Reproductive, maternal, newborn and child health today

Overview and implementation analysis

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Most often reproductive, maternal, newborn and child health (RMNCH) programmes fail to deliver on scale and are not sustainable because of ill-defined scope, poor resource allocation and weak institutional commitment. Well integrated and managed interventions in RMNCH that are designed around people's needs, with long-term economic commitment bear credible results.

The IFRC RMNCH Framework promotes the continuum approach and *Strategy 2020* emphasizes the importance of partnerships that support National Societies in connecting knowledge, resources and experience to develop effective interventions in RMNCH.

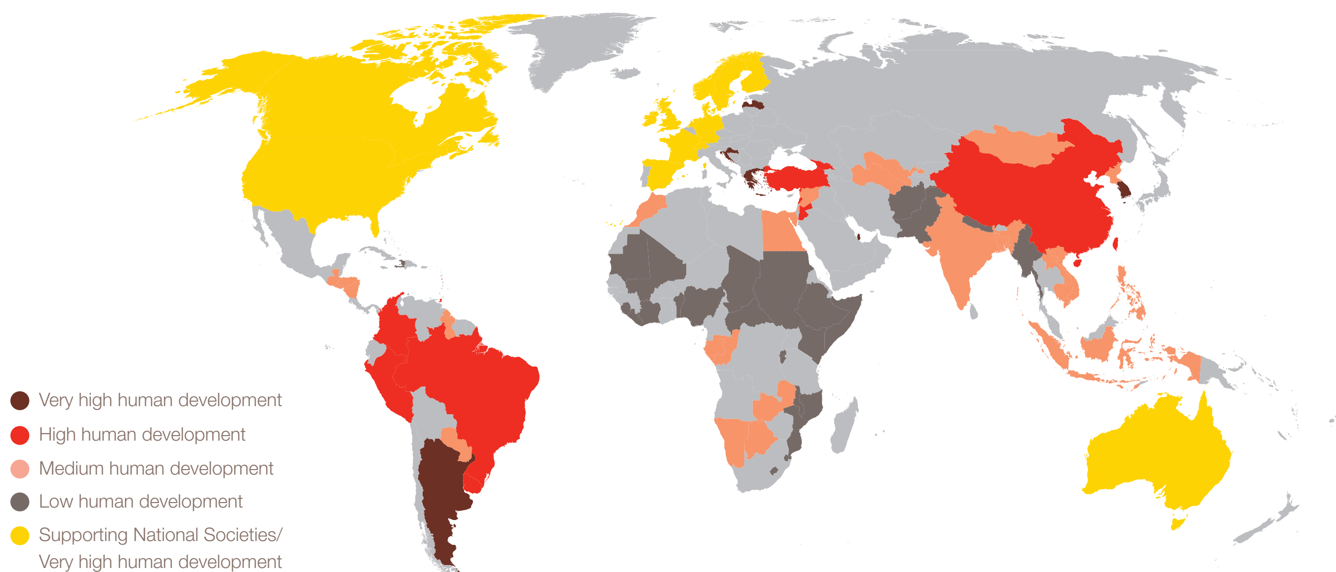
This document gathers examples of RMNCH interventions implemented by National Red Cross and Red Crescent Societies in different contexts, their achievements and findings. To consolidate our success and improve, we will gather more evidence on what works and why, for whom and in which context and conditions. Strategic decisions will align messages and actions with RMNCH vision and purpose to meet our mission, and ensure effectiveness and efficiency in programming. This in turn will inform the quality and scale of work, help build partnerships and increase advocacy, along with ensuring a long-term and well-recognized presence within communities.

Walter Cotte

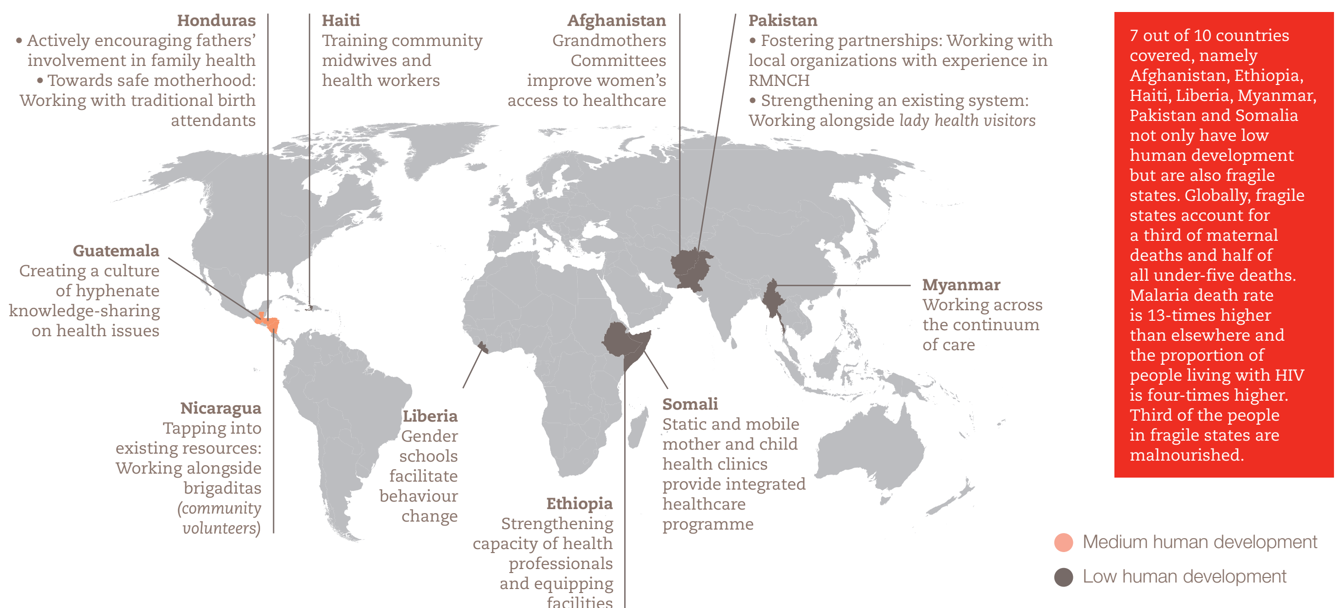
Under Secretary General
International Federation of Red Cross and Red Crescent Societies

Ashley Jackson/American Red Cross

National Societies implementing RMNCH programmes



Innovation used by National Societies



7 out of 10 countries covered, namely Afghanistan, Ethiopia, Haiti, Liberia, Myanmar, Pakistan and Somalia not only have low human development but are also fragile states. Globally, fragile states account for a third of maternal deaths and half of all under-five deaths. Malaria death rate is 13-times higher than elsewhere and the proportion of people living with HIV is four-times higher. Third of the people in fragile states are malnourished.

EVERY DAY

800

women die due to pregnancy-related causes and childbirth

18,000

children die of preventable diseases

EVERY YEAR

3.2 million

girls aged 15-19 undergo unsafe abortions

16 million

adolescent girls mostly in low- and middle-income countries give birth

Sources: IFRC, UNDP, UNICEF, UNFPA, World Bank and WHO

Introduction

The International Federation of Red Cross and Red Crescent Societies (IFRC) has supported and promoted reproductive, maternal, newborn and child health (RMNCH) for more than twenty years. IFRC's RMNCH programming has evolved in response to the medium- and long-term needs of communities. Most of these programmes are being implemented bilaterally by Supporting National Societies from Europe and North America. Programmes range from comprehensive RMNCH efforts on both the demand and supply sides of primary healthcare including community-based activities that promote appropriate health practices and care-seeking behaviour.

The proportion of National Societies with comprehensive RMNCH programming varies among the zones. South Asia, Central America and Africa are examples of zones where National Societies have been active in RMNCH, mainly by filling gaps in the delivery of essential services and by advancing national health agendas. Evidence suggests that maximum benefits are achieved when RMNCH activities are informed by context and implemented where there is the greatest need.

This document is the first step towards gathering examples of RMNCH initiatives being implemented by Red Cross and Red Crescent National Societies. The next step will be to gather more evidence on what works and why, for whom and in which context and conditions. This will inform quality and scale of work, build partnerships and increase advocacy, along with contributing towards a long-term and well recognized presence within the communities.

Purpose

This document reviews the current status of RMNCH implementation. The findings capture and promote National Society and partners' experiences in RMNCH across the continua of resilience, lifespan and healthcare. It does not evaluate or judge programmes in any way. Based on information available at a programmatic level, it presents positive gains that have been achieved by implementing RMNCH programmes. This analysis is one among a number of efforts that will feed into the development of appropriate guidance to support IFRC's work in RMNCH initiatives and to expand progressively in implementing the full cycle of the continuum of care.

Method

The overview and analysis builds on a collection and synthesis of existing data and implementation experience from RMNCH interventions. A desk review of proposals, case studies, evaluations and reports from various countries was conducted (see References and documents reviewed). Based on the documents reviewed, ten countries were identified and their experience in implementing RMNCH programmes captured in *Section 1*.

The criteria for selecting the countries was based on:

- National trends in maternal and child morbidity and mortality
- Inequity in access to health services
- Innovation in RMNCH programming
- Evidence of impact
- Geographical location (to ensure that National Societies across zones are covered)
- Country context (fragile state, socio-economic profile, other lifetime risk of complication and death).

Implementing and supporting National Societies and IFRC coordinators were consulted to complete this report and validate findings. Case studies have been incorporated to strengthen the analysis.

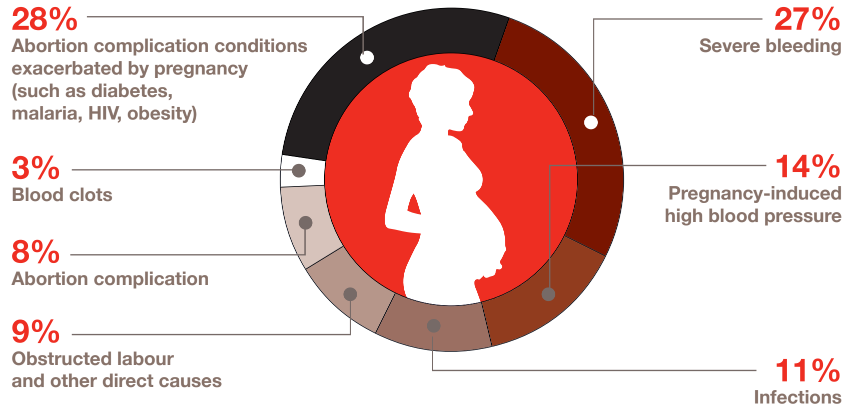
Adolescent pregnancy

95% of adolescent pregnancies occur in developing countries

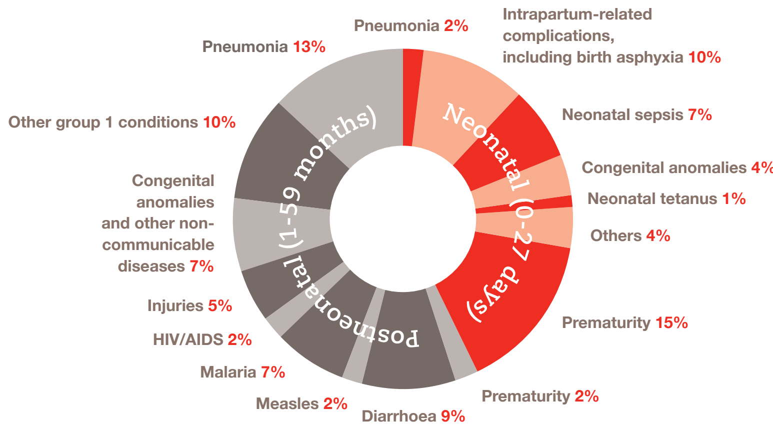
- In low- and middle-income countries, complications from pregnancy and childbirth are a leading cause of death among girls aged 15-19 years
- 70,000 adolescents die every year from complications related to pregnancy and childbirth
- Stillbirths and newborn deaths are 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years
- Infants of adolescent mothers are more likely to have low birth weight

Maternal health

- 99% of all maternal deaths occur in developing countries
- Maternal mortality is higher in women living in rural areas and among poorer communities
- Skilled care before, during and after childbirth can save the lives of women and newborn babies

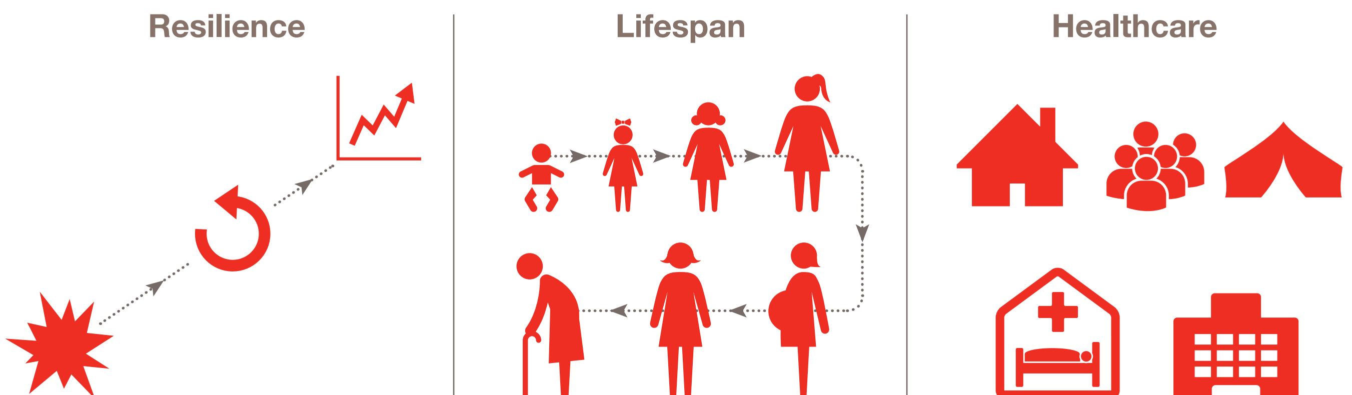


Child health



- 6.6 million children under-five died in 2012
- Leading causes of death in under-five children are pneumonia, pre-term birth complications, birth asphyxia, diarrhoea and malaria. About 45% of all child deaths are linked to malnutrition
- More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions
- Children in sub-Saharan Africa are over 16 times more likely to die before the age of five than children in developed regions

Continua of care



Sources: UNFPA, WHO and IFRC

Continuum of care

Interventions for improving RMNCH are connected and are most effective if provided through a continuum approach. The continuum of care includes integrated service delivery for adolescents, pregnant women, mothers and children – from raising awareness about sexual and reproductive health, access to family planning, seeking healthcare services for antenatal care and childbirth, postnatal care and onwards to the early days and years of a child's life.

The IFRC mobilizes its community health workers[1] to deliver culturally appropriate services to reach vulnerable families and communities. In RMNCH, experience shows that quality health services, people's knowledge and an enabling environment are critical for access to health across the three continua of care:

1. Resilience continuum: from preparedness to relief, recovery and development
2. Lifespan continuum: from birth to death
3. Healthcare continuum: from the individual to the household to the community to all levels of the formal and informal health system.

To this end, the IFRC supports provision of care by bridging the gap between health facilities and communities; promotes knowledge among women, men, children, adolescents and young adults; promotes gender equality, non-discrimination and ending violence against women and children.

Our work in RMNCH recognizes that reaching out to mothers and children who need the most support is missed out for reasons that facilities are few and far, not to the mark and poor access is perpetuated due to poverty. Recognizing the fact that interventions need to be seamlessly integrated for women and children throughout the lifecycle, we at Red Cross and Red Crescent are working consistently guided by the WHOs concept of RMNCH. Our National Societies implement programmes built on the evidence-base in community-based health thereby contributing to national RMNCH plans of individual countries.

Dr Arvind Bhardwaj, Senior Officer RMNCH

Structure

This section provides a snapshot of the countries where National Red Cross and Red Crescent Societies are currently implementing RMNCH initiatives, sets out the purpose of the overview and implementation analysis and defines the target groups. The analysis has been structured as follows:

The overview matrix provides a synopsis of the case studies featured.

Section 1 presents case studies capturing the essence and impact of the National Society RMNCH programmes and highlights the lessons learnt.

Section 2 provides an analysis based on the lessons learnt from current programmes, largely drawing on the case studies presented in section 1.

References and documents reviewed provides a list of key documents and websites reviewed to inform the analysis and for research purposes.

1. *The community-based health workforce, including Red Cross and Red Crescent volunteers, comprises all those who contribute to creating healthy and resilient communities. This is done through delivering crucial and culturally sensitive health messages, empowering individuals, households and communities to make informed decisions and increasing access to life-saving curative measures.*

Overview of case studies: Experiences of implementing National Societies

Implementing National Society	Supporting National Societies/Partners	Package	Location	Approach
Afghan Red Crescent Society	Australian Red Cross British Red Cross Finnish Red Cross	Maternal and child health	Balkh and Nangarhar provinces	Changing mind-sets by adopting innovative and culturally appropriate approaches to ensure women in rural communities can access healthcare services
Ethiopian Red Cross Society	The Netherlands Red Cross	Community-based neonatal and infant health (resilient baby)	Zones: West Hararghe, Silit, South Gondar and Jijiga	Strengthening capacities of health professionals, equipping health facilities and empowering communities to reduce maternal and child mortality
Guatemalan Red Cross	The Netherlands Red Cross Norwegian Red Cross	Family planning, maternal and newborn health and nutrition in vulnerable communities	San Marcos Quetzaltenango and Izabal	Making maternal and child healthcare services available to the indigenous population by strengthening capacities at community level and within health systems
Haiti Red Cross Society	British Red Cross The Canadian Red Cross Society Finnish Red Cross French Red Cross German Red Cross Italian Red Cross The Netherlands Red Cross Norwegian Red Cross	Maternal newborn and child health through community-based and first aid approach; reduction in neonatal and infant deaths	Bainet, Côtes de Fer	Close linkage with communities and health system, and effective coordination with all parties involved in disaster risk management are essential to ensure an immediate and effective local response to maternal and child health needs after a disaster

Implementing National Society	Supporting National Societies/Partners	Package	Location	Approach
Honduran Red Cross	The Canadian Red Cross Society Finnish Red Cross	Safe motherhood	Departments of Copán, Santa Bárbara	Mobilizing community members to take charge of their own health and that of their community makes lasting inroads in delivering RMNCH initiatives in rural communities
	Swiss Red Cross	Safe motherhood (health and disaster risk reduction)	Valle and Choluteca	Integrating traditional birth attendants in safe motherhood programmes improves access to healthcare and reduces maternal mortality. Working closely on health and disaster risk reduction widens the scope and promotion of safe motherhood services
Liberian Red Cross Society	British Red Cross The Canadian Red Cross Society Danish Red Cross IFRC	Integrated community-based health programme including maternal, newborn and child health	Nimba, Bong, Grand Bassa, Margibi, Montserrado, Bomi, Gbarpolu, Grand Gedeh and Cape Mount counties	Integrating gender equality and gender-based violence strengthens RMNCH programming
Myanmar Red Cross Society	Austrian Red Cross British Red Cross Danish Red Cross Norwegian Red Cross Swedish Red Cross	Continuum of care: Improved practice of and access to antenatal care, delivery, newborn care and reproductive health services in target communities	Mandalay and Sagaing region	From community engagement to health system strengthening and development
Nicaraguan Red Cross	The Canadian Red Cross Society	Integrated management of childhood illness including nutrition, postnatal care and immunization. Family planning is addressed with gender-focused programmes	Estelí, Madriz, Boaco, and Jinotega regions	Fostering a culture of disease prevention and community participation to improve mother and child health by complementing established ministry of health systems

Implementing National Society	Supporting National Societies/Partners	Package	Location	Approach
Pakistan Red Crescent Society	British Red Cross	Primary healthcare services with special focus on women and children with clinical and preventive services, i.e. consultations and treatment of diseases like diarrhoea, pneumonia, acute respiratory tract infections, malaria, provision of free medicines, contraceptives and immunization	Balochistan	Gaining trust of communities by adopting culturally appropriate approaches increases uptake of RMNCH services
Pakistan	The Canadian Red Cross Society		Khyber Pakhtunkhwa Province	
	Swiss Red Cross in collaboration with Aga Khan University	Strengthening maternal, neonatal and child health services	Sindh Province	Contributing with minimal support at primary level on health system strengthening improves quality. Developing trust and showing respect helps lady health visitors to access and receive women and children from rural communities in health facilities
Somali Red Crescent Society	British Red Cross Finnish Red Cross German Red Cross Government of Japan Icelandic Red Cross Norwegian Red Cross Swedish Red Cross IFRC ICRC	Continuum of care: Integrated healthcare programme including expanded programme on immunization, nutritional screening and management. National Society operates maternal and child health/ outpatients clinics and mobile health units	Somaliland, Puntland and central and south Somalia	Delivering integrated healthcare programmes to the communities with a network of maternal and child health/outpatient clinics and mobile health units

Disclaimer: The overview is based on information provided by both Supporting and Implementing National Societies and documentation that is available in the public domain.

Section 1 Experiences from the field

1.1 Afghan Red Crescent Society

Country context[2]

Almost three decades of war and internal conflict have destroyed most of Afghanistan's infrastructure and health systems. According to WHO, 70 per cent of the population "lives in extreme poverty and health vulnerability". Afghanistan has the highest maternal mortality in the world[3] and is the second highest for under-five mortality. Pregnancies and childbirth among adolescents between the ages of 15 to 19 years are not only associated with the highest risk of infant and child mortality but also present a higher risk of morbidity and mortality for the young mothers. The major causes of maternal mortality are haemorrhage, obstructed labour, pregnancy-induced hypertension and sepsis. Seventy-four per cent of the maternal deaths in Afghanistan are preventable. A major contributing factor to maternal morbidity and mortality is lack of trained female healthcare providers in the country.

AFGHANISTAN: KEY FACTS

15% deliveries take place in health facilities

34% deliveries are attended by skilled birth attendants

15% women between 15 to 49 years use contraceptives

[Source: WHO. 2013]

Local environment and approach

The Afghan Red Crescent Society collaborates with the national health authorities to provide health services to the population at risk. With its mobile health teams, the National Society responds to disease outbreak and addresses health issues across the country. Its regional health officers coordinate the deployment of mobile health teams with the Ministry of Public Health and the provincial health department. The mobile health teams provide a basic package of health services that includes:

- Outpatients department curative services particularly for women and children
- Health promotion services, i.e. health education and preventive services such as outreach vaccination
- Provision of free medicine.

To overcome cultural barriers and address the unique challenges of maternal, child and newborn health in remote areas of the country, the Afghan Red Crescent Society engaged with the local health committee in Balkh province and agreed to create "Grandmothers' Committees". Grandmothers are considered influential figures, not only in their own families but also by the rural communities at large. As such they play an important role in encouraging health seeking behaviour and are able to advice and guide young women on health issues and convince otherwise conservative husbands and fathers to let their wives and daughters seek health services and undergo medical treatment in a health facility, as and when necessary. This change in mind-set is contributing to reducing maternal morbidity and mortality.

Thus far, the Afghan Red Crescent Society has provided 135 grandmothers in Balkh and Nangarhar provinces with a five-day training on key reproductive health issues that included safe motherhood, antenatal, postnatal, safe delivery as well as tetanus

2. *Statistics in this section have been taken from WHO's* Country Cooperation Strategy at a Glance. *2011. Available at www.who.int/countryfocus/cooperation_strategy/briefs/en/*
3. *WHO.* World Health Statistics. *Geneva. 2011. Available at www.who.int/gho/publications/world_health_statistics/2011/en*

Amina Baqai/Afghan Red Crescent Society

toxoid vaccines, hygiene promotion and behavioural change activities. Both grandmothers and volunteers are referring women to health clinics for antenatal care, prenatal care and family planning.

Achievements

Since the training, 135 grandmother committee members have conducted households visits and organized reproductive health sessions with approximately 3,744 women. Around 1,170 mothers have been referred to health facilities for antenatal care services. Forty more grandmothers will be trained in 2014. Future plans expand the creation of grandmothers committees in the provinces of Samangan and Parwan.

The Afghan Red Crescent Society has about 22,000 trained volunteers, including more than 2,000 women across 34 provinces. Twenty community-based health and first aid (CBHFA) female trainers have been recruited in provincial branches to train more female community volunteers to engage in reproductive health promotion. Communities are benefiting from the key health messages that are being delivered by the grandmothers and female volunteers.

Lessons learnt

1. Innovative interventions such as, in this context, the engagement of grandmothers and capacity building at community level, has potential to contribute towards reducing maternal morbidity and mortality and developing a sustainable health system.
2. Using culturally sensitive approaches and addressing gender-specific barriers, the National Society has not only been able to develop women's confidence and recognition within their communities but also to encourage them to seek healthcare regularly.
3. Integrating both women and men into planning and training of health service delivery systems is essential in order to ensure that women, girls, boys, men and older persons have equal access to health, particularly reproductive health services.
4. Given the cultural sensitivity in Afghanistan, recruitment of female trainers to train more female volunteers in their respective communities increases opportunities for women to access health services.

1.2 Ethiopian Red Cross Society

Country context[4]

According to Ethiopia's 2011 Demographic and Health Survey, nearly half a million children under-five die every year, 120,000 of whom die in the first month of life. Neonatal mortality accounts for 30 per cent of under-five mortality. Sixty-seven per cent of all deaths of children under-five occur before a child's first birthday. Due to a weak and difficult to access health system, women continue to die as a result of preventable complications that arise before, during and after childbirth. Only 10 per cent of women deliver with the help of skilled personnel. The disparity in access to health between urban and rural areas is huge – while 45 per cent of births in urban areas are attended by skilled health personnel, this is true for only three per cent of births in rural areas. Eighty-three per cent of the country's population live in rural areas.

ETHIOPA: KEY FACTS

Ethiopia is one of five countries that together account for 50% of the world's maternal deaths

25,000 women die of complications during childbirth every year

500,000 suffer long-term disabilities from pregnancy and childbirth complications every year

[Source: UNFPA]

Local environment and approach

The Ethiopian Red Cross Society is implementing an infant and neonatal health project in West Hararghe, Silit, South Gondar and Jijiga zones with the aim of strengthening the capacity of health professionals who are attending to deliveries at health facilities in the intervention *kebeles*[5] and ensuring that the facilities are functional. This includes equipping health facilities with basic emergency obstetrical and neonatal care equipment and supplies and ensuring there is running water, delivery beds and waiting areas for mothers and family members. In the intervention areas, the Ministry of Health is the main provider of neonatal, maternal and infant health services. The Ethiopian Red Cross Society is complementing the government's efforts by:

- Training healthcare providers
- Contributing towards improving access to quality healthcare services including antenatal care, delivery, postnatal, newborn and infant care and commodities for women of childbearing age, newborns and infants
- Promoting behaviour change and developing capacity for self-care to improve care-seeking behaviour and to facilitate emergency birth preparedness during prenatal, neonatal and post-partum period
- Strengthening linkages between the community and the health delivery system.

To encourage self-care, pregnant mothers are equipped with "mama kit", i.e. a clean delivery kit and other essential commodities such as gloves, insecticide-treated nets and household water filter. Awareness is also raised on the importance of visiting a health facility for delivery. Further, to improve care-seeking behaviour, men are encouraged to get involved in caring for expectant mothers during pregnancy, labour, delivery and postpartum.

In addition, prevention of mother-to-child transmission of HIV is being enhanced by awareness raising initiatives. Community mobilization, improving antenatal care and institutional delivery coverage, routine HIV testing during antenatal care visits, improving service accessibility, public-private partnership, ensuring male involvement and involving people living with HIV are central to the programme.

4. *Statistics for this section have been taken from* Ethiopia's Demographic and Health Survey. *2011. Available at: www.usaid.gov/sites/default/files/documents/1860/Demographic%20Health%20Survey%202011%20Ethiopia%20Final%20Report.pdf*
5. *The smallest administrative unit of Ethiopia similar to a ward, a neighbourhood or a localized and limited group of people. It is part of a district that is usually part of a zone, which in turn are grouped into one of the regions based on ethno-linguistic communities.*

Achievements

Thus far, in collaboration with the Ministry of Health, the Ethiopian Red Cross Society has trained 720 traditional birth attendants who were selected by the communities in their respective *kebeles*. The training included recognizing symptoms and caring for sick new-borns, identifying and counselling on recognizing danger signs and symptoms and encouraging breastfeeding.

A total of 18,568 reproductive age women have been reached with cascading community trainings, including pregnant women, mothers, parents and community leaders. The focus of the community training is to promote household and community practices such as exclusive breastfeeding, overall neonatal health issues, and timely referral system for better investigation and management.

Sixty community conversation forums have been established across 24 *kebeles*. Each group has between 24 to 30 members. Community conversations are organized by the women's health development army and traditional birth attendants. The community conversations focus on topics such as antenatal care, low birth weight, nutrition, breastfeeding and vaccination against preventable diseases.

A total of 600 couples across 24 *kebeles* have benefited from the couple workshop on birth preparedness. The training focused on the importance of antenatal and postnatal care, identification of danger signs during pregnancy and recommended actions, understanding the benefits and components of birth preparedness and complication readiness.

Daniel Cima/American Red Cross

Lessons learnt

1. Training and re-engaging traditional birth attendants in the promotion of safe motherhood has contributed positively to an increase in institution delivery. Their work now goes further than simply attending births, to include the promotion of safe motherhood and good neonatal care practices.
2. The health facility-based mama kit distribution is an attractive incentive for women to access delivery services in health institutions.

1.3 Guatemalan Red Cross

Country context[6]

Guatemala has the highest percentage in the Americas of children under-five suffering from moderate and severe stunting[7]. The under-five mortality rate is more than double within the indigenous population compared to the national average. Seventy-five per cent of Guatemala's indigenous population lives in poverty. They often live in remote communities that lack basic infrastructure and access to healthcare services. On an average, the country has 9.7 doctors and 3.6 nurses for every 10,000 inhabitants. Trained staff assist 31.4 per cent of all deliveries. Of these, only 7.1 per cent meet the required quality standards and conditions.

GUATEMALA: KEY FACTS

Guatemala has the third highest rate of child mortality in the western hemisphere and is sixth in maternal mortality

49% children under-five are affected by chronic malnutrition

50% children 0–5 months old are exclusively breastfed

1,300,000 boys, girls and adolescents do not have access to health services

[Source: UNICEF. 2011]

Local environment and approach

The Guatemalan Red Cross has implemented a mother and child healthcare programme primarily with indigenous communities in San Marcos, Izabal and Quetzaltenango. In order to improve health practices, the project created a culture of knowledge-sharing between the women and community leaders in the villages on topics such as:

- Providing children with proper nourishment
- Importance of breastfeeding for the first six-months
- Preventing diseases
- Caring for pregnant women
- Growth monitoring
- Reproductive health

To ensure sustainability beyond the end of the project, a community-based approach was adopted. The National Society worked with and trained committees on maternal and child healthcare. *Mother support groups*, which included *mother counsellors* and Red Cross volunteers, were created. They convened meetings with groups of women to discuss topics such as breastfeeding, complementary feeding, vaccination, family planning and recognition of danger signs. In addition growth monitoring and promotion sessions were also carried out by *mother counsellors* and Red Cross volunteers who weighed children, measured development and promoted healthy behaviour.

Santos Rufina García López, a 41-year-old Mayan mother of five from Tuichilupe, a small village in Comitancillo, San Marcos works as a *mother counsellor*. Her youngest daughter, Juanita Florencia Pérez García, used to be malnourished. "Juanita is a lot healthier now than before the Red Cross came to help us with the lessons, the growth monitoring and the home visits. My daughter is now much stronger than before and I am able to give her better food than before. She was born underweight, but now she is healthy and happy. I am very glad," says Santos Rufina.

During her training, Santos Rufina also learnt that a couple can decide and plan the number of children they have, something of which she was unaware. As a *mother counsellor*, she raises awareness on a range

6. *Statistics in this section have been taken from UNICEF's* Guatemala: Country programme document 2010–2014. *2010. Available at: www.unicef.org/about/execboard/files/Guatemala_final_approved_CPD12_Jan_2010.pdf*

7. *Stunting means shortness-for-age; an indicator of chronic malnutrition and calculated by comparing the height-for-age of a child with a reference population of well nourished and healthy children. According to the UN Standing Committee on Nutrition's 5th Report on the World Nutrition Situation (2005) almost one-third of all children are stunted*

of maternal and child health issues including family planning. She has not only been able to discuss this with other women in her community but also with her 16-year old daughter.

The Guatemalan Red Cross is also working with men and youth to raise awareness about sexual health rights and family planning.

Mari Aftret/Norwegian Red Cross

Achievements

In 2013, Guatemalan Red Cross' mother and child healthcare programme in 16 communities in El Estor and Santo Tomás in Izabal department reached 1,302 families (approximately 7,808 people). Community health committees for mother and child health were established across all communities. These committees trained mothers as volunteer peer counsellors. Twenty-one mother support groups were established and were trained to perform growth and weight monitoring. The mother and child committees are now linked to local government structures. Another important activity of the programme is to support capacity building of midwives in collaboration with the Ministry of Health. The project also assesses gaps in health centres and provides basic equipment, for example, at *Casa Materna* in El Estor.

Seven hundred and thirty-nine children under-five have been enrolled in the programme. Community mobilization plans for emergency care and referrals have been developed in 15 communities. The Guatemalan Red Cross outreach workers have been working on overcoming the three delays (delay in deciding to seek care; identifying and reaching medical facility; and receipt of adequate and appropriate treatment) in pregnancy. So far they have assisted 38 families to develop a birth plan and sensitized women regarding early detection of danger signs. This has helped in facilitating 34 antenatal care referrals and an additional 36 referrals for child health services.

In close cooperation with local authorities, follow-up was carried out to promote immunization, micronutrient supplementation, breastfeeding and prenatal care by conducting home visits and training sessions. This included demonstrations on food preparation to mothers of children between six to 24 months.

The Guatemalan Red Cross has become a member of the Institutional Board for Reduction of Maternal Mortality (*Mesa Inter-Institucional para la Reducción de Muertes Maternas*), a forum to review and discuss maternal deaths reported in the area. Other members of this board include the Ministry of Health, Ministry of Family, Public Ministry, national police, NGOs, and the Forensic Institute.

Lessons learnt

1. The mother and child programme is not only promoting health but also contributing to increasing the knowledge of mothers and helping them to improve family practices to be able to lead healthier and more productive lives.
2. In some areas the RMNCH programme has experienced challenges to recruit and retain sufficient volunteers. To address this challenge the programme has worked on further developing volunteering policies and strategies at branch level.
3. There is a continuous need to address the cultural context in order to meet the different needs of specific groups. The programme has aimed to address this by initiating an open dialogue with community members and other representatives. All efforts are being made to involve community volunteers with similar cultural backgrounds to the target population, with knowledge of the local context and native indigenous languages.

1.4 Haiti Red Cross Society

Country context[8]

Haiti has the highest rates of infant, under-five and maternal mortality in the Caribbean region. More than half of the health services are concentrated in the capital, Port-au-Prince. Sixty-two per cent of the population is rural and faces problems in accessing healthcare mainly due to insufficient numbers of health facilities, high costs of services and long distances – 34 per cent of the women in rural areas have to travel 15 kilometres or more to reach the nearest health facility. The country has an average of 5.9 doctors and 6.5 health professionals per 10,000 inhabitants. Only 35.9 per cent of pregnant women deliver in health institutions and 37.5 per cent of all births are attended by skilled health professionals. The 2010 earthquake has had a massive impact on the already fragile health system which severely damaged or destroyed 62 per cent of the health institutions in the South-East Department, including the only reference hospital in Jacmel. Following the earthquake, most health centres were closed and community health care and prevention activities carried out by community health workers and traditional midwives ceased. Furthermore, the nursing-midwifery workforce was decimated and the significant emigration that followed the earthquake has created a major challenge.[9]

HAITI: KEY FACTS

Haiti has the highest rates of infant, under-five and maternal mortality in the western hemisphere

24% children under-five are malnourished

61% infants and 46% women are anaemic

11.7% of the total fertility rate is attributed to adolescents between 15 to 19 years of age

38% of married women have unmet family planning needs

[Source: National Health Policy, 2012 and UNICEF. January 2013]

Local environment and approach

Even prior to the earthquake, the Haitian population had long suffered the effects of weak health and water and sanitation systems. According to the 2005 – 2006 Survey on Morbidity, Mortality and Use of Services, the South-East Department of Haiti has the highest rate of home births (88.4 per cent) and the lowest percentage of medically assisted deliveries (12.5 per cent) in comparison to other departments. Forty-nine per cent of the births are attended by untrained attendants. Only 24 per cent of women between 15 and 49 years had used modern contraceptive methods. Using the CBHFA approach, the Haiti Red Cross Society is supporting the Ministry of Health in boosting the RMNCH services in the municipalities of Bainet and Côtes-de-Fer by providing training to community midwives and health workers.

With the acute phase of the earthquake response over, the focus of the Haiti Red Cross is now on long-term development and capacity building. The National Society is training its volunteers on the basics of RMNCH, hygiene promotion and follow-up of pregnant mothers and newborns in the community. In addition, since the majority of births and neonatal deaths occur at home, volunteers are not only promoting positive health-seeking behaviours in regard to safe motherhood, neonatal healthcare and child survival but are also serving as a vital link between health workers and the communities and are referring pregnant women and mothers and infants to the health institutions.

8. *Unless otherwise referenced, statistics in this section have been taken from the Ministry of Public Health and Population's National Health Policy 2012 and Survey on Morbidity, Mortality and Use of Services (EMMUS IV/2005–2006).*
9. *UNFPA.* State of the World's Midwifery. *2011.*

José Manuel Jiménez

The National Society is also supplementing the Ministry of Health's efforts in addressing critical gaps by carrying out small-scale renovations in health facilities and ensuring that essential supplies related to neonatal care are available.

To have a lasting impact on reducing neonatal and infant mortality, the Haiti Red Cross Society is implementing the project with the concept of continuum of care.

Note: The programme has been ongoing for a short period, hence it is not possible to draw on achievements or lessons learnt at this stage.

1.5 Honduran Red Cross

Country context[10]

In Honduras there are large disparities in the health status of people living in urban and rural settings. In remote areas, women and children are particularly vulnerable. The lack of health services and information in these communities severely limits women's access to healthcare and the likelihood that they will seek medical attention during pregnancy, childbirth and postpartum. Traditional norms vis-à-vis women and men's roles assign women the responsibility of caring for their family's health but do not give them the power to make decisions.

HONDURAS: KEY FACTS

In Honduras, neonatal mortality accounts for 61% of infant mortality

Gestational hypertension (26%) and postpartum haemorrhage (22%) are the most frequent causes of in-hospital maternal mortality

40.2% children under-five are anaemic

[Source: PAHO. 2012]

Local environment and approach

Over the period of 2006 to 2012, the Honduran Red Cross supported the delivery of RMNCH services in the rural communities of Copán and Santa Bárbara, in coordination with the Ministry of Health and decentralized health providers at the municipal level, through a project called *REDES* (meaning networks in Spanish). Under the umbrella of another project called *PRODESUR*, the National Society is working with 127 communities, in the southern departments of Valle and Choluteca, implementing community development in health and disaster risk reduction initiatives.

Delivery of key services to prevent maternal and child morbidity and mortality for the Honduran Red Cross includes:

- Training local birth attendants to assist pregnant women in remote areas
- Mobilizing male decision-makers, community leaders and heads of households
- Establishing collective emergency funds in villages.

In the rural communities of Copán and Santa Bárbara, the programme promotes safe pregnancy and child health and encourages men to participate during pregnancy, childbirth and childcare. One of the challenges faced was convincing men to be more involved in the health of their family. To overcome this challenge, Dr Constantino Rivera, the only physician in the municipality of Petoa, with a population of over 10,000 people, collaborated with Honduran Red Cross by reaching out to men visiting the clinic and raising awareness of the importance of a father's involvement in family health.

Although the National Society promotes institutional delivery, it recognizes the fact that maternal mortality and morbidity cannot be reduced without re-training and increasing the skills of midwives. The Honduran Red Cross project *PRODESUR* promotes institutional deliveries and also trains local birth attendants and women as *parteras* (midwives). The focus of the training, which is endorsed by the government, is on antenatal and postnatal care, detecting danger signs during pregnancy and postpartum and timely referral. The *parteras* ensure that each family has a preparedness plan for institutional delivery as well as being prepared to conduct a safe delivery if transportation is not possible.

10. *Statistics for Honduras: Key facts have been taken from PAHO's* Health in the Americas, 2012 Edition: Country Volume. *2012. Available at: http://www.paho.org/saludenlasamericas/index.php?option=com_docman&task=doc_view&gid=135&Itemid=*

One of the functions of the *parteras* is also to act as a link between pregnant women in remote areas and the health system. Furthermore in order to bridge the gap between health providers and the community, health committees have been established within communities. These committees serve a dual role of promoting safe and institutional deliveries as well as ensuring that vulnerable communities are aware of incentive programmes. In addition, committee members regularly meet with the health providers and monitor their presence, discuss and solve problems.

Special focus is given to mobilizing male decision-makers, community leaders and heads of households to gain their understanding and consent on why deliveries with a trained birth attendant are important. In the early stages of pregnancy, communities and families are encouraged to take precautionary measures such as establishing communal emergency funds, starting with individual savings and exploring and organizing transport possibilities to the nearest delivery centre or hospital.

Achievements

The *REDES* project has trained almost 4,000 community health workers. Communities of Copán and Santa Bárbara have seen an increase in the number of men accompanying their wives to their monthly prenatal check-ups, to the birth of their babies and to the monthly weighing of the babies.

The scale-up of community health workers with midwife training in the departments of Valle and Choluteca has led to 92 per cent of pregnant women attending four antenatal care visits and institutional deliveries have increased by approximately 30 per cent. In 2013, more than 90 per cent of the women delivered in institutions with the help of doctors while only nine per cent delivered at home, mostly under the supervision of a trained birth attendant. This project has overseen the construction of maternal health infrastructure in three health units.

Swiss Red Cross

Lessons learnt

1. Mobilizing community members to take charge of their own health and that of their community decreases access barriers and creates sustainable structures which tackle the four delays during pregnancy and childbirth – decision-making, transport, admission to hospital and seeking treatment.
2. Promoting the right to health and facilitating social accountability structures has resulted in empowered local communities who demand quality public service provision.
3. Promoting the engagement of men during pregnancy and birth is a significant factor in women knowing danger signs, taking iron supplements, and developing a birth plan.
4. Trained *parteras* and traditional birth attendants are well accepted in the community and known for their delivery skills.

1.6 Liberian Red Cross Society

Country context[11]

More than a decade after peace, Liberia is still struggling to recover from the damage caused by the 14-year civil war that has left the country's health system practically non-existent. Furthermore, the civil war has left a legacy of violence, poverty and social disorder. High rates of gender-based violence continue to create and perpetuate ill health and conflict among men and women at community level. The effects of gender-based violence are physical, psychological, sexual and social with some of the most tangible signs being unwanted pregnancies, higher rates of HIV and other sexually transmitted infections in women, distress and post-traumatic stress disorder, divorce, abandonment and social exclusion.

Preventable diseases like malaria are the leading cause of morbidity and mortality. According to the 2009 Liberia Malaria Indicator Survey, malaria prevalence in children under-five is 32 per cent. Acute respiratory infections are the second leading cause of morbidity. Diarrhoeal diseases account for four to six per cent of all outpatient consultations[12]. Malnutrition mainly affects women and children with stunting and wasting in children under-five at 39 and eight per cent respectively. Maternal mortality is very high, at 770 deaths per 100,000 births. Contributing factors include inequity in access to healthcare services, shortage of skilled health staff and inadequate referral systems. Health outcomes are extreme between the rich and the poor quintiles, counties and urban-rural areas, and services are not responsive to the local context.

Local environment and approach

The Liberian Red Cross Society in collaboration with the ministries of gender, health and social welfare and agriculture is implementing a community-based health and disaster management programme to build capacity and improve resilience for better health outcomes among 30 vulnerable communities in Nimba and Bong counties in north-central Liberia.

LIBERIA: KEY FACTS

Infant mortality in the south-central region is double that of Monrovia, and there is a difference of almost 50% between the poorest and the wealthiest quintiles.

Immunization coverage in the south-eastern region is only one quarter of that in Monrovia

20% girls experience sex before age 15, one in seven against their will.

A third of girls aged 15 to 19 years are mothers or pregnant

[Source: UNICEF. 2012]

The programme focuses on communities that have so far not benefitted from previous interventions by any organization including the Red Cross Red Crescent Movement.

Adolescent girls between the ages of 10 to 18 and single women are especially vulnerable – they have poor sexual and reproductive health status. The fragile economic situation leads them to having multiple partners and engaging in unwanted sex. Frequent sexual relations with multiple partners increase exposure to gender-based violence, frequent pregnancies and HIV and sexually transmitted infections. There is no tradition for open discussion on issues relating to sex and gender in Liberia. Traditionally *bush schools* have been run by traditional healers or birth attendants and have provided sex education for adolescents. This tradition, which is on the decrease, and the fact that sexual assault is considered shaming to the community, makes it difficult for men and women to discuss issues openly.

11. *Unless referenced otherwise, statistics in this section have been taken from UNICEF's* Country programme document 2013-2017. *2012. Available at: www.unicef.org/about/execboard/files/Liberia-2013-2017-final_approved-English-14Sept2012.pdf*

12. *WHO.* Liberia Country Cooperation Strategy at a glance. *May 2014.*

Gender schools run by *change agents* – male and female community members – who have been trained in gender concepts and sexual and reproductive rights facilitate behaviour change communication, peer group discussions and life-skills training. Gender schools are a space for learning and development to create a positive dialogue for cross-gender discussions with the ultimate aim of reducing gender-based violence.

In addition, community health volunteers are raising awareness among pregnant mothers on the importance of antenatal care as a part of a safe motherhood approach. Focus groups with pregnant mothers are organized to raise awareness on recognizing danger signs, importance of family planning, birth spacing, taking iron supplement and tetanus vaccination as well as sexually transmitted infections and HIV-testing.

Breastfeeding and weaning practices are key to infant and child health. Awareness is raised on understanding the advantages of exclusive breastfeeding, when and how to start weaning and what kind of food to give to children who are being weaned off breast milk. The project supports the expanded programme on immunization activities of health centres by raising awareness among communities regarding the advantages of immunization and by participating in campaigns to encourage mothers and caregivers to have the children vaccinated.

In Liberia, women have no place apart from their kitchen to give birth. The Liberian Red Cross Society distributes razors and antiseptic and shows midwives how to use these. Beatrice, a volunteer shares her experiences, “At the moment we have nowhere for the women to give birth and we would like a room built for this purpose, where the traditional birth attendants [midwives] can take the women instead of having to use the house which is very small. We also need help in getting more women trained as traditional birth attendants. At the moment we only have one old woman who has eyesight problems. We’ve been trying to get her to start training others but would like the Red Cross to help with this.”

Benoit Matsha-Carpentier / IFRC

Lessons learnt

1. Involving both men and women from the planning phase increases ownership and buy-in. The critical role that men can play as partners with women and agents of social change needs to be affirmed. Men and women with increased knowledge adopt attitude and behaviour conducive to promoting gender equality and sexual and reproductive rights.
2. Establishing community-based action groups for men is a good plan since men who are in the process of transformation trust fellow men to discuss issues like gender-based violence.
3. The assessments conducted found that economic empowerment through skills training is an important pull factor that answers not only the women’s needs but is also in their interest. It is recognized that gender equality requires economic empowerment of women to give them a sense of control and independence.

Note: This programme builds on lessons learnt from previous interventions. Assessments were conducted prior to the implementation of the programme by involving community members. Since the programme has been ongoing for a short period, it is not possible to draw on achievements at this stage.

1.7 Myanmar Red Cross Society

Country context[13]

Myanmar has one of the highest maternal and infant mortality rates in south-east Asia. In terms of under-five mortality, it ranks 55 in the world. The key challenge facing mothers and children, especially in rural areas, is limited access to qualified antenatal and postnatal care. Severe postpartum haemorrhage is the main cause of maternal mortality (31 per cent). The principal causes of neonatal mortality (within 28 days) are prematurity (30.9 per cent), birth asphyxia (24.5) per cent and sepsis, including pneumonia (25.5 per cent). The main direct causes of mortality among children under-five are acute respiratory infections (21 per cent), diarrhoea (13 per cent) and malaria (7.6 per cent), exacerbated by underlying malnutrition, which contributes to around 50 per cent of the deaths.

MYANMAR: KEY FACTS

56,000 children under-five die every year – 26,000 younger than one month

89.9% neonatal deaths occur in home-delivered babies, in rural areas

1:4,144 is the midwife to population ratio

[Source: UNICEF, June 2012]

Local environment and approach

Forty-eight families live in the village of Nar Tet Sam. In 2012, there were ten children born, seven of whom died within one day. In another village, Lel Gyi, villagers had not been immunized for at least 30–years. In Lesu Kyauk Pone, in the past a midwife would come to the village only two to three times a year. This trend has now changed. Community health workers ensure that a midwife visits the village every month. The Myanmar Red Cross Society is working in partnership with local health clinics and community decision-makers in 78 remote communities, that are currently excluded from or have limited access to essential health services in Chin State, and in the regions of Sagaing and Mandalay.

The National Society is focusing on the *continuum of care* by improving practices of and access to reproductive health, antenatal care, delivery, postnatal and newborn care. This includes:

- Facilitating access to pre- and postnatal care for mothers in remote regions
- Provision of basic delivery equipment to rural health centres
- Training of community-based health volunteers
- Promotion of better dietary practice for mothers and children with educational materials
- Immunization.

Chaw Su Hlaing and her husband Ye Min Paing live in Chaung Ma Gyi village in the Sagaing region. They lost their first baby when she was only two days old. Chaw Su Hlaing says, "I had to collect firewood every day – up to the day I gave birth. I had labour pains for two days. I had no money to pay for the hospital, so I had to deliver at home. On the day of the delivery, I squatted in my home to deliver with the traditional village helper". She adds, "My baby girl was born sick, with a skin disease all over her body. I don't know why my baby died – I think it might be because I had to climb the hills to get firewood all through the pregnancy".

It is common for many women in rural Myanmar to give birth at home. Transportation to hospital and medical fees can cost more than 190 Swiss francs – the equivalent of a year's earnings for some people. Access to a trained medical professional is difficult – one midwife often covers a large number of remote villages.

13. *Statistics in this section have been taken from the Ministry of National Planning and Economic Development and UNICEF. Situation Analysis of Children in Myanmar. Nay Pyi Taw 2012. Available at: www.unicef.org/eapro/Myanmar_Situation_Analysis.pdf*

The main barriers to access to healthcare services are absence of health facilities or skilled health personnel, distance, lack of means of transportation or unaffordable costs for travelling to health facilities, coupled with fear of costs related to healthcare (e.g. costs of medicines).

"Women often have to travel by boat to deliver in a health facility, or walk to the next village for treatment for their children", says Gregory Rose, British Red Cross health adviser. "Following discussions with women in remote parts of Sagaing, access to health care was identified as the most common challenge", he adds.

In response, the Myanmar Red Cross Society is training midwives and birth attendants in local areas making it easier for women physically to reach the care they need, while removing the cultural and language barriers faced by mothers from different regions. In addition, community health workers are distributing iron and folic acid, and liaising with the regional government-trained midwife. The National Society also provides cash grants to cover the cost of delivering at a hospital or rural health centre.

Using the community-based health and first aid approach, the Myanmar Red Cross Society is also training expectant and new mothers on how to identify risks, treat common communicable diseases, reduce malnutrition and improve feeding practices.

Achievements

To date, 83 auxiliary midwives have received training across 78 remote communities. The programme has enabled 421 pregnant women to attend their first antenatal care visit while another 257 have completed four antenatal visits. Skilled and auxiliary midwives have delivered 343 babies. In addition, 244 mothers have had postnatal care visists within 24 hours of delivery and 186 mothers have received four postnatal care visits. Two hundred and forty-four newborns have received care. Auxiliary midwives referred 77 pregnant women to seek emergency obstetric care and have assisted 335 children with the expanded programme on immunization. A total of 702 health education sessions have been delivered at community level by the auxiliary midwives.

The Myanmar Red Cross Society has also trained 233 community health workers. In addition, 10,350 people and 1,403 children under-five received treatment for the first time for any disease. Nine hundred and forty-two children under-five with diarrhoea were treated with oral rehydration solutions while 28 children were treated for malaria. A total of 1,732 long lasting insecticide-treated nets were also distributed.

Lessons learnt

1. Substantive material offering to communities could result in measurable changes to public health. A failure to address the issue of healthcare costs while encouraging communities to engage with health services may have a serious negative impact on household economics.
2. Monthly coordination and planning meetings at a township health department is an entry point to increase effectiveness in project implementation.
3. One of the challenges faced is to increase referrals from remote areas. This issue needs to be promoted and can be ensured by increasing awareness about systems, protocols, and criteria with villagers, village health committees, village health workers and basic health staff in remote areas. To facilitate this, village level communication material has been developed and will be distributed in the coming months.
4. Outreach visits by midwives are essential to ensure better healthcare in villages, especially in remote areas. Midwives are conducting visits in the catchment areas on a regular basis to provide immunization and other vital care.
5. For improvement in data collection at township health department level, more refresher trainings of basic health staff on the health information management system are needed. Translated reporting formats for midwives and village health workers need to be developed. While the project supports strengthening of the health management information system at township and community levels, there is a need for capacity building and strengthening systems at state and national levels.

1.8 Nicaraguan Red Cross

Country context[14]

In Nicaragua the main causes of death among children under-five are respiratory diseases, diarrhoea, malnutrition and meningitis. Chronic malnutrition is twice as high in rural areas and risk of malnutrition six times higher in the poorer quintiles than in the wealthiest quintile. Approximately 55 per cent of women in rural areas give birth at home. Maternal mortality is high in rural areas and adolescents account for approximately one-third of maternal deaths.

Local environment and approach

Over the period of 2006 to 2011, the Nicaraguan Red Cross in collaboration with the Ministry of Health and local communities launched the *Enlace* (Linkages in Spanish) project reaching 224 communities across 12 municipalities in four regions of Nicaragua: Estelí, Madriz, Boaco and Jinotega. The project promoted access to health services for children under-five, women and men of reproductive age, pregnant women and new mothers and encouraged men's participation in maternal and child health during pregnancy, childbirth and the postpartum period. Community-level support groups for men were established to raise awareness and actively involve men in the health of their families and communities, as well as to improve their own health. Over 1,200 men participated in these groups.

"The volunteers have analysed and can identify problems in their communities and are able to prioritize", says Ninette Lòpez, Project Coordinator, Nicaraguan Red Cross. Over 800 Red Cross community health volunteers were trained to identify illnesses requiring medical interventions beyond community-level treatment capabilities, and to refer these to formal healthcare facilities. Community health volunteers worked alongside the *brigadistas* (community volunteers)[15], sharing technical knowledge, skills and experience, thereby increasing access to remote areas.

NICARAGUA: KEY FACTS

17.3% children under-five suffer from chronic malnutrition

23.3% adolescents under 18 are already mothers or are pregnant, the highest rate in the region

[Source: UNICEF, June 2012]

Ensuring nutritious and healthy food is available for the family is essential. To this end, projects like family vegetable gardens combined with changes in diet and improved knowledge of food preparation and nutritional choices form an important part of the programme.

The Yalí branch of the Nicaraguan Red Cross identified and set-up the first clinical laboratory in the region that has not only filled a key service gap but has also ensured sustainability of services being provided. "Previously, people had to travel from Estelí to Jinotega and this was expensive for them", says the laboratory technician, Jimmy Rocha. Now the services are close by and less expensive.

Achievements

The partnership between the Ministry of Health and the Nicaraguan Red Cross strengthened the project by using qualified clinical health staff to support and work in close coordination with Red Cross volunteers to expand the coverage and quality of community health services. The project benefited approximately 24,000 children and over 2,000 women, linking 224 communities with eight Nicaraguan Red Cross branches and forty-eight health clinics.

14. *Unless referenced otherwise, statistics in this section have been taken from UNICEF's Annual Report 2013 available at: www.unicef.org/about/annualreport/files/Nicaragua_COAR_2013.pdf*

15. *The project benefited from Nicaragua's 30-year history of Ministry of Health-run* brigadistas*, volunteers experienced in health promotion and healthcare delivery.*

Marko Kokic/IFRC

The training received by the community health volunteers had a direct impact on the number of referrals, which increased from 268 to 2,389 over the period of 2007 to 2011. Further, between 2006 and 2011 there was a 60 per cent increase in exclusive breastfeeding of children under six months (from 22 per cent to 82 per cent). Overall there has been a 11 per cent decrease in the prevalence rates of malnutrition for children under two years of age.

In 2010, approximately 90 per cent of the women gave birth in a health facility staffed by a skilled birth attendant and between 2008 and 2011 there was a 21 per cent increase in the use of birth control methods by women (from 2 per cent to 23 per cent).

Dr. Victor Trimino, Director, Estelí Health Services attributes the success of the programme largely to community participation. He emphasizes, "Social responsibility is not only the responsibility of health workers; it is everyone's responsibility."

Lessons learnt

1. As members of their own communities, Red Cross volunteers played a key role in social mobilization empowering individuals and families with knowledge to improve their own health, and help build linkages between their communities and vital healthcare services.
2. Integration with the existing *brigadistas* network, a key component of the Nicaraguan health system, was one of the main reasons for the success of the project.
3. The *Enlace* project supported a successful referral and counter-referral system initiated by the Nicaraguan Ministry of Health.
4. The active engagement and participation in the targeted communities not only contributed to the programme's success but also facilitated the promotion of gender equality.

1.9 Pakistan

Country context[16]

Since the 1990s, Pakistan has reduced its maternal mortality ratio by 50 per cent and infant mortality ratio by 30 per cent. However, it still remains off track with regards to meeting targets of Millennium Development Goals 4 and 5. The majority of under-five deaths are due to birth asphyxia, infections, pneumonia, diarrhoea and severe malnutrition. In terms of under-five mortality, it ranks 26 in the world. Pakistan remains one of only three countries in the world with endemic polio. Routine immunization access and coverage in both urban and rural settings, remains a challenge.

PAKISTAN: KEY FACTS

One in ten children die before their fifth birthday. Over half of those die before completing the first month of life

Nearly half of children under-five are stunted

Less than half of the children are fully immunized

[Source: UNICEF. 2012]

Local environment and approach

In Pakistan there are major disparities between urban and rural areas in terms of access to health services. This situation is further exacerbated by a shortage in nurses, paramedics and skilled birth attendants. In order to ensure that essential primary health services are available in the community and unmet health needs addressed, the government of Pakistan launched a programme for family planning and primary care in 1994, identifying *lady health visitors* as key to bridging the gap in provision of services and making healthcare accessible all.

Based on the recommendations of an assessment carried out in January 2011, the Swiss Red Cross, in collaboration with the Aga Khan University[17] and their local partner Mother and Child Care Trust, is contributing to the pool of *lady health visitors* by training and expanding midwifery skills and increasing their number at different levels of healthcare, i.e. village, basic health unit and secondary health provider (the thesil (administrative division) headquarters and district hospital) in rural areas of Dadu district, Sindh province.

The *lady health visitors* receive training in emergency obstetric care and resuscitation techniques and have access to emergency medicines. Furthermore, they receive regular on-the-job training not only in technical terms, but also in good conduct and behaviour, as well as in maintaining cleanliness and sterility. A strict monitoring system helps to adhere to processes and reduces misuse of drugs and equipment. The *lady health visitors* are on call around the clock for deliveries, and conduct regular home visits. In case of complications and emergency delivery, they accompany the pregnant woman to the nearest hospital with vehicles specially available for emergencies. At the referral hospital, a *lady health visitor* is responsible for the quick administration and treatment of the referred pregnant women. The project is fully embedded in the governmental public health system and enjoys good collaboration among the different partners in health.

To improve infrastructure facilities for patients, the maternal newborn and child health bay and paediatric wards in the thesil headquarter hospital has

16. *Statistics used in this section have been taken from UNICEF's* Pakistan Annual Report 2012. *Available at: www.unicef.org/pakistan/UNICEF_-_Annual_Report_2012_-_Version_8.0.pdf*

17. *This particular project is being conducted by the Women and Child Health Division of the Aga Khan University since it has extensive experience in the delivery and development of maternal newborn and child health approaches and community-based intervention packages in Pakistan and is embedded in and trusted by communities and institutions in the region. The Pakistan Red Crescent Society has endorsed the project and is in agreement with the planned cooperation.*

Monika Christofori-Khadka/Swiss Red Cross

been renovated and equipped with the necessary instruments and essential and lifesaving medicines. Likewise basic health units have received essential medicines and equipment. Additional staff for medical care have also been hired. All medicines are given free of cost to the patients.

Furthermore, community mobilization activities to sensitize the community to the services and the transport system so that they can access the facilities are also carried out. The project staff conduct group sessions as well as one-to-one sessions with mothers, fathers and other stakeholders. The male community mobilizers support *lady health visitors* in raising awareness about safe delivery in a public facility among male members of the household.

In another project that is being implemented in Balochistan, the Pakistan Red Crescent Society operates three basic health units and one mobile health unit in three districts – Quetta, Sibi and Chamman, providing curative and preventive health services with special focus on mothers and children.

The teams include male and female doctors, *lady health visitors* and two community mobilizers linking the communities with the formal health system.

In some areas, literacy levels are low and cultural values do not encourage women to make independent decisions. Counselling sessions tackle cultural beliefs that stop people from using family planning services and provide advice and health checks as well as access to contraceptives.

Achievements

The scale-up and presence of health workers who have been trained as midwives in target communities of Sindh province has resulted in an increase in uptake of antenatal care services by 50 per cent in basic health units and 100 per cent in the district hospitals. In two out of five basic health units the institutional deliveries have increased three-fold. In the district hospital the figures have gone up by more than two-fold. The utilization increased because of better level of quality of care being provided by medical staff, 24-hour attention, improved infrastructure, availability of drugs and improved quality of care and behaviour by the trained staff.

In the first half of 2014, 881 deliveries were conducted by skilled birth attendants, 20,560 women attended safe motherhood outpatient services and more than 4,400 children were treated in the tehsil hospital. In terms of patient turnover, the thesil headquarters hospital in Khairpur Nathan Shah has turned into

the best performing and most highly frequented tesil hospital in Sindh province within a time frame of two-years.

The mother-in-law of a pregnant woman says, “We are very happy with the services this hospital [tehsil headquarters hospital] has given to us. We are poor, we cannot pay, but still everything is available. We are treated nicely with good behaviour by the staff. I brought my daughter-in-law to deliver here because I have full trust in the staff and that all goes well”.

Besides the quick increase in service uptake, the project created a sense of ownership with the community and increased their confidence in the public health system. Advocacy from community- to policy-level is geared towards positive change and has enabled an increase in and retention of *lady health visitors*. Vested interest by politicians in the hospital have resulted in public investments for hospital renovation and the water supply, as well as a gradual increase in medicine supplies paid by the hospital or public authorities budget.

In 2013, the four clinics run by Pakistan Red Crescent Society provided basic healthcare services to over 70,000 vulnerable people including 27,000 women and 28,000 children. The basic healthcare services package includes appropriate clinical and preventive services with free medicines. The priority diseases include diarrhoea, acute respiratory tract infections and malnutrition among children. There has been a significant increase in uptake of family planning services, growth monitoring and child immunization. During 2013, there were 15,000 clients for family planning services, 4,200 children screened for growth monitoring and 4,400 children immunized for vaccine preventable diseases. This is indicative of the fact that the acceptability of the Pakistan Red Crescent Society health services in the catchment areas has significantly improved.

Lessons learnt

1. Adapting to cultural contexts to reach the most vulnerable is at the core of facilitating change at the grassroot level and improving access to reproductive, maternal, newborn and child health. The *lady health visitor* programme is key to provision of healthcare for rural women and children enabling them to access services at their doorstep.
2. Rehabilitating and equipping the infrastructure is important particularly with increases in the number of patients attending the health facilities. Rehabilitation of the infrastructure and better equipment help to augment patients’ confidence and trust and may assist staff performance, particularly in emergency cases.
3. Knowledgeable and caring staff with good conduct are important. In the absence of doctors, staff taking on additional responsibilities and tasks is an important factor and may be life-saving for pregnant women. Increased task shifting can help to reduce maternal and infant mortality significantly. It does, however, require good training and supervision.
4. Government interest and investment can be maximized by working in an integrated way with the public health facilities at various levels and ensuring a functional referral system. However, changing attitudes takes patience and time.
5. Tackling the four delays during pregnancy and delivery has significantly contributed to a reduction in maternal deaths.
6. The trust of the communities in complex situations, in the areas of abject poverty, low literacy level, strong cultural beliefs and worsening law and order situation can be gained by adopting culturally appropriate techniques.

1.10 Somali Red Crescent Society

Country context[18]

The maternal and child mortality rates for Somalia are amongst the highest in the world. In terms of under-five mortality, Somalia ranks four. Leading causes of infant and child mortality are attributed to illnesses such as pneumonia (24 per cent), diarrhoea (19 per cent), measles (12 per cent) and neonatal disorders (17 per cent). High maternal mortality rates are linked to lack of access to emergency obstetric care for timely treatment of childbirth-related complications such as haemorrhage, obstructed labour and infection.

Local environment and approach

Since 1991, the Somali Red Crescent Society has been delivering integrated healthcare programmes to the communities initially with a network of static maternal and child health/outpatient clinics and later, mobile health units across the three zones, i.e. Somaliland, Puntland and central and south Somalia. Delivery of key services to prevent maternal and child morbidity and mortality forms the core of the Somali Red Crescent Society's health programming. This includes:

- Safe motherhood including referral of complicated cases to regional hospitals
- Expanded programme on immunization
- Therapeutic and preventive nutrition services
- Case management of childhood and common ailments
- Health promotion and education activities in the communities

Safe motherhood is one of the essential health services provided by health workers. The Somali Red Crescent Society has a history of working with and supporting traditional birth attendants (now re-trained and re-designated health promoters) who provide a link between the community and the health facilities and support clinical attendance[19]. The clinic staff work with traditional birth attendants (health promoters) who provide information on antenatal care, vaccination (tetanus toxoid vaccine) and births and bring or refer women in labour to the clinic for facility-based deliveries, postnatal care and infant and young child feeding.

In 2013–2014, a baseline survey[20] showed small but significant gaps between knowledge and attitude towards antenatal and postnatal care and practice despite awareness that pregnant women should attend three or more antenatal check-ups. Across all three zones, attendance at a postnatal care clinic six weeks after the birth of a child is thought necessary by fewer than 20 per cent of the respondents[21]. With the exception of clinics in Somaliland, the number of postnatal care consultations at the Somali Red Crescent Society clinics is low compared to live births and antenatal care visits.

SOMALI: KEY FACTS

One in every 12 women dies due to pregnancy-related reasons

9% births are attended by skilled birth attendants

One in every ten children dies before its first birthday

One in five children is acutely malnourished in most regions of south Somalia

[Source: UNICEF. January 2013]

18. *UNICEF. Child and Maternal Health. Available at: www.unicef.org/somalia/health_53.html*
19. *Somali Red Crescent Society and IFRC. Integrated healthcare programme: Baseline survey. June 2014. The interviews were a part of this survey. The findings the baseline survey show that the use of traditional birth attendants is high. The survey results for Puntland and Somaliland showed widespread support for facility-based deliveries. However, in central and south Somalia respondents believe that facility-based delivery is for "sick" women (complicated deliveries) and that the decision as to whether to deliver at home or at a facility is made by the traditional birth attendant.*
20. *Somali Red Crescent Society and IFRC. Integrated healthcare programme: Baseline survey. June 2014.*
21. *Somali Red Crescent Society and IFRC. Integrated healthcare programme: Baseline survey. June 2014.*

Immunization is among the most cost-effective services available to prevent childhood illness. All maternal and child health/outpatient clinics and mobile health units operated by the Somali Red Crescent Society in Puntland and Somaliland provide daily service for routine immunization, as well as service through mass health activities such as National Immunization Days. However, in central and south Somalia, lack of security and access have rendered it impossible to immunize many children for over three years. The militant group fighting the federal government does not allow house-to-house visits or mass public campaign activities, thus limiting access of the population despite their knowledge of the importance of vaccination to prevent disease among children. Delivery of immunization activities in this zone is limited to 15 out of 30 static clinics and two mobile clinics. This number fluctuates due to the security situation.

The Somali Red Crescent Society clinics routinely provide nutrition services to all under-five children irrespective of their nutrition status. Severely malnourished children without complications are admitted to the outpatient therapeutic feeding programme for treatment. Moderately and severely malnourished children with complications are referred to facilities managed by other partners that run supplementary feeding programmes.

Feeding practices relating to breastfeeding – including breastfeeding within the first hour of an infant's life, exclusive breastfeeding for the first six months and continued breastfeeding for up to two years – are extremely poor at 23 per cent, 5.3 per cent and 26.8 per cent respectively[22]. "Culturally, many grandmothers and mothers believe water and sugar are a good first food for newborn babies. There are also socio-economic factors, such as food insecurity, which result in poor diets for all members of a household, and which particularly affect lactating mothers and young children," comments Hassan Abdi Jama, Deputy National Health Officer. To address this issue, the Somali Red Crescent Society has launched an infant and young child feeding programme and has increased training for midwives, nurses and traditional birth attendants, and all Red Crescent midwives and nurses are trained to counsel pregnant or lactating women.

Achievements

The cooperation between the Somali Red Crescent Society and the local health authorities has enabled hard-to-reach communities to access healthcare, bridging the gap between the formal and community health systems. By the end of 2013, the National Society was operating 58 static and 23 mobile clinics across all the 19 regions of the country, enabling communities to access healthcare services. A total of 14,217 pregnant women went for the first antenatal visit, 11,330 for their second visit and 10,797 for their third visit. Three thousand seven hundred and twenty babies were delivered in clinics with 15,701 women accessing postnatal care services.

The Somali Red Crescent Society has vaccinated:

	Static Clinics 2012		Static clinics 2013		
	Somaliland	Puntland	Somaliland	Puntland	Total
Antenatal care 3+ visits	14,103	6,904	17,828	9,880	48,715
DPT3 (< 1 year)	18,143	4,621	22,462	5,004	50,230
DPT3 (> 1 year)	12,386	2,680	4,796	1,011	20,873
Measles (< 1 year)	17,070	4,771	18,565	5,576	45,982
Measles (> 1 year)	26,968	5,568	23,818	3,199	59,553
Tetanus Toxoid2 (Pregnant women)	11,867	3,142	10,324	4,266	29,599

22. *UNICEF. National Micronutrient and Anthropometric Nutrition Survey. 2009*

Somali Red Crescent Society

Lessons learnt

1. The use of volunteers and traditional birth attendants as health promoters in the community has been vital in promoting health seeking behaviour and practices at the community level. This strategy needs to be strengthened with both continuous training and appropriate tools to enable them to reach the community with greater success.
2. An increased partnership in a multi-sectorial approach has had a positive impact on the programme. It is estimated that unskilled health workers perform 90 per cent of the deliveries at home. However, the trend is changing within the target communities. This change can be attributed to the partnership with the World Food Programme (WFP) as well as the improved quality of services with the addition of maternity wings with delivery facilities at the maternal and child health/outpatient clinics. The provision of a food ration for antenatal mothers, mothers who deliver at the health facilities, post-natal mothers and infants in the collaboration with the WFP, appears to promote the increased use of the health facilities by pregnant and lactating mothers.
3. A potential area for reducing child, neonatal, and maternal mortality is increasing knowledge of danger signs and a facilitated referral process.
4. There is limited immunization coverage particularly in central and south Somalia due to lack of security.

Disclaimer: This case study makes references to Somaliland, Puntland and central and south Somalia as zones in Somalia. The Red Cross and Red Crescent Movement recognizes Somalia as one country.

Section 2 Finding the way forward

1. Continuum of care

Finding: With a few exceptions, current RMNCH programmes that are being implemented by the Red Cross and Red Crescent address certain aspects or a life stage along the RMNCH continuum. It is imperative to recognize that RMNCH cannot be addressed in isolation as each stage is linked to the health status across various stages of life. For example, the health of an adolescent girl has an impact on pregnancy and a newborn's health is impacted by the health state of the mother. RMNCH interventions are required at various stages that are interlinked. There remains a sizeable gap between effective programmes addressing the reproductive needs of adolescent girls and procedures to ensure safe abortion. Furthermore, while some National Societies are addressing morbidity and mortality of under-five (integrated case management of childhood illnesses and integrated community case management), programmes generally remain fragmented.

Learning: To have a greater and meaningful impact on reducing maternal and child mortality, RMNCH programmes must be implemented to cover the complete cycle of the continuum of care. Recognizing the fact that the needs are huge and resources few, to aid the work of National Societies, the IFRC secretariat will produce guidance on how to effectively and efficiently further current activities by including essential elements while working across the continuums of resilience, lifespan and healthcare.

2. Volunteer empowerment

Finding: Evidence shows that community health volunteers, as part of the community-based health workforce, are unique resources in bridging the gap between communities and the health systems. Trained community health volunteers are delivering crucial messages related to RMNCH and facilitating access to preventive and curative healthcare services, thus contributing to reducing maternal and child mortality. In Honduras, Nicaragua and Pakistan, volunteers are being recognized for their contribution in working with the Ministry of Health.

Learning: Programmes that work across the spectrum from community engagement to health system strengthening contribute to better access, referral and care. Changing mind-sets with innovative and culturally appropriate ways ensures women in rural communities can access healthcare services. Strengthening capacities of health professionals, equipping health facilities ensures availability of good quality and appropriate care.

3. Increasing access to healthcare

Finding: Community health volunteers are going the extra mile by not only connecting the communities with the health facilities but also accompanying pregnant women for health checks and in cases of complications, arranging for transportation and covering part or all of the associated expenses. They are also actively encouraging communities to set up a contingency fund so as to be able to cover costs. For example, the Myanmar Red Cross Society volunteers work together with the community and subsidise medical and transportation costs as necessary. However, it is not always possible for communities that are living in dire poverty to set aside funds or pay back loans incurred seeking healthcare. A failure to address the issue of healthcare costs while encouraging communities to engage with health services can have a serious negative impact on household economics.

Learning: Simply connecting communities with health care systems is not enough to ensure an accessible and affordable service. For an effective plan, income generation strategies and micro-finance projects need to be incorporated into community-based RMNCH projects.

23. *IFRC and The Canadian Red Cross Society. Maternal, Newborn and Child Health in the Americas: A report on the commitments to Women and Children's health. Geneva, 2013. Available at: www.redcross.ca/crc/documents/What-We-Do/Worldwide-Health/a-report-on-the-commitments-to-womens-and-childrens-health.pdf*

4. Gender equality and empowerment

Finding: Gender-related attitudes have a direct impact on the health and well-being of women and girls. Promoting gender equality by empowering women and adolescent girls and engaging men and adolescent boys is fundamental to improving sexual and reproductive health and RMNCH outcomes. Evidence from the experience in Honduras and Liberia shows that programmes actively engaging men lead to changes in attitudes and behaviours in these areas.

Learning: t is important in any community-based programme to identify issues specific to groups of men and women of different age and social backgrounds during community assessments and action plans which must be taken into account to improve effectiveness. Programmes can have a formal community feedback mechanism that can help study and plan the subsequent course of working. The underpinning requisite for this is "participation" and not "consultation".

5. Developing synergies

Finding: Based on the literature reviewed, it is evident that a number of supporting National Societies are facilitating the implementation of RMNCH programmes in the same country. It seems that there is little coordination or complementarity in linking-up these projects or replicating what is working well.

Learning: To enhance the outcomes of the project by covering the continuum of care and for scale up IFRC, supporting National Societies and other partners should coordinate efforts. A common platform to share learning, analyses and trends, and to rely on each other's strengths is crucial. This review has provided an insight into the bottlenecks in information sharing, most of which should be readily available. Currently it is not easily accessed. To facilitate information sharing, the IFRC secretariat is working on establishing a common platform whereby National Societies can share information and better collaborate in implementing RMNCH initiatives.

6. Horizontal and vertical integration

Finding: One of the findings of the RMNCH review in the Americas (Recommendation 3) that applies to other National Societies is that most of the work is based on dissemination of knowledge, institutional health promotion and supporting the government's implementation of institutional RMNCH activities.

Learning: Continued collaboration and communication with the government and health ministries is required to ensure that both community and institutional RMNCH programmes are covered. Whether we are working only in communities, just with health systems or with both, it is essential to remember the continuum of care in RMNCH. No intervention in RMNCH can be implemented in isolation (community – clinical and vice versa). Linking interventions is imperative since it not only reduces costs by allowing greater efficiency but also increases uptake and provides opportunities for promoting healthcare. Cooperation strategies need to be in place with governments and other stakeholders to ensure complementarity between preventative and curative care.

7. Resource mobilization

Finding: National Societies are committed to working with their governments and implementing RMNCH activities. However, programmes are coming to an end due to lack of RMNCH-specific funding.

Learning: Some National Societies (Honduras, Myanmar, Nicaragua, Pakistan and Somalia among others) have data available on the impact of their RMNCH programmes in reducing maternal and child morbidity and mortality in target communities. Dedicated efforts and continuous capturing of impact and evidence that programmes are sustainable beyond the project period is one of the crucial selling points to seek RMNCH-specific funding, replicating and scale-up activities.

8. Linking programmes

Finding: Prevention of mother-to-child transmission of HIV and sexual and reproductive health rights are generally covered by HIV prevention and care. They do not always link-up with RMNCH programming. Both of these aspects are crucial to the continuum of care.

Learning: The Ethiopian Red Cross Society is one of the few National Societies that addresses prevention of mother-to-child transmission of HIV with an RMNCH perspective. Good linkages and synchronization is essential for effective, efficient outcomes and maximizing the impact of the programmes by streamlining and closing clinical shifts in pathways of care.

9. Value of partnerships

Finding: In many countries, access to health and availability of healthcare services is massively impacted by wealth, location (urban versus rural settings), social exclusion, lack of funding for services, or geographical isolation (Guatemala, Honduras, Liberia, Myanmar and Pakistan among others). These disparities have an impact on who has access to RMNCH services.

Learning: With its network of volunteers and strong partnerships, the Red Cross Red Crescent has access to remote communities. Evidence shows that National Societies have been able to provide RMNCH care and consequently have a positive impact on health outcomes in communities. Collaboration with the government and external partners to identify communities with high health needs and providing capacity building on RMNCH at all levels within the project has been giving positive dividends. In some cases, National Societies (Haiti, Pakistan and Somalia among others) are collaborating with external partners to increase impact and community reach. Moving from coordination to collaboration with as many actors in the area should be explored. Essentially, a formal method of engagement with structures in the Ministry of Health and other actors working in health and WASH is critical for sustaining the achievements and developing further.

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Yoshi Shimizu / IFRC

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

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