling and group meetings.
• Support for International Breastfeeding Week.
• Initiation of and support to New Parents’ Schools.
• IMCI booklet and posters developed by project accepted by other INGO projects including “Healthy Family Project” in Uzbekistan and in the CAR.
• SM and IMCI trainers trained by CS Project have replicated the training to other oblasts and countries (Kyrgyzstan).
• Quality Improvement Seminars provided by project and Zdrav Plus (a USAID funded project, implemented by Abt Associates) trained 70 providers from 11 PHCs during three seminars.

The majority of the indicators achieved were at the service delivery level with complementary indicators and strategies at the community level. Since the Uzbek health system has a large infrastructure that reaches the majority of the population, this dual-pronged approach has been successful. Thus, Project HOPE’s strategy to work through the OHD, RHDs and communities was appropriate in this context.

**Family Planning**

**Objectives**: (1) Increase the number of women/couples with a birth interval at least 24 months after the previous surviving child; (2) Increase the number of women/adolescent/couples’ knowledge of the reproductive cycle; (3) Increase the number of non-pregnant women who desire no more children to space births and are using a modern method of FP; and (4) Increase the number of family planning clients who received counseling on contraceptive choices, common side effects, and when to return for follow-up.

**Main Strategies and Activities**: (1) Implement TOTs and train health staff in family planning; (2) Explore the possibility of continuing surgical contraception (minilap) training for health providers; (3) Initiate sessions of BCC and makhalla/community-based work focused on WRA and their partners to orient makhalla committees and leaders in reproductive health and family planning; (4) Focus on Adolescents’ Reproductive and Sexual Health (ARSH) to increase adolescents’ knowledge about sexuality and reproductive health and to develop an adolescent-friendly health services strategy; (5) Increase knowledge of reproductive health and sexuality through the BCC and makhalla/community-based efforts; and (6) Focus on improving the quality of FP service delivery through training, community education and close monitoring and supervision.
KPC Results on FP and Child Spacing

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (Feb 2004)</th>
<th>KPC FE* June 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children aged 0-23 months who were born at least 24 months after the previous surviving child</td>
<td>48.3% ±18.2</td>
<td>84.7% ±5.8</td>
</tr>
<tr>
<td>Percent of women of RA who report that women are likely to get pregnant halfway between two menstrual periods</td>
<td>9.3% ±2.8</td>
<td>45.7% ±5.6</td>
</tr>
<tr>
<td>Percent of non-pregnant women who desire no more children in the next two years, or are not sure, who are using a modern method of child spacing</td>
<td>72.6% ±4.6</td>
<td>72.8% ±9.3</td>
</tr>
<tr>
<td>Percentage of respondents who report discussing FP issues with somebody in the past 12 months</td>
<td>56.2% ±4.7</td>
<td>65.7% ±5.4</td>
</tr>
<tr>
<td>Percentage of family planning clients who receive counseling on contraceptive choices, common side effects, and when to return for follow-up</td>
<td>62.7% ±5.8</td>
<td>86.6% ±6.8</td>
</tr>
</tbody>
</table>

In the DIP, reproductive health training for the patronage nurses was planned to be separate from the maternal health care course; however great as the need was to train patronage nurses, this methodology has been fused with basic outreach antenatal and postpartum care topics. An important lesson learned by the project was the importance of training the visiting nurses to take a more active role in home based preventive health care. Patronage nurses have proved to be a key link between the communities and the health services.

The project and HD staff also indicated that quality of care improved, thanks to the project. Results of the monitoring visits have indicated that clients are more satisfied with services, that there are fewer stock outs of contraceptives, and that there is improved counseling by visiting nurses for both FP and antenatal care (before they did not provide this counseling). Also, according to project monitoring data, 91.4% of all 83 SVPs offer mothers’ classes for antenatal care, which includes information about FP.

**Breastfeeding Promotion**

**Objectives:** (1) Increase the percentage of mothers who exclusively breastfeed their infants for the first six months; (2) Increase the percent of infants being breastfed during the first hour of birth; and (3) Increase the percent of newborns that have skin-to-skin contact with the mother immediately after birth for at least 30 minutes.

**Main Strategies and Activities:** Project HOPE seeks to achieve the breastfeeding objectives by improving the quality of mother and newborn care provided by health workers. The strategy includes (1) assisting hospitals gain Baby-Friendly Hospital Certification, which includes the WHO “10 Steps to Successful Breastfeeding;” (2) forming Breastfeeding Support Groups at maternity houses; (3) implementing a behavior change strategy that involves makhallah/community-based groups when developing an intervention with grandmothers.
Mullah-Bibis, and other community leaders; (4) participating and endorsing annual “Breastfeeding Week” activities, organized and implemented by the MOH and collaborating agencies; (5) providing of TV and VCR sets to the new rayon maternity houses; and (6) monitoring adherence to Baby-Friendly protocols at maternity houses.

**KPC Results on Breastfeeding and Child Nutrition**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline Feb 2004</th>
<th>KPC FE* June 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of children aged 0-23 months who were breastfed within the first hour after birth</td>
<td>62.6% ±4.6</td>
<td>93.1% ±1.8</td>
</tr>
<tr>
<td>Percent of infants aged 0-5 months who were fed breastmilk only in the last 24 hours</td>
<td>62.7% ±9.0</td>
<td>90.0% ±3.9</td>
</tr>
<tr>
<td>Percent of children aged 20-23 months who are still breastfeeding</td>
<td>33.9% ±12.1</td>
<td>66.8% ±6.4</td>
</tr>
<tr>
<td>Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours</td>
<td>19.8% ±8.2</td>
<td>60.3% ±6.4</td>
</tr>
<tr>
<td>Number of health facilities currently certified under the National participation in the Baby-Friendly Hospital Initiative (BFHI).</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Focus group discussions conducted among mothers of children less than one year old revealed that mothers believe that if they exclusively breastfed their children for six months, they could be protected from pregnancy (LAM) and their children will be protected from different diseases. This is a good indication that the education mothers are receiving has stressed the importance of breastfeeding for both the baby's health and for family planning. Mothers also reported reading the 32-page child health booklets as well as the “Essentials of Breastfeeding” booklet.

A lesson learned from Phase 1 was that since the project only provided hospital level BF training for providers, mothers were not adequately counseled at home on breastfeeding nor were they counseled at the PHCs, where they were seen for prenatal and postnatal care. During the second half of the project, the Navoi CSP staff trained GPs and nurses to support and counsel patients about breastfeeding during antenatal and postpartum visits. Initially, project staff believed that the nutrition session in the IMCI training was enough for the providers to adequately counsel mothers about breastfeeding. The project staff soon discovered that GPs needed counseling skills training in order to talk to and convince the mothers of the importance of breastfeeding and how to breastfeed successfully. A total of 372 visiting nurses received the five-day course of breastfeeding and IMCI and 67 who received TOT training.

Community-based IMCI activities were carried out primarily by patronage nurses through home visits. The focus groups with patronage nurses showed that they visited the homes of newborn infants once a week up to the first year of life, as well as pregnant women at least twice a month. Breastfeeding promotion and education is part of their home-visit plan of activities.
Key Features of Integration

- Rayon Women’s Leaders and patronage nurses were trained to provide MCH and FP (including IMCI) services at home visits
- Parents’ Schools provided health education on a variety of topics, including breastfeeding and family planning
- Informal leaders (makhalla) were trained in key health messages on breastfeeding and family planning, and other topics
- Health Department officials were supported to improve personnel and resource management to improve coverage and quality across the spectrum of services

Concluding Thoughts

These five projects illustrate different approaches to integrating family planning with nutrition and other child survival interventions. Project implementers approached integration at both facility and community levels in different ways. Key characteristics included improving quality of care through training in addressing various health issues during home or facility visits. Community-level volunteers promoted health behaviors that spanned child survival and family planning. CBDs offered related products.

The final evaluation report from the project in Uzbekistan offered some insight about the sustainability of health efforts and outcomes through an integrated platform. Project Hope built the capacity of health authorities to manage personnel and resources to improve the quality of health services across a broad spectrum of maternal and child health needs. “Many of the activities initiated by this CS project have already been “sustained” by the MOH and are being scaled up in other parts of the oblast as well as other parts of the country, including IMCI and the Making Pregnancy Safer initiative” (p. 2).6 Integration may facilitate sustainability through institutionalizing activities that mirror a broader scope of health providers’ efforts, more so than a narrower focus on a set of activities in one health area.

Improving the quality of integrated service delivery could affect a variety of health indicators simultaneously. For example, a post-partum visit can include a check on the mother’s health, counseling on infant feeding and the immunization schedule, a check for bednets, and counseling on family planning options. Counseling from a community volunteer can cover a similar range of topics in a single visit. Since families’ health needs are integrated there is a demand for integrated service delivery to meet them.

---

6 Ibid.