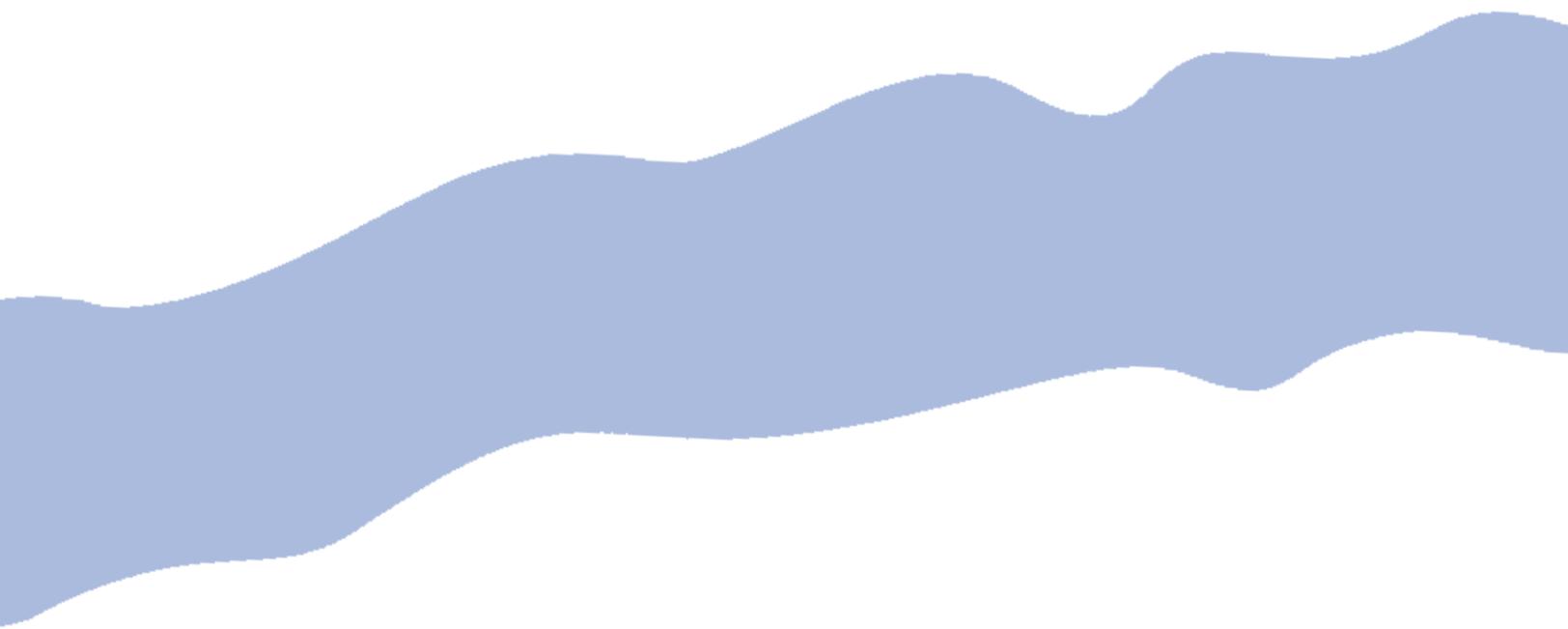


Integrating Reproductive Health Into NGO Programs

Volume 2: Safer Motherhood for Communities



Family Planning
Service Expansion
and Technical Support

By Jenny A. Huddart,
Joyce V. Lyons and
Donna Bjerregaard

The goal of the Family Planning Service Expansion and Technical Support (SEATS) Project is to expand access to and use of high-quality, sustainable family planning and reproductive health services.

John Snow, Inc. (JSI), an international public health management consulting firm, heads a group of organizations implementing the SEATS Project. These include the American College of Nurse-Midwives (ACNM), AVSC International, Initiatives Inc., the Program for Appropriate Technology in Health (PATH), World Education, and partner organizations in each country where SEATS is active.

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Table of Contents

<i>Acknowledgments</i>	i
<i>List of Acronyms</i>	iii
<i>Dedication</i>	v
<i>Foreword</i>	vii
Introduction	1
Prologue: Understanding Safe Motherhood	5
Step 1: Assessing Community Needs	15
<i>Worksheet 1: Mapping Community Resources</i>	30
Step 2: Deciding Whether to Integrate	31
<i>Worksheet 2a: Preparing a Presentation for the Board</i>	45
<i>Worksheet 2b: Identifying Potential Partners</i>	46
<i>Worksheet 2c: Managing Obstacles to Integration</i>	47
Step 3: Preparing Program Strategies	49
<i>Worksheet 3a: Applying Quality Standards for Community Services</i>	74
<i>Worksheet 3b: Selecting a Strategy for Integrating Safe Motherhood</i>	76
Step 4: Measuring Program Results	77
<i>Worksheet 4: Preparing a Monitoring Plan</i>	95
Step 5: Using Resources Effectively	97
<i>Worksheet 5a: Estimating Human Resource Requirements</i>	116
<i>Worksheet 5b: Determining Training Needs</i>	119
<i>Worksheet 5c: Determining How to Apportion Program Costs</i>	120
Step 6: Promoting Financial Sustainability	121
<i>Worksheet 6: Determining the Best Financial Sustainability Option</i>	137
Annex	A-1
Annex 1: Consequences and Actions of Obstetric Complications	A-1
Annex 2: Indirect Causes of Maternal Morbidity and Mortality	A-3
Annex 3: RH Reference Rates and Ratios	A-7
Annex 4: Overview of Focus Group Discussions and Sample Guide	A-9
Annex 5: Counseling Topics for Safe Motherhood Programs	A-13
Annex 6: Guidance on Rapid Community Surveys	A-21
Annex 7: Indicators for Monitoring Safe Motherhood Programs	A-25
Annex 8: Performance Improvement Review Package	A-31
Annex 9: Projecting Resource Requirements	A-35
Resources	R-1
Glossary	R-1
Annotated Resource List	R-4
Endnotes	R-11
Loose Worksheets	Pocket

Acknowledgments

This handbook is the second volume in a comprehensive strategy of the SEATS Project to expand reproductive health services to meet the needs of women and men who have limited access to high quality, reproductive health services. This volume recognizes the unique role that NGOs and PVOs can play at the community level in reducing the impact of the factors that contribute to maternal mortality and morbidity. We gratefully acknowledge the United States Agency for International Development for their financial support of this project through Contract # CP-3048-C-00-4004-00.

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome	M&E	Monitoring and Evaluation
BCC	Behavior Change Communication	MH	Maternal Health
BEOC	Basic Essential Obstetric Care	MHO	Mutual Health Organization
CBD	Community Based Distribution/Distributors	MMR	Maternal Mortality Rate
CBO	Community Based Organization	MOH	Ministry of Health
CEF	Childbirth Emergency Fund	NHC	Neighborhood Health Committee
CEOC	Comprehensive Essential Obstetric Care	NGO	Non-Governmental Organization
CHW	Community Health Worker	PID	Pelvic Inflammatory Disease
CPR	Contraceptive Prevalence Rate	PIR	Performance Improvement Review
DHS	Demographic Health Survey	PVO	Private Voluntary Organization
EOC	Essential Obstetric Care	RDI	Rural Development Initiatives
EPI	Expanded Program on Immunization	RHI	Reproductive Health Integration Initiative
FGC	Female Genital Cutting	Rs.	Rupees
FGD	Focus Group Discussion	RTI	Reproductive Tract Infection
FP	Family Planning	SEATS	Family Planning Service Expansion and Technical Support Project
HBV	Hepatitis B Virus	STI	sexually transmitted infection
HDP	Hypertensive Disorder of Pregnancy	TBA	Traditional Birth Attendant
HIV	Human Immunodeficiency Virus	TFR	Total Fertility Rate
ICPD	International Conference on Population and Development	TT	Tetanus Toxoid
IDD	Iodine Deficiency Disease	VHW	Village Health Worker
IEC	Information, Education and Communication	UNDP	United Nations Development Programme
IFA	Iron and Folic Acid	UNFPA	United Nations Population Fund
IMR	Infant Mortality Rate	UNICEF	United Nations Children's Fund
IU	International Units	VHW	Village Health Worker
KAP	Knowledge, Attitudes, and Practice	WELS	Women's Enterprise Loan Scheme
KPC	Knowledge, Practice, and Coverage	WHO	World Health Organization
		WRA	Women of Reproductive Age

Dedication

We dedicate this book to Martha Musarurwa, our colleague and friend who helped us to think about integration. Her ability to guide others, her strong commitment to excellence, and her gentle and supportive manner were a rare combination. We will miss her quiet, comforting presence and her spontaneous, infectious laugh ...

until we meet again.

Foreword

SAFER MOTHERHOOD FOR COMMUNITIES: A Matter of Life and Death

Birth at home remains the norm for most women in developing countries. A trusted person may attend—a traditional birth attendant, sister, neighbor, mother-in-law, spouse. Sometimes the woman gives birth alone. In most cases, birth is a much awaited, joyous event celebrated by all. But occasionally it can be very sad—a death of a mother, a death of baby, or both.

Where women deliver at home with a community member, it is not that they *can't* use the formal health services, they *may not want* to use the services. In Nigeria, a Hausa woman who had a complicated delivery said: "I will prefer to deliver at home in my room because of the dignity and self-respect. I will not be exposed." Her Bolivian counterparts expressed similar concerns: "...they say in the hospital they put us on a cold table, and we're naked and they laugh when we complain about any pain." Indonesian women do not want to think about negative birthing events or have emergency plans, as they anticipate such thoughts and plans will cause problems to occur more often. They prefer to deliver at home, even in the face of birthing complications, because the "life force" is there.

And yet, we often state births will be safest in the hands of a skilled professional provider. How do we bridge this gap? The culture of birthing is very deeply held with traditions practiced over generations. Building the trust needed to bridge the gap between these traditions and the formal systems of care can be daunting. It requires knowledge and respect for the birthing traditions, plus knowledge and credibility of formal providers and program officials.

Non-governmental organizations are in the unique position to build these bridges between communities and formal service systems. They often are located in areas where traditions may be most strongly held, and where formal services are distant, both figuratively and literally. They can provide the necessary links, perhaps providing some of the birthing services themselves, perhaps working with community members who are called upon at the time of birth, and supporting these efforts with links to providers with life-saving skills for mothers and newborns.

This handbook, *Safer Motherhood for Communities*, can help NGOs decide whether they can integrate efforts to improve the birthing outcomes, and if so the strategies that might be most effective, given their particular organizational characteristics. It also provides a template for measuring progress and for using resources effectively, with a view towards sustaining such efforts.

We in Safe Motherhood need you as partners— to reach out to women and their families, to connect them with skilled birth providers, and to help providers communicate as well as treat families in a respectful and effective way. Read this Handbook and join us!

Marge Koblinsky,
MotherCare

Introduction

The Reproductive Health Integration Initiative (RHII) works with international and national non-governmental organizations (NGOs) interested in integrating reproductive health into their existing programs.

Purpose of the Handbook:

Nearly 600,000 women die annually of complications related to pregnancy and childbirth; at least three-fourths of these deaths could be avoided if access to quality reproductive health services was available. Pregnancy complications are a leading cause of mortality, morbidity and disability among women of reproductive age in developing countries. To draw attention and help find solutions to the problem of maternal mortality, the Safe Motherhood Initiative was launched in 1987 by the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the World Bank.

RHII is designed to build on the lessons learned from the Safe Motherhood Initiative and the efforts undertaken by the formal health system in response to maternal health complications. Research and experience confirm that maternal deaths can be prevented by the presence of a skilled attendant at birth. However to benefit from that service, the community must have the knowledge and means to access the care. The objective of this Handbook is to assist interested NGOs to help communities ensure *safer motherhood*. The Handbook offers information and tools to assess, organize and implement 'safe motherhood' strategies that complement those designed to improve the health system. These strategies will make communities active partners in promoting safe motherhood by improving recognition of obstetric complications, ensuring proper decision-making to seek services and facilitating access to required services. As organizations with strong ties to their communities, NGOs are ideally suited for facilitating community-level interventions. The Handbook provides guidance to organizations about accessing the resources of the formal health system, but primarily focuses on interventions appropriate at the community level.

Why Integrate Safer Motherhood?

In addition to the nearly 600,000 annual deaths from pregnancy related complications, 60 million women endure illness and life-long medical problems. Consequences reach beyond the suffering women, placing added burdens on the rest of the family, the larger community and the already overwhelmed health system. Facilitating the family's ability to seek and receive qualified obstetric care and to ensure healthy mothers is a prerequisite for effective development interventions. Experience has shown that from an economic, programmatic and administrative standpoint, integration of services is a cost-effective and efficient approach to meeting the reproductive health needs of clients.

Who Should Use This Handbook?

"Integrating Reproductive Health into NGO Programs" is a set of three separate but inter-related handbooks that assist NGOs to develop and integrate into existing programs, community-level interventions to overcome obstacles to reproductive health. Volume 1, *Family Planning* concentrates on initiating and strengthening family planning services; Volume 2, *Safer Motherhood for Communities* focuses on community-based strategies to address factors that lead to maternal morbidity and mortality; and Volume 3 completes the trilogy by promoting HIV/AIDS and sexually transmitted infection (STI) prevention and care activities at the community level. The Handbooks are intended for NGOs that have recognized the need to improve the reproductive health of their communities and wish to explore their role in the process.

Prerequisites for successful integrated reproductive health programs are NGOs that:

- Have a long standing relationship with the community they serve;
- Promote economic, social or health development in their target area;
- Have skills and experience in the management of effective community development and/or health programs.

The Handbooks are not intended as management guides for implementing reproductive health programs; rather they help experienced NGOs to understand the key issues involved in the successful integration of reproductive health strategies.

How to Use This Handbook

This Handbook can be used as a stand-alone study and reference guide, or as the basis for a facilitated workshop for NGO participants. The Handbook is divided into a prologue, which presents an overview of safe motherhood, and six 'Action Steps' to guide NGO managers in deciding whether, and how, to integrate safe motherhood services. Each step covers essential decision-making issues, with key points summarized at the beginning. *Experiences From the Field* (shown as *postcards* in the text) are included to provide examples of how health-focused organizations have handled the step in question. *Research From the Field* (shown as *magnifying lenses* in the text) is provided to give state-of-the-art information about the latest findings on technical issues.

An illustrative case study is threaded throughout the steps to reinforce the major points covered by each step in the Handbook. This case study describes how a micro-enterprise NGO, the Women's Enterprise Loan Scheme (WELS), responded to the community's need for improved access to health care facilities for maternal health complications.

Each "chapter" of the case is accompanied by a set of questions to help the reader focus on and explore the key points illustrated by the case. The questions can also be used as learning guides during a group training session.

Action Steps

The contents of the Handbook along with a summary of the key points of section are found below. As each step is completed, the manager should decide if the NGO has the resources and commitment to complete the activities required for providing safe motherhood services.

Prologue: Understanding Safe Motherhood

- Safe Motherhood as an Element of Reproductive Health
- Factors that Influence Safe Motherhood
- Causes of Unsafe Motherhood

Step 1: Assessing Community Needs

- Defining the Safe Motherhood Problem
- Gathering Key Health Information about Women's Needs
- Identifying Existing Services and Potential Gaps



Step 2: Deciding Whether to Integrate

- Fostering Organizational Commitment
- Finding Partners in Safe Motherhood
- Managing Integration

Step 3: Preparing Program Strategies

- Identifying Effective Interventions
- Reviewing Community-Based Safe Motherhood Services
- Viewing Quality of Care from the Community Perspective
- Choosing Appropriate Safer Motherhood Strategies

Step 4: Measuring Program Results

- Setting the Context for Community-Level Monitoring and Evaluation
- Establishing a Framework for Monitoring and Evaluation
- Preparing a Monitoring Plan
- Maintaining Program Performance

Step 5: Using Resources Effectively

- Estimating the Human Resources Required
- Determining Training Needs
- Developing a Plan for Supervision
- Calculating the Material Resources Required
- Preparing a Financial Plan

Step 6: Promoting Financial Sustainability

- Options for Increasing Program Income
- Determining the Best Option for your Program
- Assessing Cost-Effectiveness

Prologue:

Understanding Safe Motherhood

Why are nearly 600,000 women in developing countries dying every year from pregnancy complications? Before an organization can address the problem of providing safe motherhood services, it must have some understanding of the issues, implications and reasons for the current maternal mortality and morbidity data.

The following key points are covered in this section:

- **Safe Motherhood as an Element of Reproductive Health**

Ensuring women have healthy pregnancies and safe deliveries is an essential component of reproductive health. This section supports the need for innovative and effective strategies by describing the magnitude of the safe motherhood problem and its implications for women, their families and communities.

- **Factors that Influence Safe Motherhood**

This section discusses the complex and interrelated set of underlying socio-economic conditions that contribute toward women's poor health and greater vulnerability to complications.

- **Causes of Unsafe Motherhood**

The direct and indirect medical reasons for mortality and morbidity provide a focus for responsive actions.



Safe Motherhood as an Element of Reproductive Health

Safe motherhood is commonly defined as a woman's ability to have a safe and healthy pregnancy and delivery.

In 1994, the International Conference on Population and Development (ICPD) in Cairo refocused population policy from a concentration on population reduction to more broadly address the sexual and reproductive health needs of people.

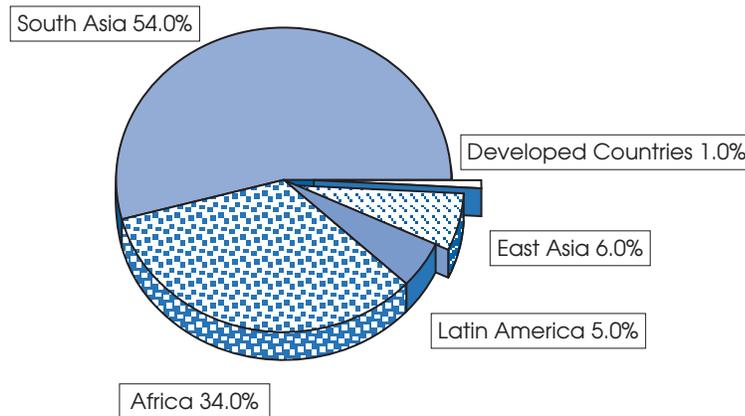
As stated by ICPD, reproductive health comprises the right of people to have the methods, techniques and services which contribute to reproductive health and well-being by preventing and solving reproductive health problems:

- A satisfying and safe sex life without fear of contracting disease;
- The capability and freedom to regulate fertility;
- Information about, access to, and freedom to choose safe, effective, affordable and acceptable methods of family planning;
- Access to appropriate health care services that will enable women to go through pregnancy and childbirth safely and provide couples with the best chance of having a healthy infant.

Magnitude of the Safe Motherhood Problem

Annually almost 600,000 women die from pregnancy-related complications, 90% of them in Asia and Africa, 1% in developed countries. These maternal mortality statistics become even more dramatic when a woman's risk of dying over her lifetime is calculated. Lifetime risk is affected by the total number of children a woman bears. According to WHO, the lifetime risk of dying from pregnancy complications in North America is 1 in 3,700; in Africa the risk is as great as 1 in 16. Contributing to this scenario is the quality and availability of obstetric care. In developed countries, 99% of women have access to maternal health services, while in developing countries only 53% are attended by a trained health care practitioner. These data reveal a public health tragedy: the rate of maternal mortality is the single largest discrepancy between developed countries and resource poor countries.¹

Maternal Deaths By Region

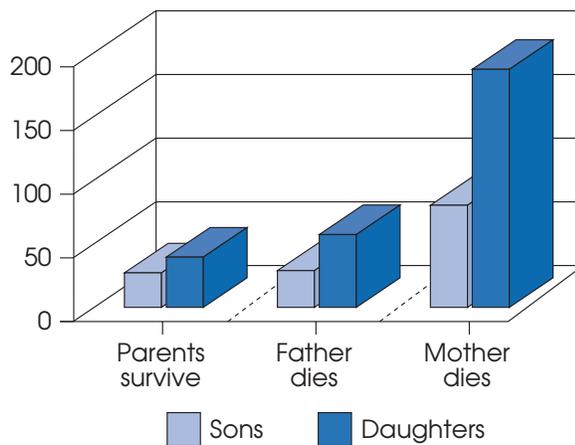


Implication of Maternal Illness and Death for the Family and Community

Family

As part of a family and community, the impact of the death or disability of a woman, particularly a mother, is felt by many. Her family is affected by the loss of her care and income. In most cases, a pregnant woman's death will be accompanied by a fetal or perinatal death. Less than 10% of those infants who survive a mother's death, live longer than a year.² In Bangladesh, surviving children are 3-10 times more likely to die within 2 years of a mother's death than children with 2 parents.³

Child Deaths When a Parent Dies⁴ Per 1,000 (Bangladesh)



Nutritionally and educationally, surviving children remain at a disadvantage. Daughters will be particularly affected, often receiving less health care, food and education than their brothers and being required at an

early age to take on the household and nurturing chores of their mothers. All children will lose the benefit of learning life skills, values and their cultural heritage from their mother. If the mother survives in a physically challenged condition, the family's financial burdens will be increased by the costs of medical care and supplies.

Community

The economic effect of a woman's death or disability on the household and community is acute. In one-quarter of male-headed households in the developing world, women provide one-half the income; women are the sole providers in one-fourth to one-third of all households. Women bear the major responsibility for farming and gardening, food preparation, gathering water and firewood, and caring for children, grandparents and those who are ill. Loss of the wages and unpaid labor of women set households, already living at or near subsistence levels, on a steep and often one-way path towards poverty. The cost of caring for motherless or orphaned children falls on the extended family and ultimately, the community. Without parental support, these children are often not able to attend school. This is a factor in the perpetuation of the poverty and low socioeconomic status of the community.

Factors that Influence Safe Motherhood

Women's Status

There are a number of underlying societal and gender-specific conditions that contribute to the low status of women, their poor general health and resulting pregnancy complications. In many developing countries, gender has a dramatic impact on one's status. Children are often at a disadvantage by being born to families with too many children, spaced too close together. However the life of a child, particularly a girl, is further influenced by the parents' income level, access to and understanding of proper nutrition, educational background and traditional beliefs. Due to the lower status traditionally awarded girls in many cultures, they are often given less food, education and health care than their brothers. This lack of attention to the needs of females becomes a life-long pattern affecting fertility and childbearing.

Increased education is often associated with reductions in maternal and infant mortality, promoting later marriage, expanding opportunities for employment and improving prospects for future children's development. Yet girls have, at best, limited access to schooling. They are instead expected to assist their mothers in labor-intensive household chores, such

as gathering water and firewood and tending to agriculture. Girls in developing countries are at an increased risk of growth failure and micronutrient deficiencies such as iodine, iron, folic acid (also called folate), zinc and vitamin A. Their chances for catching up are scarce unless effective interventions are implemented. Poor dietary intake, high energy expenditure, recurrent infections, fulfillment of the expectation of early marriage, and early and repeated childbearing, all take a toll on women's strength and newborns' birthweight.

Women's Health Status

The poor nutritional status of pregnant women in developing countries impacts their own survival and that of their children. Biological links among different generations drive the cycle of maternal malnutrition: growth failure in girl children leads to small adult women; small maternal size leads to low birthweight and low birthweight leads to subsequent growth failure in infancy and childhood. The effects of early pregnancy contribute to this cycle.

Pregnant women of short stature and inadequate nutrition are prone to anemia and infections. Poverty, poor harvests, gender inequities with respect to distribution of food and lack of information regarding proper nutrition help to maintain this vicious cycle of malnourishment and poor survival rates for pregnant mothers and their offspring.

The risk of maternal complications increases in first pregnancies, after repeated pregnancies and especially in very young adolescent pregnancies. Family planning provides families that have a desire to control the number and spacing of children with the resources to do so. By limiting the number of pregnancies and decreasing the need for abortions, often performed under unsafe conditions, family planning is an essential factor in preventing maternal mortality.

Reproductive tract infections (RTIs) and HIV affect the outcome of pregnancy and the survival of the mother and children. Not only does HIV remain incurable, but the infection can be transmitted from an HIV positive mother to her child during pregnancy, delivery or through breast milk. RTIs can cause ill-health, chronic pain, ectopic pregnancies, spontaneous abortions, increased risk of HIV infection and infertility in adults.



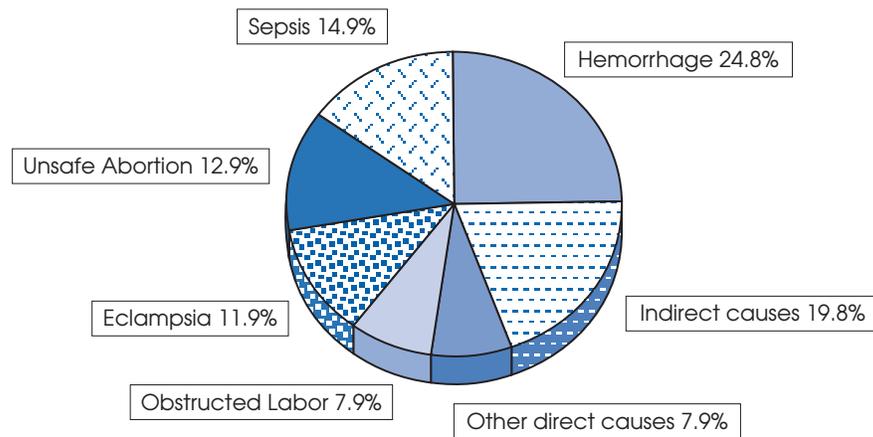
Causes of Unsafe Motherhood

Medical conditions that cause or contribute to maternal death and morbidity are typically divided into two categories: direct causes and indirect causes.

Direct Causes

The five conditions known as the direct causes of maternal mortality, are hemorrhage, unsafe abortion, hypertensive disorders of pregnancy (eclampsia), obstructed labor and sepsis. Either alone or in combination, these conditions account for more than 80% of all maternal deaths. Each of these conditions requires immediate medical attention.

Causes of Maternal Death



Leading Causes of Maternal Death

Cause	Description of Problem
<p>Hemorrhage (heavy bleeding), can occur in pregnancy or after delivery, and is generally a result of prolonged labor, uterine rupture or early separation of the placenta from the uterine wall. Postpartum causes of hemorrhage include a retained placenta, tears of the uterus or failure of the uterus to contract.</p>	<p>Leading cause of maternal death; extreme blood loss can lead to shock, severe anemia, cardiac failure and ultimately death within minutes or hours.</p>
<p>Sepsis is a serious infection caused by unhygienic practices or unclean instruments used in the birthing process or postpartum period. It often follows abortions, miscarriages, prolonged labor or ruptured membranes.</p>	<p>Contributes to 15% of maternal deaths, often setting in within 2-4 days of delivery. Sepsis can cause shock, premature labor, pelvic inflammatory disease (PID), and infertility.</p>
<p>Unsafe abortions result from abortions performed under unhygienic conditions with unsterilized tools, or the use of dangerous, sometimes poisonous, methods to induce abortion.</p>	<p>Complications include incomplete abortion (tissue remains in the uterus leading to infection), hemorrhage, RTIs, uterine perforations and infertility. Death usually results from hemorrhage or sepsis.</p>
<p>Pregnancy-induced hypertension (pre-eclampsia), tends to occur during the latter stages of pregnancy and in young women having their first pregnancy. The onset of pre-eclampsia is usually swift and without warning; if left untreated, it can lead to eclampsia.</p> <p>Eclampsia, or fits the more serious condition, occurs late in pregnancy, during delivery or shortly after. Sometimes preceded by spots before eyes, vomiting, and severe headaches; eclampsia results in convulsions.</p>	<p>Contributes to 12% of maternal deaths; characterized by high blood pressure, fluid retention (swelling in face, hands), and protein in the urine.</p> <p>If eclampsia is left untreated it can result in kidney damage, heart failure, cerebral hemorrhage; it results in as many as 50,000 maternal deaths a year worldwide.</p>
<p>Obstructed labor occurs when the infant's head is too large to pass through the birth canal either due to a sizeable baby, an immature (small) birth canal or the abnormal position of the fetus.</p>	<p>Can cause prolonged labor, exhausting mother and child and leading to shock; vaginal fistula (hole between vagina and rectum or bladder allowing seepage of urine or feces); uterine tear/ rupture, or prolapse (weakened muscles holding womb); and sepsis.</p>

See Annex 1 for more on obstetric complications, including services required for care.



Indirect Causes

A series of conditions, or indirect causes including anemia, malaria, hookworm, hepatitis B, and STI/RTIs, contribute individually and collectively to almost 20% of maternal deaths.

Conditions That Contribute to Maternal Death

Cause	Description of the Problem
Anemia (low blood hemoglobin (iron) concentration) results primarily from iron deficiency, folic acid deficiency, malaria, parasitic infection and repeated pregnancies. Women's iron requirements are higher in early adolescence and pregnancy which increases the effects of anemia.	Over 60% of pregnant women in developing countries are anemic. Anemia makes these women 5 times as likely to die from pregnancy-related causes and can lead to miscarriage or premature labor; a greater susceptibility to post-delivery infections; heart failure or circulatory shock at the time of labor and delivery and death from blood loss during delivery.
Malaria infection is transmitted through mosquito bites; the Plasmodium falciparum malaria is the most dangerous.	Pregnant women appear more susceptible to malaria infection. Loss of red blood cells can cause severe anemia, miscarriage, premature labor, stillbirth, low birth weight babies and death.
Hookworms are parasites that attach to the wall of intestines and feed on red blood cells, causing blood loss and, subsequently, iron loss.	Over 1 billion women in the developing world are infected. As a major factor in causing iron deficiency, hookworm infection contributes to anemia.
Viral hepatitis (hepatitis B) is associated with malnutrition and poor sanitary conditions and is transmitted through contact with blood and body fluids.	Leads to premature labor, liver failure or severe hemorrhage; occurs more often among pregnant than non-pregnant women and is 3.5 times more likely to be fatal.
STIs/RTIs are passed through sexual intercourse and include diseases such as gonorrhea, syphilis, chancroid or genital sores, genital herpes, genital warts, trichomonas. Often these diseases are symptomless making them difficult to detect and treat. HIV , an STI, can be transmitted sexually, through contaminated blood products, or from an infected mother to her child during delivery or through breast milk.	Leads to pelvic inflammatory disease, stillborns, ectopic pregnancy, infertility or can be transmitted to the newborn leading to complications. Eventually HIV leads to AIDS. Presently there is no cure for AIDS, which results in death for the mother and infected offspring.

Annex 2 provides more information on indirect causes of maternal complications.

Research From the Field



Vitamin A Supplements Reduce the Risk of Pregnancy Related Death

In Nepal, 44,000 young married women were given low-dose vitamin A supplements — in the form of either pure vitamin A or beta-carotene — or placebos. The low-dose supplements contained 23,300 international units (IU) of vitamin A or a similar amount of beta-carotene, which is approximately equivalent to a woman's weekly requirements. Among the women receiving pure vitamin A, there were 38% fewer deaths and among those receiving beta-carotene there were 50% fewer deaths, during pregnancy and the 3 months following childbirth, than among women receiving no supplements. Anemia was 45% lower in the women receiving supplements who were NOT infected with hookworm. The results of this study indicate that where vitamin A deficiency is common, the regular and adequate intake of vitamin A or beta-carotene by women during their reproductive years could significantly reduce their risk of pregnancy-related death. Adequate intake of vitamin A may also contribute to a significant reduction in anemia in pregnant women if combined with deworming.⁵ (Five replication studies are currently underway in order to confirm this result).

Source: West and Katz et al., 1999

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1 • Assessing Community Needs

Is there a need for safe motherhood services in your community? This section focuses on the factors to consider in assessing the need for maternal health interventions and identifies the services currently addressing the needs of women.

The following key points are covered in this step:

- **Defining the Safe Motherhood Problem**

This section discusses the importance of assessing the community's maternal health problems and the logistical, societal and system related barriers to seeking service.

- **Gathering Key Health Information about Women's Needs**

Sources of national and local data are outlined in this section along with data collection tools available to NGOs to help them understand the community's perception of their maternal health situation.

- **Identifying Existing Services and Potential Gaps**

Provides instruction for the development of a community profile of maternal resources. The section also helps identify gaps in service by comparing maternal health problems identified by the community with currently available services.



Defining the Safe Motherhood Problem

What is the problem and who is affected?

Before adding new interventions, your organization should focus on determining the maternal health needs of its present target population. What kinds of pregnancy-related health problems are they facing and what are the barriers to receiving appropriate treatment? Is it lack of services: poor quality of services; logistical barriers; or educational, economic or sociocultural obstacles that lead to the decision not to seek treatment? Whether integrating a new component or starting a new program, defining the specific needs and the groups affected by the situation is an important step for determining the type of service delivery strategies required. Involve the community, particularly key informants, e.g., women's groups, civic and religious leaders, and health workers, in this process.



Keep the following questions in mind when you assess the maternal health situation in your community

Ask mothers:

Are you aware of the need for antenatal and immediate postpartum care?
Are you aware of the danger signs for complications during pregnancy, labor/delivery or in the postpartum period?
Do you have a plan for how to get to a delivery site if a complication arises? What is your plan?
Where do you give birth?
How do you choose your delivery site?
Who is in attendance at your delivery? What kind of training do they have?

Ask families and other community members:

Are you aware of the need for antenatal and postpartum care?
Are you aware of the danger signs for pregnancy complications?
Who decides whether a woman can go for medical care? What happens if that person is not available?
Where would you take someone experiencing a pregnancy/birth related complication? Do you have the means to get there (e.g., transport, funds needed, and a person to accompany the woman?)
Do you know of women who have died or become ill during or after childbirth?
Do you feel initiating safe motherhood services is necessary in your community? Why or why not?
Do they know of women who have died or become ill during or after childbirth?
Do they feel initiating safe motherhood services is necessary in their community? Why or why not?

Investigate:

Is this a malaria or hookworm endemic area?
Is female genital cutting (FGC) practiced here? To what extent?
Are there data on anemia and micronutrient deficiencies?
Are family planning services available and utilized?
What traditional beliefs impact usage of FP?
Do women have access to maternity health care, including antenatal and immediate postpartum services?
Is there a fee for service? Does this affect usage?
Who makes decisions about obtaining care?
What percentage of births take place in health facilities?
What percentage of births are attended by a skilled practitioner?
(If many births take place at home) Will a skilled practitioner come to the home?
How long does it take to reach health centers and emergency health services?
How do people get there?



How do you determine what prevents women in your community from seeking birthing services?

Women are not always in control of the conditions that facilitate access to health care. Barriers can be physical, financial, societal or system-related. Traditional and cultural practices and beliefs surrounding the birth process can contribute to women's and their families' resistance to seek health care. Your organization should explore the root of these beliefs. Which groups advocate continuation of harmful practices; what are the misconceptions that contribute to inappropriate responses? In order to address these issues, your organization will need to learn what the impeding factors are in your community. The following will help guide your investigation:

Logistical Barriers

- Long distances
- Limited transport opportunities
- Lack of money for transport or care
- Lack of child care arrangements

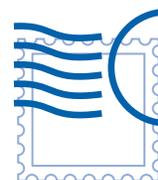
Women's status

- Low priority of women's needs
- Physical abuse
- Requires permission from other family members to travel, spend money or seek assistance
- Socialized into ignoring their own health needs
- Uses limited finances for other family members

Traditional Beliefs

- Pregnancy, a normal state, does not require medical intervention
- Women should be confined during pregnancy, preventing travel and clinic visits
- Bleeding is a cleansing process which should not be interrupted or treated
- Obstructed labor is caused by adultery during pregnancy, requiring the services of a 'diviner'
- Evil spirits or external forces control the length of labor
- Specific foods, including those that are nutrient rich, should be avoided

Experience From the Field



Responding to Traditional Practices

In some cases, traditions can be adapted by health services with few difficulties and major pay-offs. In Cochabamba, Bolivia, women did not seek hospital delivery because they could not retrieve the placenta, the burial of which is thought to be crucial for the good start of the baby. Some hospitals in Cochabamba now provide the placenta to the families, thereby saving themselves the cost of disposal and removing an obstacle to use of services.⁶

Source: Center for Health Research 1991

Health Facility Issues

- Lack of confidence in the service provided by an establishment
- Inadequate skills of health service staff
- Unavailability of drugs or medical supplies
- Length of time it takes to receive treatment
- Lack of privacy or cleanliness
- Lack of female physicians to attend to women who value modesty
- Disrespect, even abuse, shown to those who seek treatment
- Unreasonable fees
- Belief that formal health centers are only places to end life.
- Traditional birth attendants (TBAs) are often not welcomed with their clients at the health facility

Gathering Key Health Information about Women's Needs

As your organization considers devising a strategy for safe motherhood, obtaining precise data about the number of maternal deaths may be problematic and less important than understanding the reasons deaths are occurring. Determine the objectives of gathering information, and identify what data are already available and what additional information will be useful before beginning any community-based data collection.

Using National Health Data

Using existing data is the easiest, least time-consuming and most inexpensive method of gathering information. National or regional statistics can supply information, although often underestimated, on the level of maternal death. Health statistics collected by hospitals, and government and international agencies are usually obtainable from the Ministry of Health (MOH), government records and international organizations. They provide some insight into the magnitude of the problem, the types of facilities and service providers available, services offered and where health care providers are located. They also provide information on the use of services for antenatal, labor, delivery and postpartum care.

One useful source of national data is the Demographic and Health Survey (DHS) which collects information on fertility and family planning, maternal and child health, child survival, AIDS/STIs, and other reproductive health topics. For some countries, DHS includes information on males and adolescents.

See Annex 3 for more information on expected occurrences of complications within communities.

MODEL: Assessing Maternal Health Risk

Health planners use the following model to estimate maternal health risk and for planning services:

Assumptions:

Population 500,000

Complications will affect 15% of live births

Maternal deaths should not exceed 100/100,000 live births (maternal mortality ratio, MMR)

Case Fatality Rate - less than 1% of pregnancies should end in death in any qualified referral facility.

Caesareans- comprise not more than 15% nor less than 5% of all pregnancies in the population⁷

If less than 5% of your population receives caesareans or the maternal death rate is as high as 100/100,000 live births, there is an indication of a serious maternal health problem in your community. However, these statistics are only a guide, particularly in communities of less than 500,000. Within smaller populations, your statistics need to be augmented with community surveys that reveal maternal health problems and the reasons for them to help guide programmatic decisions.

Using Local Information

On a local level, village registers, clinic data (e.g., birth registers) and census information, if available, are more helpful for program planning purposes. Information from these sources can reveal the number of basic and comprehensive essential obstetric care facilities in a given geographic location; how many people use the services for delivery and may provide the number and type of complications from childbirth; the proportion of women receiving caesarean sections; and, the number of deaths, although often underestimated due to maternal complications. A more complete statistic would have to include causes of death on other wards, such as the fever or gynecological ward.

Further investigation, using tools such as surveys, when properly formulated, can provide quantitative data on the knowledge and attitudes of people toward maternal health and care. Focus group discussions and community interviews can provide qualitative data or insight into how people feel about the available services, and why they do or do not use them. Before selecting a tool, you should ensure that it meets all of your information gathering requirements, therefore it is important to decide:

- What information you are trying to ascertain;
- What you will do with this information;
- The requirements for donor reporting, if applicable;
- The criteria for monitoring and evaluation.

These decisions will guide your choice of instruments. Assistance in preparing or adapting a questionnaire, interviewing strategies and training can usually be obtained from other local or international organizations involved in research and evaluation.



Helpful Hints:

- Gather and adapt samples of existing tools/surveys, when possible
- Ensure that questions are easily understood
- Pre-test the survey or focus group guides to ensure that the questions work and the responses are appropriate
- Pre-test translations into local languages
- Discuss the survey with the community and obtain permission to implement it
- Select and train interviewers/supervisors
- Set field rules for implementation of the survey
- Ensure adequate supervision
- Establish a system for analyzing the data

The following table presents a summary of data collection tools, as well as their purpose, advantages and disadvantages.

Data Collection Tools

Data Collection Source	Purpose	Comments
Rapid Community Surveys - Quantitative Data		
<i>Knowledge, Practice and Coverage (KPC) or Knowledge, Attitudes and Practice (KAP)</i>	To collect quantitative information on health status, behavior, and knowledge of people. Establishes a baseline against which to measure progress or functions as a monitoring tool to determine progress on certain indicators.	Usually includes closed-end (yes/no or multiple choice) questions, adaptable to local populations and purpose. Easily analyzable by hand or computer program. Involves around 200-300 interviews, based on WHO cluster method. Requires training and supervision to ensure accuracy in interviewing and selecting clusters.
<i>Mini Surveys</i>	Used, when time is limited, to focus on specific issues, to develop questions, hypotheses and propositions for further testing or when quantitative data is needed to supplement qualitative information.	Can be completed in a short period at low cost. Generates quantitative data, but findings are neither generalizable nor appropriate for statistical analysis. Due to small sample (25-70 respondents), credibility questions emerge.

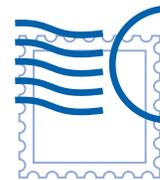
Data Collection Tools (page 2)

Data Collection Source	Purpose	Comments
Participatory Assessments - Qualitative Data		
<i>Participatory Learning Approach or Participatory Rural Appraisal</i>	Combines information gathering with an action-oriented process to involve the community in planning for change. Designed to gather qualitative information on perceptions of health priorities and village resources through 'social mapping'. Used for planning, monitoring or research.	Participatory process which requires facilitators with communication and listening skills. Advantages are quickness, community involvement and empowerment. Results are only applicable to community surveyed. Requires a cross section of the population for validity. Information, which is based on a sample of community, should be cross-checked using other methods and/or verified by community
<i>Auto-Diagnosis:</i>	Designed as a diagnostic tool and community-level problem solving process for women. Involves 'community action cycle': identification of the problem, planning together, implementing and evaluating the results.	Used in women's groups to empower women to be action facilitators. Time consuming, can take up to a year to complete a cycle; requires good facilitation skills and commitment to process.
Interviews - Qualitative Data		
<i>Focus Group Discussions (FGD)</i>	Structured but flexible discussions designed to gather information on the community's perception about the problems, causes and solutions to maternal health questions.	Used with small groups, carefully selected from women's groups, religious and civil leaders, business and agricultural sectors, village health committees, school officials, parents and TBAs. Meetings usually take 1-2 hours. Requires strong facilitator skills; results in anecdotal but helpful information although often difficult and time-consuming to analyze.
<i>In-Depth Interviews</i>	Used to reveal needs, problems and attitudes of the affected population.	Requires trained interviewers with pre-tested questionnaires and carefully selected interviewees to reflect breadth of community. Typically a series of interviews. Results can take time and be difficult to analyze.

See Annex 4 for additional guidance on FGDs.



Experience From the Field



Data Collection for Planning Health Services in Ethiopia

A participatory approach was used in five communities in Ethiopia to identify health problems and promote community involvement in planning community and health facilities activities. The methodology combined qualitative methods with a structured household survey. Household survey data were used for establishing baseline indicators for monitoring and evaluation; and qualitative data for creating communication and health education materials. MOH staff were trained and carried out the survey process with community volunteers over a period of 8-10 days. The survey collected information on key maternal and child health behaviors. The results were used to generate a list of behaviors at unacceptable levels. Three to five priority behaviors were selected for further investigation and the reasons behind the practices of these priority behaviors were explored. Interventions were suggested by community members and health staff which were then discussed at community meetings where participants were encouraged to ask questions or provide suggestions. The result was an action plan with responsibilities for implementation split among the community, MOH and project staff. The process provided a sense of ownership to both community and MOH teams and a feeling that the information collected reflected actual problems and priorities. Most importantly, it was a process for collecting and using data with community participation. The simple and quickly implemented quantitative and qualitative methods, using a minimum of resources, makes it a feasible approach for local health staff.⁸

Source: Bhattacharyya and Murray et al., 1998.

Identifying Existing Safe Motherhood Services and Potential Gaps

Once the community needs are clarified, it is time to look at the resources available within the community to support safe motherhood and reproductive health services. These resources may be provided by the government, private sector, other NGOs or community members. Mapping out the current services will help identify the logistical and programmatic gaps in service, the sources of referral for women who need additional services and the organizations available to provide technical support in developing and implementing safe motherhood strategies. It will also identify sources of commodities such as information, education and communication (IEC) materials, micronutrient supplements, drugs and contraceptives.

Use Worksheet 1 to help you analyze your own community.



Existing Safe Motherhood and Related Services

Services	Health Facilities		Private Practitioners			Community Workers		
	Hospital	Clinic	Physicians	Traditional	Mid-wives	VHW/CHW	TBA	Others
Safe Motherhood								
Information Education and Communication	X							
Antenatal Care	X	X	X				X	
Micronutrients		X				X		
Tetanus toxoid (TT)		X						
Counseling	X	X				X		
BEOC/CEOC services	X	X						
Delivery	X	X	X		X		X	
Related Reproductive Health Services								
Family Planning (FP)	X	X				X		
STI	X	X	X	X				
Post Abortion Care	X		X	X	X			
Logistical Information								
Location (distance from community)	3 hours distance	2 hours distance	.5 hour	.5 hour	.5 hour	1 hour	.5 hour	
Hours of service	10-2	10-3 daily	5-7 PM	as needed	afternoons	as needed	as needed	
Fees	yes	yes	yes	yes	yes	no	no	

Community Partnerships for Safer Motherhood

Key Questions

1. Why did it take Darbati's wife so long to reach the health center?
2. What issues would you have chosen for the community representatives and health center to investigate and why?
3. What additional information should the community representatives gather about their communities ?
4. What can the health center staff do to complete their assignment?

Partners:	Community-Based Organization (CBO)	Womens' Enterprise Loan Scheme (WELS)
	PVO	Rural Development Initiatives (RDI)
	Community District	Tikla
	Widower	Rapla
	His Sister	Darbati
	RDI Representative	Sarama (Treasurer of WELS)
		Naramaya

Assessing Community Needs

Darbati is sitting outside his house in the village of Tikla staring into the dusk. He is thinking about how his life has changed since his wife died three weeks ago, five days after their son was born. Two days after the birth, which the TBA felt had been simple and uncomplicated, his wife had developed a fever and complained about stomach pain. Both he and she thought she had a touch of malaria and he had given her some chloroquine tablets. But over the next two days, her symptoms persisted and intensified until finally he decided to take her to the health center where she died soon after arrival. He regrets not taking her sooner, but transportation is costly and difficult to arrange and her condition didn't seem unmanageable at first. Darbati's two children, a two-year old daughter and the infant son, are now being looked after by his sister, Sarama.

Tomorrow, Darbati must make an early start. He will be representing Tikla at the regular quarterly meeting of the Neighborhood Health Committee (NHC) at the health center, a four hour walk from Tikla. He has decided he is going to resign from the NHC because he is so angry about the failure of the health center to save his wife.

At the NHC meeting, Darbati greets the community representatives from the other four villages served by the health center. He also nods at the health center 'in-charge' (leader) and the midwife as the meeting begins.

Once the main agenda items have been dealt with, Darbati tells the story of his wife's illness and death and explains that because of his anger with the health center staff he is resigning from the NHC. Two of the other community representatives state that their villages also have concerns. One man's wife went to the health center because she was bleeding after delivery, but the health center staff had to refer her to the district hospital where she could receive a blood transfusion. Months later this women is still not strong enough to work in the fields. Another woman has had recurrent infections since her last child was born and has to keep coming to the health center for treatment.

continued next page

Community Partnerships for Safer Motherhood *(continued)*

The in-charge says how sorry he is about Darbati's wife and that he understands how important it is for pregnant women to receive proper care. As soon as he had seen Darbati's wife on her arrival at the health center last month, he worried that she had arrived too late to be saved. Although they started treatment immediately, the infection soon overwhelmed her. The midwife explains that things can go wrong during pregnancy and childbirth. If problems are recognized early and women are quickly taken to a facility where appropriate action can be taken, then the consequences are likely to be less severe. Although the health center can identify some early signs of problems, it cannot treat all emergencies; referral to the district hospital may sometimes be necessary.

The in-charge continues by saying that he is worried that so few women attend the health center for antenatal care. This means that the advice pregnant women get is frequently based on traditional beliefs which may be contrary to practices that support a healthy pregnancy. He tells the committee members that communities across the country have similar problems. He describes the findings from a recent survey conducted by the government before they launched their national safe motherhood initiative. This survey reported a maternal mortality ratio for the country of 650 maternal deaths per 100,000 live births and included additional information as listed in the box below. He adds that in the five communities served by his health center, seven women died last year in childbirth.

Factors	Survey Result
- % of women of reproductive age who know of danger signs of pregnancy, labor and delivery	15%
- % of men who know danger signs	2%
- % of women who know where to go if there is a problem with labor or delivery	15%
- average time from onset of problem to arrival at appropriate health care facility	60 hours
- % of women who attend antenatal clinic	20%
- % of women who take adequate dosage of iron and folic acid	10%

The representatives are surprised by the results of the survey and realize that they need more information about the situation in their communities. After a great deal of discussion, the NHC agrees that two issues need to be followed up. The first, which the community representatives will explore after clarifying the situation in their communities, is to help women with problems related to childbirth get to the health center or hospital quickly. The second issue, which the health center staff will investigate, is how to encourage better home and provider practices in relation to pregnancy and delivery. By this time, Darbati agrees to participate in the NHC's efforts to improve the care of pregnant women in the areas served by the health center.

Identifying Gaps in Services

Prior to deciding upon an integration strategy, take time to review the information you have collected on community needs and current services. The following framework will help you to analyze the maternal health problems faced by the community and whether they are being met by existing services. Review the column on the right to see whether any of these problems exist in your community. Review the column on the left to see if a service exists to address those problems. In locating those community health problems not addressed or services that are not meeting the needs of the community, you are identifying the gaps and potential problems in the present health system. The following example is based on the information provided in the Case Study: Community Partnerships for Safer Motherhood: Rapla District.

Maternal Health Assessment: Community-Level Framework

Community Problems	yes ✓	no ✗	Community Services	yes ✓	no ✗
Women's Health and Status					
Prevalence of Anemia	✓		Antenatal Care Vitamin A Distribution Iron & Folate Distribution	✓	✗ ✗
Malaria	✓		Malaria Control/Prophylaxis		✗
RTIs			STI/RTI Screening & Treatment	✓	
HIV/AIDS			HIV/AIDS Counseling, condom distribution Infant Feeding Counseling for HIV+ Women		
Malnutrition			Fortified Food Micronutrient Supplementation		
Maternal morbidity	✓		Antenatal and Postpartum Care Safe, clean delivery Postabortion Services		✗ ✗
Lack of Education	✓		Literacy Programs		✗
Physical Abuse Heavy workload FGC			Women's Advocacy Groups		

Maternal Health Assessment: Community-Level Framework

Community Problems	yes ✓	no ✗	Community Services	yes ✓	no ✗
Women's Health and Status (continued)					
Limited Role in Decision-Making	✓		Women's Groups	✓	
Early Marriage			Adolescent Programs		
Early/Frequent Pregnancy			Family Planning Services		
Community Outreach					
Knowledge of: danger signs facility location		✗	BCC/IEC Campaigns to Teach Danger Signs and		✗
		✗	Counseling to Identify Facilities and Develop Birth Plans		✗
			Outreach to Community, e.g., Village Committees	✓	
Reliance on untrained traditional healers	✓		Skilled Birth Attendants		✗
			Distribution/Sale of Clean Birth Kits		✗
			Trained Traditional Healers/TBA		✗
Access					
Means of Transport Money for Fees		✗	Emergency Transport Schemes		✗
		✗	Emergency Loan Funds		✗
Birth Plan		✗	Counseling & Education		✗
		✗	Maternity Waiting Areas		✗
			Referral Links		
Quality					
Adequately Trained Staff Disrespectful Staff Delay in Receiving Services Lack of Trained Staff Quality Standards	✓	✗	Skilled Staff		✗
	✓		Staff Trained in Interpersonal Relations and Quality Care		✗
	✓		Adequate Number of Staff		✗
		✗	Hygienic Conditions and Protocols		✗
			Availability of Medical Equipment on Site		✗
Essential Medical Supplies & Equipment		✗	Availability of Blood		✗
			Availability of Oxytocic Drugs, Antibiotics, Sedatives		✗



1 Mapping Community Resources

Complete the following map for your community. Try to answer the following questions about health facilities, private practitioners and community workers that provide maternal health services:

1. Who are the providers of maternal health services?
2. Where do they provide service?
3. What types of services do they provide?
4. How is quality of care addressed?
5. What are the characteristics of the client (e.g., age, parity, socioeconomic status, religion?)
6. When are services available and are they compatible with community needs?
7. What is the cost of services?

Indicate in the box whether the service is being provided, add any relevant notes about the service quality or additional services in the blank boxes.

Services	Health Facilities		Private Practitioners			Community Workers		
	Hospital	Clinic	Physicians	Traditional	Midwives	VHW/CHW	TBA	Others
Safe Motherhood								
Information Education and Communication								
Antenatal Care								
Micronutrients								
Tetanus toxoid (TT)								
Counseling								
BEOC/CEOC services								
Delivery								
Related Reproductive Health Services								
Family Planning (FP)								
STI								
Post Abortion Care								
Logistical Information								
Location (distance from community)								
Hours of service								
Fees								



2. Deciding Whether to Integrate

Step 1 helped you to understand community needs and resources to support integrated safe motherhood services. Step 2 focuses on the internal analysis an NGO should undergo before deciding to integrate safe motherhood activities into its current program. It assists the organization to review its capacity to undertake a new venture and to optimize its ability to plan and implement a safe motherhood strategy through establishing partnerships with other organizations.

The following key points are covered in this step:

● **Fostering Organizational Commitment**

This section reviews the organizational, political and financial issues that an NGO must consider as it makes its decision whether to integrate maternal health services. It examines the need to review the NGO's existing resources - its staff, its experience, and its funding sources - as a input to decision-making on whether the NGO should consider new safe motherhood activities to meet identified community needs.

● **Finding Partners in Safe Motherhood**

Collaboration with government, NGO and private-sector resources is discussed as a way to strengthen safe motherhood services.

● **Managing Integration**

The potential obstacles to effective integration are presented along with guidance for avoiding problems when integrating safe motherhood into ongoing program activities.

Fostering Organizational Commitment

Integrating or developing a new strategy is dependent on a combination of internal and external factors which often must be analyzed simultaneously. You must determine that there is a need for the service, analyze the range of mechanisms available to support program efforts and ensure that your organization has the ability and desire to undertake the project. Step 1 began this process by assessing client needs and identifying actual and potential services that serve the community and could assist in a safe motherhood strategy. It is now time to look inward and assess the organization's capacity and commitment to introduce and sustain a new service.

How will integration impact the organization?

Will the addition of safe motherhood interventions be a logical extension of your NGO's current program or will the design of a new program be necessary? Prior to making a decision to develop a strategy to promote safe motherhood interventions, the organization should review its mission and goals, present staffing patterns, financial resources and infrastructure to determine its readiness to take on this venture.

Organizational Mission and Goals

The Board of Directors and managers need to decide whether the addition of safe motherhood services is consistent with the established mission and goals of the organization. How will the integration of services designed to improve maternal health impact the current image of the organization? NGOs providing health services should determine whether adding these services will complement their current activities.

Considerations for NGOs providing services in fields other than health, such as sustainable livelihood programs, include (1) whether the lack of effective safe motherhood services is impeding the success of their current activities and (2) how such services would improve community participation and the health and well-being of the clients in their program.

Are the following organizational factors compatible with integration of safe motherhood activities?

- The target population of the existing program
- The current program activities
- The support of the community

- The public image of the organization
- The social mandate of the organization

Human Resources

The staff and associated volunteers that an NGO has available will influence its capacity to integrate new safe motherhood activities into its existing programs. The numbers and types of existing staff, their experience and their skills will dictate how easily an NGO can extend its program to cover new components. Even if new staff will have to be added to deal with the additional workload arising from new program components, it is important that there is a core of individuals to lead and support newcomers as they themselves are integrated into the organization and its values.



Thus, in deciding whether to integrate, an NGO needs to consider at an early stage what comparative advantage its current human resource pool offers to integration of safe motherhood. It also needs to consider whether it would be willing to recruit new staff, if necessary. It also needs to consider, if it decides to proceed with integration, how it will build commitment to safe motherhood on the part of staff currently engaged in other, sometimes competing, development programs.

In preparation for designing a strategy, you must define:

- The knowledge and skills required for each aspect of the program
- The number and type of staff required to carry out the program
- Whether existing or new staff are required
- The supervisory strategy
- The impact of integrating new programs on staff assigned other responsibilities
- How to build commitment to safe motherhood on the part of staff engaged in other, sometimes competing, development programs

Financial Resources

Adding a new program will have an effect on the organization's financial operations. It is important to assess how and to what extent the integration of safe motherhood will contribute to the financial stability of the organization. Funds may be available initially, but the community may suffer if the services discontinue for lack of funds. The reputation of the NGO will also suffer. Issues to keep in mind are:

- Costs associated with integration
- Cost-benefit of integrating programs
- Availability of donor support for new service activity
- Sustainability plans

Organization Structure and Management Systems

Integrating or adding a safe motherhood component will impact your internal management schemes and overall strategy. You need to consider how integrating safe motherhood will effect:

- Systems for planning, monitoring and evaluation
- Cross-sectoral programs such as education and health credit schemes and health/social advocacy
- Structures for staffing and supervision

Policy and Community Support

Ensuring a woman's ability to have a safe and healthy pregnancy and delivery with a healthy newborn is the objective of the Safe Motherhood Initiative. Many governments have responded by developing a national policy on safe motherhood. It is important for an NGO to ascertain what the national policy and district health mandates of the country are and whether they will support the organization's activities. In the absence of national policy, the NGO should look for community groups that have a vested interest in maternal health, e.g., women's groups and religious and civic organizations. Your NGO should determine:

- The level of community support
- Potential religious, cultural, or political opposition
- The national policy

Questions to Ask When Considering the Integration of Safe Motherhood Services

Organizational Issues	Questions to Ask
<i>Organizational Mission and Goals</i>	<p>Would safe motherhood fit in or improve the existing mission and goals?</p> <p>How would safe motherhood services impact the organizational image?</p> <p>How would the organizational image affect the use of safe motherhood services?</p>
<i>Human Resources</i>	<p>What skills and experience exist among current staff and volunteers which could benefit the integration of safe motherhood activities?</p> <p>How can you ensure commitment to the new venture on the part of existing staff and managers?</p>
<i>Financial</i>	<p>Would safe motherhood services increase the financial strength of the organization by diversifying income or subsidizing services?</p> <p>Would current funding agencies be supportive of adding safe motherhood services?</p> <p>How can you ensure sustainability of the services?</p>
<i>Management Structure</i>	<p>How will the addition of safe motherhood services impact systems for planning, monitoring, evaluation and supervision?</p>
<i>Policy and Community Support</i>	<p>Would provision of safe motherhood services be in line with national policy and district health mandates?</p> <p>Is the provision of safe motherhood services a community priority? Within which groups will opposition likely be found?</p>

Information Needed for Decision Making

The decision to integrate safe motherhood services may be based on the request of clients, funding opportunities, a change in government strategy or policy or the personal commitment of board or staff members.

Whatever reasons prompt the consideration of integrating these services, you must help your organization to analyze its own readiness as well as the external factors that may affect the success of the efforts.

For decision makers to act, new ideas should be presented clearly and in a way that addresses their concerns about the survival of the organization. Boards, which play a major role in decision making, are frequently expected to provide guidance after limited exposure to the issues. Advocates for new ideas like integrating safe motherhood will need to harness their knowledge and experience to address technical and managerial issues. Build a case to present:

- The rationale for integration
- The positive impact integration of safe motherhood interventions will have on present program activities
- The community's approval of the new venture and potential for involvement
- The estimated cost of integration, and the potential for financial, technical and logistical partnerships to lower costs and ensure sustainability
- The donor community's policy and funding options for maternal health (MH) interventions
- The impact on current structures, e.g., staffing, supervision, and monitoring

Provide a brief summary of your mapping exercise emphasizing current MH services and resources and potential funding sources. Include community comments obtained through interviews or focus group discussions. Respond to any Board concerns clearly and responsibly; follow up on issues for which more research is needed. Be clear about what you hope to achieve in the meeting and be sure the Board understands what decision they are being asked to make.

Use Worksheet 2a to help you develop your presentation.

Community Partnerships for Safer Motherhood

Key Questions

1. How should Sarama prepare for her meeting with the WELS board?
2. Who are the potential partners to support safe motherhood activities in these communities and what role could they play?
3. What additional information would you need to proceed in selecting a strategy for addressing community problems?

Part A: Deciding Whether to Integrate

Three months later, the NHC meets again and reviews its members' findings in relation to safe motherhood. Community representatives report on the results of their informal surveys. Unfortunately, safe motherhood practices in their communities are similar to those reported by the national survey. In addition, all communities have experienced problems in reaching health facilities during emergencies.

Darbati has brought his sister, Sarama, to the meeting because she has an idea that he thinks she should share with the other members. Sarama is the Treasurer of WELS, the Womens' Enterprise Loan Scheme, which has branches in each of the five villages represented by the NHC, and which was established three years ago. WELS offers low interest loans to its members for the development of small income-generating activities. Members of WELS have each paid a fee to form the required loan capital and are entitled to take loans from this capital, which must be repaid, with interest, within one year. Since transportation costs are a burden for the community, Sarama thinks that a similar scheme could be put in place to provide loans to cover the costs of transportation for emergencies related to pregnancy and childbirth. The NHC thinks that this idea could work in their communities.

The health center in-charge and the midwife present their findings to the meeting. In relation to potential resources for providing community members with information about safe motherhood, they have identified that there are TBAs in each of the villages. The TBAs are older women who assist in home deliveries and the government's Safe Motherhood Initiative is planning to provide training to TBAs in clean and safe delivery. There are traditional practitioners in the area who provide advice and treatment for illnesses (including RTIs) but do not get involved in pregnancy-related problems.

The in-charge has also gathered some information about the national Safe Motherhood Initiative:

- The district hospital has been strengthened by deployment of a doctor trained to perform caesarean sections, training of the nurses in essential obstetrics, and establishment of blood transfusion capacity.
- Health center staff have been trained to perform manual removal of the placenta, to conduct manual vacuum aspiration, and to perform complicated, non-surgical deliveries. In addition, the health center is now supplied with antibiotics, oxytocin and anti-convulsant drugs.
- In major urban areas, a social marketing program has been established to distribute clean delivery kits and iron and folic acid (IFA) tablets through commercial retail outlets at subsidized prices.
- Printed informational materials on safe motherhood have been developed and will shortly be available through the district health office.

Having jointly reviewed all this information, the NHC members agree that there is a need to encourage better use of the services available. They decide that Sarama should ask WELS whether it would be willing to establish and manage a transport loan scheme for the communities in which its branches operate and whether it could support safer motherhood education and services for the women in these communities.

Finding Partners in Safe Motherhood

This section is designed to help your organization identify potential health and non-health focused programs which can strengthen safe motherhood strategies through the development of partnerships and networks.

Partnerships help to maximize benefits to client groups by capitalizing on each organization's strength in providing services. Pooling resources between NGOs and other sectors can be an efficient and cost-effective way of reaching a wider target population with much needed services. Some organizations may decide they require additional inputs before they can make a decision.

Information about the needs of the community, gaps in services or service options can be gathered from:

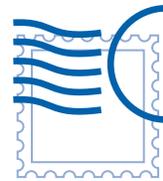
1. Other maternal health NGOs
2. MOH
3. Experts and international organizations concerned with Safe Motherhood



Partnership Opportunities

- Identify organizations whose programs are being affected by maternal health problems. For example, an NGO's women's literacy project may be hampered by student withdrawals due to adolescent pregnancies or childbirth-related complications, or a government dairy scheme will have less than expected production due to the faltering strength of anemic women.
- Find an organization or business with resources that are not fully utilized. For example, vehicles used for distribution of goods or services, community extension workers in water and sanitation projects, or commercial food producers could aid safe motherhood interventions by providing emergency transport, sale of clean birth kits, or micronutrient fortification of food.
- Work with other development sectors to mutually enrich your programs. For example, the Ministry of Education may value your input to assist teachers to develop and implement a family life education syllabus to assist adolescents to delay marriage and child bearing. The Ministry of Agriculture may be interested in organizing kitchen gardens, fortifying crops or teaching about the need for nutritional food.

Experience From the Field



A Safe Motherhood Network in Nepal

Nepal has one of the highest rates of maternal mortality in the world, 539 per 100,000 live births. To address the problem of reaching women in remote villages, the Nepal Red Cross led a coalition of NGOs, international non-governmental organizations (INGOs) and government organizations to promote safer motherhood. They began with a National Clean Delivery Day, that included distribution of IEC material and clean birth delivery kits to 41 districts by 26 NGOs. The success of this venture led to the establishment of the Safe Motherhood Network to increase understanding of safe motherhood among organizations, activate non-health sectors for safe motherhood, increase networking at the district level and move beyond awareness-raising activities. The partnership has capitalized on the strengths of its members. The NGOs have grass-roots organizing skills and are trusted by their communities, INGOs have been able to build NGO capacity, and the government has been happy to have NGOs support government policy and strategies and reach remote areas. Led by the Red Cross, they continue to organize successful events and through networking have gathered political support, enlisted a social marketing company to sell clean birth kits, got safe motherhood messages into non-formal education materials, publicized the issue through the media and reached thousands of people through local events. ⁹

Source: CEDPA 1997

Questions to keep in mind in assessing whether a partnership is feasible and advantageous are:

- Is the population served by the potential partner relevant to your proposed program, i.e. does it reach those affected by the lack of safe motherhood services (women of reproductive age or adolescents) or those who can influence whether such services are introduced (husbands, mothers-in-law, community leaders)?
- Is the partner's system for service delivery relevant to the type of services you wish to offer, e.g., does it include IEC officers, community outreach workers, agricultural extension workers, clinic-based services?
- Does the organization/business sell commercial products that may assist your project, e.g., pharmaceuticals and food supplies?
- Are other resources available through the partner, e.g., vehicles, newspapers, radios, print shops, and meeting rooms?

The following example suggests the types of resources available to assist NGOs in developing cost-effective maternal health strategies.

Use Worksheet 2b to analyze potential partners in your own community.

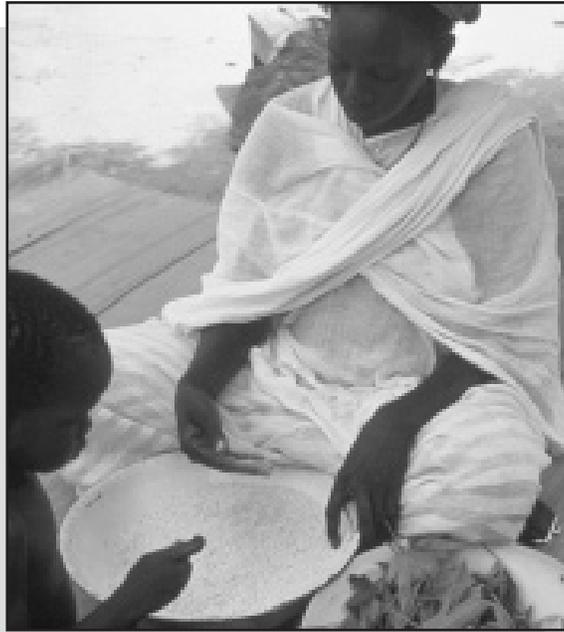
Research From the Field



Micronutrient Supplementation during Adolescence

Baseline data collection in East Java Indonesia revealed a 25% anemia prevalence rate among adolescent girls, constituting a major health problem for maternal health. As pregnancy is often too short a period to have an impact on anemia, Helen Keller International (HKI) began a micronutrient supplementation program to determine if building iron stores in adolescent girls could prepare them for the nutritional demands of pregnancy and breastfeeding, and ensure a healthy start for their future newborns. The organization implemented an iron and vitamin A supplementation and education program among 7000 girls, ages 12-15, in 34 state-run and private schools. Early results showed that the dietary intervention demonstrated a significant increase in hemoglobin in anemic girls. However follow up investigation showed that compliance was a major impediment. The study concluded that early intervention could be effective if compliance were improved by better tasting pills.¹⁰

Source: Helen Keller International 1999



Potential Partners and Related Services

Name of potential partner	Present Activities	Available partner resources
Government		
Agra Health Clinic	<ul style="list-style-type: none"> • Village Council training • TBA training • Antenatal and delivery care 	<ul style="list-style-type: none"> • Joint training of Village Councils, TBAs • Community mobilization • Referral services for safe motherhood
District Health Office	<ul style="list-style-type: none"> • Training of health staff • District planning • Resource mobilization 	<ul style="list-style-type: none"> • Staff deployment • Training of TBAs/CHWs • Mobilization & coordination of donors and partners
NGO/CBO/Religious Organizations		
Women Against AIDS	<ul style="list-style-type: none"> • Counseling • Prevention education 	<ul style="list-style-type: none"> • Counseling on Infant Feeding Practices • Mobilization for antenatal care
Catholic Diocese	<ul style="list-style-type: none"> • Home based care • Health education 	<ul style="list-style-type: none"> • Community education
Private Sector		
Unique Design Co.	<ul style="list-style-type: none"> • Printing of leaflets, etc 	<ul style="list-style-type: none"> • Copying, printing of IEC materials
Fast Delivery Co.	<ul style="list-style-type: none"> • Transport 	<ul style="list-style-type: none"> • Vehicles • Drivers

Community Partnerships for Safer Motherhood

Key Questions

1. What is the role of RDI in this case?
2. What organizations could Naramaya's group go for assistance?
3. What additional information or questions should WELS ask of its branches? of the community? its members?

Part B: Deciding Whether to Integrate

Two weeks later, Sarama attends a regular meeting of the WELS Board. WELS, a CBO, is a registered cooperative operating under national guidelines that dictate the membership, management, financial structures and procedures. One clause states that 20% of cooperative profit is to be used for social welfare programs. WELS was established three years ago with the assistance of RDI (Rural Development Initiatives), which is an international, voluntary agency committed to the economic and social development of women. Representing RDI at the Board Meeting is Naramaya.

Sarama reports on her meeting with the Neighborhood Health Committee and presents its requests. After careful consideration, the Board members make the following decisions:

- 1) WELS' involvement with safe motherhood fits with the organization's mission and goals.
- 2) It is believed that its branches could manage a transport loan scheme. However, additional analysis is required to determine which branches have the interest and required resources.
- 3) Although WELS recognizes the importance of educating communities in safe motherhood, the Board is concerned that clear strategies have not yet been formulated and that the resources that might be needed have not been defined.

Since further analysis is necessary both for the transport loan scheme and to determine an appropriate educational strategy, the Board decides that a special committee of WELS members will be set up with Naramaya's participation. This committee will present its recommendations to the Board at its next meeting.

Managing Integration

Integration will have an effect on the organization's internal management and program environment and on its relationships with donors, clients and communities. It is important for managers to recognize the possibility that integrating a new component with existing programs may cause unanticipated problems. To promote smooth transition to an integrated program, monitor program elements that can be affected by integration and provide support to limit disruptions.

Guidelines for Effective Integration

These guidelines may assist your organization in avoiding potential obstacles to successful integration:

1. Highlight how the goals and objectives for the new component complement the existing program.
2. Obtain a clear commitment from senior management regarding the financial and staff resources that will be required for the program.
3. Develop agreements between departments that will be expected to share resources.
4. Develop a system for sharing information among departments and programs.
5. Coordinate program activities with other service organizations to reduce duplication and increase cooperation.
6. Provide equal pay for jobs of equivalent responsibility.
7. Provide staff with clear and written descriptions of their responsibilities
8. Maintain the existing supervision structure whenever possible.
9. Establish mechanisms for communication between new and existing staff.

The following table reviews potential barriers that may be faced by your organization when integrating a safe motherhood program.

Guide for Monitoring Organizational Impact

Item to Monitor	Some Predictable Obstacles
Internal Factors Management support Staff acceptance Program coordination	Confusion over new role; divided commitment to new program Complaints about workload; poor acceptance of new staff Variations in pay for similar work; competition for organizational resources
External Factors: Relationships with other agencies Client relations Community relations Donor relations	Competition/poor coordination with other service providers Clients unable to accept the organization's new role Active opposition by religious groups, community leaders or volunteers Competing interests of donors

Use Worksheet 2c to assist you to consider ways to avoid potential obstacles to integrating new services.

2a: Preparing a Presentation for the Board



Many organizations require board approval before making decisions to proceed with new projects. This worksheet will assist you to develop a concise but comprehensive presentation to the Board on the benefits of integrating a safe motherhood strategy into the present activities of the organization. Your mapping worksheet will help structure your responses. Keep in mind the following parameters when preparing this brief:

1. the time allotted for your presentation
2. the audience's concerns
3. the possible need for further research
4. the timeframe for preparation of the follow up presentation

Board Background	What is the composition of the Board? Number: Affiliation:	
Objective	Identify what you hope to accomplish in this Board meeting:	
Rationale	What evidence do you have that there is a need for safe motherhood services?	
Benefit to Organization	How will integration improve your current program objectives? Give precise examples of complementarity between programs.	
Community Involvement	Is integration supported by the community? What role could the community play in a strategy? Identify what further research is needed.	
Impact	How will integration affect staffing, supervision, monitoring and finance? Identify what further research is needed.	
Costs	What potential costs are involved? What sources for funding exist?	
Sustainability	What opportunities for partnerships among government, NGO or community groups exist?	
Follow up	What additional research needs to be done before a budgeted strategy can be presented? How long will it take to accomplish?	



2b: Identifying Potential Partners

Safe motherhood is a community concern. Resources from different organizations and sectors pooled together can improve referral, skill, outreach, and access to services. Envision the potential resources in your community and the present barriers to service delivery and utilization. What specific impact could the government, NGO and private sector have on maternal health services? Write the name of the potential partner in , its present activities and the potential for contributing to your safe motherhood strategy.



Name of potential partner	Present Activities	Potential for partnership (contribution)
Government		
NGO/CBO/Religious Organizations		
Private Sector		

Worksheet 2c: Managing Obstacles to Integration

Purpose: To assist NGOs in defining potential obstacles associated with implementing an integrated program and to explore possible solutions to those problems.

Directions: Review the information in columns 1 and 2 below, then use your knowledge of your NGO to complete columns 3 and 4.

Column 1	Column 2	Column 3	Column 4
Item to Monitor	Some Predictable Obstacles	Obstacles Your NGO May Encounter	Actions You Can Take to Avoid Obstacles
Internal Factors Management support Staff acceptance Program coordination	Confusion over new role; divided commitment to new program		
	Complaints about workload; poor acceptance of new staff		
	Variations in pay for similar work; competition for organizational resources		
External Factors Relationship with other agencies Client relations Community relations Donor relations	Competition/poor coordination with other service providers in the community and referral sites		
	Clients unable to accept the organization's new role		
	Active opposition by religious groups, community leaders, or volunteers		



2



3 • Preparing Program Strategies

To have an impact on reducing the risk of mortality and morbidity associated with pregnancy and childbirth, women need access to appropriate services for basic maternity care and for obstetric emergencies. In communities where no facilities exist, the challenge is threefold: first, to educate men and women about safe motherhood; second, to help women to have healthier pregnancies and births and third, to assist women who have emergencies. This step focuses on community level interventions that can make a difference. The following key points are covered in this step.

● Identifying Effective Interventions

Field experience and research are reviewed and priorities for effective safe motherhood interventions in the community are established.

● Reviewing Community-Based Safe Motherhood Services

Brief description of services are offered to guide NGO selection of community-level safe motherhood activities. Service options reviewed in this section include: community education, counseling, care for pregnant women, and accessing care for obstetric emergencies.

● Viewing Quality of Care from the Community Perspective

This section highlights the importance of quality for community- and clinic-based services. Principles for ensuring quality of community-based strategies are reviewed along with specific guidance for selecting referral centers for obstetric emergencies.

● Choosing Appropriate Safe Motherhood Strategies

The following three strategies for contributing to safe motherhood in the community are presented in this section: (1) strengthening the safe motherhood focus of community-based activists; (2) creating partnerships with CBOs; and (3) creating partnerships with the private commercial sector.

Identifying Effective Interventions

Since the goal of safe motherhood is to reduce maternal morbidity and mortality, it is helpful to know what community interventions are considered effective and appropriate. Field experience and research provide the following useful guidelines for the selection of safe motherhood interventions. Programs are effective when they contribute to reducing pregnancy-related illness, disability and death; reflect community needs and build on existing resources. Specifically, effective programs enable communities to improve the ability of women, families and communities to:

- Access a skilled health provider to ensure safe, clean delivery;
- Prevent and recognize obstetric problems;
- Decide to take action to resolve the problem;
- Reach facilities where quality care is available.¹¹

Your program can address all or some of these elements. In a community where no programs are in place, you may need to develop a strategy that includes all components. In communities where a component is weak or missing, for example poor access to quality facilities, the strategy should address the gap in services.



Photo Credit Mothercare Project

Research From the Field



Research supports the belief that community based programs contribute to preventing maternal deaths, particularly those caused by hemorrhage, infection, tetanus and hypertension. Furthermore, some community based programs are more effective in addressing maternal deaths than others. The following table is based upon a hypothetical model developed at Columbia University.

Preventable Maternal Deaths (Est)¹²

Community-Based Program	Total % Deaths Prevented*
Conventional TBA Training	3%
New TBA Training (trained to treat some complications)	7%
Antenatal Care	11%
Family Planning	26%
Transportation to Health Center	25%

* Cumulative estimated total for deaths caused by hemorrhage, infection, hypertension, abortion, obstructed labor, and tetanus.

Establishing Priorities for Community Action

An NGO focus on strengthening community-level action for safe motherhood can make a significant contribution to reducing maternal mortality. The following table can assist your organization to select appropriate community based program activities. The activities are listed in priority order; for example, priority 1 actions are more likely to result in a decline in maternal illness and death than priority 2 actions.

Establishing Priorities for Reducing Maternal Morbidity and Mortality in the Community¹³

Priority 1: Ensure Access to Medical Treatment for Obstetric Emergencies	Community Level Actions
Action <ul style="list-style-type: none"> • Ensure access to a skilled health provider for every birth • Improve emergency treatment for obstetric complications in existing referral facilities • Upgrade capacity to provide obstetric first aid • Inform the community about the danger signs during pregnancy • Work with the community to improve access to emergency care 	<ul style="list-style-type: none"> ✓ ✗ ✓ ✓ ✓
Priority 2: Reduce Exposure to the Risks of Unwanted Pregnancies Action <ul style="list-style-type: none"> • Provide accessible and acceptable family planning services • Provide postabortion care 	<ul style="list-style-type: none"> ✓ ✓
Priority 3: Establish and Improve other Maternal Health Services Action <ul style="list-style-type: none"> • Train TBAs who deliver many women to refer and treat women with complications • Improve antenatal services • Establish maternity waiting homes • Establish and equip community maternities 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✗

Reviewing Community-Based Safe Motherhood Services

The focus of this section is to describe safe motherhood services that are appropriate and feasible for implementation by NGOs at the community level. Four options for community-level interventions to promote healthy pregnancies are presented and explained in this section.

- Educating community members
- Counseling women and their families
- Caring for pregnant women
- Accessing care for obstetric emergencies

Educating Community Members

Lack of knowledge, often cited as a reason for maternal health complications, is frequently addressed through information campaigns. However, to motivate people to change their behavior, knowledge must be combined with clear directions for alternative actions. Behavior change communication (BCC) provides key information and knowledge to promote or strengthen positive health behaviors. For example, by presenting facts about danger signs of pregnancy and details about where and how to seek help, behavior change programs help raise awareness of specific behaviors that reduce the risk of maternal death. Well-focused behavior change activities can also encourage communities to take actions, such as setting up community loan funds for emergency care or transportation.

Remember when thinking about designing activities to influence behaviors, it is necessary to define the message, its objective, the target audience and the communication medium. Preparing information campaigns requires technical knowledge and specific communication skills. In many countries, government agencies, national NGOs, UN agencies and donors support the development of behavior change campaigns to address national and community needs. These agencies conduct research to guide the development of appropriate health messages and provide technical support required for effective message development. The finished products (e.g., posters, flyers, curriculum materials, and radio programs) are frequently available at no cost to NGOs. Organizations with limited resources in BCC can increase their effectiveness by seeking technical guidance and materials from specialist organizations



Behavior Change Issues for Safe Motherhood

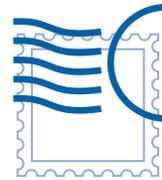
Message Focus	Objective	Audience	Media
Use of a skilled health attendant for delivery	Promote safe and clean delivery practices	Pregnant women and families	Signboards, radio
Recognition of danger signs	Raise awareness about danger signs	Pregnant women & families	Posters, drama, radio
Health center location and services	Promote health seeking behaviors	Community members	Radio
Use of social marketing commodities, e.g., contraceptives, clean delivery kits, micronutrients	Improve local access to health care supplies	Women and men	Signboards
Delayed age of marriage and first pregnancy	Promote healthy women and pregnancies	Teachers, youth group leaders, and adolescents	Youth-focused media such as newsletters, call in radio programs
TT immunizations for pregnant women	Promote healthy pregnancy	Pregnant women	Health centers posters/health education talks
Nutritional supplementation or eating well	Promote healthy women and healthy pregnancies	Women of reproductive age	Radio, posters
Post-abortion care	Reduce complications of abortion; encourage use of FP	Women of reproductive age	Radio, posters
Voluntary testing and counseling for HIV	Encourage health seeking behaviors and limit transmission	Women and men	Radio, posters, drama, health education talks

Organizations that have well established roots in the community but limited technical skill in development of behavior change strategies have an important role to play in planning behavior change programs with their technical partners. The following guidelines can help:

- Base messages on research that documents people’s beliefs and traditions and obstetric dangers in the community.
- Involve community representatives in designing campaigns.
- Ensure that any recommended referral services are accessible, available, high quality and willing to take on new clients.
- Establish partnerships with community and technical organizations that have relevant experience and expertise in safe motherhood and message development.

- Select messages that are focused, easy to understand, and culturally appropriate.
- Use eye catching and interesting visual presentations.
- Field test to ensure the message is clear and monitor to ensure it is effective.
- Consider how safe motherhood messages can be integrated with existing community education programs; for example, adding safe motherhood messages to adolescent education or skill development programs.

Experience From the Field



The Green Pendulu and Maternal Health in Mali

The Dioro Child Survival and Maternal Health Project was designed to improve maternal health. Health workers, challenged by the fact that men and women considered pregnancy a taboo subject, researched the traditional communication channels among the Diori community. These included stories, songs, proverbs and poetry. They enlisted the services of a griot (bard), and used a song and the nonverbal cue of a women's bed clothes (a white pendulu) as tools in a behavior change campaign. The griot developed a song about the key maternal health messages: high risk pregnancies, communication between spouses and partners, use of health services and use of a green pendulu as a signal that a woman was pregnant. Assemblies were held with the griot singing and the pendulu distributed to all married women in seven villages. The green pendulu was only to be used when the woman was pregnant as a cue to talk about the maternal health messages covered in the song. An evaluation held 3 months later revealed that 65.6% of the couples discussed pregnancy and maternal health issues versus a 3% baseline rate. 94.4% of the survey couples had heard of the pendulu; 32.3% of men said they would talk to their wife about pregnancy if she wore the green pendulu; 41.7% said they would lighten her workload; and 49.6% said they would make sure she eats right.¹⁴

Source: Africare 1999

Counseling women and their families

Women frequently need counseling on problems that can influence the outcome of their pregnancy. The purpose of counseling women on safe pregnancy practices is to assist them in recognizing problems and deciding to seek care. They also need answers to their questions about where to seek pregnancy and delivery care. Women in some cultures do not recognize pregnancy as a time needing special care; others recognize some but not all signs of complications; and most have difficulty distinguishing problem

severity. By establishing a counseling relationship directly with the woman or through women's groups, NGOs can effectively reach vulnerable women and their family members. Individual and small group counseling sessions give women an opportunity to have their concerns addressed in a privileged and supportive environment. When helping women with the decision to seek care, it is particularly important to counsel other family decision makers such as husbands or mothers-in-law.¹⁵

Counseling for Birth Planning

Birth planning is an important counseling function to increase women's access to care. Birth planning counselors start by assisting pregnant women to understand the signs of complications and distinguish among problems. They guide women to prepare a plan for reaching an appropriate facility in the event of complications of labor or, in the case of normal delivery, how to make it safe and clean. Good birth plan counseling also prepares family members to recognize danger signs of obstetric complications; involves family decision makers in selecting an appropriate emergency facility; pinpoints the mode of travel; and arranges for the necessary finances for transportation, supplies and service fees.

Other important counseling issues include:

- Prevention and management of STIs and HIV during pregnancy;
- Infant feeding practices, particularly in communities where HIV is prevalent;
- Maternal nutrition, eating well and vitamin supplements;
- Unsafe abortions.

For further information on client counseling for the preceding topics see Annex 5.



Caring for Pregnant Women

Antenatal Care

The traditional use of antenatal care as a means of *screening* women to identify those at risk of a pregnancy complication is changing. According to recent research, many of the assumed indicators of complications do not in fact predict poor pregnancy outcomes. For example, 90% of pregnant women who were identified as *at risk* during screening at a health center in Kasongo, Zaire, did not develop complications. Studies have also shown that a history of pregnancy induced hypertension, commonly used as a predictor of future hypertension, is not an effective means of predicting hypertension in subsequent pregnancies.

Since the *at risk* screening approach has failed to identify women who would develop complications, emphasis has shifted to ensuring that every pregnant woman has access to high quality maternity care. This change in approach refocuses community activities away from screening toward detection of life threatening conditions and treatment of illnesses that have a proven relationship with poor pregnancy outcomes.

The following antenatal care interventions have been shown to effectively improve maternal health:

- Detection and treatment of chronic anemia;
- Detection and treatment of certain types of infection, especially STIs such as syphilis;
- Detection, investigation and referral of hypertensive disorders of pregnancy;¹⁶
- Recognition and referral of any woman who experiences bleeding during pregnancy;
- Counseling of women and their spouses on recognition of danger signs and help with plans in case of such an emergency.

CBOs that integrate services for pregnant women into their existing activities can make an important contribution to healthy pregnancies. Consider the situation in your community and how your organization may integrate pregnancy care into your ongoing activities while you review the list of care options given below .

Condition	Community Care Options
Anemia	<ul style="list-style-type: none"> • Iron and folic acid supplements during or before pregnancy • Education on use and storage of iron-rich foods and nutritional needs of pregnant women • Advocacy for reduced work load during pregnancy
Malaria	<ul style="list-style-type: none"> • Medical prophylaxis and treatment • Promotion of insecticide treated bed nets • Information on reducing mosquito breeding areas.
Hookworm	<ul style="list-style-type: none"> • One dose of oral anthelmintic during 2nd or 3rd trimester in endemic areas • Information and education to raise awareness about preventive measures, i.e. sanitation, footwear
STIs and HIV	<ul style="list-style-type: none"> • Use of condoms • Behavior change activities: avoidance of multiple sexual partners • Diagnose/treat in early stage • Assist HIV+ pregnant women to avoid newborn transmission during labor, delivery or breastfeeding
Pregnancy-Induced Hypertension	<ul style="list-style-type: none"> • Measurement of blood pressure and testing for proteinuria • Examination for edema (swelling) • Referral to health institution for delivery

Delivery Care

At the community level, NGOs may consider their options for improving care for normal deliveries and emergency situations. Three possible interventions are described here: (1) preparing community level providers to support normal deliveries;(2) the use of clean delivery kits to reduce infection in both mothers and newborns; (3) preparing birth attendants to provide obstetric first aid thereby stabilizing a mother in crisis prior to referral.

Community Providers

Support for women during normal labor can be provided by family and other trusted members of the community. Community members trained in simple ways to support women during birth are an important element of care during birthing. Training should focus on hand washing, providing emotional support during birth and “doing no harm” during normal deliveries.

Delivery Kits

Clean delivery kits contain the essential items needed for a clean delivery. Kits are usually produced and distributed locally and sold at subsidized or unsubsidized prices. Although the items contained in the kit vary due to local availability, essential items include:

- A piece of soap to be used by the birth attendant for hand washing and washing the mother's perineum;
- A plastic sheet to place under the woman;
- A razor blade for cutting the cord;
- String for tying the cord;
- Instructions for using the kit.

An organization's involvement in promoting the use of clean delivery kits can range from simple to complex, i.e. from information dissemination, to behavior change activities to production and distribution of kits. Many factors will need to be considered when defining the organization's possible involvement, including:

- Current acceptance of kits by the community;
- Availability and price of kits;
- Cost of production and distribution;
- Community members' ability to pay;
- Organizational experience in commodity distribution.

Emergency Support

Obstetric first aid is the use of basic first aid procedures to stabilize a woman while transportation to the nearest health facility is being arranged. Although referral to an appropriately staffed and equipped facility is essential when obstetric emergencies occur, some simple measures can be employed by family members or birth attendants to support women during emergencies. While waiting for transportation, women should be kept warm and given oral rehydration fluids. Appropriately trained birth attendants can also control bleeding by applying uterine compression or direct pressure on lacerations, prevent convulsing women from injuring themselves, and administer antibiotics and antipyretics to treat fever.¹⁷

Accessing Care for Obstetric Emergencies

Recent attempts to understand the factors contributing to maternal mortality and the role of communities in reducing maternal mortality have highlighted the importance of reducing delays in reaching referral health facilities. “Transportation problems,” considered a major contributor to delays in reaching the health facility, are actually a complex set of issues rooted in other problems such as poor planning, poor roads, great distances to services, difficult terrain, lack of vehicles, and lack of money.

Organized communities use a number of strategies to address these difficulties and improve access to care. Where available, owners of private vehicles, animals and wagons are asked to participate in emergency transport schemes; CBOs are emphasizing the need to plan for emergencies; emergency notification arrangements have been organized; loan schemes have been implemented to support emergency transportation and health facility costs.

NGOs, particularly those with existing presence in the community and strong links to CBOs, such as farmers groups, health committees or village councils can support and facilitate community efforts to overcome transportation problems. Safe motherhood activists, members of the community who have received training in safe motherhood, also play an important role in organizing transportation, alerting health centers to the emergency, and accompanying women to facilities.

Viewing Quality of Care From the Community Perspective

Since improvement in maternal care requires attention to both prevention and management of maternal complications, NGOs that decide to support community-based programs need to address quality of care at two levels: the quality of community-based interventions and the quality of referral site services. Furthermore, community-based safe motherhood interventions that are not supported by good referral services are unlikely to significantly reduce maternal mortality.

The following section follows WHO guidance in highlighting the minimal standards for both community-based and referral services.

Quality Element	Quality Standards
Accessibility	<ul style="list-style-type: none"> • Full range of services available as close to the community as possible • Lowest level facility provides needed service
Continuity	<ul style="list-style-type: none"> • Service acceptable to users • Continuum of care available including antenatal, delivery and postpartum services • Responsive to cultural and social norms • Adequate client follow-up
Technical Competence	<ul style="list-style-type: none"> • Trained service providers offering accurate information and skillful care • Care guidelines available • Supervision and technical support provided
Interpersonal Relations	<ul style="list-style-type: none"> • Respect, understanding and trust shown toward clients, their families and other community providers, e.g., TBAs • Providers non-judgmental and responsive to client needs • Providers allow family and/or community members to attend birth
Information and Counseling	<ul style="list-style-type: none"> • Women and their families viewed as active participants in health care decisions • Providers available and trained to answer questions and guide decisions
Supplies and Equipment	<ul style="list-style-type: none"> • All essential supplies and equipment available • Regular supply and storage facilities established • Procedures for inventory management, i.e. ordering and record keeping and supervision in place

Use worksheet 3a as you apply the standards of quality in community-based safe motherhood services.

Establishing Appropriate Referral and Clinical Back-Up

An effective referral system ensures that women are moved rapidly and safely to a facility that is appropriately staffed and equipped to handle their problem. Each of the four steps to developing an effective referral system given below should be addressed when referral arrangements are being made.

1. Select the referral site

Obstetric emergencies require rapid and skillful response in facilities where equipment, drugs and trained health workers are available. NGOs planning to initiate a community-based program for safe motherhood need to identify and assess facilities serving their communities. Health planners have defined two levels of care for obstetric care, *basic* and *comprehensive*. At a minimum, an acceptable referral site should meet the requirements set out for basic essential obstetric care (BEOC) and should build on provision of good, normal birthing care.

Use the following table to guide your assessment of care at a service site. The chart helps you decide if a site provides the essential services to be considered a basic or comprehensive essential obstetric care site (CEOC). If the site does not meet these standards your organization should consider: (1) improving the referral site; (2) selecting an alternative site; or (3) the ethical implications of starting a community-based program in the absence of an appropriate referral site.

Basic Essential Obstetric Care Sites	
<ul style="list-style-type: none"> • Administer injectable or intravenous antibiotics • Administer oxytocic drugs • Administer anticonvulsants for pre-eclampsia and eclampsia • Perform manual removal of the placenta • Perform removal of retained products (e.g., manual vacuum aspiration) 	<ul style="list-style-type: none"> • Perform assisted vaginal delivery • 24-hour service • Services provided for all women with obstetric emergencies • Links to facilities providing comprehensive care • Monitor labor • Manage problem pregnancies
Comprehensive Essential Obstetric Care Sites	
All characteristics of a basic essential obstetric care site plus <ul style="list-style-type: none"> • perform surgery (caesarean section) • perform blood transfusion 	



2. Formalize relationships with referral sites

After selecting a referral site, NGO staff should meet with community leaders and referral center staff to discuss and agree on how emergencies will be handled.

3. Inform community members and volunteers about referral facilities

Community members and family who have been selected to provide direct care for pregnant women, are arranging transportation or facilitating communication with the referral sites need specific information about the referral site to share with women and their families. Their training should include details about the referral site including distance to the site,

transportation options, types of providers and equipment available at the site; they should also learn the procedures for reporting and documenting the referral. Training should include visits to referral sites to familiarize volunteers with the facilities and the staff.

4. Develop a referral information system

Referral information is essential for judging the effectiveness, strengths and weaknesses of community efforts to improve access to obstetric care. Reports on the nature of the emergency, the amount of time taken to reach care, the amount of time to receive care once at the facility and the outcome of the emergency are essential for program assessment and for assisting community members to determine the program's contribution to safe motherhood.

Choosing Appropriate Safe Motherhood Strategies

How does an organization select a single intervention or a combination of interventions to offer as part of the existing program? This decision emerges after the organization sorts through many organizational and community variables to determine the best fit between their existing program and the community's needs. The organization's strategy emerges when the following conditions have been met:

- A set of activities is selected that respond to community needs;
- The organization determines that resources and commitment to implement the activities exist;
- Partnerships, networks, referral arrangements and other support requirements have been identified and planned.

Strategies for Contributing to Safe Motherhood in the Community

Organizations with existing community-based programs have an opportunity to use their knowledge and position in the community to introduce activities that can reduce pregnancy-related illness and deaths. NGOs in health and other sectors can introduce needed inputs rapidly by building on their knowledge of community needs, trusting relationships with community leaders and credibility with community members.

Three distinct strategies for providing safer motherhood services are presented here along with guidelines for implementation and examples of successful programs. The three strategies are:

1. Strengthening the safe motherhood focus of community-based activists;
2. Partnerships with CBOs;
3. Partnerships with the private commercial sector.

Community-Based Safe Motherhood Activists

Strategy: Expand the role of existing community volunteers, government workers or NGO program staff to address specific safe motherhood concerns of the community. Develop the selected group as safe motherhood promoters or activists

Strategy Components

Safe Motherhood Activists

Trained and untrained birth attendants, agricultural extension agents, community health workers, water and sanitation workers, traditional practitioners, and teachers conducting formal and non-formal education activities for adolescents and women, religious leaders and local politicians.

Strategic Advantage

Integration of new tasks into the responsibilities of existing workers builds on existing institutional and manpower resources, is cost effective, takes little time for start-up, and has a high probability of being sustained.

Depending upon their entry-level skills and position in the community, safe motherhood activists can be matched to any of the safe motherhood services mentioned earlier: education, counseling, care giving and improving access to services.

NGO Role

Build upon existing presence in the community to promote integration of safe motherhood activities into the responsibilities of formal and non-formal community workers.

Strategy Requirements/Inputs

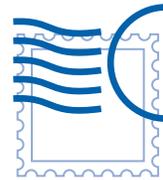
- Clear understanding of community needs
- Accepted community-based volunteers/ workers capable of and interested in a role as a safe motherhood activist

- Roles and activities of activists defined
- Work load and time analysis for new responsibilities completed
- Supervision needs analyzed and procedures prepared

- Resource analysis completed
- Technical capacity requirements defined and supported
- Financial plan for implementing and sustaining the intervention prepared

3

Experience From the Field



Community Activists Support Safer Motherhood

In India, the Triubhuvandas Foundation trained VHWs, employees of milk cooperatives in the district of Kheda, to provide health care to rural women, visiting three times during pregnancy. The foundation is also manufacturing clean delivery kits. VHWs dispense IFA tablets; provide advice on nutrition; and distribute safe delivery kits to TBAs, pregnant women or their mothers-in-law. TBAs were given an incentive of 10 rupees (Rs.) if the clean delivery kits were used. (There are approximately 40Rs. to one US\$.) Initially, 40% of cases were delivered using the kits; now 80% of deliveries are done with a clean delivery kit. Assembling the kits is becoming a village industry.¹⁸

Source: London School of Tropical Medicine and Hygiene, 1998.

3



Partnerships with Community-Based Groups

Strategy: Assist CBOs to raise awareness of safe motherhood issues and to use their networks to promote improvements in care and access.

Strategy Components

Community Groups

Neighborhood health committees/councils, women's and men's coops, women's health committees, youth groups, religious organizations, etc.

Strategic Advantage

CBOs are well positioned to educate, advocate, and promote behavior change among members. CBO networks can be used to initiate and support emergency transportation and communication networks. CBOs are good candidates for development and maintenance of loan schemes to support emergency transportation and care. CBOs can facilitate the use of new technology for improving nutritional status such as solar food dryers.

NGO Role

To select and support CBO involvement in safe motherhood activities through technical support, training and grants.

Strategy Requirements/Inputs

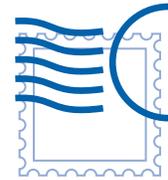
- Established relationship between NGO and CBO partner
- Clear understanding of CBO's role, membership, networks and acceptability by community members
- Capacity and commitment within CBO leadership to take on additional role

- Membership skills assessed
- Roles and activities of CBOs defined
- Work load and time analysis conducted
- Management plan developed

- Resource requirements defined
- Technical capacity to respond to needs
- Financial plan for implementing and sustaining the intervention



Experience From the Field



Community Partnerships for Safe Motherhood

In Bolivia, Save the Children worked with women's groups in the remote rural province of Inquisivi (population 15,000) to reduce maternal morbidity and mortality. The major strategy used to achieve objectives was the organization of women's groups to increase their knowledge and awareness of specific maternal health problems. Fifty groups of women participated in a problem identification and prioritization exercise; results of the exercise guided the training of birth attendants. Both women and men were trained on safe birth practices and women's groups prepared clean delivery kits and links were made with a referral site. Project results included reduction of perinatal mortality from 11 cases 1988-90 to 7 cases 1991-93; increase in at least one antenatal care visit from 45% to 77%; increased use of trained birth attendants from 13-57%.¹⁹

Source: MotherCare 1994.

3



Partnerships with the Private Commercial Sector

Strategy: Develop and support partnerships with private sector to promote safe motherhood activities.

Strategy Components

Private sector

At the community level, likely private-sector partners include: shop keepers, transportation service workers, local employers (large and small), commercial farm owners, and participants in income-generating schemes.

Strategic Advantage

Where the interests of the private sector and the community overlap, there is an opportunity for partnership.

Shopkeepers' product line could profitably be expanded to include sales of subsidized products such as clean delivery kits, vitamin supplements, IFA tablets, etc.

Organization of emergency transportation networks presents an income-generating opportunity for the local transportation business.

Larger businesses may see advantage to providing and subsidizing safe motherhood education and services for their work force.

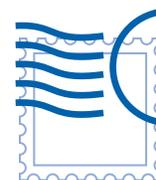
NGO Role

Advocate for and support private-sector involvement in community safe motherhood activities. Develop partnerships with private-sector. Design service strategies and projects that build upon private-sector involvement to provide the community with safe motherhood services.

Strategy Requirements/Inputs

- Relationship between NGO and private-sector partner established
- Clear understanding of private organization's products and services and its acceptance by community members
- Commitment to safe motherhood among the organizations' leadership
- Analysis of product sales potential and profitability
- Sales force training
- Supply and storage issues addressed
- Resource/feasibility analysis completed
- Payment scheme designed and accepted
- Organization and implementation plan developed
- Analysis of cost savings associated with healthy workers
- Resource requirements defined
- Technical capacity to respond to needs
- Financial plan for implementing and sustaining the intervention

Experience From the Field



Private-Sector Involvement in Safe Motherhood

A scheme for mobilizing transport for obstetric emergencies was implemented in Miayama LGA, Nigeria, where the population is 110,000. Focus group discussions and a village case study revealed delays in transportation of women with obstetric complications. Shortages of vehicles and fuel and the unwillingness of drivers to transport women at affordable rates contributed to the problem. Since commercial vehicles were the only reliable and sustainable transport option, the project team engaged in dialogue with officials of the National Union of Road Transport Workers. Union representatives and drivers also attended regularly scheduled community mobilization meetings where views were exchanged. Officials and drivers were trained in the basics of reproductive health, pregnancy complications and how to convey a woman experiencing an emergency. A system for notifying drivers of the emergency was devised and the trucks of participating drivers were marked with a sticker so they can be identified. The transportation scheme was well established and functioning independently at the end of two years. A total of 29 women with obstetric emergencies were transported to health facilities; 28 survived. The transport system is also used to transport other types of emergencies.²⁰

Source: *International Journal of Gynecology and Obstetrics* 1997.

3

Use Worksheet 3b to help you determine an appropriate strategy.

Community Partnerships for Safer Motherhood

Key Questions

1. Do the strategies proposed by Sarama and Naramaya address the community problems?
2. How do you think loan repayment should be promoted?
3. What mechanisms do you see for supervising the social marketing project?
4. What implications do you think the decision not to provide community education will have on the project?

Preparing Program Strategies

After visiting each of the WELS branches to discuss the NHC's request for assistance, Sarama and Naramaya present their proposals at the meeting of the WELS Board.

a) The Transport Loan Scheme

Sarama reports that her feasibility analysis shows that the WELS branches within the communities do not have sufficient reserves to create their own loan funds. She has prepared the following calculations to share with the Board:

Projected Transportation Need	
Total population in the 5 communities	21,000
Women of reproductive age (22% of total)	4,620
Women pregnant at any one time (15%)	693
Expected obstetric complications (15%)	103

Projected Trips in one Year	Cost/Trip	Total Cost
26 trips to the health center	Rs. 200	Rs. 5,200
77 trips to the district hospital	Rs. 400	Rs. 30,800
Total (103 trips):		Rs. 36,000

Based on her figures, Sarama proposes that, in keeping with WELS commitment to social welfare programs, it devote a proportion of its profits this year (Rs.36,000) to create the capital for a central transport loan fund which will serve all five communities. Families requiring emergency transport will obtain the necessary funds from the WELS branch treasurer and sign a repayment agreement. Loans must be repaid within six months; no interest will be charged if a loan is repaid within three months. The village council will maintain a list of all those with outstanding loans and will encourage them to comply with repayments.

Community Partnerships for Safer Motherhood *(continued)*

b) The Social Marketing Program

Naramaya, who has assisted the government to set up the national social marketing scheme, suggests that RDI negotiate with the government social marketing program to extend its reach to cover Rapla District. This would mean that local shops would sell clean delivery kits and IFA tablets. Shopkeepers would purchase the products at subsidized prices and make a small profit on sales. RDI will educate shopkeepers about the products and how they should be used, train them to counsel women on management of possible side effects and assist them with record keeping and restocking procedures.

c) Community Education

Sarama and Naramaya believe that communities lack awareness of safe motherhood issues and that community education will be needed. Their idea is that WELS members in each community should be trained as educators for safe motherhood and be provided with materials to help them share information about healthy habits during pregnancy, danger signs during pregnancy and what to do when there is a problem. The WELS educators would share information at formal gatherings and through informal contacts with family and friends. RDI would be prepared to provide the training together with the health center midwife. WELS would seek assistance of the village elders to ensure that men are involved.

Despite Naramaya's efforts to stress the importance of community education, branch members did not support this suggestion, as they felt they would not have enough time to spare for education activities.

After some discussion, the Board chairwoman thanks Sarama and Naramaya for their hard work and summarizes the day's decisions. WELS will establish and manage a transport fund for obstetric emergencies for an initial trial period of three years. The Board supports RDI efforts to expand the social marketing scheme and will encourage their shop-owning members to enroll in the program. Finally, the chairwoman explains that, although she recognizes the importance of community education, WELS Board must abide by the decision of its members not to participate at this time. Before adjourning the Board decides to name their initiative "Mothers First".



3a: Applying Quality Standards

Objective: To apply the standards of quality in setting expectations for community safe motherhood services

Directions:

1. Select a SM service that your organization or another organization is providing for the community. For example:

- Education for pregnant women and their families;
- Counseling; women and their families
- Caring for pregnant women; i.e. antenatal care or delivery care;
- Assisting women to access emergency service.

2. With the service you have selected in mind, please answer the questions below with a yes or no and qualify your negative responses with a brief comment.

Provide a brief description of the selected service:

Quality Standards for Community Based Safe Motherhood Services

Quality Element	Review Questions	yes ✓	no ✗	Comment
Accessibility	<ul style="list-style-type: none"> • Are there sufficient numbers of workers to provide the service? • Is the service available to all community members? 			
Continuity	<ul style="list-style-type: none"> • Is the service acceptable to community members? For example, are cultural and social norms considered? • Does the service link the client to other needed services? • Can the program maintain contact with clients who have been linked to other services? 			

3a: Applying Quality Standards



Quality Standards for Community Based Safe Motherhood Services (continued)

Quality Element	Review Questions	yes ✓	no ✗	Comment
Technical Competence	<ul style="list-style-type: none"> • Does the program have the capacity to train and monitor service providers? • Does the program have and use technical guidelines for service providers? 			
Interpersonal Relations	<ul style="list-style-type: none"> • Are clients satisfied with the service? 			
Information and Counseling	<ul style="list-style-type: none"> • Are women and their families actively involved in decision-making regarding their care? 			
Supplies and Equipment	<ul style="list-style-type: none"> • Are supplies and equipment always available? • Is there a system for monitoring and maintaining supplies and equipment? 			



Worksheet 3b: Selecting a Strategy for Integrating Safe Motherhood

This worksheet will help you formulate a program strategy. The answers to each question address an important element of your strategy. Share your ideas with others in your organization and invite them to do the same. Discussions about each of the elements will help you agree on the right approach.

Strategic Questions	Proposed Strategy Elements
1. What is the specific population to be served? <ul style="list-style-type: none"> • Characteristics (WRA, adolescents, etc.)s • Geographic setting • Population density 	
2. What is their need/problem?	
3. What resources does your organization have now?	
4. What services can you provide? <ul style="list-style-type: none"> • Educating Community Members • Counseling • Caring for Pregnant Women • Accessing Care for Obstetric Emergency 	
5. Where will you refer your clients? How accessible is this site?	
6. What will you do to ensure the quality of these services?	
7. Who will be your partners (other resources in the community and their possible roles)?	



4: Measuring Program Results

Program monitoring and evaluation assist managers to determine the extent to which program activities are contributing to achievement of objectives. Your organization's ability to measure program achievements is enhanced when basic principles of monitoring and evaluation (M&E) are known and applied. This step focuses attention on using evaluation techniques to measure community-level safe motherhood activities and offers guidance for establishing a system of program review enabling managers to identify and solve performance problems.

The following key points are covered in this step:

- **Setting the Context for Community-Level Monitoring and Evaluation**

The following issues affecting M&E plans for community-level programs are presented: linking program strategies and results; selecting appropriate measures of success; using data; and conducting monitoring and evaluation for an integrated program.

- **Establishing a Framework for Monitoring and Evaluation**

Evaluation approaches are reviewed and discussed to highlight those that are most useful and feasible for measuring progress of community-level programs. Illustrative indicators are given for the four community level service options described in Step 3: community education, counseling, care, and access to services.

- **Preparing a Monitoring Plan**

The elements and characteristics of a monitoring plan are provided along with an illustrative example.

- **Maintaining Program Performance**

This section defines quality assurance and contains guidance for using periodic performance review to assist program managers in explaining program successes, identifying the causes of faltering performance and selecting actions for program improvement.

Setting the Context for Community-Level Monitoring and Evaluation

Development and implementation of a strong monitoring and evaluation plan provide managers with essential information about program progress, highlights problems and sets the stage for initiating program improvements. Planners' knowledge of the program environment contributes to the development of a strong monitoring and evaluation plan; particularly at the community level where the lack of evaluation models, great variation in resources and lack of health infrastructure are a challenge.

Planning for community-level monitoring and evaluation is therefore enhanced when attention is given to the following activities before the monitoring and evaluation plan is designed:

- Establishing a logical link between proposed program services and the desired result;
- Identifying achievement measures appropriate for the selected community based interventions;
- Selecting or developing community-based data sources for measuring program quality and achievements;
- Integrating monitoring and evaluation within the context of the ongoing program.

Linking Selected Program Services to Results

The first challenge for implementing organizations is choosing strategies and activities that effectively promote healthy pregnancies. Researchers, using quantitative methods, have established causal relationships for some safe motherhood interventions such as administering tetanus toxoid to reduce maternal death due to tetanus. However, quantitative research methods have not established the relationship between many community-level interventions and reduction of maternal mortality, primarily because the numbers are too small. Therefore, selection of community-level safe motherhood interventions must draw largely upon current wisdom established through historical review, program experience and logical reasoning. As you review your selected strategies and prepare to develop a monitoring and evaluation plan review the guidance in Step 3 *Preparing Program Strategies* which prioritizes community-based program actions using wisdom gained from *best practices*.

Selecting Appropriate Indicators for Measuring Program Success

Use of Population-Based Indicators: Population-based indicators of maternal health status, maternal morbidity and mortality rates and ratios are effective measures of health trends among large populations over significant periods of time. They are not appropriate for measuring changes among small numbers of people such as those normally associated with community-based programs. However, community-based survey methodology has been developed to measure qualitative effects of programs on target populations. Community surveys are designed to help managers collect qualitative information on health status, behavior, and knowledge and assist programs to determine the results by providing answers to questions such as: “What do people know about antenatal care?” or “What do they do about pregnancy danger signs?”

See Annex 6 for additional guidance on planning and implementing surveys.

Use of Output and Process Indicators: Programs that provide specific services to small populations over short periods of time are not expected to have a direct measurable effect on population-based indicators such as mortality and morbidity. Therefore, in these programs, output and process indicators which provide information about program trends, quality and achievements are usually selected to measure results. For example, to measure the achievements of a social marketing program for clean delivery kits one useful *output* indicator is the number of kits distributed.

Selecting Data Sources for Documenting Quality and Quantity

The data needed to document community-level program results are often difficult to find in existing records. Potential data sources include:

- Records kept by literate community-level workers such as TBAs and CHWs;
- Records of existing non-health field workers which are adapted to integrate safer motherhood data;
- Records of health centers and other referral sites for data about care given to women experiencing normal birthing as well as those with obstetric emergencies.

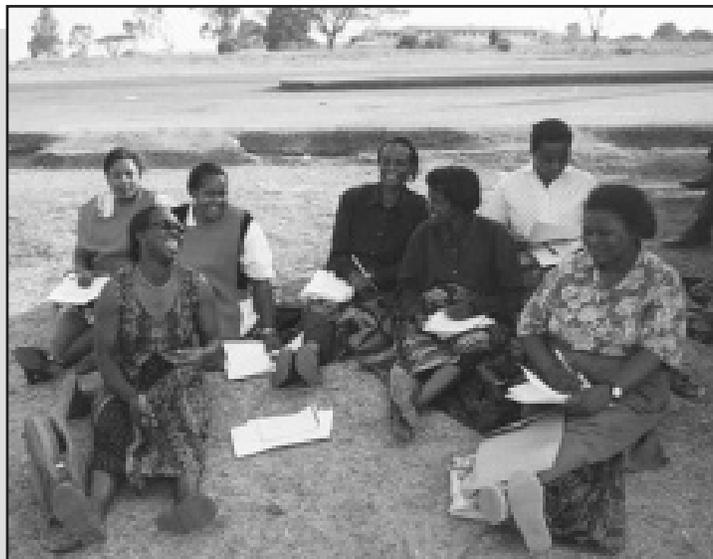
While existing and adapted community-level records can be useful in quantifying program outputs, for example, use of a skilled birth attendant, these records rarely offer sufficient information about the quality of services. Organizations seeking information on service quality often conduct periodic surveys including exit interviews and focus group discussions to gather descriptive information on the quality and achievements of community-based programs.

Performance data gathered during periodic program reviews augments routine records and enables managers and their implementation teams to focus on problem identification and agree on specific actions for program improvement.

Monitoring and Evaluating of Integrated Programs

Organizations that have chosen to integrate safe motherhood into ongoing community programs have an opportunity to reduce the time and costs associated with program review activities. A few practical benefits of integrated program reviews are listed below.

- Monitoring events such as client interviews and community meetings are combined and jointly scheduled.
- Records for the existing program are adapted to include the data needed to monitor and evaluate the safe motherhood interventions rather than developing parallel records.
- Implementing partners participate in safe motherhood monitoring activities thereby reducing the workload for program staff while promoting sustainability.
- Roles of existing supervisors can be revised to include new responsibilities rather than hiring new supervisors.

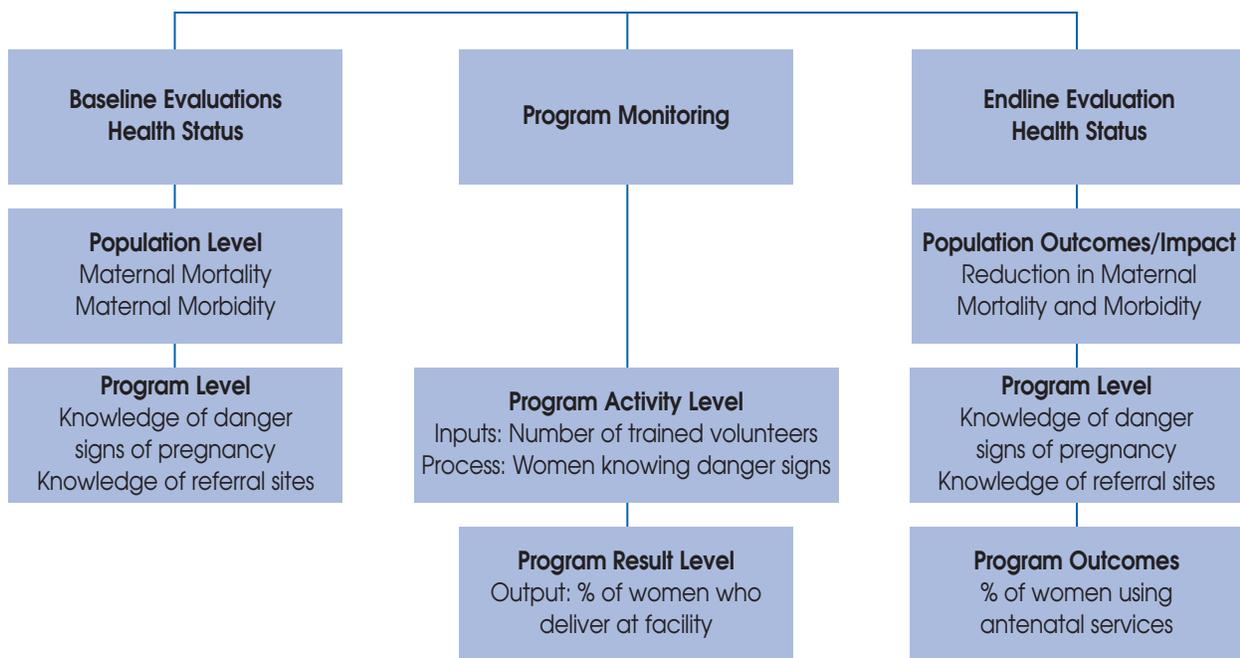


Establishing a Framework for Monitoring and Evaluation

When planning to monitor and evaluate community-based programs, successful programs focus on assessing both the processes and results of implementation so that trends, problems and achievements emerge. Prior to beginning a new program it is essential to establish a baseline description of the existing maternal health conditions in the community. Usually, the baseline survey is designed to measure behaviors, knowledge and attitudes that have a clear relationship to the planned program interventions. When this approach is used, the baseline serves as the foundation for evaluation; it is not feasible to measure changes without baseline data. Programs with sufficient resources conduct periodic community surveys to check for changes in behavior, knowledge and attitudes. Most programs rely upon routine monitoring of selected, key indicators of quantitative and qualitative achievements to ensure that their efforts are on track.

The following evaluation framework displays the relationships between program monitoring and evaluation.

Evaluation Continuum and Sample Indicators



The monitoring and evaluation plan answers questions such as, “How well did the program work?” and “Did the expected change occur?” Keep these questions in mind when selecting indicators to measure the achievements of major program components.

The following table displays levels of monitoring and evaluation and their application in community-level programs. Types of evaluation considered inappropriate for community assessment are marked X.

Evaluation of Community Level Programs

Level of Monitoring & Evaluation	Answers the Questions	Example of Indicator	Feasible at Community Level
Process	How well did the program work ?	Number of TBAs trained	✓
	What and how many activities were implemented? (quantitative) How well were they implemented? (qualitative)	Number of women counseled	✓
Program Results or Outcomes	Did the expected change occur at the program level? (output or intermediate outcome)	% of women with complications who deliver at a facility	✓
	at the population level? (outcome)	reduction in maternal mortality ratio	X
Population Results or Outcomes	To what extent can the change be attributed to the intervention/ program? (Commonly used in research or large scale surveys)	Reduction in maternal mortality ratio	X

4

Definitions Commonly Used in Monitoring and Evaluation

Program objectives are clear and specific statements of the desired program achievements.

Evaluation is the use of accepted methods for data collection and analysis to assist in judging performance and improving program implementation.

Monitoring is the process of measuring important elements of program performance using evaluation methods. Monitoring data are collected and reviewed at specified points in program implementation to determine if the program is on course and to identify actions for program improvement.

Indicators are measures used to track program progress and achievements. Indicators are measurable and are commonly grouped in the following categories.

Process indicators measure how well the program works by tracking aspects of the program such as how many activities are implemented, and how well they are implemented.

Output indicators document progress toward achieving the expected change at the program level. For example, if the program objective forecasts that 50% of pregnant women will receive folic acid tablets; an output indicator is the percentage of women who receive folic acid tablets by the end of the program period.

Outcome indicators document the effects of program activities on the population being served. Outcome indicators are called “program outcomes” when they provide information about the immediate effects of the intervention on the group served; they are called population indicators when they measure the long term effects of a program on the population. When population effects are measured they are also called impact indicators.

4

Indicators for Community Services

This section guides your selection of appropriate and feasible indicators for measuring program performance. Examples of the four types of safe motherhood services are presented and indicators for these services are given on the following table. When choosing indicators remember to think about where the data can be obtained and whether the data are readily available.

Community-Level Services

- Educating community members
- Counseling for women and their families
- Caring for pregnant women
- Accessing care for obstetric emergencies

Indicators

Community Education

Program Component: Neighborhood health committee trained to share safe pregnancy guidance with community members.

Indicator: Percentage of adults in the community who recognize the signs of pregnancy complications and know where to go for services.

Counseling

Program Component: Non-formal literacy program classes that have integrated a component for counseling women on the developing birth plans.

Indicator: Percentage of pregnant women in literacy classes who have prepared a birth plan.

Care

Program Component: A network for distribution of clean delivery kits through commercial retail outlets serving the community.

Indicator: Percentage of pregnant women in the program catchment area using a delivery kit during childbirth.

Access

Program Component: A scheme for transportation of obstetric emergencies.

Indicator: Percentage of women with perceived complications using the transportation scheme.

Annex 7 contains additional information on selecting indicators.



Photo courtesy of Mothercare Project

Community Partnerships for Safer Motherhood

Key Questions

1. Are the selected indicators appropriate and sufficient for monitoring program performance?
2. Is the data collection scheme adequate?
3. What are some of the causes of the poor performance of the loan and social marketing scheme?
4. How can demand for services and products be increased?

Part A: Planning for Results

As part of their internal project planning and approval process, WELS and RDI drafted the following objectives and indicators for the Mothers First program.

Objective	Indicator	Target
WELS to establish a loan scheme, by the end of the current financial year, for transportation of obstetric emergencies to the district hospital or health center from the 5 communities in which their branches are located	<ol style="list-style-type: none"> 1. Number of loans made for journeys to the health center and to the district hospital. 2. % of women with perceived obstetric emergencies who reach the health center or the district hospital. 3. Loans fully repaid on time. 4. % of those transported who died at the destination. 	<p>103 loans given in a year</p> <p>100% of obstetric emergencies (103)</p> <p>All loans (103)</p> <p>0%</p>
RDI to negotiate the extension of the national social marketing program to 50% of the retail sales outlets in Rapla District in the next 6 months.	<ol style="list-style-type: none"> 1. Number of clean delivery kits sold as a % of total expected deliveries within the 5 communities. 2. Number of women buying a full supply of IFA tablets (180 tablets per pregnancy) as a % of total expected pregnancies within the 5 communities. 3. Number of retail sales outlets in the communities with trained sales agents. 	<p>25% year 1; 35% year 2; 50% year 3.</p> <p>25% year 1; 35% year 2; 50% year 3.</p> <p>50% of retail sales outlets in the communities with socially-marketed products and trained sales agents.</p>

Community Partnerships for Safer Motherhood *(continued)*

After one year, the WELS Board and RDI meet to review experience with the social marketing program and transport loan fund. It was very easy for WELS to compile data on the transport scheme since each branch had been recording progress and submitting quarterly reports to the directors. In conformity with national social marketing program procedures, each retail outlet submits quarterly sales reports which, in combination with data on supplies distributed from the central warehouse, provide a comprehensive picture of activity in the district. Naramaya, therefore, had all the data on the social marketing program readily available.

First Year Results of “Mothers First”

Transport Loan Scheme:	
- Number of loans made	38 (37%)
- Full loan repayments made within 6 months.	35 (34%)
- Number of women with obstetric emergencies who reach the health center/district hospital	48 (47%)
- Number of those transported who died at destination	1
- Number of maternal deaths in home	1
Social Marketing Scheme:	
- Number of clean delivery kits sold as a % of total expected deliveries within the 5 communities.	69 (10%)
- Number of women buying a full supply of IFA tablets (180 tablets per pregnancy) as a % of total expected pregnancies within the 5 communities.	69 (10%)
- Number of retail sales outlets in the communities with trained sales agents.	10 (50%)

Results from both programs are not very encouraging. Naramaya explains that the shopkeepers involved in the social marketing program are not sure whether it is worth their while to continue to stock items for which there is little demand.

As Board members are reviewing the figures, Sarama adds that there have been two recent problems in her village. One woman has died in labor at home and a second nearly died as her husband was away and nobody in the household was willing to authorize her journey to the hospital, even though she had been in labor for more than 18 hours. Darbati’s brother’s response to these two incidents has been one of outrage, and he has already talked to members of the village councils and other men and is convinced that they would be willing to learn more about what is happening. The Board decides to postpone a discussion about what to do until after they have had lunch.

Preparing a Monitoring Plan

The monitoring plan is a road map to guide periodic assessment of the program. Prepare the plan when the program is designed, include monitoring in the program action plan to ensure that monitoring becomes an integral part of program activities. Team members have a better understanding of their roles in monitoring trends and performance quality when monitoring is included as an important aspect of program implementation. The elements and characteristics of a monitoring plan are given in the following table.

The Monitoring Plan

Element	Characteristics
Purpose of monitoring	<ul style="list-style-type: none"> • To set expectations and track achievements of quantitative results • To improve performance through problem identification and program improvement • To determine the cost of the program
Program elements to be monitored	<ul style="list-style-type: none"> • Focus on priority program elements • Number and quality of activities conducted by the program • Changes in quality and quantity of services provided over time
Indicators	<ul style="list-style-type: none"> • To reflect implementation strategy and program components
Sources of data	<ul style="list-style-type: none"> • Identification of data source to document achievement of each indicator • Focus on quality and quantity of program inputs and outputs, and achievement of program objectives. • Select data source on the basis of ease of data collection and need for adaptation or development of records and/or surveys
Timing of data collection	<p>When making a change in or introducing a new strategy, frequent monitoring is needed to:</p> <ul style="list-style-type: none"> • Establish a problem-solving culture, • Clarify approaches, and • Correct implementation problems
Sharing results	<ul style="list-style-type: none"> • Disseminate progress and trends to team, partners, staff, and community • Team to use results to address program weaknesses or gaps

The following example shows how the monitoring plan elements fit together. See the case study for an example that includes projected performance targets.

Monitoring Plan

Purpose of Monitoring

To measure achievement and identify ways to improve performance

Program Objective

In partnership with the government clinic serving 5,000 people, the Marabel Women's Coop will establish a community-based program to increase acceptance and use of IFA tablets for the full regimen (180 tablets) by pregnant women from 15% to 65% in 3 years

Program Components

- Training for 30 TBAs to counsel women and men on danger signs, location of obstetric care facilities, nutrition for healthy pregnancy and distribute iron folate.
- Organization of the distribution system for IFA tablets

Selected Indicators

Data Source

Timing *

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • # of trained TBAs | <ul style="list-style-type: none"> • project staff records | <ul style="list-style-type: none"> • annually |
| <ul style="list-style-type: none"> • # of adults counseled | <ul style="list-style-type: none"> • community survey | <ul style="list-style-type: none"> • quarterly |
| <ul style="list-style-type: none"> • % of women receiving iron folate | <ul style="list-style-type: none"> • project records | <ul style="list-style-type: none"> • quarterly |
| <ul style="list-style-type: none"> • % women satisfied with TBAs | <ul style="list-style-type: none"> • community survey | <ul style="list-style-type: none"> • baseline, mid-point & endline |

Sharing Results

Bi-annual review and decision-making meetings are planned for Marabel's program manager, supervisor, referral clinic staff and TBAs to discuss findings, review progress and agree on future actions to improve performance.

* More frequent reviews should be planned for new programs and those experiencing problems.

4

Worksheet 4 will help you to prepare a monitoring plan for your organization

Community Partnerships for Safer Motherhood

Key Questions

1. What suggestions can you make for establishing links between the proposed husband activists and trained TBAs with the health center and district hospital?
2. What can Naramaya do to ensure local shopkeepers benefit from the new campaign?
3. How will the proposed changes affect M&E plans?
4. What information, if any, would you suggest be collected?

Part B: Monitoring and Re-Planning

When the Board reconvenes after lunch, the members return to a discussion about what can be done to improve the results of the transport loan and social marketing schemes. All the members now agree that community members simply do not understand enough about how to promote safe and healthy pregnancies, and therefore, have not been giving priority to the opportunities offered by these two schemes. The Board recognizes that it needs to revisit its earlier decision to omit community education from Mothers First.

Darbati and Sarama have come to this meeting with some new suggestions about what could be done. Recognizing that the WELS members are too busy to devote time to community education, they now propose using a two-pronged approach to reach out to both men and women. Darbati says that village council members are interested in being trained to share safe motherhood information with men who attend the various community meetings, and to influence how husbands behave. The health center in-charge has agreed to conduct this training, but will need some funds to cover his travel costs. Darbati is willing to coordinate these activities.

Sarama reports on some discussions she has had with the local health center staff, focusing on the potential role of TBAs in the catchment communities. The midwife has said that while TBAs have been trained in safe and clean delivery, she believes that more effort is needed to help people understand how to prevent some of the common pregnancy problems. She is proposing that TBAs make at least one pre-delivery visit to all pregnant women well in advance of their expected delivery time to discuss things they can do to protect themselves and their babies. She is willing to conduct special training for the TBAs in the area, but needs some money to cover the costs of TBA travel and refreshments. Safe motherhood materials can be provided free by the government's Safe Motherhood Initiative.

Darbati and Sarama have estimated that the total costs of the village council and TBA training would come to Rs.6,000. Given the efforts already made, the WELS Board agree to put up the additional Rs 6,000 and to support the new activities. The Board asks Darbati and Sarama to prepare a schedule for the training and for post-training follow-up meetings with the village councils and health center staff to review progress.

Finally, Naramaya reports that the government has agreed to put more effort into the social marketing program since it recognizes that the program has not been achieving the anticipated results. In order to increase demand, the government will be running a national advertising campaign for safe motherhood products and will be providing promotional material, in the form of posters and signs, which can be displayed by participating retailers.

Maintaining Program Performance

Quality assurance is a process of developing and maintaining high quality services with the involvement, commitment and cooperation of staff and partners. Quality assurance focuses on achieving the desired health outcomes and ensuring client satisfaction in a cost-effective manner. An effective quality assurance process starts with a clear and shared understanding of program objectives and a plan for routine and period measurement of progress (monitoring plan). Routine performance reviews provide recurrent “snapshots” of program status and document trends. During reviews, program staff use standardized instruments to gather, analyze, and share information. The quantitative and qualitative information generated through reviews assists staff to identify factors that influence program successes and faltering performance and agree on actions for program improvement.

4



The following table contains the key elements to include in a program performance review.

Element for Review	Focus of Data Collection
Management and Organization	<ul style="list-style-type: none"> • Complementarity with existing program • Commitment of management/staff • Staffing requirements • Financial management • Partnerships • Status of integration
Quality of Service	<ul style="list-style-type: none"> • Staff training, knowledge and skills • Supervisor performance • Client satisfaction • Referral system • Counseling • Recording and reporting
Community Commitment and Involvement	<ul style="list-style-type: none"> • Satisfaction and support • Leadership participation • Integration with community activities • Knowledge of safe motherhood issues and concerns
Supply/Distribution System	<ul style="list-style-type: none"> • Continuity of supply and distribution regularity • Record accuracy • Storage conditions
Sustainability	<ul style="list-style-type: none"> • Partnerships and linkages • Monitoring and evaluation process • Financial planning • Program expenses and revenues • Recording and reporting systems
Quantifiable Program Achievements	<ul style="list-style-type: none"> • Progress toward performance targets



The preceding table shows performance review elements and focus and provides guidance on what to include in a performance review. The following section provides advice on how to conduct a performance review.

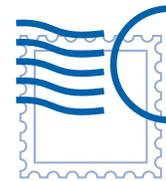
See Annex 8 for a description of the Performance Improvement Review (PIR) Package developed by Initiatives for the SEATS Project to guide community-level program review.

4

Guidelines for Planning a Review

- Conduct performance reviews every six months to track trends and determine if corrective actions have been effective.
- Prepare implementing partners such as MOH, other NGOs, and staff from referral sites to participate as members of the review team.
- Conduct interviews and observations of supervisors, service providers, clients, and community members to obtain a snap-shot of program quality.
- Review records to track quantitative achievements and trends.
- Engage partners in identifying and clarifying problems, selecting remedial actions and assigning responsibility for follow-up.
- Share results and proposed actions for program improvement with community representatives.

Experience From the Field



Reviewing Program Performance

The Zamtam Project, an integrated family planning project in Zambia, has adapted PIR as their biannual quality review process. The project implements a community-based model using volunteer CBDs. By reviewing the findings from the eight instruments included in the PIR package, the project was able to identify areas of strength and weakness and take action to improve performance. Through client interviews, it became clear that the counseling they received about contraceptives was not complete. Clients were not knowledgeable about all contraceptive methods or method advantages and disadvantages, nor did they understand how to manage potential side effects. The client/provider observations confirmed that not all methods were being discussed. Following the monitoring review, the supervisor and service providers discussed the reason for the omission. CBDs responded that they had difficulty remembering all the methods when counseling clients. Together, the supervisor and CBDs brainstormed about how to fix the problem and decided upon a homemade chart with pictures of the methods and drawings of the male and female reproductive systems. This visual aid reminded all workers to include the entire list of contraceptives in their counseling sessions. The clients, prompted by the pictorial cues, became more involved in the process, seeking information and clarification by pointing to a method or diagram while asking questions. Subsequent monitoring reviews showed a more complete counseling session, a higher percentage of new users, and better continuing client follow-up increasing from 45% to 72% over a 6-month period.

Source: World Vision, Zambia 1999

Community Partnerships for Safer Motherhood

Key Questions

1. How would you interpret the data Naramaya presented on maternal deaths?
2. What do you think of the advice from RDI on the KAP survey?
3. What do you think that the WELS Board should decide in relation to future support of safe motherhood in the 5 communities?

Part C: Final Evaluation

It is now two and a half years since WELS established the transport loan scheme and the WELS Board is meeting to discuss the results of the recent evaluation of the three elements of the safe motherhood program - transport loans, social marketing and community education. Other groups that have participated in the program are also present at this meeting, including the in-charge of the health center, the health center midwife, Naramaya from RDI and Darbati who has coordinated the work of the village councils. The Board chairwoman has opened the meeting by stating that the evaluation results will help WELS to decide whether there is a need for their continued support to safe motherhood in Rapla District.

Naramaya, who had coordinated the data collection for the evaluation, presented the following information relating to the two and one half years of the program:

Annual Results of Mothers First

Program Component	Target	Year 1	Year 2	Year 3 (6 mths.)
Transport Loan Scheme:				
- Number of loans made	103	38 (37%)	55 (53%)	38 (37%)
- Full loan repayments made within 6 months.	100%	35 (34%)	46 (45%)	35 (34%)
- % of women with obstetric emergencies who reach the health center/district hospital	100%	48 (42%)	60 (58%)	45 (44%)
- Number of those transported who died at destination	0	1	1	0
Social Marketing Scheme:				
- Number of clean delivery kits sold as a % of total expected deliveries within the 5 communities	50%	69 (10%)	173 (25%)	311 (45%)
- Number of women buying IFA tablets as a % of expected pregnancies	50%	69 (10%)	139 (20%)	208 (30%)
- Number of retail sales outlets in the communities with trained sales agents	50%	10 (50%)	12 (60%)	12 (60%)

Community Partnerships for Safer Motherhood *(continued)*

Naramaya told the meeting that in planning the evaluation, she had consulted with her colleagues at RDI. They advised her that a KAP survey would not help WELS to determine whether their investment in the community education component was effective. Effectiveness would best be demonstrated by people's purchase of socially-marketed commodities and their participation in the transport loan scheme and these were already included as achievement indicators.

However, Naramaya had collected information about the number of maternal deaths in the community from health center records, since she felt that this one additional item of information would help WELS assess a change in health status to which their safe motherhood program would have contributed.

	Year 0	Year 1	Year 2	Year 3
Maternal deaths	7	6	5	3

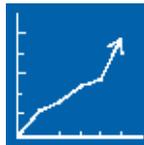
Finally, Darbati informs the meeting that he has some concerns about the village councils' contributions to the program. He says that three of the councils have been active: they have raised the importance of safe motherhood at several meetings; have introduced the TBAs and their expanded role to community members; and are promoting the transport loan scheme. However, two of the councils don't seem to be doing much at all. Darbati is asked to work with Naramaya and the health center midwife to explore what is happening and to come up with some solutions.

Worksheet 4 • Preparing a Monitoring Plan

This worksheet will assist you to develop a monitoring plan for your safe motherhood program. Review each major component of your strategy separately to complete the form. Organizations planning to integrate the new interventions into an existing program should complete the “Comment” column.

Monitoring Plan

Purpose of Monitoring Program Objectives				
Program Component	Indicators	Data Source	Frequency	Comment: Potential for Integration with Existing M&E



4



STEP 5: Using Resources Effectively

The success of a community-based safe motherhood program depends, in part, on the availability of the resources - human and material - needed to implement the planned activities. Having specified the objectives for the program and determined the strategies to be followed, an NGO will need to consider the human, material and financial resources that will be required to implement the program.

The following key points are covered in this step:

- **Estimating the Human Resources Required**

This involves defining the tasks that will need to be carried out to implement the program, deciding who will perform these tasks and determining how many people will be needed.

- **Determining Training Needs**

The people who will be responsible for implementing the program may need training to prepare them for their responsibilities. This section provides guidance on how to determine training needs, design and implement relevant training, and monitor the effectiveness of the training provided.

- **Developing a Plan for Supervision**

All programs require sustained efforts to maintain the quality of the services provided and the motivation of the people involved. This section explores the ways in which both the NGO and the communities served can participate in supervision of the service providers.

- **Calculating the Material Resources Required**

This section looks at the need to estimate the commodities, informational materials, transportation and communication required to implement the program and provides guidance on how this can be done to ensure that important resources are not overlooked at the planning stage.

- **Preparing a Financial Plan**

This section examines some of the special issues involved in financial planning when integrating a safe motherhood component into an existing NGO program portfolio.

Estimating the Human Resources Required

The people required to implement a program may include both paid and voluntary workers, depending on the nature of the program and on local circumstances.

Based on the strategy and objectives you have selected for your program, you need to:

- Define the specific activities that need to be carried out
- Decide who should carry out these activities
- Estimate how much time will be needed to carry out each activity

Defining Activities and Assigning Responsibilities

An NGO decided to improve understanding of good nutrition during pregnancy and of the pregnancy danger signs which indicate that a woman needs to seek medical care among 5 communities with which it is already working. The NGO plans to make use of the five women's literacy groups that it has established to inform its members so that they can act as safe motherhood activists within their communities.

To implement this strategy, the following tasks are allocated:

The NGO's literacy teachers will need to:

- Be trained in safe motherhood
- Use safe motherhood informational materials within the literacy program

A midwife from the local health center will need to:

- Train the literacy teachers and the NGO's program managers in safe motherhood at the community level
- Provide supervision and support to the safe motherhood activists

The safe motherhood activists will need to:

- Organize and conduct group counseling sessions with community members
- Visit pregnant women at least three times during their pregnancy to discuss how they are and to assist them in birth planning
- Meet with the midwife
- Have follow-up discussions with husbands and other family members

- Estimate the number of activities to be carried out (perhaps over a one-year period)
- Estimate the total number of people required to carry out all the activities

Estimating the Number of People Required

The NGO's records indicate that there are a total of 60 women enrolled in its literacy program. With the assistance of the local health center, it estimates that each of the 5 communities covered has approximately 250 women of reproductive age of whom 15% (38) may be pregnant at any one time.

The NGO determines that since the safe motherhood information will simply replace the material currently used in the literacy classes, the integration of safe motherhood into the literacy program will not cause additional work for the literacy teachers.

To estimate the number of safe motherhood activists that will be needed within the five communities to be served, the NGO carried out the following analysis:

Workload in each community:

At least 4 community meetings each year x 2 hours per meeting	8 hours
Visit pregnant women (38 women x 3 visits x 2 hours per visit)	228 hours
Follow-up discussions with husbands/family members (38 men x 1 visit x 2 hours)	76 hours
Meetings with midwife (once/month = 12/year x 2 hours + 2 hours travel)	48 hours
Total time required in one year in each community	360 hours
Average time per month in each community	30 hours

The NGO, through consultation with the members of the literacy groups, believes that each safe motherhood activist would be able to spend about three or four hours each week on the program. Therefore, two or three activists will be needed in each community.

To estimate the additional workload for a clinic midwife, the NGO carries out the following analysis:

Training of literacy teachers (5) and program managers	40 hours
Supervision of activists (once per month x 15 activists x 2 hours)	260 hours

The analysis shows that the midwife would not have enough time available to meet separately with each activist each month. The NGO, in consultation with the midwife, agreed that the activists would meet with the midwife jointly each month, with each meeting taking place after one of the literacy classes, which the midwife and other activists would observe. This would also provide an opportunity for refresher training and for learning from each other.

Worksheet 5a will help you to calculate the human resource needs for your program.

When determining staff and volunteer needs, it is important to think beyond the start of the program. People who are appointed at the start may leave; others may not be able or willing to carry out their duties and will need to be replaced. So recruitment and training should not be seen as one-time exercises and plans need to be made at the beginning for subsequent rounds.

Similarly, it is important to remember that while *volunteers* may be willing to give their time to a new program, they may only continue to do so if they feel that their work is important, that their efforts are valued, and if the time demands do not exceed what they are able to contribute.



One idea is for program planners to set a time limit for the period during which a volunteer is expected to be active. For example, volunteers may be asked to agree to work for two years. This may give the volunteers a feeling that they are in control and may make their contribution appear more viable. Should a volunteer under such an arrangement wish to continue to function in the program, that can be arranged.

5

Determining Training Needs

Why is Training Important?

Training may have several objectives: to orient staff to a new program; to help those who will be working on the program to overcome any anxieties about their new responsibilities; to provide staff and volunteers with the knowledge and skills to effectively fulfill these responsibilities; and to give them the opportunity to contribute to the program strategy.

Who Needs to be Trained?

Given the possible objectives of training, participants may come from a much wider group than those who will be directly responsible for the day-to-day implementation of the program. For an NGO implementing a new or expanded program, it is important that its existing staff understand the new activities and how these may be affected by, or may affect, existing NGO activities. This can be called *orientation*.

For those who are to be directly involved in the implementation of safe motherhood activities, it is important during the planning stage for the NGO to follow a series of steps to determine the training needs for a particular individual or groups of individuals:

- List the tasks that a particular job will entail;
- Define the knowledge that the job holder will need to perform each task;
- Define the skills that the job holder will need to perform each task;
- Compare the knowledge and skills required to perform the task with the present knowledge and skills of those who will be expected to do the job to identify gaps for which training will be needed.

It is particularly important to remember that supervisors need to know as much about the program as the workers they will be supervising. Their knowledge should include the principles of safe motherhood, the interventions the program will cover, and the methods to be used during implementation. In addition, as discussed later in this section, it is important for supervisors to be trained in the objectives of their job and in the skills of performance review, coaching, and supportive communication.

A definition of the knowledge and skills required for the Safe Motherhood Activist given in the previous example is shown in the following box.

Defining Knowledge and Skill Requirements of the Safe Motherhood Activist's Job

Task	Required Knowledge	Required Skills
Organize and conduct group counseling sessions with community members	<ul style="list-style-type: none"> • Key steps to promote healthy pregnancy • Constraints to healthy pregnancy among community • Danger signs during pregnancy and delivery • Source/s of obstetric care for community 	<ul style="list-style-type: none"> • Organization skills • Presentation and communication skills • Skills in encouraging group participation in discussion • Use of relevant IEC materials • Record-keeping skills
Visit pregnant women to discuss how they are and to assist them in birth planning	<ul style="list-style-type: none"> • Key steps to promote healthy pregnancy • Constraints to healthy pregnancy among community • Requirements for a safe delivery and care of the newborn • Danger signs during pregnancy and delivery • Details about source/s of obstetric care for community • Options for reaching obstetric care in an emergency 	<ul style="list-style-type: none"> • Interpersonal communication skills • Counseling skills • Problem-solving skills • Record-keeping skills

Worksheet 5b can be used to help you to define the training needs for your program.

Implementing a Training Program

One golden rule about training is that the trainer should have both the knowledge and experience in the areas they are training others to perform. An NGO implementing a safe motherhood program for the first time and with no existing staff experienced in this field should look outside for suitable training expertise. Potential sources of trainers might be the MOH, a mission hospital, or other NGOs already providing safe motherhood services.

However, identifying a source of trainers is not an NGO's only responsibility in relation to training. Since the safe motherhood program is to be implemented by the NGO, it also needs to ensure that any training conducted for its staff and volunteers is appropriate, relevant and effective.

The analysis conducted to determine training needs for different categories of worker (see example above) can be used to brief possible trainers on what is required, together with information about the trainees themselves (including their age and educational and literacy status) and the resources they will have available to help them in their work (such as recording sheets, IEC materials, etc.). Potential trainers will also need to understand the source and frequency of supervision so that they can reassure the participants that they will be able to get further help and support after their training. It is also very important that those chosen to supervise workers on the safe motherhood program are provided with full information on the content of the training their supervisees have received. If indicated in the training needs analysis, the supervisors should receive the same training. All training conducted should focus on both knowledge and skills, and provide ample opportunities for skill development in terms of exercises, practical tasks, role plays and problem-solving situations.

Following training, the NGO has a responsibility to monitor the performance of those trained to ensure that the objectives of the training have been met. The prime source of information for monitoring will be the supervisor/s, who should be asked to carry out an assessment of the effectiveness of the workers performance not more than six months following the training. Having reviewed the task list for each category of worker (see examples *Defining Activities and Assigning Responsibilities and Defining Knowledge and Skill Requirements of the Safe Motherhood Activist's Job*) the supervisor should be asked to answer the following questions about each of the tasks a worker is expected to perform and to document their answers:

- Are all or most of the workers able to carry out the task effectively?
- If not, what are the most common problems?
- Are these problems related to a lack of knowledge or of skills?
- What type of further training is needed to improve performance?

Developing a Plan for Supervision

Supervision is the process of reviewing, with a worker, the quality of the work performed and the results that have been achieved. The purpose of supervision is *not* to find fault; rather its purpose is to identify ways in which the worker can be helped and supported to improve his or her performance. Supervision is often one of the weakest points in many projects, yet good supervision can make the difference between a mediocre and an effective, dynamic program.



For community-based programs, there are two important principles in relation to supervision:

- To really understand how a worker is performing, a supervisor must visit the place/s of work and observe the activities. It is not sufficient to meet with a worker in the supervisor's office and to ask questions.
- An NGO's safe motherhood program needs both to be accepted by and to be of benefit to the communities it serves. It is therefore essential that communities themselves are asked to actively participate in the supervision process to help to ensure that the program is responding to community needs and that communities take ownership of the activities.

As part of preparing for a new program, an NGO needs to prepare a supervision plan. This plan must answer the following questions:

- Who is going to do what?
- When are they going to do it (the frequency)?
- How are they going to do it?
- How and to whom are results to be reported?
- Who is to be responsible for following up on issues identified?

As supervision is so important, yet is frequently not as effective as it could be, it could be important for an NGO to consider whether its supervisors should receive training, by the organization, in how it expects its staff to carry out supervision.

Supervision Plan

Who is going to do what?	<p>The NGO supervisor will:</p> <ol style="list-style-type: none"> 1. Meet with each worker to review records and discuss progress and any problems 2. Visit each worker in the field, observe activities and provide feedback and advice 3. Meet with community representatives to discuss the program
When are they going to do it?	<ol style="list-style-type: none"> 1. Meet with workers once a month (not in months when a field visit is made) 2. Conduct field visits at least once every 6 months (depending on identified problems) 3. Meet with community every 6 months
How are they going to do it?	<ol style="list-style-type: none"> 1. Meetings with worker: <ul style="list-style-type: none"> • Ask worker to report on activities carried out and how successful they were (with examples) • Discuss any problems faced by worker and agree what can be done, by whom, to resolve them. Agree plan of action • Provide feedback to worker on known results of program • Agree on date of next field visit (when appropriate) and on what the supervisor will observe/participate in 2. Field visits: <ul style="list-style-type: none"> • Meet worker at agreed time and place • Observe agreed activity • Discuss performance on activity and offer advice/help where appropriate 3. Meetings with community representatives: <ul style="list-style-type: none"> • Review what community knows about the program • Ask what the community thinks about the program • Ask what the community thinks about the field workers • Ask what suggestions the community has for improvement
How and to whom are results to be reported?	Monthly written report to be submitted by the supervisor to the program manager and jointly discussed
Who will follow up on issues identified?	Joint decision by the program manager and supervisor

Community Partnerships for Safer Motherhood

Key Questions

1. What are the suggestions made by Darbati, Naramaya and the midwife meant to achieve?
2. What are the differences between supervising volunteers and supervising staff?
3. What are the incentives/rewards for council members participation in a program such as the WELS Mothers First project?

Part A: Community-Directed Supervision

In following up the request by the WELS chairwoman, Darbati is meeting with Naramaya and the midwife to discuss the question of the poor performing village councils. Darbati tells his colleagues that he has met with all five of the village councils and gathered some more information about what is happening. The two councils that are less active told him that they had discussed safe motherhood at community leaders' meetings shortly after their initial training but had stopped their activities because there didn't seem to be much interest. Darbati also found out that far fewer transport loans had been made in these two communities. His feeling is that the members of these two councils are trying to be supportive, but simply don't have sufficient understanding of their role or how their actions could change behaviors in their communities.

Based on Darbati's assessment, the three individuals agree that the following suggestions should be discussed with the village councils and, with their agreement, put into action:

- 1) The two less active councils would convene a special planning meeting to which Naramaya and/or the health center midwife would be invited. The meeting would focus on clarifying what the council wishes to achieve as their contribution to the safe motherhood program, defining the specific activities the members will carry out and determining how the council will measure the success of its efforts.
- 2) A member of the safe motherhood program - Darbati, Naramaya or the health center midwife - would be allowed to attend a meeting of the council in the two target villages at least once every quarter.
- 3) Each village council's representative on the NHC would make a report on their council's efforts at each NHC meeting.

Calculating the Material Resources Required

All too often it becomes evident during program implementation that some essential items were omitted from the original budget or had been overlooked in the program activity plans. This can cause frustration to the program implementors, and result in delays or even cancellation of program components.

Although some requirements may never be foreseen, most needs can be identified during the program planning stage with careful and systematic consideration. One tool that can be helpful is a checklist that can be reviewed with staff and communities to try to ensure that nothing has been forgotten. An example of such a checklist is given in the box below. This example divides the users of the resources (or those responsible for their organization and use) into program staff, volunteers and head office. Items may be used by any or all of these categories, but it may help to ensure that nothing is forgotten.

Once you are sure that no item or user has been forgotten, the next step is to determine the quantities that will be required and the unit costs, if the items are to be procured. If it is anticipated that items can be obtained free of charge or donated, this should also be indicated with the source from which they can be obtained.

See Annex 9 for guidance on compiling a comprehensive list of resource requirements for your program.

Resource Requirement Checklist

Item		Program Staff	Volunteers	Head Office
Salaries		✓		✓
Incentives (uniforms, bags, etc.)		✓	✓	
Travel:	vehicle fuel & maintenance	✓		✓
	public transport allowances		✓	
	other transport allowances		✓	
	per diem	✓		✓
Training:	trainer fees			✓
	trainer per diem			✓
	trainee travel	✓	✓	
	trainee per diem	✓	✓	
	training materials			✓
	stationery			✓
Equipment	procurement			✓
	rental			✓
	maintenance & repair			✓
Supplies:	IEC materials	✓	✓	✓
	stationery	✓	✓	✓
	service delivery		✓	
	commodities	✓	✓	
	record books/forms			
Communications:	post			✓
	telephone			✓
	courier			✓
	radio			✓
Meetings:	refreshments	✓	✓	
	travel	✓	✓	
	stationery	✓	✓	
M&E	consultants			✓
	travel			✓
	per diem			✓
	report production			✓
	report duplication			✓
	report dissemination			✓
Contract Services:	photocopying			✓
	printing			✓
	consultants			✓
	accounting services			✓

Preparing a Financial Plan

Developing the Budget

A budget is a financial plan that details the types and amounts of resources required to implement a program. A budget helps managers to plan each activity in detail. It also:

- Provides those who will be funding the program with information on the resources that will be needed to achieve the objectives;
- Provides a baseline against which actual program spending can be monitored;
- Helps guide spending decisions during program implementation.

When safe motherhood is being added to an existing program, three questions will need to be considered:

1. Is the program to be funded by a donor?

If your new program is to be supported by a donor, it is important to know the limitations or conditions that may be attached to their support.

Each donor has its own regulations on what it is allowed to fund and the maximum amount it may fund under a particular category. Of particular importance is whether and to what extent a donor is willing to contribute towards an NGO's indirect (or overhead) costs such as office rent, utilities, auditors' fees, manager's salaries, etc.

Each donor may have its own requirements for how a budget is presented, relating to such areas as the categories of expenditure, the currency to be used, and whether the budget should reflect future cost increases due to inflation.

Since your budget is an *estimate* of program costs, donors usually allow some flexibility in how the money is actually spent, so long as the total amount of the grant is not exceeded. However, it is important to clarify with a donor how firmly you will need to hold to the budget limits on each category of expenditure.

2. Is the way that your NGO charts income and expenses adequate to record and analyze the safe motherhood program activities?

Your NGO's *chart of accounts* (the headings your organization uses to record its income and expenses) should have a separate line item for each type of income or expense that needs to be tracked separately for internal management decision-making and for donors. The categories and line items used in your budgets and in the financial reports required by donors or internal management should match the categories and line items in the chart of accounts.

Adding a safe motherhood program to your NGO's portfolio may require that your organization's chart of accounts be expanded to include such items as:

Assets	Expenses
Equipment inventory	Supplies and equipment
Commodities inventory (such as IFA tablets)	Field worker training
	IEC materials
	Commodity purchases
Income	Meeting costs
New donors	Staff travel
Commodity sales	
Fees for service	

3. How can your NGO separate costs that are shared by different programs?

When safe motherhood services are integrated with other activities, it may be difficult to separate safe motherhood costs from the costs of other programs, particularly when these programs deal with health or other social services. For example, the same service providers and the same supplies may be used by different programs and the costs of supervision may cover more than one program.

In preparing your safe motherhood budget, you need to decide which shared costs should be separated and how to do this. Whatever decision you make at the beginning of the program about sharing costs across different programs will determine the way actual costs must be recorded throughout program implementation.

Separating Shared Costs

An NGO employs civic education officers who work with communities in several districts to inform them of their human and civil rights and assist community members to obtain government services and information to which they are entitled. In two districts, the NGO has decided to respond to community requests to improve their access to obstetric treatment at the local health centers and hospitals. In coordination with the district public health nurses, the civic education officers will assist communities to organize emergency transportation when needed, discuss with health center and hospital staff the services that can be provided and community expectations for courtesy and quality of care, and relay important information and advice through community meetings.

In preparing the budget for this new initiative, the NGO decides that there are two categories of costs that are shared between the civic education and safe motherhood programs: salaries and other employment costs of the civic education workers; and the travel costs for these workers associated with the safe motherhood activities. For each category of costs, the NGO decides on the following means of apportionment:

Salary and other employment costs:	The percentage of the total working time that the civic education officers spend on safe motherhood activities.
Travel costs (vehicle fuel and maintenance)	The percentage of total vehicle mileage associated with safe motherhood activities.

If a donor is willing to contribute towards overhead costs, these can be apportioned across programs using the same approach. The basis for the apportionment can be as simple as the proportions of total direct expenditures which are attributable to each individual program, as shown in the box below.

An NGO's Overhead Cost Distribution

Program	Previous Year's Expenditure	Proportion of Total *
Literacy	10,500	45%
Micro-Credit	4,700	20%
Safer Motherhood	8,400	35%
TOTAL	23,600	100%

* These percentages to be used to apportion overhead costs across the three programs

On the other hand, your NGO may decide that the effort involved in separating the shared costs of an integrated program outweighs the benefits and that costs will be allocated to the *main* program only (that program which incurs the greatest cost). However, before doing this, you should confirm with any donors that this practice is acceptable. You should also ensure that all financial reports clearly indicate that they do not reflect the true costs of the program.

Worksheet 5c can assist you in determining whether and how to apportion shared costs across programs.

Setting Targets for Revenue Generation

An NGO must be interested in promoting the sustainability of the programs it initiates, at least in the sense that the results achieved by its interventions can be sustained. One important aspect of sustainability is the continued availability of the resources (financial, human and material) needed to sustain the program results. At the same time, donors are becoming increasingly sensitive to the question of sustainability and may be neither willing nor able to continue funding a program over a long period. Both these factors require an NGO to consider sustainability before any new program is initiated. Step 6 provides further information on financial sustainability.

One way to ensure that financial sustainability becomes a key component of the efforts devoted to a new program is for the NGO to set targets, at the planning stage, for the resources it plans to generate to implement the safe motherhood activities. These targets should cover two categories for resource generation:

- Resources that can be generated without recourse to a donor;
- Resources that can be generated through donations.

Resources that can be generated without recourse to a donor might include income from fees charged for services or commodities provided through the program; contributions from the communities served in the form of human resources (volunteers), transportation, or other commodities or assistance; and subsidies from other programs being supported by the NGO (such as a proportion of profits derived from service fees or sale of goods.)

Relating Costs to Results

During the planning stage, it can be instructive to relate the program costs included in your draft budget to the results that your program plans to achieve (its objectives and related indicators of achievement). This can help you to assess whether the cost per gain achieved appears reasonable and to assess the cost-result differences between alternative strategies that you can choose between. In effect, this is predicting the cost-effectiveness of your selected strategy. Cost-effectiveness is explored in Step 6.



Community Partnerships for Safer Motherhood

Key Questions

1. What do you think are the advantages and difficulties of building and maintaining a “partnership program”?
2. What are some of the difficulties that WELS has faced in implementing its partnership program?
3. What do you think that WELS should do in the future in relationship to the Mothers First Program?

Part B: Resource Analysis

In preparation for the annual meeting of the WELS Board, Sarama was asked to prepare an analysis of the resources devoted to Mothers First. This will help WELS to make a decision about what social welfare programs they might be able to support in the following year.

As she sits down to start work on this analysis she is surprised at how many different people and organizations have been contributing to the safe motherhood effort. She summarizes her information in a table to be presented at the annual meeting.

Partner	Contribution
WELS	<ul style="list-style-type: none"> - Capital for transport loan scheme - Loan scheme administration (both at headquarters and branch levels) - Funds for training of TBAs (in antenatal visits), village councils (safe motherhood promotion) and WELS members (transport loan administration) - Overall Mothers First program coordination
RDI - Naramaya	<ul style="list-style-type: none"> - Technical support
Government	<ul style="list-style-type: none"> - Social marketing program (training of shop-keepers, subsidizing prices of drugs and safe delivery kits, promotional materials for products). - Safe Motherhood Initiative (training of TBAs in clean and safe delivery; safe motherhood promotional materials)
Health Center in-Charge and Midwife	<ul style="list-style-type: none"> - Training of TBAs - Training of village council members - Referral site for pregnancy care - Technical support for Mothers First program
Village Councils	<ul style="list-style-type: none"> - Promotion of Mothers First among men and wider community - Monitoring compliance with transport loan repayments - Monitoring maternal deaths
TBAs	<ul style="list-style-type: none"> - Antenatal visits to promote healthy pregnancy

continued next page

Study Community Partnerships for Safer Motherhood *(continued)*

Looking over what she has put into her table, Sarama decides to review each of WELS' inputs to the program and to consider the consequences of reducing or withdrawing WELS support. She prepares the following notes for her presentation to the Board.

Transport Loan Capital

If WELS withdrew all its capital for reinvestment elsewhere, a new source of funds would be required for the scheme to continue. Community confidence in WELS might be damaged and may result in lower participation in other WELS programs. In addition, the government may lose confidence in WELS as a future partner in development projects. A reduction in WELS' financial contribution may be possible, but will require more detailed analysis of fund utilization, interest earnings and repayment defaults.

Loan Scheme Administration

Should WELS decide to withdraw its members from administering the transport loan scheme at the village level, it would be difficult for the community to find an alternative source of expertise and the loan scheme could well collapse. This would result in a loss of confidence in WELS and its branches by both communities and government. Reduction in WELS administrative support would not be feasible.

Coordination of Mothers First Program

As the coordinator, Sarama believes that her inputs to the program were essential, particularly in developing and supporting the partnerships that make the program possible. If WELS withdrew its support for the coordinator position yet continued to participate in some aspects of the program, it would reduce its present advantage of being able to influence overall program implementation. Furthermore, another agency would need to fill this role. Recently, less of Sarama's time has been required for program coordination, so it is possible that WELS's future financial obligation for this could be reduced.

Training

Sarama believes that WELS does not need to spend more on training under the Mothers First program. The government has decided to include antenatal care in future TBA training. Since there is little turnover among WELS membership and since any new members are easily trained on the job by their colleagues, no further investment in formal training will be necessary. With regard to the village councils, it would appear at this time that no further training is necessary.



5a: Estimating Human Resource Requirements *(page 1)*

This worksheet is intended to help lay out your calculations for the number of people needed for your safe motherhood program. Use this page by listing out all the tasks that will need to be carried out, then decide which category of staff or volunteer should perform them. Then turn to page 2 and estimate how much time will be needed to carry out each activity and then to calculate how many people will be needed for your program.

Task	Who will Carry out Task
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

5a: Estimating Human Resource Requirements (page 2)



Based on the list of all the tasks that need to be carried out to implement your safe motherhood program and your decisions on who should carry them out, this worksheet helps you to assess the number of individuals of each kind that will be required.

Write the category of worker at the top of the worksheet and then, from page 1, copy each of the tasks that these workers will need to perform into column (a). In column (b), estimate the time it will take to complete this task once. In column (c), enter the number of times in one year that this task will need to be carried out. To complete column (d), multiply the entries in columns (b) and (c) which will give you the total time per year required to complete that task. By adding the total times for all tasks, you will derive the total estimated time requirement for that category of worker.

Staff Category:			
Task (a)	Time per Task (b)	No Tasks/Yr (c)	Total Time/Yr. (d)
1			
2			
3			
4			
5			
6			
7			
8			
Total Time Required in one Year			



5a: Estimating Human Resource Requirements (page 3)

To calculate the total number of workers of each sort that will be needed, you first need to define the total working time available for each category.

For staff, you need to take into account the standard working hours per week (multiplied by 52), minus the number of hours each year which can be taken for public holidays and vacation. Other items should also be taken into account, if you can estimate them, including: average number of hours taken each year for sickness, compassionate leave, maternity leave, etc. The net number of hours available for work each year can then be calculated. Using the worksheet below, for each category of staff, fill in the appropriate information.

Staff Category	Per Week	Per year
Working hours	(x 52)	
- Annual vacation leave hours		-
- Annual public holiday hours		-
- Average hours of sickness		-
- Average hours of compassionate leave		-
- Average hours of maternity leave		-
Total working hours available		

For volunteers, you will need, from your experience or through discussions with community members, to define the number of hours each week that an individual would be able to contribute without it interfering unduly with their other responsibilities. The derived number of hours each week can then be multiplied by 52 to determine the hours that can be contributed over one year.

Finally, complete the following table to calculate the number of individuals of each category required to implement your program.

Category of Worker	Total hours that one person can give to Safe Motherhood in one year	Total hours needed for the Safe Motherhood program in one year	Number of people required (time needed/ time available)

5b: Determining Training Needs



This worksheet is intended to help you consider and record the knowledge and skills required to implement your safe motherhood program. The results of your work should then be compared with the existing knowledge and skills of those who will be working on the program to identify gaps that will need to be filled through training.

Category of Worker	Tasks	Required Knowledge	Required Skill
1			
2			
3			
4			



5c: Determining How to Apportion Shared Program Costs

This worksheet is intended to help you decide which shared costs should be apportioned across the relevant programs and how this apportionment will be done. The example on this page should help you to complete your own information in the blank boxes that follow. Remember to look at each shared cost separately, since the basis for apportionment may differ. Once you have made your decisions about all costs you may find that several costs are to be apportioned using the same method of calculation.

Example of Cost Apportionment Decisions

Cost Item	Programs that Share the Cost	Basis for Calculating Cost Apportionment
Salary of WELS Treasurer (Sarama)	Income generation program	% of Sarama's time spent on each program
	Safe motherhood program	
Transportation costs	Income generation program	% of total mileage estimated to be spent on safe motherhood activities
	Safe motherhood program	
WELS Accounting costs (overhead)	Income generation program	% of total direct costs expended on each program
	Safe motherhood program	

Cost Item	Programs that Share the Cost	Basis for Calculating Cost Apportionment



6: Promoting Financial Sustainability

An NGO must be concerned with promoting the sustainability of the programs it initiates, in the sense that the results achieved by its interventions can be sustained over the long term. The foundation of financial sustainability is to ensure that income to implement activities is sufficient to cover the expenses of implementation. This step examines financial sustainability options that an NGO can consider as it plans its safe motherhood program.

The following key points are covered in this step:

● Options for Increasing Program Income

A brief review is offered of some of the experiences that have been gained as programs around the world try to strengthen the financial sustainability of their efforts. To explore means of increasing income for program implementation, the section examines several options including health care insurance appropriate to low income, rural communities; funds that can be used to finance loans to help families cope with sudden health expenses; fees for service and commodities that can help to finance safe motherhood activities; and subsidies for safe motherhood services from profits derived from other programs.

● Determining the Best Option for Your Program

This section helps you to assess the context of your program in terms of your NGO's experience and financial capabilities, in terms of the community's understanding and experience of paying for services, and in terms of national policies relating to health financing. This will help you to decide which approaches you can best take to promote the financial sustainability of your program.

● Assessing Cost-Effectiveness

An important component of the financial sustainability of a program is the extent to which the strategies used are achieving the program objectives at a reasonable cost. In this section we review what is meant by cost effectiveness and examine how to assess the cost-effectiveness of your program.



Options for Increasing Program Income

Many NGO programs have been, and continue to be, financed by a donor. As all NGOs know, donor resources are becoming scarcer and, in addition, donor funding often brings with it several constraints. There is usually a lengthy period of negotiation over the design of the program and the budget before the funds are made available. The NGO may be required to meet certain conditions before funding is approved. The reporting and other grant requirements specified by the donor can divert NGO staff from program activities. Perhaps most important from the point of view of the program beneficiaries, the duration of the funding is likely to be relatively short-term. This last factor can result in the collapse of program activities as soon as the grant period is over which can mean that the community situation returns to its pre-program status. It can also damage the reputation of the NGO with its communities. Given the importance of making steady improvements in morbidity and mortality of both the mothers and their infants over the long term, NGOs need to give careful consideration to how they could improve the financial sustainability of their safe motherhood programs.

Financial sustainability can be viewed as a continuum, with the least sustainable option being a program that is grant-driven (donor funded), given the reasons listed above.



Partial Cost Recovery

The sustainability of a program can be improved when beneficiaries contribute financially towards the cost of the activities by paying an affordable charge for services or products provided through the program. However, given that an NGO safe motherhood program is likely to be targeted to communities with little disposable income, the potential for generating sufficient revenues from the pool of beneficiaries alone to fully fund the program may be limited. Nevertheless, in locations where communities have little access to government health services or where the government services are perceived by the community to be of poor quality, families often turn to private health care providers, such as TBAs and healers, private midwives and doctors, and find the resources to pay

for services. In fact, many studies have shown that clients often value services more if they are required to pay for them.

Fees may be charged for services and/or commodities at levels that are affordable to the average community member and that encourage utilization. Establishing the level of fees to be charged must also take into account what other providers (the public sector, the private sector and other NGOs) charge.

There are also approaches to pricing that help to promote the use of certain important services, such as providing a discount on the price of delivery when a woman has attended the clinic for a specified number of antenatal check ups. The communities themselves should be consulted in establishing the fee structure and levels of charges. The community should also be involved in determining what to do in cases where an individual or family cannot pay.

Experience From the Field



The Ashish Gram Rachna Trust (AGRT), Maharashtra State, India

AGRT is an NGO involved in the provision of health services and other development programs (such as water and biogas plants) to 60,000 people in Aurangabad District. AGRT runs a 35-bed hospital and a community-level Comprehensive Health and Development Project. The hospital is almost entirely self-financing through fees charged for out-patient and in-patient services and drugs (plus income from the government in the form of a family planning grant).

The community services are provided by community health workers (CHWs) and TBAs (called dais). The CHW detects pregnancy, motivates mothers to get immunized, provides health education and treats common ailments. The dais provide antenatal care, including tetanus toxoid vaccine and iron folate supplementation, delivery and postpartum care, and refer complications to the hospital. The CHWs and dais both carry drug kits and charge for drugs and immunizations. In addition, each pregnancy for which the dai provides antenatal examinations, tetanus toxoid vaccine, IFA tablets, conducts a safe delivery and provides postpartum care and after which the child survives to 3 months, earns the dai a honorarium of Rs.12. The community workers retain the money from drug sales and immunizations (charged at 1Rp), and this income represents 60% of their total earnings. This was found to provide significant incentives to the CHWs and dais to conduct their work regularly and thoroughly and has clearly had an impact on the quality of care. Given these arrangements, the cost recovery is aimed at improving health worker performance and the quality of care.²¹

Source: Ashish Gram Rachna Trust, 1990

Self Financing Approaches

Community Loan Schemes

Community loan schemes are based on the establishment of a *loan fund* from which loans can be made to individuals or families to cover emergency expenditures related to health care. These loans must then be repaid, at some lower level of interest than available in the commercial sector to replenish the original fund. A loan fund can be established either through a one-time donor contribution or through a *savings and credit* mechanism whereby individual members contribute a regular amount to their account as savings which earn interest. Where a savings and credit scheme is in place, members (and, in special circumstances, non-members) may borrow from the scheme to cover emergency expenses and then repay this loan, within a defined period of time, at the interest rate offered to savers.

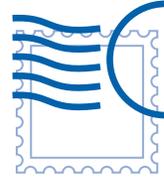


Revolving Commodity Fund

Where a program intends to provide commodities (e.g., IFA tablets, delivery kits, malaria prophylaxis or treatment, treated bed nets, oral contraceptives and condoms, and hookworm treatment), it may be determined that these commodities should be sold to promote financial sustainability. If the commodity component of the program is intended to be self-financing, then the goods must be sold for a charge equivalent to the cost of purchasing new stocks.

There are two issues with this approach that need to be considered at the design stage.

Experience From the Field



Revolving Fund for Community Kits in Zambia

DAPP in Zambia is working on a USAID-funded Integrated Child Health Project in Chililabombwe District. The project is both community-based and community implemented and consists of both preventive and curative components. The preventive component aims at sensitizing and practical demonstrations on healthy living, including general cleanliness of the environment, digging and maintaining refuse pits and latrines, etc. The curative component includes drugs for distribution by CHWs and the provision of mobile clinics by the district.

Drugs in the CHW kit must be bought. Given the severe financial constraints experienced by the government health services, discussions were held with the community over what to do when the district was unable to provide the kit. The communities valued the availability of the kits and 2 weeks after the subject was initially discussed the communities accepted that replenishment of the kits must be their responsibility. To achieve this, community members proposed a fee for CHW services and a fee level was agreed. On behalf of the community, the CHWs collect the payments which they deposit with the treasurer of the NHC who banks the money each month. The CHWs monitor their drug stocks and, with the consent of the NHC, are given money from the account to replenish the drugs as needed. Procurement of the drugs is checked by the clinic staff.

Source: Development Aid from People to People (DAPP), 1999

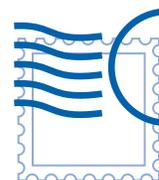
Firstly, there may need to be some mechanism put in place to ensure that those who really cannot afford to pay for the products are not denied access; and secondly, careful attention needs to be paid to rising procurement costs since a revolving commodity fund must be replenished at a level that allows for restocking, otherwise the fund will be exhausted and the scheme will collapse.

Subsidies from Other Programs

Many NGOs operate several community-based programs simultaneously. One or more of these programs may generate income, such as micro-credit schemes, sales of goods derived from an income-generating project, or child sponsorship programs where at least a proportion of the sponsorship income must be used to benefit the whole community. A proportion of this income could be used to subsidize other programs which have more limited capacity to be self-financing. In some countries, NGOs running income-generating programs must contribute a set percentage of any profits to support the general community.



Experience From the Field



CASP-PLAN Ambulance Association

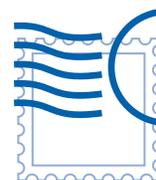
CASP-PLAN implements a community-based Child Survival and Maternal Health Project in a slum community outside of New Delhi. The Project purchased an ambulance for transporting obstetric emergencies, which was entrusted to an Ambulance Association, composed of community members, for management and upkeep. The community in collaboration with Project staff, established criteria for obstetric emergencies. A garage was rented and a driver and back-up driver selected. Costs associated with maintaining the vehicle and driver are paid for by the three Health Guide (CBD) Associations (HGAs) using money collected from clinic fees. Clinic fees are paid directly to the HGAs for the work done by health guides at the clinic. A portion of the sum collected is donated to the Ambulance Association for vehicle and driver upkeep.²²

CASP-PLAN 1999

Pre-Payment and Health Savings Plans

Pre-payment is where individuals or families pay a fixed fee at the start of a period and can then receive health care without further payment during that period. The services that may be obtained under a pre-payment plan must be determined during the design phase, together with the fee amount and the extent of the coverage (individual or family). This approach provides the health care provider with a regular income as well as giving the beneficiaries the security of knowing that they can receive health care in times of need without worrying at that time about finding the money to pay for it.

Experience From the Field



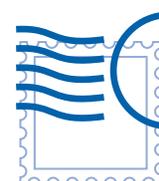
Government Health Center Pre-Payment, Zambia

In Zambia, charges are made for care received at all levels of the health service. As an alternative to charging fees at the time of requiring care, many districts offer pre-payment plans for individuals and families within their catchment areas. Under these plans, a set fee may be paid at any time during the year which then entitles participants to receive services during that year at no additional cost. The level of the annual fee is approximately US\$2.00 and, for women, covers antenatal, delivery and postpartum care as well as other health needs. The fees are paid to the health center and, apart from a small administrative charge levied by the district, can be retained by the health center for local use.

Source: Central Board of Health, Zambia 1998

Health savings are a form of pre-payment. Individuals or families pay a small amount weekly or monthly into a savings account then, when they need health care, they can withdraw from their savings to pay for the costs of the service.

Experience From the Field



Trade Association Loan Scheme in Nigeria

In Lagos, a group of health care providers joined with a number of trade associations and the local community bank. Members of the trade association (market traders, taxi drivers, carpenters, etc.) would pay a certain amount every month for their family. The money would be kept in an account in their name at the community bank. The money could only be withdrawn for health-related services provided by the participating providers. If the service costs exceed what they have in their savings, they are billed for the difference (and have a given time to pay the difference). If they do not use all their savings they can roll it over or take a percentage out at the end of the year. They chose this mechanism because the concept of insurance (risk sharing, coverage when ill but paying in even if you do not use the services) was not comfortable for the target population.²³

Source: Abt Associates, 1998

Health Insurance

Health insurance is a scheme whereby individuals or families pay a premium at regular intervals which entitles them to defined services, perhaps up to a certain value, without further payment. Insurers operate their health coverage by mobilizing members' resources to spread the costs associated with the risks of illness among all their members. Health insurance is possible in locations where individuals are generally required to pay for health services (even those provided by government) and where there is at least one existing health facility nearby which offers an acceptable quality of service.

In some parts of the world, health insurance schemes (provided through *Mutual Health Organizations* (MHOs) have been designed to provide coverage for lower income, rural populations. In these instances, health care providers, faced with the task of raising revenues directly from the public, are often interested in participating in schemes which pool the health risks of many individuals, create a wider revenue base, and increase community access to their health care. In this way, partnerships between health care providers and their surrounding communities can improve the health of the communities while contributing to the viability and financing security of the providers.

However, although such schemes have shown that they have the potential to extend health care access to people who have very limited resources, it has also been found that establishing a successful scheme requires considerable skill and experience. The design of effective insurance schemes require skills in such areas as setting premium rates, determining the package of benefits members can be provided, contracting with providers, marketing the scheme with potential members, determining the appropriate benefit package and keeping track of the results.

6

Experience From the Field



Lalane Diassep Mutual Health Organization

The Lalan Diassep Mutual Health Organization was established in 1994 in two villages in Senegal. It has 989 beneficiaries out of a total population of 1,200. The MHO, which is owned by its members, has negotiated for its members to be provided with health care at affordable rates by a nearby mission hospital. The scheme allows members up to 15 days of hospital care (excluding surgery). The hospital is perceived as providing good quality care so is acceptable to members. The hospital itself has accepted a lowering of its normal charges in exchange for more reliable payment by the MHO.²⁴

Source: Abt Associates Inc., July 1998

Determining the Best Option for Your Program

The decision on how to promote financial sustainability has to be made within an understanding of the context in which the program will operate. The contextual factors that are important to consider include your NGO's experience, national policies and regulations, and the community setting.

Your NGO's Experience

An NGO that already has had experience with cost recovery, with establishing and helping to manage community savings or loan schemes, with running income-generation projects, or with managing community-based insurance schemes can apply the principles of those efforts to a safe motherhood program.

None of these approaches are simple; all require careful analysis and design. In terms of cost recovery, appropriate and affordable fee levels have to be established for services and/or commodities; decisions must be made on how to deal with clients who cannot afford to pay; arrangements must be made on how and by whom the money is to be collected, recorded, and passed on; agreements must be reached on how the revenues obtained from fees are to be used; and procedures designed for how fee levels are to be monitored and reviewed when necessary.

Savings and loan schemes require analysis of the number of potential members and the amounts they are able to save each period, analysis of the maximum loan that may be made given the size of the savings account, analysis of appropriate interest earnings for savers and interest charges for borrowers, decisions on who would be allowed to borrow from the account and the repayment period, and decisions on how repayment is to be monitored and what steps will be taken with defaulters.

If your NGO is already involved in an income-generating project, then you need to consider the potential for linking a safe motherhood program to this project, both in terms of the relationship between participants in the project and target beneficiaries of the program, and in terms of the potential for cross subsidization (i.e. the ability of the income-generating project to contribute towards the cost of the safe motherhood program).

Health insurance schemes require considerable expertise in their design and implementation. In some parts of the world (namely West and Central Africa, Asia and Latin America), there is growing experience in health insurance schemes aimed at improving access to health care for rural and low-income communities. These schemes are only feasible in a

situation where fees for service are charged by both public and private providers, where there is a nearby health facility offering good quality care, and when this facility is interested in improving utilization of its services and the regularity of payments for these services. Such schemes require determination of appropriate premium rates based on projections of in-patient and out-patient attendance by each member, the costs per day or visit that will be charged by the facility, the NGO costs related to the administration of the scheme, the estimated number of members, and anticipated collection rates for premium payments. Attention also needs to be paid to ensuring that health risks are effectively shared (minimizing adverse selection of participants) and that procedures are in place to reduce abuse of the system. An NGO considering establishing such a scheme must seek advice from experienced individuals and organizations.

National Policies and Regulations

A government's policies and regulations concerning health care provision will dictate the freedom of NGOs to implement financial sustainability actions. In countries where the public health system is free to nationals, the potential for an NGO to charge for services may be limited both by government regulation and by community expectations. In countries where there is experience with either private (such as mission facilities) or public facility health fees, the context will be much more favorable for fee-charging NGO programs.

Even where fee paying for health services is the norm, government regulation may well cover the levels of fees that may be charged, required exemptions from fees (for specific individuals or health conditions), and standards of service provided (which individuals are allowed to provide which services, and the types of commodities and drugs that may be dispensed).

Some governments also enforce regulations governing the use of profit derived from income-generating programs. In some cases, regulations require that this profit support social services in the community where the program operates. In such countries, the prospects of a safe motherhood program receiving financial subsidies from profit-making ventures are favorable.

The Community Setting

The characteristics and preferences of members of the community to be served by your program will also influence your options for promoting financial sustainability. The availability of cash within their economic situation, their sources of income and the seasonality of their income are obviously key. There is also the question of willingness to contribute to their

community - their sense of social responsibility and solidarity. Members past experiences with community development projects will also influence their attitudes towards a new safe motherhood program. Existing programs related to income generation and savings and loans initiatives will also color their views. Above all, their perceptions about how they are treated at nearby health facilities will influence their eagerness to contribute to a cost-sharing or insurance-based safe motherhood program.

Any decision taken by an NGO regarding how to promote financial sustainability must take the views and attitudes of the community members into account if the program is to succeed.

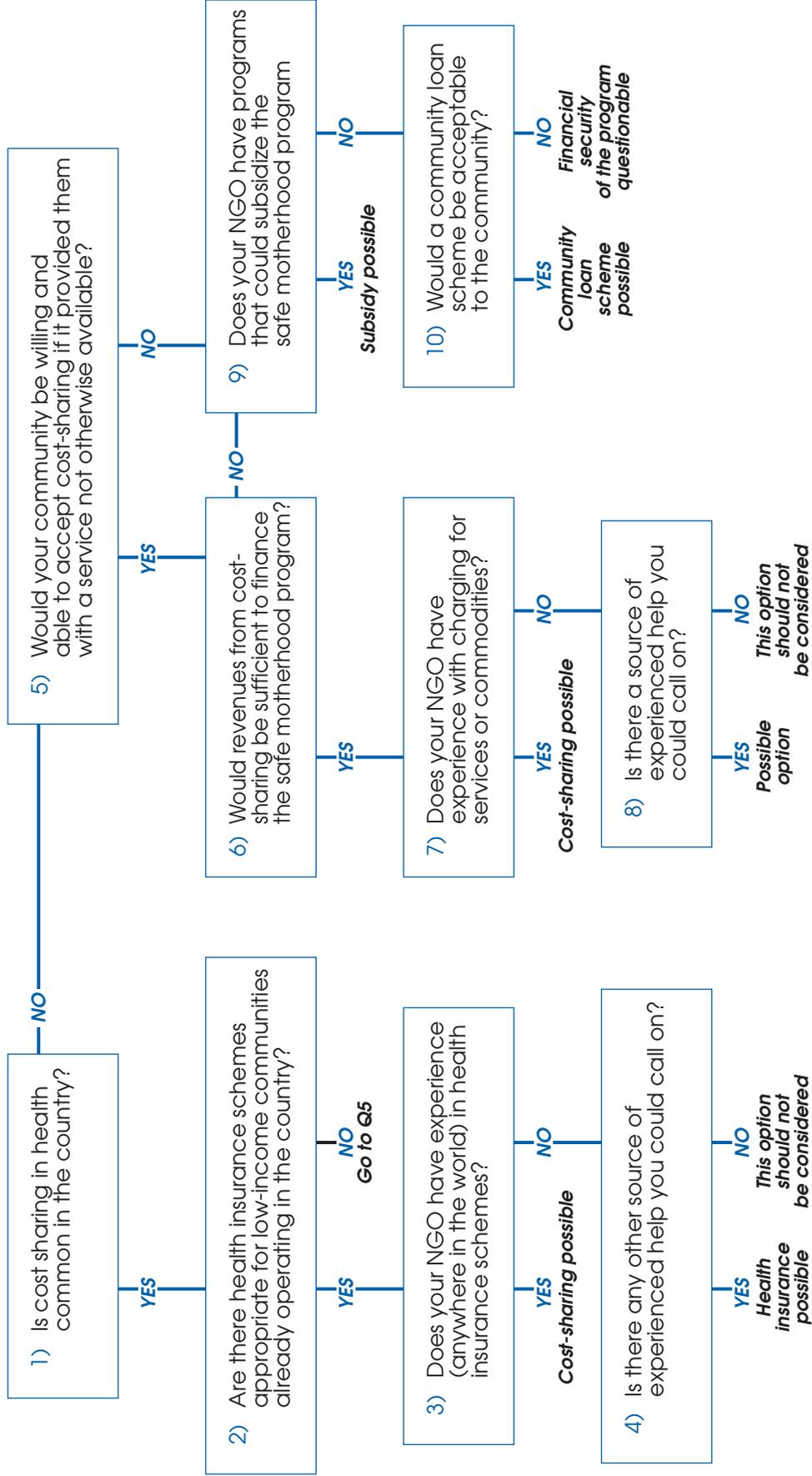
Given the description of the steps that other organizations are taking to promote the financial sustainability of their programs and the review of some of the contextual factors that should influence your decision on what you can do for your program, the decision tree on the following page asks you to answer a series of questions that should help you to identify possible options. This decision tree does not intend to suggest that only one option might be appropriate for your NGO, but is intended to help you to explore all options to determine which one/s might be feasible for your NGO to pursue.

Worksheet 6 can be used to record your answers to the decision tree questions.





Decision-Tree for Determining Financial Sustainability Options for your Program



Assessing Cost-Effectiveness

Cost-effectiveness means that a particular intervention (or collection of interventions) is achieving the desired result at a level of expense that is not more than the cost of other interventions that achieve the same result.

Cost-effectiveness is therefore a *relative* measure, meaning that it can only be assessed when at least two alternatives are compared against each other. This means that for an NGO to assess the cost-effectiveness of its safe motherhood interventions, it must either be able to compare the experiences of two different locations where the same interventions are being offered, or must be able to compare the results of its own program with that of another program implemented by a different organization.

An NGO will want to know whether its strategies are cost-effective; donors most certainly will wish to ensure that their resources are being used to achieve the results to which they committed their funds.

To assess cost-effectiveness, an NGO will need to:

- Assign costs to the service to be assessed.
- Select a quantifiable indicator as a measure of the program's results.
- Calculate the cost per indicator by dividing the total costs of the service by the value of the indicator.

The indicators selected for a cost-effectiveness analysis will, of course, depend on the objectives of the safe motherhood program and the indicators selected as part of the monitoring and evaluation plan.



Some examples of quantifiable indicators that might be used for a cost-effectiveness analysis for a community-based safe motherhood program include:

Indicator	Cost-Effectiveness Analysis
Numbers trained	Cost per individual trained
Couple Years of Protection (CYP)	Cost per CYP achieved
% of pregnant women attending antenatal clinics	Cost per additional woman (over a baseline) presenting for antenatal care
Proportion of deliveries attended by a trained TBA or midwife	Cost per additional woman (over a baseline number) delivering with the help of a trained TBA or midwife
Number of facility-based deliveries	Cost per additional woman (over a baseline number) delivering at a health facility
Number of women who reach a health facility with an obstetric complication	Cost per woman who reaches health facility with an obstetric complication

Where the results of a program are shown to be more expensive (less cost-effective) in comparison with the same results achieved by another program, then the program managers should examine how they could lower the costs of implementation. Possible strategies to consider might include changing the staffing structure of the program (e.g., sharing staff, and increased use of volunteers), reducing the cost of drugs and supplies through bulk purchase either by the NGO alone or through combining purchase with another organization, and seeking more efficient use of transportation through sharing with another program or changing transport schedules.

It is also important to bear in mind that, while a particular service offered to a particular community may appear to be more expensive (less cost-effective) in comparison to the same service offered to other groups or in a different part of the country, there may be other factors that need to be taken into account. For example, costs may be higher due to difficult terrain or due to cultural or traditional constraints. Yet the group being served may not have access to any other source of service.

It can be seen that assessing cost-effectiveness is rarely simple. An NGO interested in conducting an assessment might wish to contact other agencies (such as the Safe Motherhood Program in the MOH or an international NGO working in the field of safe motherhood) that might be willing to offer some support or assistance.

Community Partnerships for Safer Motherhood

Key Questions

1. How would you vote if you were a member of the WELS Board and why?

Promoting Financial Sustainability

As she arrives for the annual meeting of the WELS Board, Sarama meets Naramaya at the entrance. Sarama tells Naramaya that she has prepared her presentation on the resources that have been devoted to the Mothers First program and asks whether Naramaya has brought details of the childbirth emergency fund that has been successfully established in communities in the north of the country. Naramaya confirms that she has all the information and has even done some calculations that might help the Board's discussions on what should be done in the future.

As the Board reaches the agenda item on the Mothers First program, Sarama presents her analysis of the options available for WELS' future involvement. The chairwoman thanks Sarama for her work and states that she agrees that WELS should continue its involvement in the Mothers First program. However, she also says that there are competing demands for use of WELS' social welfare fund and that the Board believes it will be necessary to reduce its level of support for Mothers First. She asks members for their views on how this might be achieved without damaging WELS's reputation with its partners or the program itself.

At this point, Naramaya states that she has some ideas that might help the Board. She describes a scheme that has been successfully piloted in one of the northern districts. The Childbirth Emergency Fund (CEF) is a community-based insurance program that enables those who have paid a membership fee to have the costs of emergency obstetric services and related drugs paid promptly by the Fund. Members then have one year in which to repay the loan with interest. Naramaya tells the Board that this scheme has proved popular with both communities and the district health services: families are assured that their women can have access to necessary services without the immediate worry of how to meet the cost; and the district is assured of prompt payment. Naramaya adds that she believes if such a scheme were implemented in the Mothers First communities, it could generate additional capital through membership fees and interest payments. This would enable WELS to reduce its investment while expanding women's access to emergency services.

She presents the Board with a preliminary analysis of the feasibility of setting up a CEF locally.

continued next page

Community Partnerships for Safer Motherhood *(continued)*

Potential Membership year 1	
50% of pregnant women	350
Expected obstetric complications/year	52
Maximum Cost of one Obstetric Emergency	
Hospital registration fees	Rs.200
Drugs	Rs.500
Transportation	Rs.400
Sub-Total	Rs.1,100
Fund Capitalization	
Total cost of 52 projected emergencies	Rs. 57,200
Sources of Fund Capital	
Membership fees for 350 persons @ Rs.100	Rs.35,000
Projected interest earnings	Rs. 5,655
WELS contribution	Rs.17,000
Sub-Total	Rs.57,665

Sarama is excited and reports that this would overcome one of the problems currently facing use of the transport loan scheme, where some people are unable to pay the hospital fees immediately as required and therefore do not take advantage of a transport loan.

The chairwoman moves that the Board vote on whether WELS should endorse the establishment of a CEF and continue to support the Mothers First program by allowing Sarama to continue her role as coordinator.



6: Determining the Best Financial Sustainability Option



This worksheet is intended to allow you to record your answers to the questions posed in Decision Tree given in Step 6 of the Handbook.

Question	Your Answer	Comments/Notes
1) Is cost-sharing in health common in the country?		
2) Are there health insurance schemes appropriate for low income communities already operating in the country?		
3) Does your NGO have experience in health insurance schemes?		
4) Is there any other source of experienced help you could call on?		
5) Would your community be willing and able to accept cost-sharing?		
6) Would revenues from cost-sharing be sufficient to finance the SM program?		
7) Does your NGO have experience with charging for services or commodities?		
8) Is there a source of experienced help you could call on?		
9) Does your NGO have programs that could subsidize the SM program?		
10) Would a community loan scheme be acceptable to the community?		

Annex 1 • Consequences and Actions of Obstetric Complications²⁵

Obstetric Complications	Danger Signs	Estimated Time Interval Before Mortality	Minimum Services Required at Referral Sites for Basic and Comprehensive Obstetric Care
Hemorrhage prior to delivery → during or after delivery:	slight to severe bleeding usually in last 4 months placenta undelivered after 30 minutes continued or severe bleeding after placenta is delivered	12 hours 2 hours	Comprehensive essential obstetric care (CEOC) services which includes the ability to perform blood transfusions and manually remove placenta
Sepsis	fever, headaches, pain in lower abdomen, foul-smelling discharge, vomiting or diarrhea	6 days	Basic essential obstetric care (BEOC) services including the ability to administer parenteral (injectable or intravenously) antibiotics)
Unsafe Abortion	fever or chills, pain in abdomen, cramping or backache, bleeding from the vagina can be heavy, foul-smelling discharge from vagina, over 6-week delay in restarting period	variable depending on condition	BEOC services including the ability to administer antibiotics intravenously or by injection, manually remove retained products (manual vacuum aspiration)
Hypertension/prior to delivery → pre- eclampsia eclampsia	swelling of feet, ankles, hand, face severe headaches, blurred vision, spots before eyes, vomiting, convulsions, loss of consciousness	2 days	BEOC services including the ability to administer anticonvulsants for pre-eclampsia and eclampsia by means of an intravenous infusion (drip) or injection
Obstructed Labor	in labor for 12 hours or more, baby appearing malpresented during delivery, e.g., breech	up to 3 days	CEOC services including the ability to perform surgery (caesarean section)





Annex 2 • Indirect Causes of Maternal Morbidity/Mortality

Anemia

Anemia (low blood hemoglobin concentration) affects approximately 60-70% of pregnant women in developing countries. About 90% of all anemia is due to iron deficiency, the most common form of malnutrition affecting over 500 million women worldwide. Folic acid deficiency is another nutritional cause of anemia and it often appears associated with iron deficiency. Women's iron requirements are higher in early adolescence and pregnancy. In early adolescence, more iron is needed because girls experience both a growth spurt and the onset of menses. In pregnancy, iron requirements increase significantly as a result of tissue synthesis in the mother, the placenta, and the fetus and blood loss at delivery. The consequences of anemia in pregnancy are staggering both for the mother and her infant. Anemia can lead to heart failure or circulatory shock at the time of labor and delivery, death from blood loss during delivery, and a greater susceptibility to post delivery infections. Anemic women transfer less iron to their fetuses. Their infants are at an increased risk of low birth-weight and iron-depletion in early infancy, increasing their likelihood of death. Pregnant women should receive iron and folic acid supplements daily, starting as early as possible but preferably by the fourth month of pregnancy and continuing for 24 weeks. If supplementation is initiated late in pregnancy, it should continue into the postpartum period.

Malaria

Malaria kills more people than any other communicable disease except tuberculosis. In many developing countries, particularly in Africa, malaria takes an enormous toll in lives, medical costs, and days of labor lost. Worldwide prevalence of the disease is estimated at 300-500 million clinical cases each year. More than 90% of all malaria cases are in sub-Saharan Africa. It results in over one million deaths each year, mostly among young children with poor access to health services. Other high-risk groups are women during pregnancy, and non-immune travelers, refugees, displaced persons and laborers entering endemic areas.

Malaria is transmitted by Anopheline mosquitoes. Symptoms include fever, shivering, pain in the joints, headache, repeated vomiting, generalized convulsions and coma. If not treated, the disease, particularly that caused by the mosquito-borne parasite, *Plasmodium falciparum*, progresses to severe malaria which is associated with death. However, severe anemia (exacerbated by malaria) is often the attributable cause of death in areas with intense malaria transmission.



More than any other disease, malaria hits the poor. Malaria endemic countries are some of the world's poorest. Malaria is particularly dangerous during pregnancy. It causes severe anemia, abortion, stillbirth, premature birth and low birth weight. It is a major factor contributing to maternal deaths in malaria endemic regions. Pregnant women who have malaria and are HIV-positive are more likely to pass on their HIV status to their unborn child. Malaria is one of the five major causes of under-five child mortality. Measures that protect against infection are protective clothing, repellents, bednets, insecticides and environmental management to control transmission. Measures which protect against disease but not against infection include prophylactic drugs. Disease management through early diagnosis and prompt treatment is fundamental to malaria control.²⁶

Hookworm

Parasitic diseases, such as hookworm, are closely related to the lack of sanitation (unavailability of potable water, inadequate disposal of human waste, lack of latrines) or the absence of personal hygiene. They are also closely linked to warm and humid climates, and are, therefore, considered tropical diseases. Approximately one billion people are infected with hookworm. The infection is particularly dangerous to pregnant women as the iron deficiency caused by blood loss can cause the most severe type of anemia. Worldwide, an estimated 51% of pregnant women suffer from anemia - almost twice as many as non-pregnant women. In severe anemia cases, the risk of perinatal maternal and child death increases up to 500-fold. Anemia, due to maternal iron deficiency, affects the fetus by causing retarded intrauterine growth and by reducing fetal ability to absorb iron provided by the mother.

Hookworm infections often begin in childhood; the worm enters the body through the skin, multiplies or reproduces. Their preferred habitat is the jejunum in the intestines, where they attach to the mucous membrane to feed, and secrete an anticoagulant causing bleeding. Little attention has been given to the treatment of pregnant women because of unavailability of safe antiparasitic drugs and fear of teratogenesis. However, there are new treatments, and antihelminthic drugs may be administered in schools and organized women's groups in communities. During pregnancy antihelminthic treatment can improve maternal, fetal and infant health. Treatment given every four months has been shown to interrupt the transmission cycle of the parasite and help to improve the iron status of all women. Treatment should be linked to preventive strategies, such as promoting the use of shoes; introduction of potable water; and education and treatment of the population at large, especially the school-age population.^{27 28}



Sexually Transmitted Infections

STIs are a major concern for pregnant women and women of reproductive age. Every year over 333 million people are infected with a curable STI. Trichomoniasis is the most prevalent STI and accounts for 167.2 million cases each year. Chlamydia, gonorrhea and syphilis are other prevalent STIs. Nearly one million new STIs are contracted each day.

Women are disproportionately affected by STIs, especially in the developing world. STIs lead to serious health problems including pelvic inflammatory disease (PID), ectopic pregnancies, early deliveries, pregnancy wasting, infertility and even death. Infants may be born early and infected with congenital syphilis, conjunctivitis, gonococcal or chlamydia eye infections, and systemic infections.

STI symptoms are often vague and go undetected until severe complications occur. STIs carry enormous social and economic consequences for individuals, families, communities and nations. Where possible, it is important to screen pregnant women for the most prevalent STIs, i.e. trichomoniasis, chlamydia, gonorrhea, and syphilis. Health programs should provide clients with culturally acceptable sex education and promote responsible sexual behaviors.

Hepatitis B

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). Over 2 billion people have been infected and more than 350 million of them are chronic carriers (i.e. able to pass on the infection). Many people are asymptomatic when infected, while others may develop abdominal pain, flu-like symptoms including fatigue, nausea, vomiting, fever, chills, dark urine and jaundice (yellowing of the eyes and skin). Persons with Hepatitis B can become chronic carriers of the virus and many years later develop cirrhosis of the liver or liver cancer.

A vaccine is available to prevent hepatitis B infection and to prevent the chronic carrier stage from developing in 95% of cases. Current recommendations include vaccinating all infants and those adults who are at risk of exposure, especially health care workers.

Many people in developing countries are infected during childhood. HBV is transmitted by blood and other body fluids including semen, vaginal secretions and breastmilk. It is most often transmitted by:

- Sexual contact with an infected person.
- Sharing needles or use of unsterilized needles.



- Using contaminated razors or tattoo needles.
- Perinatally from mother to fetus.
- Occupationally through exposure to contaminated blood or other fluids.

In addition, cases have been documented in children who live with hepatitis B carriers, though no known contact with contaminated fluids occurred. It may be that the children were infected through scrapes or cuts in the skin or contact with mucous membranes. HBV is not spread through food and water like other hepatitis viruses.

Pregnant women can transmit HBV to their fetuses. It is believed that transmission occurs during delivery. If the infected infant is not vaccinated shortly after delivery, s/he is at high risk of developing serious liver complications. The infected infant should receive the hepatitis B vaccine and HBV immune globulin immediately and two subsequent doses of the vaccine during follow up visits. Women who are suffering from advanced cases of hepatitis B are at increased risk of developing pregnancy complications.

Getting vaccinated with the hepatitis B vaccine is the best way to prevent infection. Other ways to decrease one's risk of infection are to use condoms during sex, limit the number of sexual partners, avoid sharing needles and other drug paraphernalia, avoid skin piercing and tattoos and for all health care practitioners, practice standard precautions.^{29 30}



Annex 3 • Reproductive Health Reference Rates and Ratios

These statistics are meant for non-RH specialists to provide estimates of conditions they might expect to see and begin to plan to address³¹.

Abortion	15%	of all pregnancies may spontaneously abort before 20 weeks gestation
	90%	of these will occur during the first 3 months/12 weeks
	15- 20%	of all spontaneous abortions will have complications requiring medical care
Hypertensive disorder of pregnancy (HDP) or pre-eclampsia	5%	of all pregnancies will develop HDP
	5-10%	of all first pregnancies will develop HDP
Labor and delivery complications	15%	of all pregnancies will require some type of intervention
	3-7%	will require a caesarean section
	10%	of deliveries will experience a hemorrhage within 24 hours of delivery
	1-1.0%	of deliveries will experience a hemorrhage 24 hours after delivery





Annex 4 • Overview of Focus Group Discussions and Sample Guide

Focus Group Discussions³²

Purpose of Focus Group Discussions

- To gather information on the community's perception about the problems, causes and solutions to community problems.

Description

- A small group discussion, facilitated by a trained leader
- Typically lasts between one and two hours.
- Participants are selected on the basis of commonality, i.e. equal status, same sex, similar age group, to enable sharing of ideas

Pre-Discussion Preparation

- Develop and pre-test topic checklists for different target groups
- Translate into local language and do not use technical terms.
- Pretest the questions for clarity and length.
- Questions should be adapted for different target groups: older women, husbands, adolescents, TBAs, religious leaders, community leaders, etc.
- Train facilitators on how to listen, and encourage people
- Make logistical arrangements: i.e. contact local leaders to inform them and ask permission place, time,

Facilitator Responsibilities

- Thank participants and introduce yourself.
- Explain purpose and how information will be used.
- Describe what a focus group is and how long it will take; explain any equipment.



- Outline rules: all should be able to express opinion; no right or wrong answers, etc.
- Tell participants all is confidential.
- Guide discussion; do not allow one person's perception to dominate
- Be flexible but assume control when the focus is shifting or not helpful.

Note-Taker Responsibilities

- If group allows, use a tape recorder for gathering most information
- Record responses and expressions
- Note background characteristics: sex, age, marital status, residence, religion and ethnicity

The following example provides guidance on how to conduct a FGD for obtaining information on obstetric complications. If you are interested in gathering information on other safe motherhood topics, relevant questions and probes must be developed.

Community Focus Group Discussion Guide³³

Purpose:

To identify barriers to prompt and effective treatment of obstetric complications in order to develop appropriate strategies to address these problems.

Objectives

To obtain information on community's understanding of obstetric complications

To explore the factors affecting the decision-making process concerning obstetric complications

To obtain community input concerning potential strategies for the improving the utilization of emergency obstetric care



Discussion Topics:

Recognizing Obstetric Complications

What are some of the things that can go wrong when a woman gives birth?

Probe: Are these problems dangerous to the woman?

How does one know when the problem has become serious? (repeat for each complication)

Obtaining Care for Obstetric Complications

What can be done if the woman experiences one of these problems?

Probe: What would be the best thing to do if a woman experiences one of these problems?

Who can help her? (in the community?)

Where would she be taken first?

What are the problems involved in taking her to seek care?

Probe: How would she be transported?

Where would she get the money?

What have you heard about this place (where woman is taken for care)?

Probe: What do people say about the staff at this place?

Is the place equipped to handle emergencies?

What are some of the difficulties that might be experienced at the place where she seeks care?

What are the costs involved in seeking care?

Probe: How would the family obtain the money for this?

What would be done if they cannot get the money?

Decision-Making Concerning Obstetric Care

Who makes the decision to seek help for a woman if she experiences a problem in child birth?

Probe: Alternative decision-makers (e.g., if husband is not at home?)

Who is consulted about such a decision?

What considerations are taken into account in making the decision? (e.g., financial, distance)



Suggestions for Addressing Barriers to Care

(Moderator summarizes some of the problems the community has identified)

You have mentioned that (e.g., transport, money, supply shortages, etc.) is a problem when a woman needs emergency obstetric care. What are some of the ways in which this problem could be addressed?

Probe: What could be done here at the community
What could the government do?

Who in the community should actively work to do something about addressing these problems?



Annex 5 • Counseling Topics for Safe Motherhood Programs

This annex contains important points to cover when counseling pregnant women on the following topics:

- Sexually Transmitted Infections (STIs) and HIV during pregnancy
 - Infant feeding practices, particularly in communities where HIV is prevalent
 - Maternal nutrition and vitamin supplements
 - Unsafe abortion
-

STIs/HIV During Pregnancy

It is important to protect pregnant women and fetuses from STIs and HIV. Pregnant clients should understand that standard safer sex practices are applicable during pregnancy. These include:

- Abstaining from sexual intercourse (safest option);
- Consistently using latex condoms during sex;
- Only engaging in sexual practices with one person who does not have HIV or an STI.

Many STIs and HIV can be transmitted to the fetus from an infected mother. HIV transmission from a pregnant woman to her fetus is more likely if the mother is infected during pregnancy (or while breastfeeding), has AIDS, has an STI or has Vitamin A deficiency.

Early detection helps prevent serious complications. Pregnant women should be aware of the signs and symptoms of common STIs and that many women experience no symptoms. If a pregnant woman has any of the signs listed below and/or suspects that she has an STI, she should seek medical care immediately. Once an STI is diagnosed, prompt treatment should follow for her and her partner. If your NGO does not treat STIs, the client should be referred to a nearby clinic which does. If possible, partners should also be tested and treated if positive. Both partners should be retested following treatment.



Below is some important information to share with clients:

STI Signs in Women

- Unusual vaginal discharge
- Foul-smelling discharge
- Pain in the pelvic or abdominal area
- Pain or itching during urination, difficulty urinating
- Painful or itchy genitals
- Sores, bumps or blisters in the genital area or around the mouth, may be painful or not painful
- Pain when having sex
- Fever, chills and aches - flu-like symptoms
- Often no signs or symptoms

If an STI is left untreated there can be serious consequences for the infected woman and her fetus. Some of these consequences include:

Consequences for untreated woman	Consequences for fetus
<ul style="list-style-type: none">• death (HIV or syphilis)• damage to reproductive organs• sterility• heart problems• blindness• arthritis• brain damage	<ul style="list-style-type: none">• general infection• conjunctivitis• meningitis• pneumonia• premature delivery• death (HIV or syphilis)• low birthweight• hepatitis• cirrhosis of the liver

The most common STIs can be cured with antibiotics that are safe to use during pregnancy.

Infant Feeding Practices (particularly in communities where HIV is prevalent)

The first objective in preventing transmission of HIV from a mother to her child is preventing the initial infection through information, safer sex promotion, early detection of STIs, and safe and hygienic medical practices. Once a pregnant woman is infected, risk of transmitting the virus to her child can be reduced by antiretroviral therapy and replacement feeding (i.e. artificial formula).

HIV is transmitted through breastfeeding to approximately 14% of infants born to HIV infected women. If a mother becomes infected with HIV or has AIDS while breastfeeding, the chances of the child becoming infected increase.

HIV positive mothers should be told about the risk of breastfeeding. If they choose to use breastfeeding substitutes they should be helped to find the healthiest and most hygienically prepared alternatives. The risk of illness due to unsanitary water sources, unsafe formula preparation or malnutrition should not be greater than the risk of HIV transmission.

Specific counseling points include:

- All infant feeding options and their risks (e.g., commercial formula, homemade formula, animal milk, wet nurses);
- Whether the mother/family have resources for adequate and hygienic replacement feeding;
- Whether buying replacement feeding for the infant will affect the health and nutrition of other family members;
- Family and community support for replacement feeding;
- The mother's and family's past experiences with replacement feeding;
- Setting up follow-up antenatal visits to monitor infant's nutritional status and
- Other factors, including social or cultural norms, and fear of violence or abandonment due to feeding method selection.³⁴



The following framework was developed by the LINKAGES Project for health workers³⁵.

Situation	Health Worker Guidelines
Confidential testing not available or not used (mother's HIV status not known)	<ul style="list-style-type: none"> • promote availability and use of confidential testing • promote breastfeeding as safer than artificial feeding • teach mother how to avoid exposure to HIV
Mother HIV+ Breastmilk substitutes are available, affordable, and safe Adequate health care available and affordable	<ul style="list-style-type: none"> • treat mother with AZT or ZDV if possible • promote artificial feeding as safer than breastfeeding • help mother choose and provide safest available alternative feeding method • teach mother how to avoid transmission of HIV
Mother HIV+ Breastmilk substitutes not available, not affordable, or not safe	<ul style="list-style-type: none"> • promote breastfeeding as safer than artificial feeding • teach mother how to avoid transmission to HIV
Mother HIV-	<ul style="list-style-type: none"> • promote breastfeeding as safest infant feeding method • teach mother how to avoid exposure to HIV



Maternal Nutrition and Vitamin Supplements

Nutrition and micronutrients are key factors in women's health. It is important that women consume adequate levels of micronutrients through food intake, food fortification or supplementation. Micronutrient intake impacts women's overall health status, pregnancy outcomes, fetal development and breast-fed children's health and nutritional status.

General recommendations to improve women's nutritional status and to maintain acceptable levels of micronutrients include:

- Diversify food intake;
- Increase daily consumption of fruits and vegetables;
- Eat animal products where possible and acceptable;
- Use fortified foods such as sugar with Vitamin A and iodized salt;
- Adolescent girls should increase food intake to meet growth spurt needs;
- During pregnancy, increase food intake and take iron and folate tablets;
- While breastfeeding, try to eat the equivalent of an extra meal each day
- In areas with prevalent vitamin A deficiency, take a high-dose vitamin A capsule (200,000 IU) as soon as possible after delivery, but no later than 8 weeks postpartum.³⁶



The following chart can be used to counsel clients on important nutrients and how to include them in their diet:

Nutrients	Foods high in this nutrient	Foods often fortified with this nutrient ³⁷
Vitamin A	liver, whole milk, butter, egg yolks, dark green, yellow and orange fruits and vegetables	sugar, corn flour, MSG (experimental), margarine, oil (experimental), ghee, noodles, milk
Folic Acid	meats, dairy products, eggs	wheat flour
Iron	liver, other organ meats, blackstrap molasses, red meat, egg yolks, leafy greens, legumes	corn flour, wheat flour, noodles
Calcium	milk, leafy greens, ground sesame seeds	
Zinc	beef, chicken liver	
Iodine	saltwater seafood, salt	salt
Vitamin E	vegetable oils, egg yolks, legumes, corn	oil



Unsafe Abortion

Complications from unsafe abortions lead to tens of thousands of maternal deaths each year. Many of these deaths can be prevented by counseling women before they seek an abortion and ensuring they have the knowledge to recognize complications and seek prompt treatment if complications occur.

Unsafe abortion complications include incomplete abortion, sepsis, hemorrhage and intra-abdominal injury. Each untreated complication can lead to death, serious disability, and complications in future pregnancies. The chart below lists the most common complications with their related symptoms.

Complication	Signs and Symptoms
Incomplete abortion	pelvic pain cramps backache persistent bleeding soft, enlarged uterus
Sepsis/Infection	Initial infection: fever chills four-smelling vaginal discharge If infection spreads to the abdominal cavity: high fever difficulty breathing low blood pressure
Hemorrhage	heavy vaginal bleeding signs of shock including: low blood pressure fast heart beat edema difficulty breathing restlessness
Intra-abdominal injury (internal hemorrhage)	possible vaginal bleeding signs of shock as above





Annex 6: Guidance for Rapid Community Surveys³⁸

Many managers have no way of determining what the real health needs of their target population are. What do people know about antenatal care? What do they do about pregnancy danger signs? In addition, they have no way of assessing the effects that their program activities are having on those needs: What have mothers learned about danger signs? Are they using modern family planning contraceptive? What improvements have been made in delivery hygienic conditions? To properly plan strategies and monitor their effects, data about the present health status and knowledge level of the target population is essential.

Rapid community surveys have been developed as an economic and efficient substitute for generating quantitative data on a specific focus. They are designed to help managers collect population-based information on health status, behavior, and knowledge. The typical survey can be carried out in two to three weeks, from design to final report. It involves 200-300 household interviews, drawn from 30 clusters of seven to ten respondents each. The interview schedule is short (20-30 items), and the questions are phrased in “yes”/“no” terms to permit statistical tests of significance. The surveys are often pre-coded so that the data can be entered into a local computer and immediately analyzed. The data can also be manually tabulated

Limitations

- Questions must be limited in number and scope to yes/no format
- Results are quantitative not analytical
- Results are not comparative among groups. To see differences among population groups, separate surveys must be done for each group.
- Interviewers can be biased, for example limiting interviews to those logistically simpler to access.

Planning steps:

- State the objectives of your rapid survey.
- Identify what will you need the quantitative data for
- Determine how many respondents will you need to interview to make the survey statistically significant



- Decide on a sampling technique: questionnaire or cluster
- Ensure the survey is appropriate for your needs and the community
- Translate the survey into the languages in which it will be administered
- Pre-test the survey to ensure that the questions work and the responses are appropriate.
- Discuss the survey with the community and obtain permission to implement it
- Select and train interviewers/supervisors
- Set field rules for implementation of the survey
- Decide how the information will be used and distributed
- Make a report outline
- Draw a list of information to collect to ensure that you are asking necessary questions only

Implementing Steps

- Ensure interviewers are following ground rules about interviewing techniques and respondent selection
- Ensure adequate supervision
- Check each survey for completeness and accuracy
- Check that you enough time, staff and resources to complete the survey. Specify the geographic scope of the survey. Will it cover the entire catchment area or a part of it?

Sampling Technique

Decide between a questionnaire or a *cluster register*. Questionnaires usually provide more information, including instructions for the interviewer, the exact phrasing of each question, and pre-coded responses. You will need one questionnaire for each of the 210 respondents. That is, a minimum of 210 pages, 420 if it is a two-page questionnaire. Cluster registers allow the interviewer to record the responses of all seven or eight respondents from one cluster on the same page. This means you will need only 30 pages, one for each group.



Determine the size of the clusters

Although most people think of clusters as natural groupings of people (villages, census tracts, urban blocks), clusters have a different meaning in sampling. In cluster sampling you divide your total survey population into 30 equal groups. Each of those groups will be a cluster. Then you will identify seven respondents in each of those clusters.

Divide the total survey population by 30. For example, if your catchment area has 45,000 people, each cluster will include 1,500 people ($45,000/30 = 1,500$). It doesn't matter if there are fewer or more than 30 villages or districts, since you will define the clusters by dividing the total population into 30 groups of equal size. It also doesn't matter if the population is scattered over a large area. If you want your sample to represent all of your target population, then do not leave any *natural clusters* out. However, if it is not feasible to include some areas, then leave them out. BUT, remember, your sample will not represent those who are left out. If you limit your sample to people within one kilometer of a health center, for example, then that is all it represents.

If your population is very small, approximately 15,000 or less, you should make sure that there will be enough respondents in each cluster to interview. For example, WHO estimates that the target group for expanded Programme Immunization (EPI) surveys of children 12-23 months of age, averages 3% of the population in developing countries. Thus, you would need clusters of at least 250 people to find 7 children in this age group. To take account of those who are away, ineligible, etc., WHO suggests doubling that number to 500. For 30 clusters, therefore, you would need a minimum of 15,000 people to do a survey of that target group.

Selecting Households

The selection of the starting household must be made from within the cluster. The first house is selected at random; it would be best to select all seven households at random. This may be possible if there is an up-to-date household listing of the community. The listing must be up to date, otherwise the sample will be biased toward old-timers. Use currency notes or the random number table to select your seven households. To be safe, select ten, just in case there are refusals, ineligible respondents, or people have recently moved away. If there is no list but the community is small, it would be best to do a quick enumeration of all households and then select the sample at random. If that is not possible, the next best approach is the EPI method. The typical approach that WHO uses is to select the first household at random in each cluster, interview an eligible woman, if there is no one at home, and then go to the next nearest household to find the next respondent. Respondents who are not home are skipped, even if they are eligible. This search continues until the



required number of interviews, usually seven, has been completed. The starting household is usually selected by choosing some central point in the community, such as a market; spinning a bottle to select a direction at random; walking in that direction, counting, mapping, and numbering the households you pass as you walk from the central point to the edge of the community; and finally selecting one of these houses at random. This house is the starting point.

Given the distances that might have to be traveled to get to a cluster, the standard WHO/EPI procedure is to interview only those women who are at home. This can produce significant bias, particularly during planting and harvest periods when many able-bodied women are away in the fields. This problem can be largely avoided, by scheduling the survey during seasons when respondents are likely to be home, by visiting villages early in the morning or in the evening, by arranging the visit to coincide with a special event, or by making call-back visits. The trade-off is that this can increase the costs of and the time needed to conduct the survey.

Estimate the Data Collection Requirements

Pre-testing should give you an idea of the amount of time it will take to find a respondent, and complete an interview. With this information you can estimate the number of interviewers you will need and the number of days it will take to complete data collection. Usually you will want a two-person team to complete at least one cluster per day, seven or eight interviews. You will also need several supervisors, the number of which will depend on the number of interviewer teams you have and the distance the supervisors will need to travel between clusters. If the questionnaire is short, the respondents are easy to find, and distances between clusters are short, then a team should be able to complete two or three clusters each day.



Annex 7 • Indicators for Monitoring Safe Motherhood Programs

Use this comprehensive list of indicators as a guide for selecting the critical few indicators that reflect the major components of your program. It is important to select both quantitative indicator and to identify the data sources that will be used to monitor performance.

Illustrative Integration Indicators

Indicator	Source of Data	Comments
Number of services, by type, provided to clients at each visit	Service records and exit interviews	Helpful where safe motherhood has been introduced into a setting offering other health services.
Community response to integrated program	Community meetings	Important to analyze community need and acceptance of new service into NGO portfolio.

Illustrative BCC Indicators

Indicator	Source of Data	Comment
Percentage of the target population who recognize the signs of pregnancy complications and where to go for service	Survey data	Moves beyond imparting knowledge to ensure women have accurate information to take action. Should be coupled with indicator on improved usage of health facilities/trained birth attendants to see that message has been effectively communicated
Proportion of births to mothers less than 18	Village records, focus group discussions (FGDs)	Indicates that message for delaying adolescent births is effective for women and families
Proportion of marriages occurring before age 18	Village records, FGDs	Similar to preceding, indicates cultural acceptance of later marriage/child birth
Percentage of women attending antenatal clinics (or using nutritional supplements, receiving TT immunizations)	Clinic records, community survey	Linked to the specific intervention chosen, this indicator will measure progress toward objective



Illustrative Counseling Indicators

Indicator	Source of Data	Comments
<p>Percentage of pregnant women receiving counseling on developing a birth plan</p> <p>Percent who have birth plan</p>	<p>Clinic records, community survey</p> <p>Survey</p>	<p>A good indication of preparedness for delivery and complications</p>
<p>Percentage of pregnant women receiving counseling on STD prevention, recognition of symptoms and referral sites</p>	<p>Clinic records, community survey</p>	<p>A helpful measure to improve women's health</p>
<p>Percentage of pregnant women receiving counseling about complications from abortion and safe abortion sites</p>	<p>Clinic records, community survey</p>	<p>Should be coupled with information on number of abortions taking place.</p>
<p>Percentage of HIV+ pregnant women who receive counseling about the implications of breastfeeding for their newborn</p>	<p>Clinic records, community survey</p>	<p>Important in locations that have integrated HIV services and provide comprehensive counseling</p>
<p>Percentage of women receiving contraceptive counseling after an abortion</p>	<p>Clinic records, community survey</p>	<p>Helping to plan births is an important preventive measure toward pregnancy complications</p>
<p>Percentage of women who delivered who receive contraceptive counseling</p>	<p>Clinic records, community survey</p>	<p>The risk of complications increases each time a woman gives birth. This is an opportune time to have the women learn about contraceptives and a good example of integration of services.</p>



Illustrative Care Indicators

Indicator	Source of Data	Comments
Number of health sites with obstetric emergency facilities	Clinic Records, community survey	Only reflects availability of sites, does not indicate if services are being offered at site or used by women
Number of women with complications admitted to health center	Health center data	Availability of transport, recognition of danger signs and birth planning should increase usage of facilities
Number of pregnant women delivering with a clean birth kit	Clinic records, community survey	This reflects usage of the kit. Other indicators could be used to measure number of sites selling kits and number of kits purchased to determine if marketing scheme is effective.
Number of pregnant women diagnosed and treated for anemia/STIs/hypertension	Clinic records, community survey	Choose only one intervention for each indicator.
Number of TBAs or birth attendants trained to provide obstetric first aid	Training records	This is a training indicator, if your organization chooses to implement training programs or arrange for them from another source.



Illustrative Access Indicators

Indicator	Source of Data	Comments
Number of vehicles available for transport	Community Survey, Transport vehicle Log	This should be coupled with the next indicator to provide a picture of availability and usage
Number of cases transported	Community survey	Proper counseling and availability of transport should lead to increased number of cases arriving at health center.
Time required to get to service delivery site	Vehicle log, clinic records, community interviews	In combination with the two previous indicators, a picture of easier and faster access should emerge. Another indicator would look at actual time between arrival and receiving treatment at the care site.
Number of emergency loans granted	Fund records, village leader interviews	If funds are needed and available, this indicator will generate information on usage of emergency funds. An additional indicator to assess effectiveness of the loan scheme is monitoring whether the loan is repaid and how quickly.
Percentage of women who can decide for themselves to seek care	FGDs, community survey	This is an important indicator of cultural barriers to care. It might point to a need for BCC strategies for family and community.
Percentage of women attending antenatal clinics	Clinic records, community survey	Good indicator of performance of education and preventative health campaign.



Illustrative Quality Indicators

Indicator	Source of Data	Comments
Percentage of women satisfied with the care received	Exit interviews, FGDs	Client satisfaction is key indicator for sustainability and quality. Should be continually reviewed.
Percentage of the target population who recognize the signs of pregnancy complications and where to go for service	Surveys of target population	Although many programs use indicators of knowledge of danger signs as indicators, knowing where to obtain services reflects program emphasis on what to do with that knowledge. This is a vital link to using services.
Percentage of women and their families with realistic birth plans	Community Records	This is especially useful with the above indicator as it requires families to have an operational plan to access a facility





Annex 8. The Performance Improvement Review Package

Introduction

As a greater number of NGOs and PVOs develop programs to provide services at the community level, they encounter new and challenging issues related to program quality, sustainability, management and community participation. The Performance Improvement Review Package, developed by Initiatives Inc. for the SEATS Project, is an internal review process that provides organizations that are integrating community-based programs with the tools and guidance needed to conduct quick, effective and self-directed program reviews, identify key problems inhibiting program success and develop action plans to address those problems. Tied to the six steps presented in the handbook *Integrating Reproductive Health into NGO Programs Volume I: Family Planning*, PIR was especially designed for community-based family planning programs, however, it can be adapted for use in other community-based programs, such as safe motherhood initiatives.

The PIR Conceptual Framework

Successful programs have strong management and organization; a consistent and complete supply system; are sustainable; deliver high quality service; enjoy support, participation and dedication from the community; and have strong measurable results. The PIR conceptual framework embodies all of these essential elements. In addition, the conceptual framework provides the foundation for the PIR review instruments and ensures that all factors contributing to program success are addressed.

PIR reviews the program elements defined below.

- Management and Organization refers to the capacity of an organization to provide the proper structure to effectively staff, finance, plan and implement an integrated family planning program.
- Supply System covers the information necessary to maintain effective commodity support: consistent stock and distribution, adequate storage and acceptable methods for calculating needs.
- Sustainability is a result of good partnerships, comprehensive plans, strong financial systems, community promotion and client satisfaction.
- Quality of Service is dependent upon proficiency in family planning counseling skills, technical competence, supervision, referral systems and client satisfaction.



- Community Commitment measures the community’s contact with NGO staff, its role in decision-making about the family planning project and its knowledge of family planning.
- Results addresses three critical quantitative factors in measuring program success: client follow-up, effective referral, and Couple Years of Protection (CYP).

The PIR Instruments

A set of eight data collection instruments makes up the information-gathering component of the Performance Improvement Review Package. Instruments cover the whole scope of an integrated project from internal management issues to client and community experience and opinions. In all, the instruments are designed to provide a broad “snapshot” of program performance at all levels. Included in the set of data collection instruments are:

Instrument 1:	Record Review	Initial Visit	Follow-up Visit
Instrument 2a:	Manager Interview	Initial Visit	Follow-up Visit
Instrument 2b:	Supervisor Interview	Initial Visit	Follow-up Visit
Instrument 3:	Community Interview	Initial Visit	Follow-up Visit
Instrument 4:	Service Provider Interview	Initial Visit	Follow-up Visit
Instrument 5:	Client Interview	One copy	
Instrument 6a:	CBD-New Client Observation	One copy	
Instrument 6b:	CBD-Continuing Client Observation	One copy	

The PIR Process

PIR steers organizations through a four-step self-assessment process that enables them to gather information from program staff and clients and to analyze and interpret this information in order to assess the strengths and weaknesses of the integrated program. Data collection, analysis and decision-making are carried out in a participatory fashion, involving partners in defining appropriate program improvement strategies. The monitoring and review exercise guided by PIR assists organizations currently implementing community-based integrated RH programs to systematically monitor management and implementation, diagnose problems, and initiate changes that improve the quality and sustainability of their programs. Consistent monitoring and mapping of results with PIR enables organizations to chart program progress over time.

The four-step PIR approach to project monitoring includes:

Step 1: Planning. Preparation includes scheduling the monitoring exercise with CBDs, partners, and the community; creating a budget; assembling the monitoring team; and conducting the monitoring team planning meeting. Typically, the program manager or supervisor organizes the review. During this phase, the monitoring team gathers to discuss the schedule, assignments and logistics of the data collection exercise, and to review, adapt and translate the instruments as needed.

Step 2: Data Collection. The team uses the set of PIR instruments to guide interviews, observations and record reviews. The interview instruments assist the team to assess basic knowledge and obtain the views of managers, providers and clients. Guided observations measure performance against expectations, completing the picture of service delivery by providing concrete evidence of competence and quality of services. The record review adds valuable information about structure, financial management and sustainability, and about how management, supervisors and CBDs use and share information.

Step 3: Data Analysis. The team gathers to review data. Data analysis includes a process of translating the qualitative data in each instrument section to number ratings. In PIR this translation is called scoring. In addition to scoring instruments, the team analyses data by compiling quantitative results, discussing problems, and preparing a graphic presentation of program performance.

Step 4: Preparing a Performance Improvement Plan. Results are reviewed during a summary meeting that brings together the data collection team, CBDs, community representatives and other partners to discuss the results of the monitoring review. Action plans for addressing problems and improving program quality are defined and assignments for specific actions determined. The summary meeting is also a forum for continuing education.



Abbreviated Comprehensive Review

The PIR package provides tools and guidance for a quick but detailed performance review. Some organizations may want to use PIR to guide less comprehensive, more focused or faster assessments. An abbreviated review follows steps 1 and 2 thoroughly and uses all the data collection instruments. In analysis, however, calculating results is optional, the abbreviated review focuses on identifying problems and skips the steps of quantifying and mapping results. Problems are then transferred to an action plan. (Note that the guidance for scoring provided in PIR may help organizations identify problems even if they are not assigning scores to the data).



Annex 9 • Projecting Resource Requirements

The following table can be used as a checklist by the NGO and its implementing partners to ensure, at the program planning stage, that all the resource requirements for program implementation have been identified. This checklist can be completed and then handed to those who are preparing the program budget. Items which may be provided, free of charge for use by the program, should also be referenced on the checklist, although a "0 cost" would be entered into the "Unit Cost" column.

Item	Required for/by	Quantity	Unit Cost	Source

This chart provides a framework for the elements of a program budget. It lists some of the resources that may be required, your NGO may need to amend or add to the list of items as appropriate for your program. Columns are provided for the quantity of each item, the unit cost (the cost of buying one item), and the source (if it is anticipated that the item can be obtained free of charge).



Annex 9. Projecting Resource Requirements (continued)

Item	Required for/by	Quantity	Unit Cost	Source
Salaries:				
Benefits: (specify)				
Transport allow's				
Per diem				
Training:				
trainer fees				
trainer per diem				
trainee travel				
trainee per diem				
training materials				
stationery				
Equipment: procurement				
maint.& repair				
rental				
Supplies: IEC materials				
stationery				
service delivery				
commodities				
record books/forms				
Communications: post				
telephone				
courier				



Annex 9. Projecting Resource Requirements (continued)

Item	Required for/by	Quantity	Unit Cost	Source
Meetings:				
refreshments				
travel				
stationery				
M & E:				
consultants				
travel				
per diem				
report production				
report duplication				
report dissemination				
Services:				
photocopying				
printing				
consultants				
accounting services				
Overhead:	Use the next column to identify which overhead costs should be apportioned into the safe motherhood budget			
office rental				
utilities (water, power)				
salaries				
communications				





GLOSSARY

Antenatal: The period from conception until the onset of labor, approximately 40 weeks.

Anthelmintic: A drug used in the treatment of hookworm infection.

Antipyretics: Drugs used to reduce fever.

Basic Essential Obstetric Care (BEOC) Facility: This facility is able to assist in vaginal delivery, remove retained products, manually remove the placenta and administer injectable antibiotics, oxytocics and anticonvulsants.

Breech: presentation or malpresentation: condition in which the fetus is not lying with its head pointed downwards at the time of delivery, causing the feet or buttocks to come out first.

Cesarean Section: Removal of the baby and placenta through a surgical procedure in which the abdomen and womb are cut open.

Comprehensive Essential Obstetric Care (CEOC) Facility: This facility provides all the services of a BEOC and performs cesarean sections and gives blood transfusions.

Community maternities: A place where local women can come once labor has begun. They should be staffed by a trained TBA or midwife and have minimal supplies, such as ergometrine to stop bleeding and antibiotics in case of infection or prolonged rupture of the membranes.

Ectopic pregnancy: Implantation and development of a fertilized egg outside the uterus, generally in the fallopian tubes. This condition often ends in spontaneous abortion and causes severe bleeding or death.

Edema: A condition in which excess fluid is absorbed by body tissues causing swelling. It is often associated with pre-eclampsia.

Female Genital Cutting: A traditional practice in which all or part of the external reproductive organs of the female are removed.

Fetus/Fetal: The term for a baby in the womb from the 3rd month of pregnancy until birth.

Folic Acid: A Vitamin B complex needed for cell growth and reproduction.

Gestation: Pregnancy, period of carrying the baby in the womb between conception and birth



Helminths: worms, especially those considered pathogenic including tapeworms and roundworms.

Hemoglobin: A protein-iron compound in red blood cells that carries oxygen from the lungs to the cells and carbon dioxide from the cells to the lungs.

Hypertension: High blood pressure, it has various causes, such as heart disease, kidney disease and pre-eclampsia.

Labor: The process by which a baby is born.

Manual vacuum aspiration: a method of removing tissue from the uterus by suction for diagnostic purposes or to remove the elements of conception.

Maternal Mortality Rate: The rate reflects the maternal mortality ratio and the fertility rate; it is influenced by the likelihood of becoming pregnant and by the obstetric risk. The number of women who die while pregnant or during the first 42 days following delivery per 100,000 women of reproductive age in a given year for any cause related to or aggravated by pregnancy, but not from accidental or incidental causes.

$$\frac{\text{Number of Maternal Deaths in a Year}}{100,000 \text{ Women of Reproductive Age in the Population}}$$

Maternal Mortality Ratio: The ratio that measures the risk women face of dying once pregnant. The number of women who die during pregnancy or during the first 42 days after delivery per 100,000 live births in a given year from any cause related to or aggravated by pregnancy, but not from accidental or incidental causes.

$$\frac{\text{Number of Maternal Deaths in a Year}}{100,000 \text{ Live Births in a Year}}$$

Maternity Waiting Homes: A facility designed for pregnant women, with actual or potential complications, for the purpose of awaiting labor near a health facility.

Menses: Menstruation; monthly flow of bloody fluid from the uterus through the vagina.

Oxytocic drug: A drug that stimulates contractions of the uterus. It is used to both induce labor or to stop bleeding after delivery.

Parasitic: Any organism that survives by living off a host, such as a human, and damages the host in the process.



Parenteral: Drugs administered by injection or intravenous infusion (drip).

Pelvic inflammatory disease (PID): An infection of the reproductive organs that can result in infertility, often caused by a sexually transmitted disease.

Perinatal: a period of time pertaining to the time and process of giving birth or being born

Perineum: vaginal and rectal area

Placenta: A fetal organ inside the womb to which the fetus is attached and through which the fetus receives oxygen and nourishment.

Plasmodium falciparum: A type of parasite that causes malaria, borne by a mosquito.

Postpartum: After childbirth; the period from the delivery of the placenta through the first 42 days after delivery.

Proteinuria: the presence of albumin, a protein substance, in the urine, which is often associated with pre-eclampsia and eclampsia.

Puerperium: The period during following delivery when the womb returns to normal: normally six weeks after birth.

Retained placenta: A placenta that remains inside the womb after delivery. It must be removed by a trained health worker as soon as possible to avoid heavy bleeding.

Teratogenesis: Adverse action of drugs on the fetus, abnormalities can occur when certain drugs are taken by the mother.

Tetanus: An often fatal disease affecting a newborn which can be prevented by the mother receiving a tetanus toxoid immunization during pregnancy.

Uterine rupture: A tear in the uterus, the organ in which the baby develops.

Vaginal fistula: A hole that develops between the vagina and the rectum or bladder, often as a result of obstructed labor.



Annotated Resource List

Print

Arkutu, A. A. 1995, 2nd ed. *Healthy Women, Healthy Mothers: an Information Guide*. New York: Family Care International.

Offers essential information about women's reproductive health issues and problems. Written in non-technical language with dozens of illustrations and charts, the book covers everything from the reproductive system to antenatal care, to the complications of delivery, to menopause. It can be used by health workers for their own reference, as a counseling or teaching aid for providing health education or with *Getting the Message Out*, as the basis for preparing pamphlets, posters and flip charts.

Feuerstein, M. T. 1993. *Turning the tide. Safe Motherhood: A District Action Manual*. London: Macmillan.

A set of practical guidelines to use and adapt in the field for front-line planners, managers, and practitioners working at district levels in developing countries. Chapters cover what Safe Motherhood is, basic steps for mobilizing and planning for safe motherhood projects, placing women at the center of projects, the importance of district-level care, community level action, partnerships between levels of care, monitoring & evaluation and research.

Howard-Grabman L. 1993. *The Warmi Project: a Participatory Approach to Improve Maternal and Neonatal Health. An implementors manual*. Washington D.C.:MotherCare.

Uses the Auto-Diagnosis method as a means to empower women by identifying women's and newborns' health problems, through decision making to determine the community needs and plan ways to meet those needs. Based on experience with women's groups in rural Bolivia. Examples of NGO and community involvement.

International Journal of Gynecology and Obstetrics. June 1995. 48(Supplement). Reproductive health: The MotherCare experience.

A collection of articles covering the MotherCare experience. Sections include conceptual frameworks for those programming in the field of maternal and neonatal health and nutrition; an overview of the linkages between the magnitude and consequences of reproductive health problems for women and newborn infants; specific features for assessing country situations for the purpose of developing a strategy for programming in reproductive health; results from demonstration projects aimed at reducing maternal mortality; integrating project and policy formation.



International Journal of Gynecology and Obstetrics. November 1997, 59(Supplement No. 2). Prevention of Maternal Mortality Network.

A collection of articles and research-based studies describing the Prevention of Maternal Mortality (PMM) Network and its experience. Articles are grouped under the following topics: background; improving the quality of emergency obstetric care in hospitals; improving the quality of emergency obstetric care in health centers; examples of collaboration; improving related services; improving access to services and improving utilization of services.

Koblinsky, M., A. Tinker and P. Daly. 1994. Programming for Safe Motherhood: a guide to action. *Health Policy and Planning*; 9(3).

This paper reviews lessons learned in reducing maternal mortality from the experience of industrial countries and from demonstration projects in developing countries and proposes intervention strategies of policy dialogue, improved services and behavioral change.

Lyons, J. V. and J. A. Huddart. 1997, 2nd Ed. *Integrating Reproductive Health into NGO Programs. Volume 1: Family Planning*. Boston: Initiatives, Inc.

A handbook on integrating family planning programs in to already well-established NGOs that are interested in adding family planning to their portfolio of programs. The handbook can be used either for self-guided study and reference, or as the basis for a facilitated workshop for NGO participants. It is divided into six action steps which allow an NGO manager to assess whether and how to integrate family planning services, measure program results, identify staff requirements, develop a contraceptive supply system and manage finances for an integrated program.

Maine, D. M., A. Akalin, V. Ward and A. Kamara. 1997. *The Design and Evaluation of Maternal Mortality Programs*. New York: Center for Population and Family Health, School of Public Health, Columbia University and UNDP.

A technical document with a development aim. This manual provides guidance and tools for the design and evaluation of maternal mortality reduction programs. Its broader aim is to enhance the ability of people and institutions to identify key challenges and generate effective responses to them. Offers a way to think about project design and evaluation.

McGinn, T., D. Maine, J. McCarthy and A. Rosenfield. 1996. *Setting Priorities in International Reproductive Health Programs: a Practical Framework*. New York: Center for Population and Family Health, School of Public Health, Columbia University.

Developed in response the ICPD's Programme of Action, this framework identifies key factors that should influence the decision to implement an intervention. These key factors include: importance of the reproductive health problem; efficacy of potential interventions; program requirements and costs; capacity of health systems and cultural, policy and legal factors. A case-study of induced abortion-related morbidity and mortality is used as an example.



Rae Ross, S. 1998. *Promoting Quality Maternal and Newborn Care: a Reference Manual for Program Managers*. Atlanta: CARE.

A technical reference manual for those working with maternal and newborn care. Synthesizes the latest literature with lessons learned from field experience. Large reference list included. Chapters include why women and newborns die; pre-pregnancy factors; pregnancy-related factors; program design, monitoring and evaluation; interventions and best practices and lessons learned through country programs.

Starrs, A.M. and R. R. Rizutto. 1995. *Getting the message out: Designing an Information Campaign on Women's Health*. New York: Family Care International.

Offers step-by-step guidelines on how to design, implement, and evaluate an effective information campaign to improve women's health. Examples of messages and materials included. Covers seven stages of an information campaign with questions to monitor how well the campaign is going and whether changes need to be made.

Tinker, A. and M. Koblinsky. 1993. *Making Motherhood Safe*. World Bank Discussion Paper 202. Washington DC: World Bank.

Defines safe motherhood and what safe motherhood programs should include based on a country's level of health services. Describes roles for the private sector, NGOs and government organizations. Examines costs, monitoring and provides examples of field projects.

UNHCR. 1995. *Reproductive Health in Refugee Situations: an Inter-agency Field Manual*. Geneva: UNHCR.

A comprehensive guide describing the need for safe motherhood programs in refugee situations. Provides recommendations for basic programs, supplies, staffing, and planning. Also included checklists, indicators and needs assessment guidelines. Examines gender violence, STIs, family planning, abortion adolescents, IEC and legal issues as they relate to safe motherhood issues.



Videos

Family Care International
588 Broadway, Suite 503
New York NY 10012
sm10@familycareintl.org
website www.safemotherhood.org

- 1) *Safe Motherhood Experiences: a Video Composite from Around the World.*
Highlights problems and solutions needed to save women, including basic rights to access to health care, education and information about Reproductive Health, technology that exists to reduce the problem and efforts being made to prioritize women's health.
- 2) *Safe Motherhood Africa...Starting Now 1991.*
- 3) *Safe Motherhood South Asia: We Can Get There from Here 1990*
- 4) *Madres y Mujeres: Logrando una Maternidad sin Riesgos (Spanish) 1992*
- 5) *Vital Allies: Making Motherhood Safe for the World's Women 1992*
The above videos integrate regional specifics into problems and solutions of maternal mortality.

Division of Publishing, Language and Library Services
WHO Headquarters
CH-1211 Geneva 27
Switzerland
Tel: 41 22 791 2476/2477
Fax: 41 22 791 4857
website: http://www.who.int/inf/video_dsa.html

- 1) *Why did Mrs X have to die?*
A video tracing the death of a woman from preventable causes. Available in English, French, Spanish and Arabic.
- 2) *Open the Gates to Life.* Available in English and French.
- 3) *Women's Right to Health.* English only.



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Jakarta 10012 Indonesia

Unacceptable risks-confronting maternal deaths in Indonesia.

22 minute film looks at safe motherhood from a variety of angles and attempts to explain why Indonesia's maternal mortality rate is too high.

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Website: www.jhuccp.org/mmc/vidshare/sublist.stm

Time to Care: Three Visits (Uganda) 1997.

Two 25-minute episodes in English. Mirembe's excitement at being pregnant for the first time turns to anxiety after witnessing her elder sister's death while delivering her fifth child. Mremebe is advised to go for antenatal checkups, but her husband, Kato, is not easily convinced that they are worth his hard earned money...until Mirembe develops a serious complication. VT-UGA-19

Aahat (The Approaching Sound) (Pakistan) 1991.

A 3-hour TV drama series in Urdu with English subtitles. The story of Rabia and Aamir, a young married couple who, because of Aamir's desire to produce a male heir, keep having children. Their dreams are shattered because they cannot provide for their large family, and Rabia's health pays the price for Aamir's obsession. VT-PAK-10, 11, 12 (Parts I, II, III)

Nijaat (Pakistan) 1993.

A 7-episode, 350-minute TV drama series. In Urdu. Multi-episode drama which revolves around three families: Zareena, a health worker, and her family; Sajida and Hazoor, who have so many children that Sajida has very poor health; and Mr. Assad, the new Area Coordinator, and his wife. The drama follows their hopes and frustrations, as they strive for a better future while trying not to sacrifice the past. The emphasis is on family planning and community health reforms. VT-PAK-17



Oh Ibu Dan Ayah, Selamat Pagi (Oh Good Morning, Father and Mother)

(Indonesia) A 74-minute drama in Indonesian with English subtitles. Kurnia refuses to marry Samsu, the man with whom she is in love, because of her fear of giving birth. Both her mother and her aunt died while giving birth, and these traumatic experiences cause nightmares and hysteria. With help from Sans and the mothers of the children she teaches, Kurnia's life gradually changes. A baby's cry becomes a sound of hope instead of loss. Eventually Kurnia overcomes her fears and looks forward to becoming a mother. VT-INO-47

Perkawinan Siti Zubaedah (Siti Zubaedah's Wedding) (Indonesia) 1997.

A 58- minute drama in Indonesian with English subtitles. At first Zubaedah's marriage goes well, but over time her husband, Kodjat, proves to be a difficult person; he becomes critical, jealous and unfaithful. The pregnant Zubaedah works hard to please Kodjat, toiling and performing heavy labor which almost costs her the pregnancy. In the end she gives birth to a health boy, and Kodjat must evaluate his behavior and the hardships his wife has had to endure. VT-INO-48

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Reaching Out to Men as Partners in Reproductive Health. 1997.

A 13-minute video discussing the role men play in reproductive health and how service programs can reach out to them. In English, Spanish and French; NTSC, PAL, SECAM. \$90



Websites

General

<http://www.acnm.org>
<http://www.cpmcnet.columbia.edu/dept/sph/popfam/pmm.html>
<http://www.familycareintl.org>
<http://www.initiativesinc.com>
<http://www.jsi.com/intl/mothercare/home.htm>
<http://www.jsi.com/intl/seats>
<http://www.linkagesproject.org>
<http://www.popcouncil.org>
<http://www.rho.org>
<http://www.safemotherhood.org>
<http://www.unicef.org>
<http://www.unfpa.org>
<http://www.who.org>

Health Information

<http://www.gyneweb.fr> (*French-language site with ObGyn articles*)
<http://www.ippf.org/pubs/medical/index.htm>
<http://www.ama-assn.org/special/womh/>
<http://www.bireme.br> (*similar to MEDLINE database with articles in English, Spanish, and Portuguese*)
<http://www.obgyn.net>
<http://latina.obgyn.net/> (*Spanish and Portuguese articles*)

Measuring Progress

<http://www.lshtm.ac.uk/eps/mceu/MCEintro.htm>
<http://www.measureprogram.org>
<http://www.macoint.com/dhs/>

Micronutrients

<http://www.jsi.com/intl/omni/>

Preventing Unsafe Abortions

<http://www.ipas.org>

RH Materials

<http://www.reproline.jhu.edu>
<http://www.med.jhu.edu./ccp/>



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