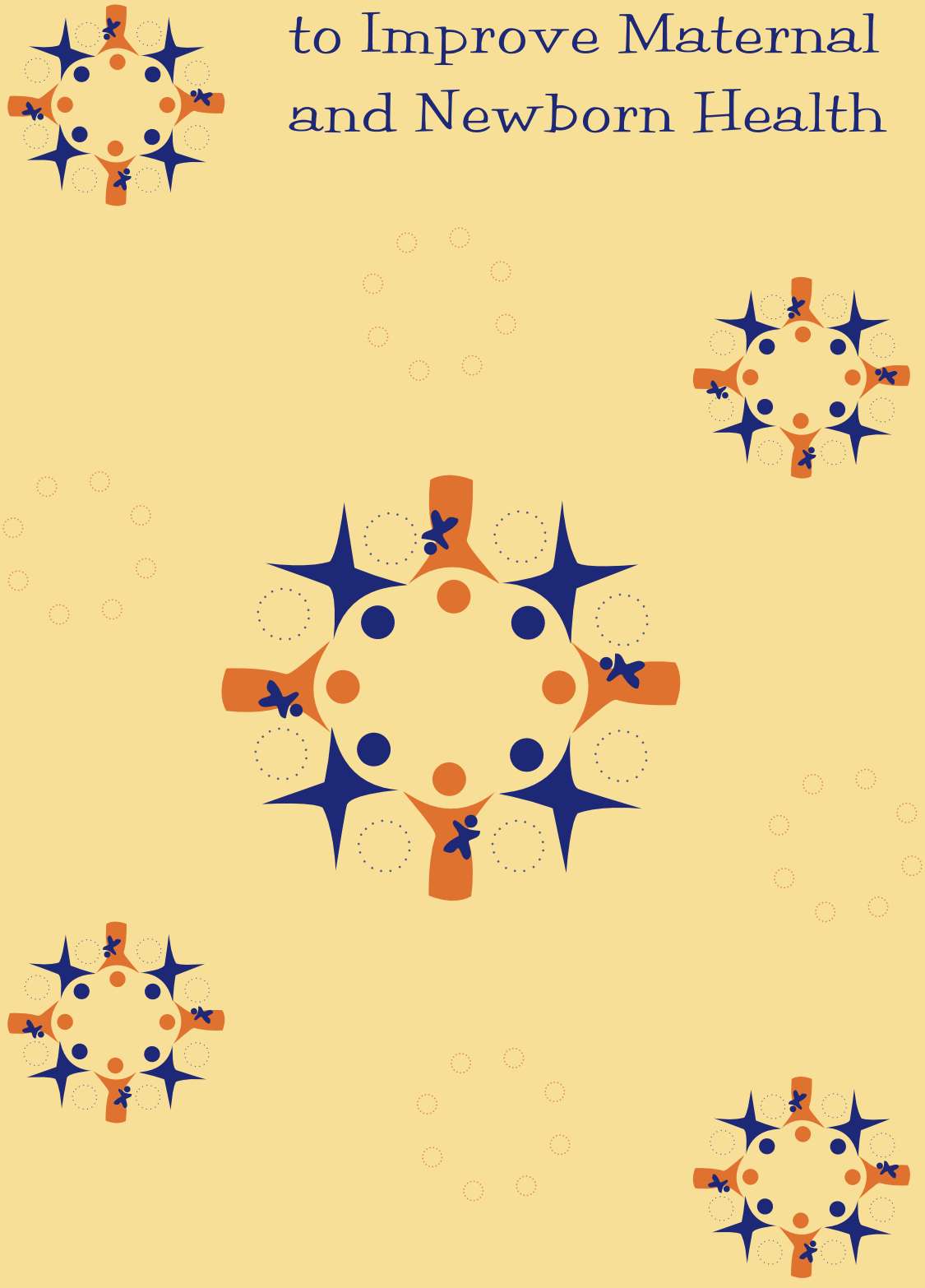
Working with Individuals, Families and Communities to Improve Maternal and Newborn Health



World Health Organization

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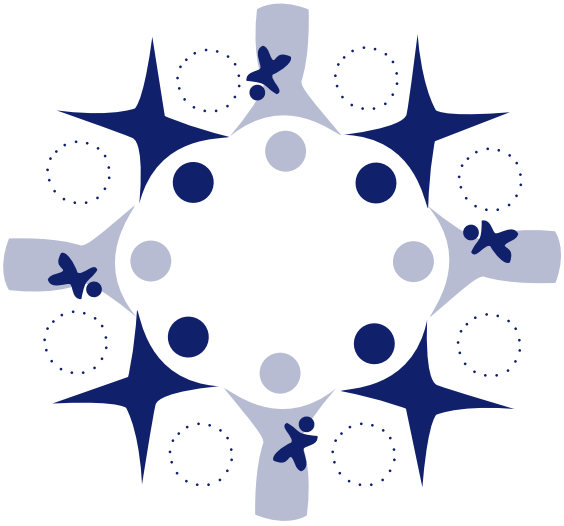

World Health Organization

Department of Making Pregnancy Safer

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ABBREVIATIONS

AFRO	WHO Regional Office for Africa
AIDS	Acquired immune deficiency syndrome
AMRO	WHO Regional Office for the Americas
BCC	Behaviour change communication
bEOC	basic essential obstetric care
CAH	Department of Child and Adolescent Health and Development/WHO
CHW	Community health worker
DFID	Department for International Development (United Kingdom of Great Britain and Northern Ireland)
DOTS	Directly Observed Treatment, Short- course (WHO recommended TB control strategy)
EMRO	WHO Regional Office for the Eastern Mediterranean
EPI	Expanded Programme on Immunization/WHO
EURO	WHO Regional Office for Europe
FCI	Family Care International
FP	Family planning
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmBH (German Technical Co-operation)
HCD	Health care delivery
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IFC	Individuals, families and communities
ILO	International Labour Organization
ILO/STEP	Strategies and Tools against Social Exclusion and Poverty/ILO
IMCI	Integrated Management of Childhood Illness
MNH/JHPIEGO	Maternal and Newborn Health/John Hopkins Program for International Education in Gynecology
MPS	Department of Making Pregnancy Safer/WHO
NGO	Nongovernmental organization
NMH	Non-communicable Diseases and Mental Health/WHO
OR	Operations research
OSD	Department of Organization of Health Services Delivery/WHO
PAHO	Pan American Health Organization
RBM	Roll Back Malaria Partnership/WHO
RHR	Department of Reproductive Health and Research/WHO
RTIs	Reproductive tract infections
SEARO	WHO Regional Office for South East Asia
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
Stop TB	Department of Stop TB/WHO
SWAps	Sector-wide approaches
TBA	Traditional birth attendant
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHCs	Village health committees
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

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EXECUTIVE SUMMARY

The Making Pregnancy Safer (MPS) Department was established to enhance WHO's efforts in Safe Motherhood. MPS states that both improvement of health services and actions at the community level are required to ensure that women and their newborns have access to the skilled care they need, when they need it.

Working with individuals, families and communities (IFC) is considered by MPS to be the critical link in ensuring the recommended continuum of care throughout pregnancy, childbirth and the postpartum periods. Furthermore, it is recognized that the availability of quality services will not produce the desired health outcomes where there is no possibility to be healthy, to make healthy decisions, and to be able to act on those healthy decisions.

Based on the Health Promotion approach as outlined in the Ottawa Charter, the present document proposes a framework for the development of interventions at the IFC level to improve maternal and newborn health. It is a first step for the WHO MPS towards the elaboration of a consistent and validated IFC approach.

The aim of working at this level is to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and newborn health, as well as to increase the access and utilization of quality health services, particularly those provided by the skilled attendants. Interventions are organized into four priority areas:

- developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies;
- increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health;
- strengthening **LINKAGES** for social support between women, men, families and communities and with the health care delivery system;
- improving **QUALITY** of care and health services and of their interactions with women, men, families and communities.

A comprehensive strategy, with interventions from each one of the four priority areas, is recommended. The complex nature of maternal and newborn health, and of work at the IFC level, requires an integrated approach that maximizes the benefits of a broad range of activities, both internally within the health system and externally with other sectors (intersectoral approach), in particular with education and income-generating programmes.

Making Pregnancy Safer has specific roles, based on the mission and comparative advantages of WHO. Major efforts for working with individuals, families and communities to improve maternal and newborn health will be expended in the following areas of action:

- building a body of research and experiences related to this area,
- actively promoting the critical importance of this work, and
- establishing partnerships for implementation within maternal and newborn health strategies.

1. INTRODUCTION, BACKGROUND AND CONCEPTS

1.1 Introduction

The Making Pregnancy Safer (MPS) initiative was launched in 2000 to enhance WHO's efforts in Safe Motherhood. The initiative (now a Department within WHO) is oriented to assist countries in strengthening their health system, focusing on evidence-based interventions that target the major causes of maternal and newborn mortality and morbidity. It states that both improvement of maternal and newborn health services and actions at the community level are required to ensure that women and their newborns have access to the skilled care they need, when they need it. Further, the important role of women, their partners, families and the larger community in improving health is emphasized.

The purpose of this document is to establish a common vision and approach, as well as to identify the role of the WHO Making Pregnancy Safer initiative, for working with women, men, families and communities to improve maternal and newborn health. Part 1 of the document defines the concepts, values and guiding principles; Part 2 presents strategies, settings, and priority areas of intervention; Part 3 proposes an implementation process; and, finally, Part 4 considers the role and functions of WHO.

The main conceptual basis for the development of the document is the Health Promotion approach as outlined in the Ottawa Charter, 1986,[1] hereinafter referred to as "Health Promotion", which emphasizes the positive and active role played by individuals and groups to improve health, and the wide array of influences on health (see Annex 1 for a brief presentation of Health Promotion). Other important references include several WHO regional and country strategies for working at the community level for maternal and newborn health, as well as the report of an informal consultation on the subject held at WHO Headquarters in October 2001.

The primary audience of this concept and strategy paper are also its main contributors: the WHO Making Pregnancy Safer global team, other WHO staff involved in maternal and newborn health work, Safe Motherhood partners and other technical specialists in related areas. The paper is the result of a consultative process, including visits to Bolivia and Indonesia, participation in the Reproductive Health programme managers' meeting of the African Region and meetings with WHO Reproductive Health Advisers and partners.

1.2 Background

The MPS initiative

The MPS initiative aims to reduce maternal and neonatal mortality and morbidity by contributing to an improvement of care for pregnant women and an increase in the number of women benefiting from skilled attendants during pregnancy, childbirth and the postpartum periods. MPS focuses on six areas

Every year: about 210 million women become pregnant; an estimated 30 million develop complications and 515 000 of these women die; three million babies are stillborn, a further three million die in the first week of life and millions more are disabled. It has long been recognized that these tragedies are largely avoidable.[a]

[a] *Maternal mortility in 1995. Estimates developed by WHO, UNICEF and UNFPA.* World Health Organization, Geneva, 2001. WHO/RHR/01.9

of the MPS initiative work which are: 1) Advocacy, 2) Technical support to countries, 3) Partnership building, 4) Norms, standards and tools development, 5) Research, and 6) Monitoring and evaluation of global efforts.

MPS rationale for working with individuals, families and communities

The rationale is based on a wide array of experiences and lessons learned from Safe Motherhood over the past ten years, on evidence of the effectiveness of Health Promotion as defined in the Ottawa Charter and on various international declarations and consensus statements on the importance of the roles of individuals, families and communities in improving health (see box).

- The conference on Primary Health Care in Alma-Ata in 1978
- The Ottawa Charter of 1986
- The International Conference on Population and Development (ICPD) in Cairo in 1994
- The Fourth World Conference on Women in Beijing in 1995
- The WHO, UNICEF, UNFPA and World Bank joint statement on the Reduction of Maternal Mortality in 1999

With this strong foundation, the Making Pregnancy Safer initiative states that an active role of women, men, families and communities and the development of their capacities for health and making healthy choices are essential for achieving improvements in maternal and newborn health. Further, given the personal, familial and social nature of pregnancy and childbirth, the initiative considers it essential to develop capacities to assure supportive household and community environments.

MPS also states that working with individuals, families and communities is the critical link to ensure the recommended continuum of care throughout pregnancy, childbirth and the postpartum periods. To be effective, the continuum of care should extend from the woman, her family and the community level to the health provider and health services, including access to essential obstetric and neonatal care. This continuum also facilitates access to a skilled attendant when obstetric and neonatal complications arise, which has been identified as one of the most critical health care delivery determinants for the survival of women and newborns.

Finally, in accordance with the *WHO Framework for Health System Performance Assessment* (1999), the Making Pregnancy Safer initiative highlights that individuals, families and communities in their decisions and actions for health, and their expectations of health services, are important actors and resources of health systems.[2, 3] Thus, a health system approach would inherently include strategies for working with health services as well as with individuals, families and communities to improve health.

1.3 The Making Pregnancy Safer concept for working with individuals, families and communities

The concept for working with individuals, families and communities herein proposed by the Making Pregnancy Safer initiative is rooted in the Health Promotion approach defined as "a process of enabling people and groups to increase control over, and to improve, their health and quality of life."[1]

The availability of quality services will not produce the desired health outcomes where there is no

possibility for women, men, families, and communities to be healthy, to make healthy decisions, and to be able to act on these healthy decisions. The interventions at the IFC level are to foster the supportive environments for survival but also for healthier mothers, healthier newborns, healthier families and healthier communities.

The aim of working at the IFC level is to contribute to the empowerment of women, families and communities to improve and increase control over maternal and newborn health, as well as to increase access and utilization of quality health services, particularly those provided by skilled attendants.

- *Empowerment* in this context is defined as a process through which women, men, families and communities gain control over maternal and newborn health and related potential problems. An empowerment process allows them to act for maternal and newborn health and will occur at both individual and collective levels.
- With regards to *access and use of health services* and skilled care, working at the IFC level will allow for developing processes and actions as needed in different contexts to support women and their newborns in accessing and using the quality care they need, when they need it.

The aims will be achieved through strategies of education, community action for health, partnerships, institutional strengthening and local advocacy, implemented largely in the settings of household, community and health services (the concept of "settings" is further developed in the following section). Interventions for working at the IFC level are organized into four priority areas:

- developing **CAPACITIES** to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies;
- increasing **AWARENESS** of the rights, needs and potential problems related to maternal and newborn health;
- strengthening **LINKAGES** for social support between women, men, families and communities and with the health care delivery system;
- improving **QUALITY** of care and of health services and of their interactions with women, men, families and communities.

A comprehensive strategy, with interventions from each one of the four priority areas, is recommended. Increased capacities and awareness of women, men, families and communities need to be developed while strengthening linkages in the communities and between the communities and health services. Also, the development of IFC interventions will not achieve its full effect if maternal and newborn health services are not available and of the required quality. These areas work synergistically to improve maternal and newborn health.

Special importance is to be given to the different interventions that address the status of women, in particular within the family. Health outcomes of pregnant women and newborns, both positive and negative, are determined largely by decisions made within the household.

To be sustainable, maternal and newborn health improvements have to be conceived to facilitate the development of individual and social **CAPACITIES**. Interventions will need to consider how to support the active role of women, men, families and communities in maternal and newborn health, beyond those measures which limit them to passive recipients of messages and care.

Self-care is intended as capacities for healthy living, health-related care and decision-making, including care-seeking behaviours. Self-care is a social behaviour learned in cultural contexts.[4] Women, men, and

families have abilities for self-care that they apply in the area of maternal and newborn health. Efforts need to be aimed at increasing and improving those abilities, such as knowledge, cognitive abilities, and health competencies for making healthy choices.

For the development of capacities, partnerships with the education sector, nongovernmental organizations (NGOs), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and other international agencies will be the best way forward. Interventions in workplaces, schools, adult education and through multi-channel communication must be employed as interacting strategies. Health workers and skilled providers, in particular midwives, can also contribute to improving capacities. The multiplier effect of these efforts is to influence sociocultural norms that are the basis of the low status of women and gender inequity. Girls' education also must be a priority as there is a clear relation between access to education for girls and literacy and reduced maternal mortality.[5]

Closely linked to developing capacities is an increased **AWARENESS** of gender issues and the dimensions of maternal and newborn health, including direct and indirect causes of morbidity and mortality, appropriate care and adequate responses in emergencies. Increased recognition that safe motherhood and birth are human rights, the promotion of the role of men as partners and fathers, and the promotion of support from other family and community influentials[b] are key interventions to increase awareness of maternal and newborn health needs and to reduce gender inequities. These efforts also contribute to preventing violence and discrimination against women, factors that lead to unwanted pregnancies and adverse pregnancy outcomes, including low birth weight. Addressing adolescent reproductive and sexual health in awareness processes is pertinent to reduce teenage pregnancy and gender abuse.

Individual and collective awareness and capacities will be maximized through the establishment or strengthening of *social networks,* which are able to collaborate and interact with *health service networks.*

Community involvement in analysing information on maternal and newborn health creates awareness, and at the same time stimulates social support and participation in problem-solving related to maternal and newborn health. This involvement contributes to the establishment of mechanisms for transparency and accountability of health services to the community.

Individual and collective awareness and capacities will be maximized through the establishment or strengthening of *social networks,* which are able to collaborate and interact with *health service networks.* Partnerships between individuals, community organizations and other actors of the district health system and at the community level are the basis of social networks. All actors and resources should be considered, including traditional healers, health development committees, NGOs and local government. Social network organizations and structures can participate in analysing the situation of maternal and newborn health, finding solutions for transport and health expenses, contributing to improvements in the quality of care, and participating in local level advocacy, resource mobilization and health education processes. In particular, community health financing schemes can increase access and stimulate community action for health.

Social network activities strengthen the **LINKAGES** between pregnant women, mothers and their newborns, the family and the overall community, while reinforcing the linkages with health services. These links foster working alliances for complementary and coordinated actions for maternal and newborn health protection and promotion. These structures are needed to enhance the interface

[b] Within this document, the term "influentials" is used to indicate decision-makers as well as those persons who influence the outcomes of decisions.

between self-care and professional care. Linkages can also be improved by establishing clear roles for existing traditional birth attendants (TBAs), and assuring appropriate relations with the formal health care delivery system. This remains a central issue in a number of countries where TBAs still provide care. Partnerships between TBAs and skilled attendants and their role within the referral system, in the dissemination of health messages and in building social support may be considered.

While it is important to empower communities to work with the health sector, it is just as important to empower the health sector to work with communities. A strong entry point for community and health service collaboration can be through approaches to involve the community in defining and monitoring the **QUALITY** of care. The MPS concept of IFC embraces a community-centred approach to quality; therefore, community involvement in defining quality is key.

In addition to improved services and improved satisfaction with services, community involvement in quality also strengthens relations between the health service and the community. Determinants of use such as belief in the efficacy of care, in the capacity of the care available to solve health issues, and perceived sensitivity to sociocultural realities are also addressed through these approaches. Other ways to improve the quality of maternal and newborn care include developing providers' intercultural and interpersonal skills and assuring a supportive and caring environment during childbirth.

International and national partners should advocate addressing the underlying factors of improved maternal and newborn health, in particular poverty alleviation, gender equity, and the education of girls and women to produce the desired long-term improvements. IFC interventions should work closely with these advocacy efforts at the district health system level, to raise awareness, improve the quality of services, build alliances with other sectors, and influence decisions for finding solutions and allocating resources for maternal and newborn health.

Prevention of unwanted pregnancy and reproductive tract infections (RTIs), malaria, HIV/AIDS and the prevention and management of unsafe abortion represent other related sexual and reproductive needs to be addressed where appropriate at the IFC level. In particular, adolescent reproductive and sexual health should be considered through a strong collaboration with relevant partners. Both poor and good health are cumulative and reflect an individual's development experiences over time (family health cycle approach).[6, 7]

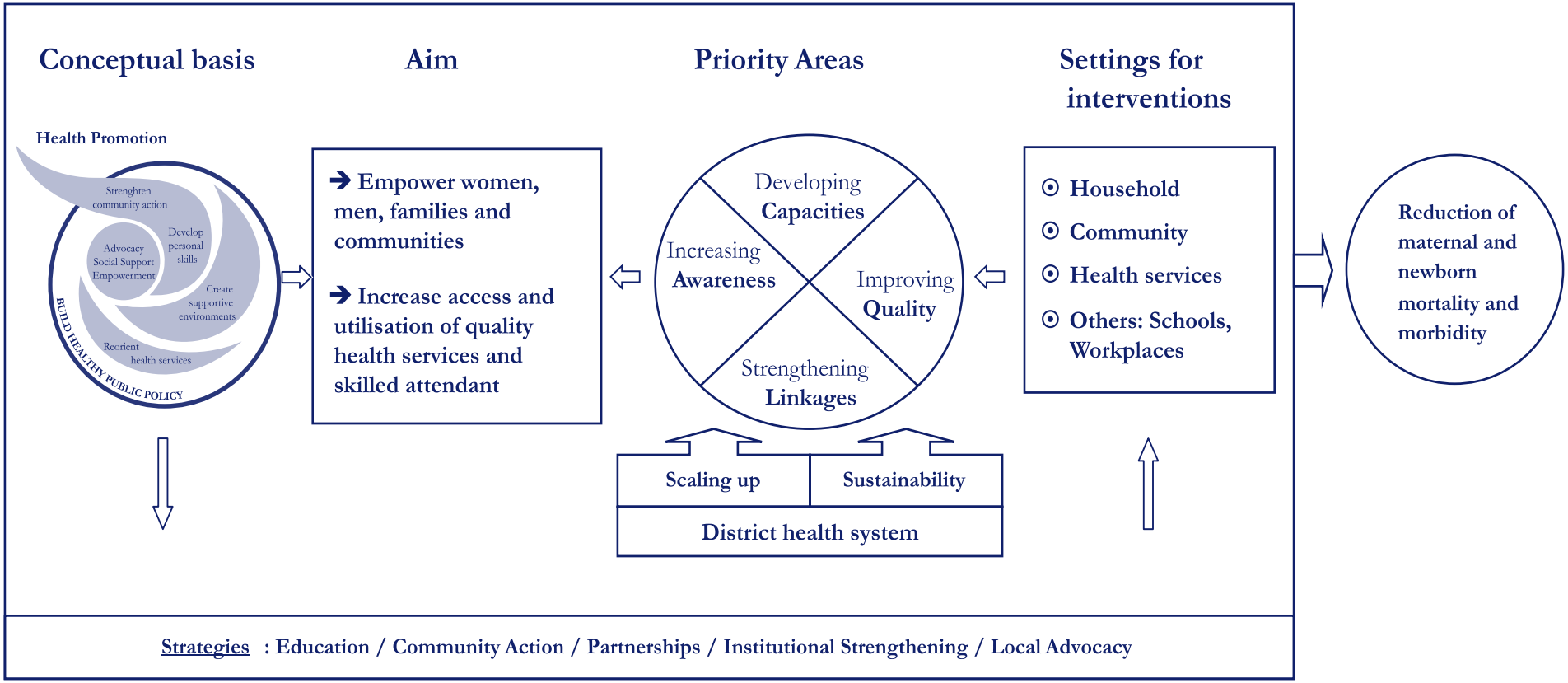
The complex nature of maternal and newborn health, and of working with, and at, the individual, family and community level, requires an integrated approach that maximizes the benefits of a broad range of activities, both internally within the health system and externally with other sectors, in particular with education and income-generating programmes. Comprehensive strategies, based on the synergies between areas of intervention, should respond to a specific region's, country's and district's needs and priorities. Simply said, there is no silver bullet.

1.4 Guiding principles

Principles guide the work with individuals, families and communities to improve maternal and newborn health, namely: 1) pursue social justice and poverty reduction to address health inequities, 2) facilitate the respect, protection, and fulfilment of the human rights of women, men, adolescents and newborns, 3) respect the basic values of choice, dignity, diversity, and equality, 4) address gender and cultural sensitivity, and 5) emphasize existing social and personal resources. These principles form the underlying basis for the implementation of the strategic framework of interventions at the IFC level, presented on the next page.

1.5 Strategic framework for the development of IFC interventions

Health Promotion is "a process of enabling people and groups to increase control over, and to improve, their health and quality of life".[3]



Source: Adapted from Indonesia Health Promotion concept, Healthy Indonesia (July 2002)[8]

Health promotion image (see page 46 for a larger image) adapted from *National Safe Motherhood Action Plan 2001-2005: Western Pacific Region* [9]

2. STRATEGIES, SETTINGS AND PRIORITY AREAS

2.1 Strategies

The strategies to achieve the aim of working with individuals, families and communities for improved maternal and newborn health are outlined in this section of the document. These strategies have been identified because of their long-term perspective, their capacity to achieve the proposed aims, and their relationship with the priority areas of intervention set forth. These strategies are intended to interact and be mutually reinforcing.

Education

Education is cited in the Declaration of Alma-Ata as the first of eight essential elements of primary health care and is considered as one of the more important contributors to maternal and newborn health.[10, 11] For the purpose of this work, education refers to a) health education and a health sector responsibility and b) health sector collaboration with the education sector (basic and adult education). The term "Health Literacy" is often defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[10] Education for IFC builds on health literacy, and goes further to provide women, men, families and communities with the knowledge and skills to act, maintain, preserve, promote and improve maternal and newborn health.

A broad perspective for health education is required, that would include:

- intrapersonal factors (knowledge, attitudes, behaviours, self-concept, skills);
- interpersonal processes (social support systems, families, work groups);
- institutional factors (social and health institutions);
- community factors (relationships among organizations and groups);
- public policy (local and national laws and policies).[12]

Communication approaches such as information, education and communication (IEC), social marketing, and behaviour change communication (BCC) represent systematic attempts to influence positively the health practices of large populations.[11] Their main goal is to bring about improvements in health-related practices. The MPS IFC approach proposes that communication approaches will be combined with health education approaches for empowerment.

We distinguish here between the education approach proposed for MPS and the mentioned communication approaches in that the former promotes social support and has an ultimate goal of individual and community empowerment, rather than a focus on achieving a desired behaviour.[11] More specifically, socio-interactionist education approaches will be promoted as a theoretical basis, as they are more likely to empower individuals and groups.[13] Furthermore, education processes should be oriented to create knowledge, not deliver knowledge. The assumption is that knowledge is developed and obtained through a process of critical reflection and deliberation where new knowledge is linked to existing knowledge.[14]

Collaboration with the education sector in basic and adult education programmes is complementary to health education actions. This can be achieved mainly through the introduction of maternal and newborn and reproductive health issues into these programmes. This collaboration provides a cost-effective way to influence some of the underlying factors of maternal and newborn morbidity and mortality including societal norms related with women's status, sexuality and capacities for self-care.[15]

Community action for health

Community is defined within MPS as a pertinent group of people, sharing common needs and problems. The concept of community goes beyond a geographical expression (which is the meaning most commonly used). An idealistic vision of the community, as being a homogeneous group with shared values and norms, a collective personality and a willingness to work together to resolve problems, must be put aside. There is a need to take into account economic and social differences and interests within the community when working at the IFC level. Interventions in the community setting must begin with a clear and unambiguous identification, based on economic and social criteria, of the people who constitute the "community".[16]

"Community dialogue" recognizes the central role of communities in decisions and actions that influence their health and well-being.

The concept of IFC interventions embraces the model of "community action for health", defined as "a complete and sustainable process in which any community–social, geographical or professional– is involved as a full partner at all stages of the health care process. Identification of needs, selection of priorities, planning, implementation and evaluation of activities occur in close cooperation with the health sector, as well as with other sectors concerned."[17]

As with education, community action for health is critical in all the priority areas of interventions outlined below. The community has a particularly strong role to play in strengthening linkages with health services (financing and transport schemes), in increasing awareness of maternal and newborn health needs (community epidemiological surveillance, etc.) and in improving the quality of care (community involvement in quality). In these areas, increased knowledge of the community results in increased action for health and increased participation in problem-solving to meet maternal and newborn health needs.

"Community dialogue" (between the community and health services) is an innovative methodology that can serve to improve mutual understanding and increase awareness of the reality, perspective and conditions of the other party.[18, 19] Dialogue is a discussion process to exchange ideas and opinions, aimed at seeking a solution. It recognizes the importance of current knowledge as a starting point, of introducing information on maternal and newborn health needs for discussion and debate and of the central role of communities in decisions and actions that influence their health and well-being.

Consistent with a Health Promotion approach, "community dialogue" seeks to empower individuals and groups, and to facilitate a deeper understanding of the efforts of the communities, households and women in promoting healthy pregnancy and childbirth, so that interventions and contributions from the outside can be more relevant and appropriate.[18, 19]

Partnerships

Partnership is defined as "a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labour".[20] Building partnerships is an essential element of the implementation process of the IFC component, as described in Parts III and IV below. Partnerships are foreseen nationally (within the district health system and externally with other sectors) and regionally and internationally (between the different United Nations organizations, bilateral organizations, technical assistance agencies and international NGOs). Forming partnerships between a variety of organizations, including ministries, international agencies, community groups, NGOs, and private groups, both at the national, intermediary and district levels is essential for scaling up of interventions and sustainability.

Partnerships within the district health system

Different countries have experiences in partnerships to facilitate coordination between public and private health services, and between the Ministry of Health, NGOs and community organizations.[c] WHO has developed related experiences known as "local systems" and "partnerships for health".[21] Partnerships at the district level are essential to assure coordination and convergence of efforts, ensure quality and avoid duplication of activities. Also, formal coordination between public and private actors would be useful to develop coherent health planning at the local, intermediary and national levels.

Intersectoral partnerships

In accordance with a Health Promotion approach and with several World Health Assembly resolutions promoting the concept of intersectoral action,[21] determinants such as nutrition, education for women and transport infrastructure need to be included in efforts to improve maternal and newborn health. At the national level, intersectoral partnerships should be promoted with relevant ministries, international agencies and NGOs. At the district health system level, intersectoral partnerships provide opportunities for local government, NGOs, civil society organizations, and other stakeholders to actively collaborate for maternal and newborn health. Existing platforms or collaborations both at national and local levels should be considered.

Attention must be given to strengthening intersectoral efforts that link social and development activities to maternal and newborn issues, for example, agriculture-related projects that increase the quantity and variety of food relevant for nutrition of pregnant women, or microenterprise and microcredit activities to be combined with health insurance schemes. Intersectoral efforts are not based on formal and rigid structures and are not integral development programmes, but are primarily for information sharing, collaboration and coordination.

Coordinated approaches such as the United Nations Development Assistance Framework (UNDAF) can help to minimize duplication and wasted efforts at the district level. The framework aims to draw all of the United Nations agencies and the World Bank into the development of joint programme activities, based on intersectoral and coordinated approaches.[22] Sector-wide approaches (SWAps) have also been promoted to set up needs-based mechanisms for pooling available resources and allocating them to primary care, as an intent to improve management of cooperation and outcomes.[22, 23]

[c] Examples: "Unité Communautaire de Santé" in Haiti, "Sistemas Integrales de Atención en Salud" in Guatemala, Community Driven Development (CDD) promoted by the World Bank.

Institutional strengthening at the district health level

As decentralization occurs, efforts and planning must consider institutional strengthening for district and community organizations so that they can actively assume ownership of maternal and newborn health strategies. Capacity building efforts may be required for the planning, implementation, monitoring and evaluation of programmes at the district and community levels, including community diagnosis, participatory approaches, elaboration of tools and evaluation methodologies. In the initial situation analysis, it will be important to identify the available resources and gaps for the required skills. At the planning stage, a skills development strategy should be formulated that takes into account the gaps identified.[24] Sustained financing, management skills for implementation and organizational capacities have been identified as key factors for the development of district health systems.[25] For IFC interventions, skills for community mobilization, community dialogue, communication, research, educational approaches and for interacting with the community, need to be assessed. These efforts should be incorporated into existing processes of institutional strengthening.

Local advocacy

IFC efforts should work closely with advocacy efforts of maternal and newborn health programmes. Several IFC interventions are advocacy-oriented, increasing the "demand" from women, men, families and communities, raising community awareness about maternal and newborn health issues and participation in the decisions taken at the district level for finding solutions and allocating resources. However, raising demand and increased participation are required not only to change policies and to develop the supporting environment, but also for empowerment of individuals and groups. The media will be an important partner in advocacy work, both for the larger maternal and newborn health programme and for IFC efforts.

2.2 Healthy settings for the woman, the mother and the newborn

"Healthy settings", as defined by Health Promotion, is an effective approach that pursues the development of a comprehensive set of interventions in a defined physical context to provide a healthy and supportive environment.[26] It is important to note that "settings" as used in Health Promotion are distinct from channels of communication or target groups. Those settings of special importance for maternal and newborn health are households, communities and health services. Other supportive settings are schools and workplaces. Depending on regional and national context, additional settings can be identified (for example, Healthy Islands in the case of the WHO Region of the Western Pacific).

Household

In this document, "household" is considered a setting equivalent to family. Family in the context of this document refers to "any group of persons that assumes responsibility for maternal and newborn health."[6] Health outcomes of pregnant women and newborns, positive and negative, are determined largely by decisions made by the woman's partner and the family and within the household. Healthy households include increased capacities and awareness of women, men and the family for seeking and using skilled care, support from the partner and the family during pregnancy, birth

and the postpartum period, improved nutrition, as well as an improved status of the woman in the household.

Community

A healthy community for pregnant women, mothers and newborns is an informed, participatory and supportive community, playing an active role for supporting access to skilled care, such as developing financing and transport schemes, as well as supporting other maternal and newborn health needs, for example, reduced workload of pregnant women, supporting breastfeeding and others. The role of men and other influentials/decision-makers is to be considered when designing healthy community programmes for maternal and newborn health.

Health Care services

For maternal and newborn health, health care services include basic essential obstetric care (bEOC) at the primary and referral level (dispensary, health centre, district hospital) in order to minimize delays and receive adequate treatment at the facility.[27] Based on community input, the health service environment, including the services provided and the forms of care, can be modified to make services more responsive, adequate, appropriate, and gender and culturally sensitive to women, men, families and communities. Some examples of issues that can be addressed include service hours for emergency and for assuring male involvement, waiting times, respectfulness, room colours and temperature, providing appropriate information and counselling, availability of providers that speak local languages, access to family members during care and birth, appropriate equipment for bEOC, and returning the placenta after birth.[28, 29]

Supportive settings

Schools: As articulated by UNICEF, the formal education system is "the developing world's broadest and deepest channel for putting information at the disposal of families, school personnel, and community members as well as students."[30, 31] School health programmes delivered through health promoting schools can be one of the critical factors in addressing reproductive health issues.[32] Schools enable children and adolescents to learn critical health and life skills, to make healthy choices and adopt healthy behaviours. The impact of schooling is clear in benefits such as reduced fertility rates, delayed age of marriage, increased use of family planning methods, and improved care-seeking behaviour.[33]

Workplaces: A healthy workplace is essential for pregnant women. This is important in large-scale enterprises, but also in informal work settings, small-scale and micro enterprises. In addition to schools as a setting that can support women and newborns, workplaces have a value of their own as sources of income for women and men. Moreover, comprehensive workplace approaches take into consideration physical, organizational and social factors to support the health of pregnant women. Appropriate information and approaches for working with men and other community and household influentials can also be transmitted in some work environments.

2.3 Priority areas of intervention

A brief description of each of the priority areas of intervention is provided below. Actions from each of the four areas should be implemented concurrently to contribute to improvements to maternal and newborn health. Selected areas of intervention will depend upon the local situation, context and resources available, as outlined in Part 3 of this document. For example, where transportation does not contribute to delays in seeking care, community transport schemes will not be a consideration. An initial assessment will be needed to determine priorities. Ongoing monitoring and evaluation will allow implementation to be dynamic and to respond to changes over time.

Overview of interventions in the priority areas

Developing CAPACITIES *to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies*	Increasing AWARENESS *of the rights, needs and potential problems related to maternal and newborn health*	Strengthening LINKAGES *for social support between women, families and communities and with the health delivery system*	Improving QUALITY *of care, health services and interactions with women and communities*
▪ Self-care ▪ Care-seeking behaviour ▪ Birth and emergency preparedness	▪ Human & reproductive rights ▪ The role of men and other influentials ▪ Community epidemiological surveillance and maternal-perinatal death audits	▪ Community financing and transport schemes ▪ Maternity waiting homes ▪ Roles of TBAs within the health system	▪ Community involvement in the quality of care ▪ Social support during childbirth ▪ Interpersonal & intercultural competence of health care Providers

Developing CAPACITIES

Self-care

Essential to a Health Promotion approach and to the IFC concept is the development of knowledge and skills for self-care of the mother and the newborn, including those patterns of daily living that can protect and promote health,[4] as well as those decisions and actions that can avert emergencies. In summary, self-care includes developing healthy lifestyles, care-seeking behaviour and compliance with care recommendations. Self-care is closely linked to knowledge and social norms. Some authors also recognize self-care as a household process.[4, 34, 35]

Improvement of capacities and competencies for self-care can be achieved through education–both health education programmes and the formal education system. Health education interventions related to self-care should be designed with pregnant women, their partners, and other influentials in household decision-making processes. Changes in knowledge, norms and the corresponding behaviours will occur over a long time period through linking with basic and adult education.

Special attention is to be given to girls' education. It has been shown that women who have attended school have a greater probability of having smaller families and seeking care; phenomena that become more evident as the years of schooling increase.[36, 37, 38]

Schools are an important setting for this area of intervention as formal education has a strong role to play in promoting self-care and in increasing capacities to make healthy decisions,[33] including assertiveness. Other important settings include the household, health services, the community, workplaces and schools.

Key elements of self-care for the woman/mother and newborn

- ✓ Maternal issues: diet and nutrition; alcohol and other drugs; workload/activities; gender and violence; hygiene; antenatal care; childbirth care; postnatal care; STI/HIV/AIDS prevention; birth spacing and family planning
- ✓ Newborn issues: childbirth care; keeping mother and baby together; infant feeding practices

Sources: WHO (in preparation)[39] and Nachbar, Baume and Parekh, 1998[40]

Care-seeking behaviour

Promoting care-seeking behaviour, including the use of skilled care throughout pregnancy, childbirth and the postpartum periods (for the woman/mother and newborn) is a primary objective of WHO and other key partners.[41, 42] The different moments to visit the skilled attendant are indicated in the box below. The MPS team is currently developing, in conjunction with partners, technical standards for maternal and newborn care, which will define the content of the services to be offered.

IFC interventions will support the use of these services through multi-channel communication and health education activities implemented with women, men, other influentials and the larger community. The following may need to be in place or developed concurrently in order to maximize results: developing the abilities of the health system to effectively deliver health education; the design, production, and use of appropriate support and educational messages, materials and approaches; increased individual and social awareness of women's health needs and rights as well as maternal and newborn health needs and rights; and collaboration with community health workers (CHWs) and TBAs to ensure the continuum of care and for social support.

Studies and reviews have been done to develop the lessons learned and demonstrate the effectiveness of different health education and communication interventions for care seeking behaviour. Efforts must continue to strengthen the base of documented experiences and research results which link different education approaches to outcomes of increased knowledge, increased self-care and increased use of services. Also, an initial understanding of the reasons for use and non-use of the services of a skilled attendant in the different moments of pregnancy, birth and post-partum periods is fundamental

to developing appropriate strategies and messages for health education and communication. Thus, research is an important part of the development of this area of action.

Achieving an increase in care-seeking behaviour is closely linked to actions to develop transport and financing schemes, improve gender dynamics, enhance support of men and other influentials, and increase community involvement in the quality of care. Settings for this area of intervention to take place include the household, health services, the community and workplaces.

Key moments of care-seeking behaviour/use of skilled care

- ✓ Four antenatal care visits for the pregnant woman without complications
- ✓ Childbirth and immediate postnatal care
- ✓ Postnatal care visits for the woman and newborn
- ✓ Obstetric emergency
- ✓ Neonatal emergency

Source: WHO (in preparation)[39]

Birth and emergency preparedness

Birth and emergency preparedness is a key component of globally accepted safe motherhood programmes[43] and is widely promoted by international agencies. Factors that contribute to delays in receiving skilled care include the lack of planning for use of a skilled birth attendant for routine births, and inadequate preparation for action in the event of complications.[44] In some cultures there may be resistance to the concept of planning ahead, particularly for emergencies. Efforts are currently under way to strengthen the base of demonstrated experiences and research results which link birth and emergency planning interventions to outcomes of increased use of services. Many programmes are also now testing the effectiveness and mix of interventions to increase planning. For example, MNH/JHPIEGO Program Birth Preparedness Matrix considers a multiple intervention scheme at the policy-maker, facility and provider levels, in addition to at the women, men, family and community levels.

The Making Pregnancy Safer initiative views birth and emergency preparedness as a key contributor not only to the reduction of delays, but also for improving women's, men's and families' capacities, intra-family communications and relations with providers. Preparedness is necessary for both maternal and newborn care.

This intervention is linked to: developing providers' skills for interpersonal communication and counselling to support decision-making; developing providers' knowledge of the elements to be discussed in preparing for births and emergencies; the design, production, and use in antenatal care of a "birth and emergency preparedness card"; increasing individual and social awareness of signs of labour and of emergency for mother and newborn; promoting communication between couples and within the household to support planning and implementation; and collaborating with CHWs and TBAs for additional social support.

Birth and emergency preparedness is also closely linked to actions to develop transport and financing schemes and those actions to increase the role of men and other influentials. Settings for this area of interventions to take place include the household, health services and the community.

Key elements of a birth and emergency (obstetric and neonatal) plan

- ✓ Selecting a birth location (home, health centre or hospital)
- ✓ Identifying the location of the closest appropriate care facility, in case of emergency
- ✓ Identifying a skilled attendant
- ✓ Identifying a companion for birth and for emergency
- ✓ Identifying support for care of the home and children during birth and emergency
- ✓ Planning for funds for birth-related and emergency expenses
- ✓ Arranging transport for facility-based birth and in case of emergency
- ✓ Having adequate supplies for birth (depending if at home, in a health centre or hospital): a clean birthing kit, clean cloths, clean water (and a way to heat that water), clothes for mother and baby, soap, food and water for the mother and the companion
- ✓ Identifying a compatible blood donor in case of haemorrhage

Sources: WHO (in preparation)[39] and Moore, April 2000[43]

Increasing AWARENESS

Human rights and reproductive rights

Critical to improving maternal and newborn health outcomes is the recognition that safe motherhood and birth are human rights. The Universal Declaration of Human Rights states that "motherhood and childhood are entitled to special care and assistance."[45] The right to go safely through pregnancy and childbirth has been further protected in subsequent elaboration of human rights treaties, charters and covenants and is now widely recognized, as demonstrated by the emphasis given to safe motherhood in international consensus documents such as the International Conference on Population and Development's Programme of Action.[d]

To assist countries to better protect, respect and fulfil their human rights obligation to safeguard pregnancy and childbirth, the MPS team has developed a Health and Human Rights Assessment Framework and Tool. This framework and tool assists countries to review the legal, policy and practice situation in their countries related to maternal and newborn health using a participatory methodology to include the perspective of all relevant stakeholders including representatives of individuals, families

[d] See for example, Committee on Economic, Social and Cultural Rights, General Comment 14: the Highest Attainable Standard of Health (Article 12); Human Rights Committee, General Comment 28: equality of rights between men and women (Article 3); Committee on the Elimination of Discrimination against Women, General Recommendation 24: women and health (Article 12); ICPD Cairo Programme of Action, 1994.

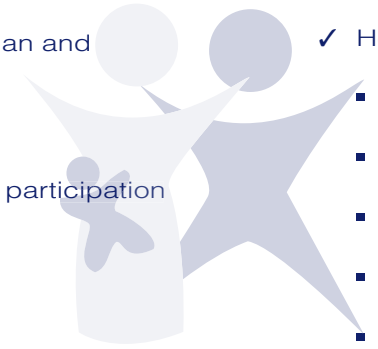
and communities. The assessment process, unlike other service-based assessments, reviews gaps and/or barriers to maternal and newborn care from the individual, family and community to tertiary care and then, through a participatory approach, helps the stakeholder group identify those issues which most impede access, utilization and delivery of maternal and newborn health care services. As has been well documented, barriers exist at all levels.[46] The assessment process will address legal, policy and practice interventions to reduce delays in seeking and delivering care.

A human rights approach can also reinforce the concept that access to, and the provision of, appropriate services is a right that people are entitled to demand from their governments and an obligation the government has made to them through its participation in the international consensus on human rights.[47] Thus, the approach aims to facilitate women, men and communities to advocate and act at district level, to ensure that comprehensive maternal and neonatal care services and information are accessible and available to them, when they most need them. Also, raising awareness of rights can further "empower" women, men and communities to "demand" quality services that meet their needs and the mechanisms to be put in place that will allow their voices to be heard in the planning, monitoring and evaluation of those services.

Finally, at the individual level, those users who are more informed about their reproductive rights should have improved interactions with providers. Women who are aware of their sexual and reproductive rights are in a stronger position to determine how they will interact in the family, how they are able to access health and how they are treated by health services.[48]

Human rights related to maternal and newborn health include

- ✓ Life, security, survival and identity
  - Life, survival and development
  - Liberty and security of the person
  - Freedom from inhuman and degrading treatment
  - Identity
- ✓ Non-discrimination and participation
  - Non-discrimination
  - Participation
- ✓ Information and education
  - Seek, receive and impart information
  - Education
- ✓ Health and maternity
  - Rights relating to health
  - Benefits of scientific progress
  - Marry and found a family
  - Privacy
  - Decide freely and responsibly on the number and spacing of children



Source: Harvard School of Public Health and WHO, 2002[49]

Health services and other partners can support this area by disseminating information related to reproductive rights and the clients' rights. Community dialogue on human rights, partnerships with

community-based organizations for the development of advocacy and communication strategies and long-term educational approaches through schools, are other ways to approach this intervention.

The role of men and other influentials

Reproductive health programmes have gained increased awareness of the role of men in maternal and newborn health as partners, fathers and community members.[36] This role is defined by an interplay of cultural, social, gender and economic factors, which do not in general prepare men to participate in the crucial aspects of pregnancy, childbirth and postnatal care.[50] Also, there is an increased acknowledgement of men's reproductive rights and their own reproductive health needs, including active and informed involvement in maternity, childbirth and childcare.

Men are key decision-makers in maternal and newborn care-seeking behaviour. They need to understand the needs, risks and danger signs of pregnancy, childbirth and postpartum periods to support women. Promotion of the role of men as partners and fathers is essential for their involvement and support.

Yet, health programmes are traditionally designed to interact with women and generally do not address men. This is true in IEC aspects of programmes, as well as in the different moments of care provision. Programmes need to broaden their understanding of men's needs and perspectives related to pregnancy, childbirth, postnatal care of the mother and newborn and fatherhood (without compromising women's reproductive rights).[51]

As with self-care, working to create a new vision of men's role will occur over the long term and will be achieved mainly through education (health education programmes and the formal education system). These interventions should work together with men and women (adolescents and adults), positioning gender perspective and reproductive rights as pertinent to both.

Health care workers need to be prepared to work with men as well as with women, to support them in their roles. Health services can consider convenient hours for men so that, when feasible, women can be encouraged to invite their partners to accompany them for care or fathers can be allowed to attend deliveries for support. Providers also need the interpersonal skills to work with men to support them in their roles and to support women in developing capacities for decision-making. Birth and emergency preparedness will also reinforce the need for couple communication and decision-making.

Community leaders, family members, TBAs, and other influentials can also be positive agents for supporting women and newborn health needs and decision-making. Depending on the context, elder family members, such as mothers-in-law, have a strong, culturally sanctioned power for decision-making and care, for example, the diet of pregnant women, workload and household responsibility, and the use of emergency services.[35] Here also, health education and coordination with the education sector will be useful to ensure the inclusion of content in primary and adult education. Influentials can also act as positive examples. In the "Positive Deviance" approach, communities are mobilized based on the observation that the uncommon behaviours of a few successful individuals have enabled their families to achieve better health than neighbours with the same resources.[52] Settings for this area of intervention will include the household, the health centre, the community, workplaces and schools.

Themes for the role of men in maternal and newborn health

- ✓ Maternal and newborn health needs
- ✓ Couple communication and shared decision-making for birth planning
- ✓ Participation in antenatal care, childbirth, postnatal care of the mother and newborn
- ✓ Emergency signs and appropriate care for the woman and newborn
- ✓ Prevention of STIs/HIV/AIDS
- ✓ Birth spacing and postpartum family planning
- ✓ Support for breastfeeding
- ✓ Participation of men in raising and educating their children
- ✓ Responsible paternity and adulthood (for youth)

Sources: WHO (in preparation)[39] and PAHO, 2001[36]

Community epidemiological surveillance and maternal-perinatal death audits

To assume a role in improving maternal and newborn health, communities first need information regarding local maternal and newborn health needs. There are different methodologies and tools designed for health systems to gather information regarding maternal and newborn death and morbidity. Several of these recognize the value of the community as a source of information. Under the MPS IFC concept, for the use of methodologies and tools such as community epidemiological surveillance, community-based death reviews, maternal and perinatal death audits, verbal autopsies, and other research on maternal and newborn health issues, the community is considered a partner in all moments, including gathering, analysing and using the information. Considerable experience has been gained in this area, including in two MPS spotlight countries (Bolivia and Indonesia), the WHO Region of the Americas, as well as by Save the Children, JHPIEGO and USAID.

In addition to increasing community knowledge and awareness, the findings can serve as the basis for community dialogue both within the community itself and also between the community and health services. The information gathered, particularly relating to the contributing factors to mortality, can also serve as a basis for the development of comprehensive strategies and subsequent actions. The community should also participate in the design, planning and implementation of these strategies and actions. Maternal mortality committees, at national and local levels, are increasingly carrying out the identification and investigation of maternal deaths (through audits, for example) and, subsequently, recommending actions to be taken.[28]

This is an area closely linked to advocacy efforts as well as efforts to improve the quality of care. As noted by PAHO, a key concept is the interchange of data with communities and organizations that can then use the data to advocate for positive changes at the health policy or provider level.[28]

In **Bolivia**, the Ministry of Health has organized Committees for the Analysis of Information (CAI) both at the community level and at the facility level. A "Community" CAI involves health personnel, community leaders and authorities, representatives of community-based organizations and CHWs who meet periodically to analyse health information and make decisions. These experiences have been found to:

- ✓ serve as a basis for the development of community action plans,
- ✓ promote care at the family and community levels, and
- ✓ strengthen linkages and communications between the health centre, CHWs and the community.

Source: Ministerio de Salud y Previsión Social de Bolivia, 2001[53]

Community involvement in audits and research should act alongside other educational initiatives. Women, men, families and communities can learn about the conditions which contribute to mortality and morbidity from cases within their communities and discuss what actions can be taken to prevent these. Settings considered are the household, communities and health services.

Strengthening LINKAGES

Community financing and transport schemes

The areas of intervention above have focused on building individual and social awareness, capacities and social support for increasing access to care. But, a very real factor in access to care is the ability to reach and use services. The availability of financing and transport schemes can affect individual and household decision-making processes, can facilitate access and, therefore, reduce associated delays in receiving skilled care. Also, financing aspects are related with one of the fundamental goals of health systems which is to be fair in financing[2] and with the larger issue of social protection. A major effort is being undertaken in the area of financing and transport schemes by key partners, particularly GTZ, UNFPA, ILO-STEP, UNICEF and USAID.

Financing schemes

Universal coverage through national health insurance has been introduced in several countries. Bolivia has implemented a national insurance programme which aims to provide free maternal and newborn health services, including antenatal, childbirth and postnatal care, access and treatment for obstetric and neonatal emergencies. Subsequently, a decentralized scheme involving the allocation of national resources to the municipalities to ensure a financing mechanism was introduced. Considerable impact has been achieved in terms of overall use of maternal and infant health services (increase from 16% to 39% for antenatal care and from 43% to 50% for childbirth).[28]

More local approaches to social protection include micro-insurance, rural health insurance, mutual health insurance, revolving drug funds and community involvement in user-fee management. A review of these approaches in Africa and Asia concludes that such approaches improve access to needed health care and support the hypothesis that broad risk-sharing in health financing has a significant impact on the level and distribution of health.[54]

A study of mutual health organizations, conducted in 1998 in West and Central Africa, shows a potential to increase coverage, to extend social protection to disadvantaged sections of the population, and to increase quality improvement.[55] In Latin America, micro-insurance schemes are proposed as complementary extension mechanisms, linked to the State-provided social protection systems.[56] Experiences in loan funds to improve access to obstetric care have been developed and documented in several countries, by several institutions.[57, 58, 59, 60]

The different studies reveal the need to strengthen the institutional, managerial, and administrative capacities of community organizations involved, as well as the importance of involving governments to establish a favourable legal, fiscal, and institutional context.[55, 56] The sustainability of these systems may sometimes be a limitation. Since these schemes are designed for people with limited resources, reinsurance mechanisms supported by the State (as in Bolivia) and possibly international cooperation are needed.[56] Also, these community-based efforts need to be linked to the larger social protection system, if existing.

Another positive measure for sustainability is to build on existing financial solidarity schemes. With existing functioning groups, the administrative cost for the extra health-related elements will not be as high as in the case of forming a new insurance entity. In addition, the fact that they are based on mutual understanding minimizes the possibility of adverse selection.[61]

Increasing access to services is one benefit of community health financing schemes. These systems can also contribute to increasing the accountability of health services to the community and, thus, improving quality of health services at the local level.[62] These mechanisms also stimulate community organization and action for health, and empower women and the community in their relationship with care providers.[56]

Key elements for community health financing schemes

- ✓ Build on existing financial solidarity schemes, community initiatives and organization
- ✓ Provide technical and financial support for management and sustainability
- ✓ Promote increased and active involvement of women in the management of schemes
- ✓ Seek synergies with income-generating activities and broadening support from other key actors, including community organizations
- ✓ Involve governments to establish a favourable legal, fiscal, financial and institutional context
- ✓ Help health care providers to become genuine partners

Source: ILO and PAHO, 1999[56]

Transport schemes

The availability of transport to reach care is an important factor in access. Lessons learned from maternal health projects in Africa, Asia, and Latin America suggest that community-based systems of emergency transport in case of obstetric complications can be an effective means of reducing the delay in reaching care, in the absence of public services.[63] Adapting solutions to specific local

contexts as well as ensuring that communities are actively involved in the process from beginning to end appear to be essential ingredients for success.[64, 65]

"Bicycle ambulance", trucks, buses, boats, ox-carts, modified tricycles with platforms, canoes, taxis, three-wheeled motorcycles and trailers, are some local solutions encountered.[66, 67] Agreements can be found with local transport unions, with private drivers, and with bus companies, when available. Funds for emergency transportation (special funds or within-community financing schemes) may be made available to increase the use of transport facilities.[58] Communication for referrals is also an issue related to access and transport. Two-way radio communication systems can be used to contact midwives at designated referral facilities.

For the development of this area of interventions (financing and transport schemes), a number of supportive actions are required including: increased individual and social awareness of maternal and newborn health needs, including labour and danger signs; linkages with CHWs and TBAs for referral support; and partnerships with NGOs and community-based organizations with experience in these areas. As mentioned, financing and transport schemes are also closely linked to birth and emergency preparedness. Settings considered are the household and the community.

Maternity waiting homes

In those geographical areas where availability of skilled care is extremely limited, due to the lack of skilled attendants and/or distance to reach them, maternity waiting homes may be worth considering.[68, 69]
The purpose of a maternity waiting home is to provide a setting near to skilled care where women can stay in the final weeks of pregnancy. Some maternity waiting homes also conduct education and counselling activities to improve self-care for the woman and newborn.

Different models of maternity waiting homes exist (see case studies in Bangladesh, Cuba, Ethiopia, Indonesia, Malawi, Mongolia, Mozambique, Nicaragua Nigeria, Papua New Guinea, and Zimbabwe). Although there has been no formal evaluation of their effectiveness, their continuing existence indicates some local sustainability.[69] The importance of community awareness of maternal and newborn health needs, as well as community involvement in the planning, implementation and ongoing monitoring and development of culturally appropriate homes which meet local needs are important to successful implementation and long-term sustainability. These homes should not be stand-alone interventions, but rather serve to link communities with the health system in a continuum of care.

Key considerations for effective management of maternity waiting homes

- ✓ Services to be offered
- ✓ Liaison with community health services and referral system
- ✓ Administration and staffing requirements
- ✓ Equipment and supplies
- ✓ Cost considerations

Source: WHO, 1996[69]

Roles of traditional birth attendants within the health system

While WHO and partners move ahead in the promotion of skilled attendants and skilled care, the responsibility of TBAs in maternal and newborn health, *in those countries and areas where they currently exist*, must be specified. In several developing countries, TBAs are available for pregnancy, childbirth and/or postnatal care. Due to their cultural and social acceptability, knowledge and experience, TBAs can be considered an important ally for health education and social support and a positive link between women, families and communities and the formal health care system.[70]

The Joint Statement on Reduction of Maternal Mortality (WHO/UNFPA/UNICEF/World Bank, 1999) recognizes that, in many places, the services of skilled attendants are currently not available, nor will they be in the near future. While countries are encouraged to develop and implement plans to ensure access to skilled attendants, in the meantime, it is recognized that TBAs may continue to be an important source of care. In these situations, and even those where a skilled attendant is available but the services of the TBA also exist, a useful strategy is to strengthen the capacities of TBAs in recognizing problems during the prenatal, childbirth and postpartum periods, and when necessary, and if possible, to guide women to, and through, the formal health care system.[35, 71, 72]

Where skilled attendants, and in particular midwives, are available, partnerships and arrangements with TBAs should be defined and developed.[50] Possible roles for TBAs are outlined in the box below. These roles should be negotiated and defined with the TBAs, not imposed upon them. The community should also be consulted in this regard. TBAs are not a homogeneous group and there is much variation from site to site in their level of skills and the services they provide.[35, 40]

"In those sites where TBAs play an important role in providing care or in educating women and the community, TBAs can and should be included as a member of a "health team" that works together to improve access to and quality of care."[73] In a team setting, TBAs can help staff understand and respect local knowledge and traditions.

In defining roles and responsibilities, it is important to take into account the interests of the different stakeholders, including income generation, cultural preferences and professional rivalries. The role and functioning of the TBA needs to be better understood by skilled attendants and health professionals.[74] TBAs need to feel that they are part of the system and that they must support the system, instead of feeling that any referral was a result of "failure to keep their commitment to women and families."[75]

Possible roles for TBAs within the health system

- ✓ Advocate for maternal and newborn health needs
- ✓ Encourage (even accompany) women to attend essential antenatal and postnatal care and have skilled care during birth
- ✓ Support women and newborns in self-care and care compliance (nutrition, treatment, supplementation, immunization, scheduled appointments, birth and emergency planning, family planning, infant feeding, etc.)
- ✓ Disseminate health information in the community and within families
- ✓ Provide social support during and after birth, either as a birth companion, or provide support to the household while the woman is away at birth
- ✓ Serve as a link between women, families and communities and local authorities and formal health services

Source: WHO/ICM/FIGO, 2003[70]

Improving QUALITY

Community involvement in the quality of care

A common element in frameworks for improving quality of services is a focus on the community's definition of quality and their perspective as to the responsiveness of the services to their culture and needs. Different methodologies have been developed to meet these elements, including organized and ongoing processes of community involvement in the quality of care, also referred to as "community-driven quality", consumer participation in quality and other approaches.

It has been shown that cultural differences in women, family and community preferences and health worker treatment and procedures may limit the use of care even when improved services are available.[35, 36, 37, 59] Thus, one of the most effective ways of truly ensuring good-quality care and increased use of services is to involve the community in the planning, management and evaluation of the services.

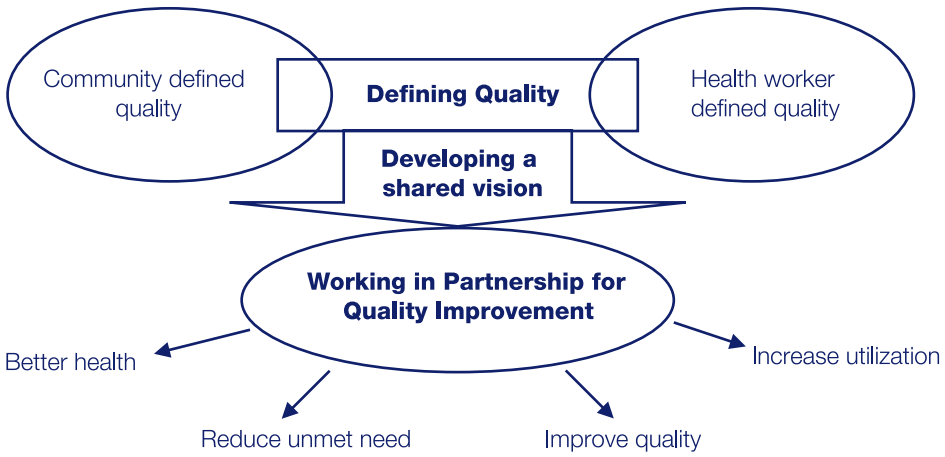
Establishing with the community, and women in particular, their beliefs, perspectives and preferences related to pregnancy, birth, and postnatal care of the mother and newborn is particularly important as these different moments are associated with social and cultural values, significance and rites. Services can take these elements into account as well as other inputs from the community to increase accessibility and acceptability, the perceived quality of care, and subsequently, the use of services. In this case, the aim is to move beyond "clients" or "users" of services, to respond to the larger community needs and to reach potential users as well.

Links with TBAs, other community health providers and community groups can also play a role in supporting services in understanding the community's preferences and needs. The district health team, women, community members and representatives of different community groups can together develop a complementary vision of maternal and newborn health needs and can together find solutions. Also, community involvement helps to make care-seeking and use of services a more collective decision, rather than exclusively an individual or household behaviour.[76] Finally, community involvement in quality of care matters can subsequently lead to a greater understanding of the existing situation, difficulties and limitations faced in delivering care, and of feasible solutions which can be assumed by the services and/or the community.

As in other areas related to community participation, a different range of approaches and methodologies has been used to establish community involvement in quality. "Most health facilities have no formal mechanism for communities to provide regular feedback to facility and health workers on their perceptions of quality of the service and their suggestions for improvement in the services. An initial step may be to seek community input through group meetings or through household surveys. A further step may be to set up regularly scheduled meetings with the community. Some projects have established community advisory boards or community management of the health facility by a community board."[29]

Lessons learned from quality improvement programmes indicate that what is important is establishing quality as an organizational culture and as a continuous and ongoing process. Thus, community involvement in this process should meet the same criteria.[77]

Community-driven quality framework



Source: Maximizing Access and Quality, Community Driven Quality Sub-committee[77]

Supportive actions are: advocacy for establishing policies and mechanisms that promote community involvement in quality; developing skills within health programmes for interacting with the community; increased community awareness of the value of participating in the organization of health services. Settings for this intervention to take place include the household, the health centre and the community.

Social support during childbirth

As mentioned throughout, interpersonal and cultural sensitivities play an important role in the perceptions of the quality of care offered. Researchers studying quality of care in different settings have particularly stressed these elements of care during childbirth. Social support during childbirth is a cost-effective way to improve maternal and newborn health and women's satisfaction with the care received. Having social support during labour, in the absence of emergencies, has been shown to have impact on the outcome of routine birth for both the woman and the infant.[48]

It has been shown that social support during childbirth permits: reduced incidence of medical interventions such as drugs to control pain, forceps delivery, caesarean sections; shortened length of labour; increased woman's satisfaction with birth; quicker physical recovery after childbirth; facilitation of breastfeeding and strengthening of the early mother-infant relationship.[78, 79] Also, social support during labour in busy, technology-oriented settings is associated with a positive labour experience.[42]

Social support during labour and birth means that those attending pay attention to a woman's wishes, feelings of well-being, need for information and choices.[48] Social support includes the presence of a birth companion selected by the woman, as well as a positive and respectful attitude of professional health workers.

For the development of this intervention, associated actions are: advocacy for establishing policies that promote social support during labour; birth and emergency planning so that women decide in advance their birth preferences and identify a companion; developing the skills of the skilled attendant; increased men and community awareness of the value of social support during labour;

and linkages with CHWs and TBAs who are often preferred birth companions for many women. Settings for this intervention include the household, health services and the community.

Key elements of social support during childbirth

- ✓ Presence of a selected birth companion
- ✓ Partnership between the woman, her birth companion and the skilled attendant
- ✓ Attention to the woman's wishes, including preferred positions for labour and birth
- ✓ Birth in the preferred location (home, health centre or hospital)
- ✓ Positive and respectful attitude of skilled attendant and other health workers

Sources: WHO, 2002[42] and The Panos Institute, 2001[48]

Interpersonal and intercultural competence of health care providers

Quality is determined not only by technical capacity, but also by cultural appropriateness and the dynamic interaction between clients and providers.[80] WHO and other key partners support improving provider interactions with women, men and the community as a key element of quality. Furthermore, different studies have shown that improving providers' interpersonal and intercultural competencies can influence compliance with care recommendations, women's knowledge, perceptions of quality of care and the use of services.[35, 36, 80, 81]

As they promote the right of women and men to accurate information, to make reproductive choices, to indicate their birthing preferences and to participate in decisions affecting their health, providers need the skills to support and provide these services. Counselling for decision-making and problem-solving as proposed for birth and emergency preparedness and new approaches to health education will require the ability to listen, to actively engaging the women in the session, to work with respect for current knowledge, to demonstrate cultural sensitivity and to provide support, moving away from the customary sessions with women based on information giving.[82]

Promoting the role of men will require each health provider to review their own attitudes and develop skills for interaction and support. Depending on their functions, providers may need to develop those skills needed for individual interactions as well as skills for working with the larger community. Midwives may be well placed for this larger work, as these skills are considered essential to comprehensive midwifery practice (see *Foundation module: the midwife in the community,* of the WHO Midwifery training modules).[83]

All health workers should be aware of the importance of good communication, that good counselling is also a lifesaving skill, that intercultural and interpersonal competencies increase use of care, that communication and health education functions are not separate or less important than their more clinical functions.[35] Increased awareness and change in providers' practices can result in providing "care" to women and newborns rather than just "curing".[84]

This intervention must be coordinated with provider education and training strategies. Training and supervisory support can serve to help providers discover their own prejudices in their interactions with patients.[36, 85] Equally important for improving providers' skills is understanding the providers' perspective and incentives to increase health workers' motivation.

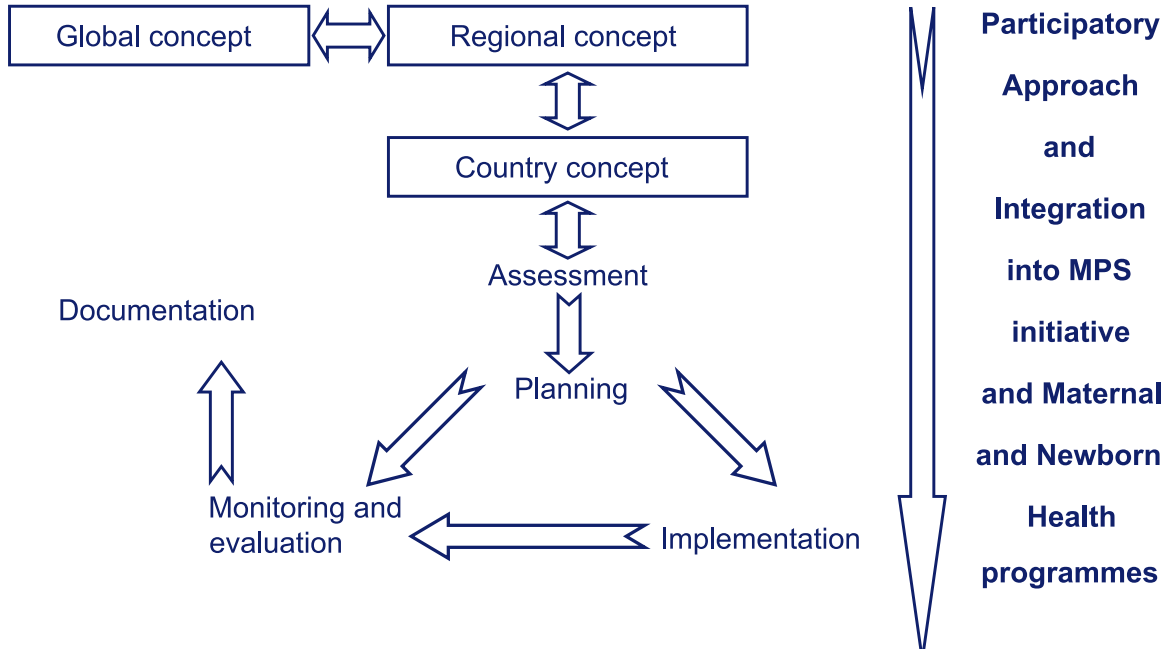
Key aspects of interpersonal and intercultural competence for providers

- ✓ Attend to human needs
- ✓ Be accessible to the woman or newborn
- ✓ Attend to emotional needs
- ✓ Respect human dignity/rights
- ✓ Create, not deliver knowledge
- ✓ Counsel for decision-making and problem-solving
- ✓ Involve the partner and family, as the situation permits
- ✓ Support the role of men
- ✓ Incorporate cultural context

Source: Moore et al, 2002[84]

3. OPERATIONALIZING CONCEPTS AND STRATEGIES

This concept and strategy paper for working at the IFC level will need to be adapted according to the specific context and needs of each region or country. A participatory approach is needed throughout and at each level. The main stages for implementation are proposed in the scheme below.



3.1 Developing national IFC strategies

Irrespective of which institution initiates the process, it is essential from the outset that individual countries own and drive their respective process to develop national concepts and strategies for working with individuals, families and communities to improve maternal and newborn health.[e] From the start, an IFC component should be integrated and implemented within a larger national strategy for improved maternal and newborn health. To define a national process, a first step would be to integrate into an existing task force or establish one if not existing. Such a task force could include the Ministry of Health, other relevant ministries, United Nations agencies, donors, international and national NGOs, women's health advocates, representatives of youth and community organizations and other stakeholders.

As part of the task force, a small committee responsible for the overall coordination of the implementation of the IFC strategy should be formed.[22] The participants should represent those agencies with experience in the area, leadership, long-term commitment and a willingness to develop an interactive process. All potential sources of technical support and funding should be identified for

[e] In the case of WHO, regional offices will provide guidance for this process.

the assessment, planning, implementation and evaluation phases.[22] United Nations agencies and other international and national agencies can provide technical support, when needed.

Existing knowledge and information may be sufficient for the development of an initial IFC national strategy. But additional research may be needed to fill the gaps identified and establish baseline information.

In general, three levels are present from an administrative point of view: a national level, an intermediary level (province, state, region) and a district level. It is envisioned that the district will be the key administrative level for the implementation of maternal and newborn health programmes, including working at the IFC level. The district is the most appropriate level for linking up local priorities with national health policy guidelines and resource allocations, and for coordination between health delivery services and communities, between government and private sector, and between health and other sectors, particularly in those countries embarked on a process of decentralization and health reform.[17] District health systems permit interaction between the social network and the health services network, described in Part 1 above. District health systems should be considered within the area of influence of local government.

The existence of policy and strategies both at national and intermediary levels can help planning and implementation at district level.

3.2 Assessment, priority selection and planning at the district level

A participatory assessment and planning process is critical to the successful implementation of the IFC strategy at the district health system level. The national strategy is not set forth as a defined set of standard interventions, but will serve as a guide. Planning for IFC at the district level requires responsiveness to the local needs identified in the assessment phase. Existing research and information should be gathered. More in-depth assessments may be necessary to define appropriate areas of intervention, establish a baseline for monitoring and evaluation and to plan implementation strategies that consider the sequenced introduction of interventions, according to the context and situational needs.

District strategies must be developed as a consensus-building process among the different partners and stakeholders, according to the identified needs, and should build on existing community and district resources, structures and activities.[24] Feedback into the national strategy should be provided from the local assessment and implementation process.

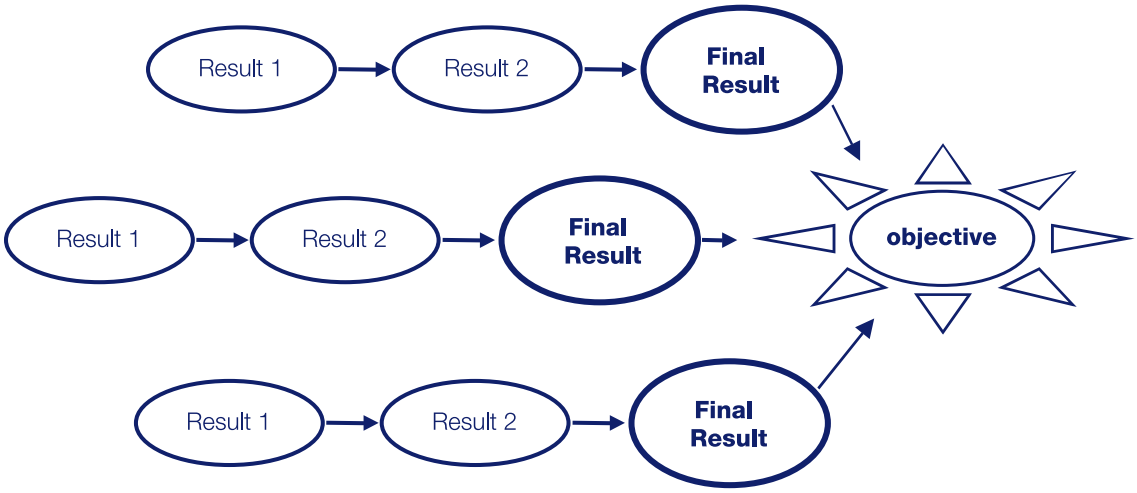
Although a comprehensive strategy is recommended, existing capacity and available resources for the implementation of complementary interventions must be considered. For a lower- resourced context, one or two priority areas could be implemented initially, with others to be added gradually over a determined time-period. Priority areas for initial implementation should be chosen strategically, according to their capacity to influence the problems identified and those which are seen to have a compounding effect.

It is recommended to use a strategic planning approach to:

- identify and choose the most effective strategies to achieve the proposed objective;
- desegregate complex interventions into intermediary results;

- allow for flexibility if changes intervene in the situation and the context of the problem;
- visualize the chain of results needed to achieve the objective.

STRATEGIC PLANNING



Source: Zehnder R et al., 2001[86]

Some areas should be given additional consideration, namely:

- increasing awareness of maternal and newborn health needs, to enhance the role of men and community influentials;
- birth and emergency preparedness;
- care-seeking behaviour, mainly antenatal care, basic essential obstetric care and neonatal care, postnatal care for the mother and newborn;
- increasing access by developing community health financing systems and transport schemes;
- improving quality of care by strengthening providers' interpersonal and intercultural competence and involving the community in defining the quality of services.

As described above, community dialogue can serve as an important catalyst for any of these areas and, more generally, for the initiation of a comprehensive strategy. Special needs of minority, indigenous or marginalized groups, including refugees/displaced people and poor populations should be taken into account when planning and implementing IFC interventions.

For "staggered" implementation, or the sequenced introduction, of priority areas of intervention at the district health system level, the following considerations should be kept in mind.

- The areas of intervention should be identified as priority by the different stakeholders, including community members, district authorities and other partners in implementation.

- The sequential implementation of interventions should be outlined from the initial planning.
- Throughout programme development (assessment, planning, implementation and evaluation), key stakeholders of the district health system, including community representatives should be involved.
- Key indicators for monitoring and evaluation should be defined and agreed upon by the stakeholders.[29]

Scaling-up and sustainability perspectives should be considered in the design of the IFC strategy and throughout the process of staggered implementation. Coordination and partnerships are central issues to address these perspectives.

In addition, coordination between the different areas of health such as reproductive health, child's health, immunization, malaria and others should be pursued to support district health system planning. In fact, it would be useful to have a common methodology and approach–even if applied to specific programmes and health aspects–for assessment and planning at the district health system level.

3.3 Implementation

In the implementation of the IFC strategy, special attention needs to be given to mobilizing existing resources, including a number of "hidden resources" (local organizations, traditional structures, groups) to integrate or link them into the district health system. The key principle is to start with what exists and build on it. Partnerships and formal collaboration and coordination between stakeholders are required to develop coherent implementation processes at the district, intermediary and national levels.

Through the district health system [87]

After the World Health Assembly in 1986, the WHO Global Programme Committee defined a district health system as: "a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, and communities, through the health sector and other sectors. These elements need to be well coordinated ... in order to draw all together into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities."[88]

To summarize, the district health system includes:

- health service structures (hospitals, health centres or health posts) and health service management structures and staff;
- health development structures: village councils, civil society organizations (women's, self-help, youth, labour, credit, peasants, religious, ethnic, cooperative), development committees, health committees, NGOs, business, and other sectors.[89, 90]

These two structures are complementary; they include and represent the two networks (health service network and social network) presented in Part 1 of this document. A number of concrete actions could help to develop partnerships between these two structures, such as:

- undertaking an inventory of existing or potential health development structures within a particular district;
- understanding how these structures could contribute to health development at the district level;
- establishing mechanisms that link the health service network and social network;
- determining the kinds of support local health development structures need to enable them to be more effective in the promotion of health.

Local government can play a key role, at the district level, in promoting integration and coordination, and in developing comprehensive plans, mobilizing resources, ensuring rough balance between sectors, and generating essential information. Recent developments permit a major consideration of local government roles.[88]

Building on and integrating existing resources

The hidden resources

For implementation of the IFC strategy, a major focus should be given to the potential of local health and development structures at the district level. A study of local health development structures was conducted by WHO in 1992. The major finding of this study is that there exist a significant number of structures dealing with health or with the potential to do so. They are found within the formal health sector (village health committees, for example) and outside of the formal health sector (for example, women's, youth and agricultural organizations, community development committees). These structures are "hidden resources" that should be tapped into for the purpose of enhancing health development.[89]

It is more effective to build on the inherent strengths in local communities, so that people have a sense of ownership of health development structures, rather than establishing new and separate ones which may have no local credibility.[17] The availability and effectiveness of local organizations vary. However, virtually all communities have organizations of some kind. Programmes should identify these organizations at the outset.

At the community level, there also exists a wide range of persons who work to improve health. Some are formal caregivers who work within a well-defined framework that may be public or private. Others are caregivers recognized by the community they serve, such as traditional healers. The quality of care and advice given by community caregivers relies, in part, on a definition of roles and coordination of these resources at the community level.[24]

Local media and popular channels of communication (theatre, art) are resources that can be coordinated and mobilized for increasing knowledge and awareness of the population and of decision-makers.

Existing health programmes

MPS advocates building on existing community health programmes to maximize IFC interventions. A convergence of efforts is needed at the community level between the different areas of health such as reproductive health, child health, immunization, malaria and other programmes operated by Ministries of Health as well as NGOs.

This convergence of efforts is needed at all levels (international, regional and national) and then consolidated at the intermediary and district levels, or it can be implemented directly at the district level. Village Health Committees (VHC) or community health organizations can serve as the formal link between the community, health services and community health workers. Also, existing health care facilities and other health efforts assumed at the community level by community organizations, religious institutions and NGOs should be considered and integrated in the convergence of efforts.

Community health workers[21]

At the IFC level, CHWs, including TBAs, are recognized as important resources for many national health systems. They are asked to develop and support various IFC interventions, mainly as a referral link and for social support. Whether in isolated rural villages or fast-growing urban slums, CHWs are an important resource for available, accessible, acceptable and affordable health care within the continuum of care needed. Their care functions for mothers and newborns are less important where there is ready access to skilled care, private or public. However, their developmental and promotional functions are useful in all circumstances and are crucial in less-resourced and dispersed communities.

There is a strong relationship between district health systems and CHWs. The district health system is the support framework that the CHW must have in order to function effectively. This support should combine systematic skills-building and supervision of practising CHWs with a reliable referral system, technical assistance, a supply system and an information system.

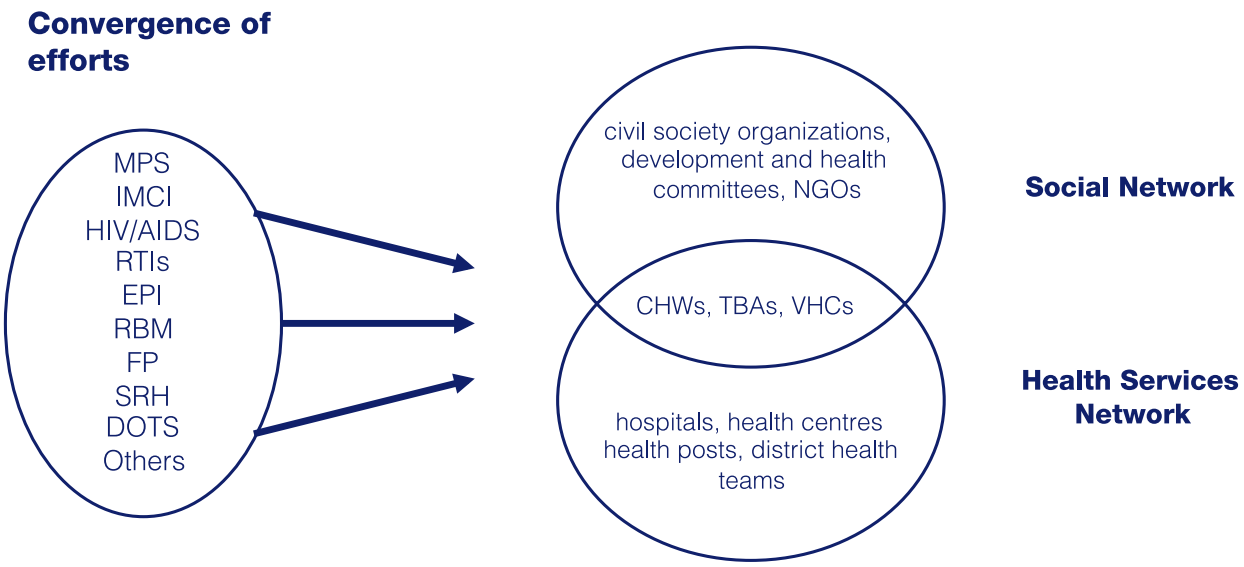
Nongovernmental organizations

Some international and national NGOs have much experience and expertise with the development and implementation of household and community approaches, and in particular with community mobilization. NGOs are increasingly becoming key partners with governments and agencies at the international, regional, national, provincial, and district levels, to impact positively on health systems, particularly under decentralization.[29, 91] In many cases, they have developed approaches to implementation at the community or district level that could be scaled up.

NGOs can have a significant role to play in creating an enabling community environment, for example in the areas of building linkages, of strengthening capacities of community groups, training of CHWs and others. They can play a role in institutional strengthening of the district health system and in particular for participatory planning, joint monitoring and assessment, operations research and multisectoral coordination. More generally, NGOs have the ability and flexibility to develop integrated approaches and innovative programmes that can be scaled up when feasibility, effectiveness and efficiency have been demonstrated.

Finally, national organizations, and in particular women's NGOs or women's associations have the potential to extend the capacities of IFC interventions. They are partners of special interest. They can support the implementation of actions through their membership and structures at district level, and advocate both at the local and national levels.

Local government area



Source: WHO, 2002[92]

3.4 Monitoring and evaluation

Establishing the performance of IFC interventions and their contributions to the well-being and survival of mothers and their babies is a central issue of maternal and newborn health programmes. A pragmatic approach to the monitoring and evaluation of IFC interventions is to select a variety of measurement methods and pursue a number of indicators, both quantitative and qualitative, so that the limitations of any one measure are offset by the advantages of another.[73] Use of a variety of sources and approaches, depending on the setting and resources available, is thus recommended, supplementing quantitative data with qualitative information.[93]

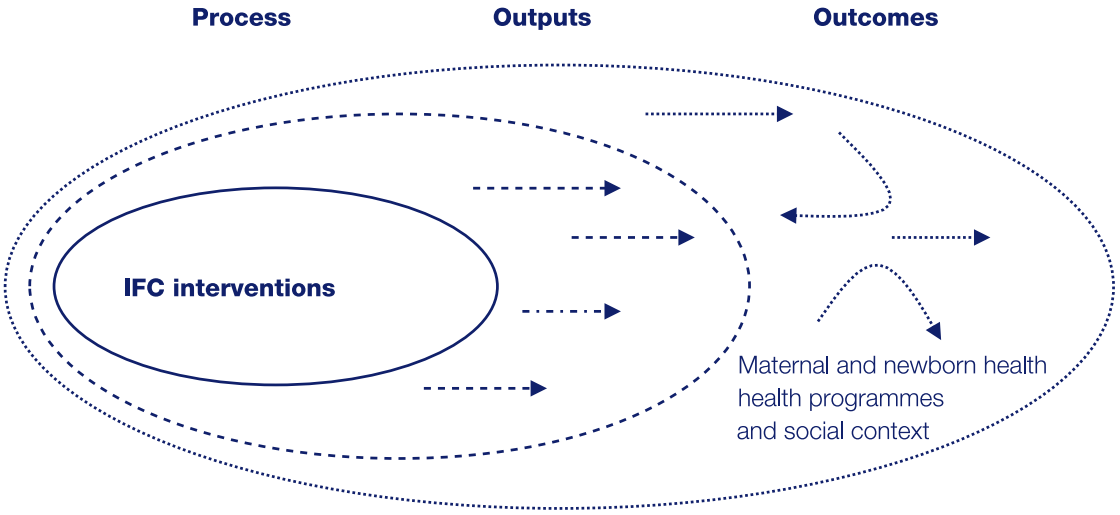
Indicators for health monitoring programmes are normally organized into an input/process/ output structure that leads to outcomes. That is, indicators are used to evaluate how the inputs to a programme are converted through activities (processes) to produce results (outputs) and eventually changes at the population level (outcomes).[73]

Example:

Input	Activity	Output	Outcome
Financial resources	Training of providers	Improved communication skills	Increased use of health services and skilled attendants

Process indicators refer to the multiple activities that are carried out to achieve the interventions of the programme, including what is done and how it is done. Outputs indicators refer to the result of efforts at the programme levels (directly related to inputs and activities).

Outcome indicators of IFC interventions are difficult to measure because they are achieved in collaboration with other partners and through the combination of health service and IFC interventions for maternal and newborn health. They depend heavily on the performance of the health sector, and also on the social context that strongly influences any maternal and newborn health programme.



Source: Handouts on Monitoring Systems. Bern, Swiss Development Cooperation, 2000

Monitoring and evaluation of the component in terms of outcome indicators should then be integrated into the existing mechanisms and processes employed by actors in maternal and newborn health and the overall Making Pregnancy Safer initiative (see Annex 2 for a proposed outcome model for the MPS framework for the development of IFC interventions). Monitoring and evaluation of maternal and newborn health programmes must expand their scope to include IFC programmes. This is needed for establishing the performance of the IFC programmes and their contributions to maternal and newborn health.

The focus in IFC programmes will be on performance indicators (process, outputs). Process indicators will be the main alternative in most settings.[94] It is not clear however that these indicators are, in fact, a sensitive marker for changes in maternal mortality.[73]

Output indicators should be linked to the aim of IFC interventions and thus give indications related to empowerment of women, men, families and communities, and increased access and utilization of quality health services, particularly services that are provided by skilled attendants.

Data sources to measure the outputs are mainly a) population-based data (most commonly collected via sample surveys) which provide information on a target group and about IFC- related interventions, and b) service-based data, which comprise data on service use and outcomes from health information systems (i.e. registers and case notes), client exit interviews, situation analysis, and audits.

A combination of process and output indicators (performance assessment) should also permit the tracking of progress made in achieving the intermediary and final results defined in the strategic planning process to achieve the objective of the programme. They should permit programmes to evaluate if the defined chain of results is achieved and in particular if the hypothesis underlying the sequenced chain is valid. The information is used by the programme managers and the stakeholders to document interventions and make adjustments, as needed, to the strategic planning.

Performance assessment helps partners to strengthen the effectiveness of the programmes:

- by improving the knowledge and identifying lessons on what works and why;
- by providing information on whether interventions are appropriate, efficient and effective;
- by improving accountability to people interested in or affected by development intentions.

Information on the performance of the IFC interventions will be collected by:

- *monitoring* (feedback gathered systematically during the process of implementation to check performance);
- periodic *reviews* (analysing performance information to check whether interventions are on track towards strategic objectives or whether mid-course corrections are needed); and
- *evaluation* (providing a more fundamental assessment, as systematic as possible, of an ongoing or completed programme, in terms of its design, implementation, outputs and outcomes).

Examples of indicators to measure IFC efforts are: percentage of deliveries with a skilled attendant, increased use of antenatal and postnatal care, increased satisfaction and preferences for care, improved interpersonal and intercultural skills of staff, community plans for transport, increased knowledge and awareness about maternal and newborn health issues. Indicators for self-care need to be stressed as an important area of evaluation to be developed. Nevertheless, indicators need to be selected based on the scope of the programme being evaluated.

Non-indicator methods, such as maternal death audits, can also be important to monitoring and evaluating. Audits of barriers and problems encountered by women in need of care, conducted anonymously and using aggregate indicators, can also be effective in measuring the impact of IFC interventions.[72]

More generally, assuming a Health Promotion approach leads to important differences in perspective as to what represents success and the process to measure it.[95] The process of gathering information to determine performance and "success" should be conducted in partnership with the different actors and stakeholders and, in particular, with community representatives.

Participatory approaches at the community and district levels, and multisectoral involvement in monitoring and evaluation should extend from design to data gathering to analysis and sharing of results. Evaluation is intended to be part of empowerment and quality improvement processes.

4. THE ROLE OF WHO

The role of the WHO in working with individuals, families and communities to improve maternal and newborn health is defined according to the following criteria.[f]

The area of work is related to the mission and expertise of WHO, and the areas of work of the MPS initiative.

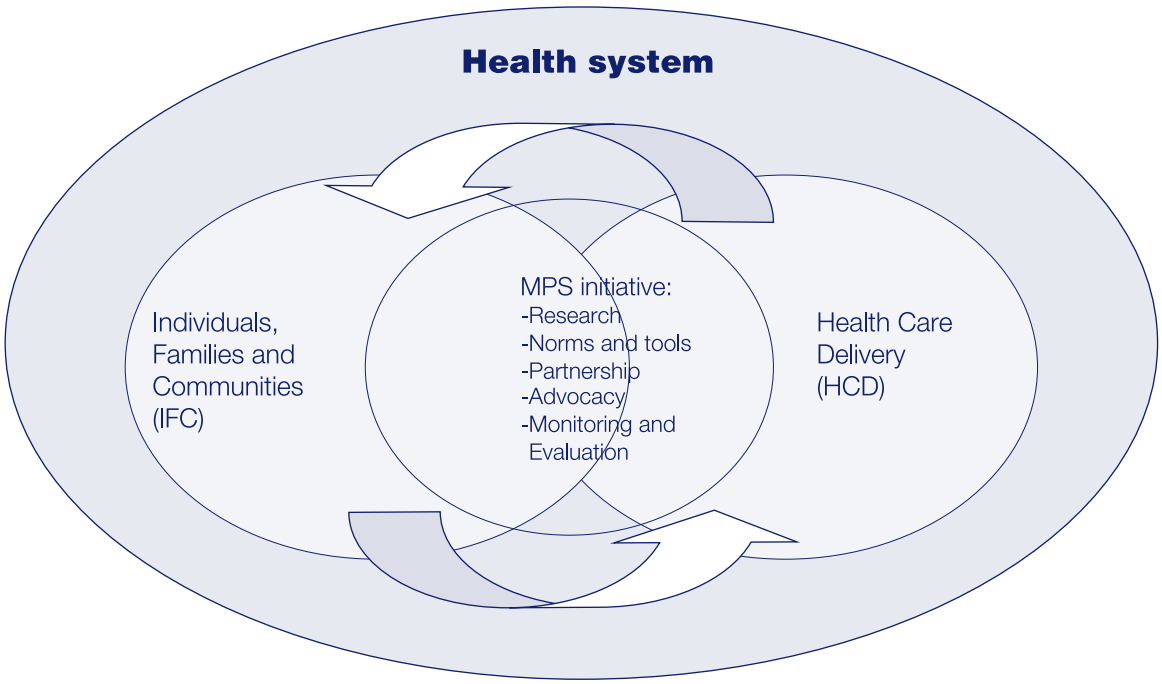
WHO supports efforts of Member States, their Ministries of Health, and other sectors with responsibility for contributing to maternal and newborn health.

WHO complements, rather than competes with, the strengths and initiatives of other United Nations agencies, multilateral and bilateral development agencies, NGOs, and the private sector.

The diagram below shows that the role of the Making Pregnancy Safer initiative is to contribute to both health care delivery and to the building of an enabling environment at the IFC level.

The diagram also shows that MPS is one of multiple actors, with specific areas of work (research, norms and tools, partnership, advocacy, monitoring and evaluation), working in coordination and synergy with partners.

Making Pregnancy Safer, one of multiple actors



[f] Designed to be coherent with *Strategic Directions for Improving the Health and Development of Children and Adolescents*. Geneva, World Health Organization, 2002. [draft document]

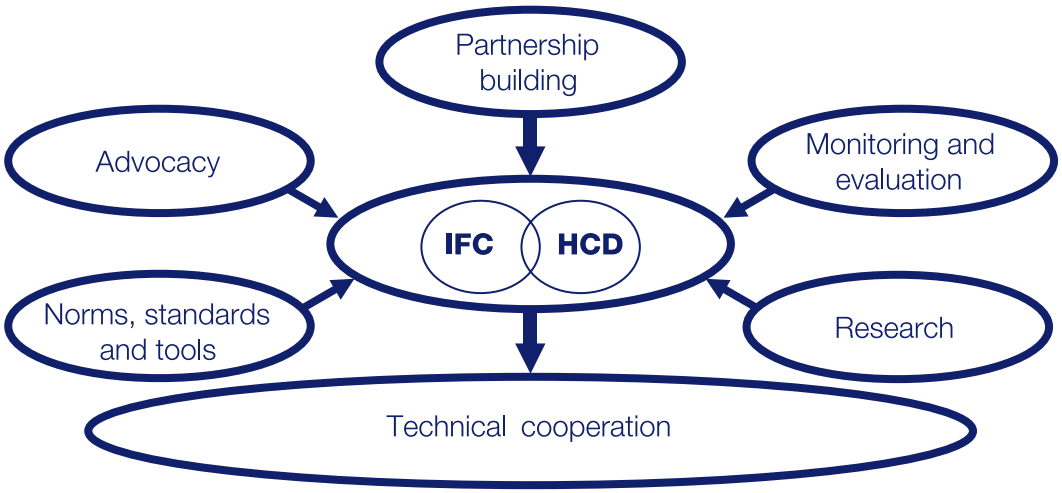
4.1 Specific roles

Specific roles of WHO for working with individuals, families and communities to improve maternal and newborn health include:

- building and disseminating a body of evidence and experiences related to working at the IFC level;
- strengthening and building international, national and local commitments to, and accountability for, working at the IFC level and for the integration of this area into policies, strategies and programmes;
- integrating the concept and principles of MPS IFC and related considerations into WHO norms, standards and tools;
- developing tools and technical guidance to support the implementation of IFC interventions;
- cooperating with all partners to develop agendas and plans to work at the IFC level;
- providing technical support for effective implementation and coordination at international, regional, national, intermediary and district levels related to IFC strategies and interventions;
- documenting and monitoring progress in the implementation of IFC strategies and interventions at national, regional and global levels.

These roles are integrated into the current areas of work of the larger MPS initiative, as presented in the figure below.

Making Pregnancy Safer activities



4.2 Activities

Review, documentation, dissemination and evaluation should be included across all levels of the MPS global team (headquarters, regions, countries). Documented approaches and lessons learned from country activities will permit interchange and scaling-up of successful local programmes. In addition, systematic review of the current literature and experiences developed worldwide in the IFC priority areas of intervention, and dissemination of the reviews, will be assumed by the initiative.

WHO will identify research needs, and advocate for more operational research (OR) relevant to working with IFC. Priorities will be established based on the need to update and validate knowledge to strengthen the strategic framework, on areas of research currently not addressed by others, and on needs identified at the country level, in health facilities and communities. The initiative will also promote research in the IFC priority areas of intervention.

Research results, expert consultations and systematic reviews will lead to the development of approaches, guidance and tools to support assessment and implementation of the strategic framework. Also, these IFC findings will be reflected in WHO standards and tools. The Global team will work with Ministries of Health and other partners to integrate the approaches, and to adapt or develop guidelines and tools to individual country and programme needs. WHO will advocate that country policies reflect a commitment to a broad approach to health (Health Promotion), and integrate IFC interventions in their maternal and newborn health programmes.

The WHO team will provide coherent programmatic and technical support, ensuring that the full array of knowledge and experience is made available at country level. In particular, the WHO team will ensure the transfer of updated knowledge and policy orientations, and will assist in building capacity for implementation at all levels.

4.3 Partnerships

Close collaboration is needed within RHR and with other WHO departments, in particular with CAH,[g] Roll Back Malaria, Gender and Women's Health, HIV/AIDS, Nutrition, and the WHO Health Promotion team, and more specifically with the School Health Component of WHO's Mega Country Network for Health Promotion. Partnerships with other United Nations agencies, multilateral and bilateral development agencies, NGOs and increasingly the private sector, civil society and communities are also essential for the development of IFC interventions and the fulfilment of Making Pregnancy Safer roles.

The fundamental premise is to build on existing knowledge and expertise of different partners and actors, at international, regional and country levels. As presented in Part 2, UNDAF could be a useful approach at country level for the implementation of a coordinated programme.

An example of possible collaboration is the Quality of Care Project.[19] With funding from the United Nations Foundation, the project is a UNFPA-led coalition of United Nations agencies (ILO-STEP, UNICEF, WHO) to develop a methodological framework that involves both users ("demand") and providers ("supply") to improve the quality of sexual and reproductive health care. Each of the four United Nations partners will bring into the effort their specific area of expertise.

[g] Within WHO, CAH will be a key partner due to their work in newborn and adolescent health.

A table which summarizes the different contributions of different partners to improved maternal and newborn health should be elaborated at global, regional and country levels. This will be a concrete first step in determining existing programmes, resources and expertise.

However, specific mechanisms should be established to make partnerships operational. At a global level, there are several bodies which can serve this role. For example, within WHO headquarters intra-cluster or inter-cluster committees can be formally established. The Safe Motherhood movement has an Inter-Agency Group, responsible for coordination and technical guidance. A sub-committee for IFC could be formed. At the regional level, coordination of efforts exists, such as the Prevention of Maternal Mortality networks. Many countries have established national committees to coordinate work for safe motherhood and newborn health.

4.4 Perspectives...

The effectiveness over time of the proposed MPS strategic framework for the development of IFC interventions will depend upon its flexibility and its capacity to review and validate the options proposed. A systematic process will be undertaken for monitoring and evaluating the efforts of the MPS initiative in relation to the IFC component. The role, level of effort and areas of action for WHO will shift in response to progress and the priorities of countries, other agencies and organizations.

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ANNEX 1

Health promotion as a conceptual basis for working with individuals, families and communities to improve maternal and newborn health

Health Promotion proposes an approach that is rooted in an analysis of the wide array of influences on health and in a vision of the positive and active role played by individuals and groups. Thus, it provides an excellent foundation for working at the individuals, families and communities level. Health Promotion, as stated in the Ottawa Charter (1986), is "a process of enabling people and groups to increase control over, and to improve, their health and quality of life."[3] Health is envisioned as "a positive concept emphasizing social and personal resources, as well as physical capacities."

Health Promotion is intended to initiate and drive processes of social change, aiming at the improvement of living conditions conducive to health,[96] the determinants for health, such as peace, shelter, education, adequate income, social justice and equity. This focus calls for a shift from medical and preventive paradigms, based on illness and health problems, to a socio-ecological paradigm, addressing inequities, social justice and social norms, as conditions to improve health. There is also a shift from individual to collective outcomes, and towards a more comprehensive approach that gives increased legitimacy to inter-disciplinary and intersectoral work.[96]

Three principal strategies of social action are at the core of the Health Promotion approach: empowerment, social support and advocacy.

Empowerment is the essence of an effective Health Promotion strategy, developed at two complementary levels that interact and affect each other:[97, 98]

- at an individual level–efforts are aimed at increasing resources like knowledge, cognitive capacities, health competencies and the capacity for making healthy choices;
- at a collective level–efforts are aimed at making structural changes to the local and global environment to improve access to social, economic and political resources.

Health Promotion recognizes that individuals have competencies and abilities that they apply in their daily life to maintain health. Considerable improvements in health are achieved by reinforcing and improving these competencies and abilities, largely through educational processes. With this priority in mind, the Jakarta Declaration states "Health Promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organizations or communities to influence the determinants of health."[20]

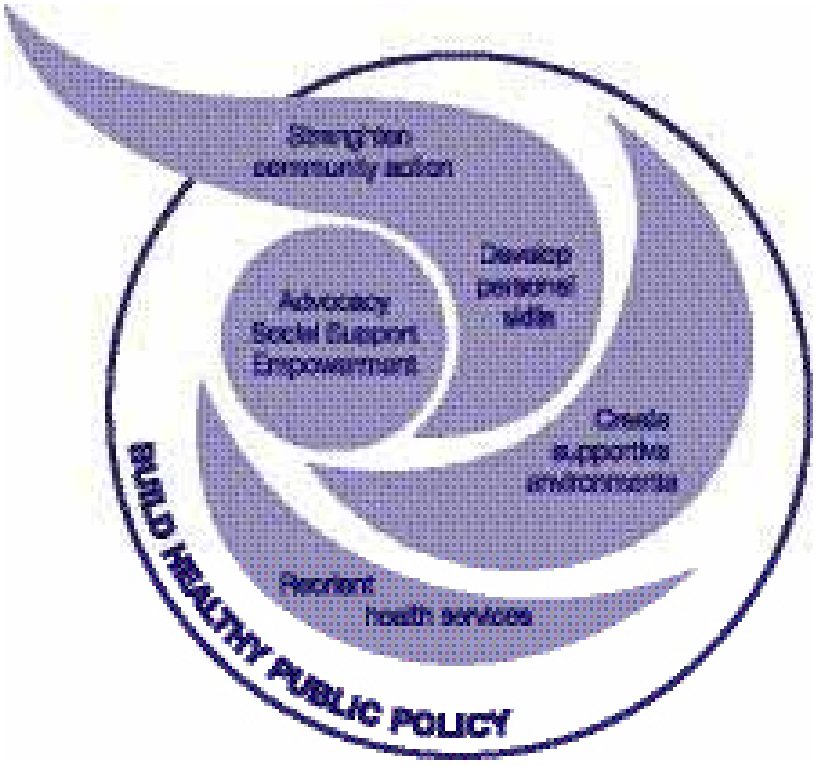
Social support is developed through groups, community organizations and institutions that encourage healthy lifestyles and healthy environments as a social norm and foster community action for health. It is comprised of systems that provide health care services and promote related development activities which influence health.

Advocacy, as a central strategy of social action, aims to generate public demand, to place health issues

high on the public agenda and convince those who are influential to act in support of health. Advocacy, political commitment and supportive policies are often products of social support and empowerment of people, and therefore should be seen as complementary.[99]

To operationalize the concepts embodied in Health Promotion, the Ottawa Charter proposes a framework of actions:

- *building healthy public policy*, puts health on the agenda of policy-makers in all sectors and at all levels of the health system;
- *creating supportive environments*, links people and their environment, and generates living conditions that are safe, stimulating, satisfying and enjoyable;
- *strengthening community action*, includes empowerment of communities through information, learning opportunities and resources;
- *developing personal skills*, focuses on supporting personal and social development and on enabling people to learn in different settings and stages;
- *reorienting health services*, shares the responsibility for Health Promotion amongst all actors and envisions a mandate beyond providing clinical and curative services, with sensitivity and respect for cultural and personal need.



The full strength of the Health Promotion concept is achieved when the five areas of action are developed concurrently and comprehensively, through the core strategies, using values and guiding principles as the underlying basis.

Source: WHO/WPRO, 2002[9]

ANNEX 2

An outcome model for the Making Pregnancy Safer framework for the development of IFC interventions

Health and Social Outcomes	**Health Outcomes:** measures include contribution to improvement of morbidity, disability, mortality, avoidable mortality of mothers and newborns **Social Outcomes:** measures include contribution to improvement of gender status, equity, empowerment, social support		
Intermediate Health Outcomes (determinants of health and social outcomes for maternal and newborn health; fundamental goals of Health Promotion)	**Health status** Measures include: appropriate care and self-care of the pregnant woman, including adequate nutrition, non-use of alcohol/ drugs, vitamins, medicine and treatment compliance, adequate workload and hygiene, appropriate care of the newborn, including cord care, mother-baby together, infant feeding, vaccination	**Health services care** Measures include: appropriateness and responsiveness of maternal and newborn services, including antenatal, childbirth and postnatal care	**Supportive environments** Measures include: safe physical environment; supportive economic and social conditions; adequate food supply; restricted access to alcohol and drugs; access to skilled attendants and health facilities
Health Promotion Outcomes (personal, social, and structural factors for changes in determinants)	**Health literacy** Measures include: knowledge and skills related to maternal and newborn health; care-seeking intentions; healthy decisions	**Social action and influence** Measures include: community participation; community empowerment; social norms; public opinion	**Healthy public policy and organizational practice** Measures include: regulation; resource allocation; organizational practices at district health system level; participatory planning process
Health Promotion Actions	**Education** Examples include: training of health workers in interpersonal and intercultural competencies; health education; school education; adult education; media and other communication channels	**Social mobilization** Examples include: community organization; group facilitation; men and family involvement; community dialogue	**Advocacy** Examples include: community epidemiological surveillance; community participation in health committee and health planning; lobbying for reproductive rights

Source: Nutbeam D, 2000[95]

ANNEX 3

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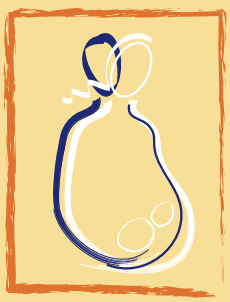

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