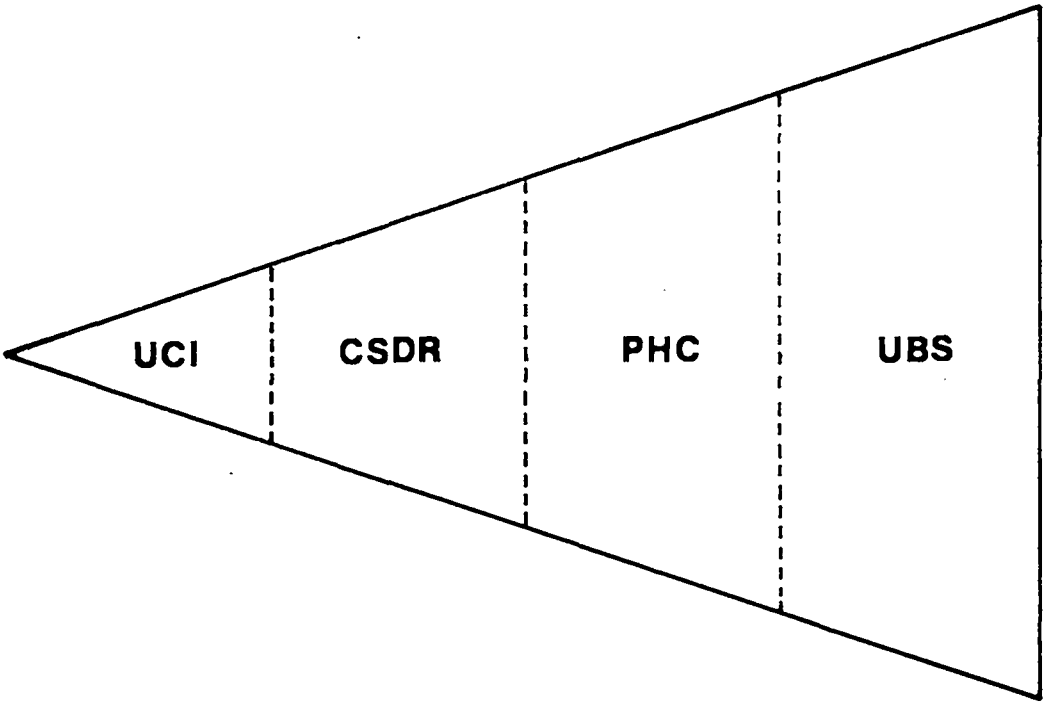
URBAN EXAMPLES

JUNE 1986 UNICEF UE-12

CHILD SURVIVAL AND DEVELOPMENT AND URBAN BASIC SERVICES



THE CSD - UBS CONTINUUM

Thanks to all colleagues in Sudan, Colombia, Somalia, Thailand, Philippines, India and Mexico who sent cases for this issue and to Ludette San Agustin for her assistance.

Marie Pierre Poirier (Urban Section)

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INTRODUCTION

This issue is concerned with the relationship among four UNICEF priorities and strategies: Universal Child Immunization, Child Survival and Development, Primary Health Care and Urban Basic Services (UCI, CSD, PHC and UBS). It is an attempt - a kind of acronymic analysis - to dispel some confusion and emphasize the continuity and congruence among them.

The diagram on the cover of this issue represents one way to look at the relationship. It is a triangle on its side with UCI as "the cutting edge" or the initial wedge of a programme which broadens out to include other components of the Child Survival and Development Strategy, such as oral rehydration therapy (ORT) and nutrition. CSD, in turn, can eventually fit into the supportive context of a community-based Primary Health Care system which includes water and sanitation as well as broader MCH elements. Finally, the PHC approach can be broadened even further to become a comprehensive, need-based Basic Services programme including components as diverse and related as pre-school education, income-generating activities for women and female literacy (which is part of the CSDR).

The cases from Sudan and Colombia are almost classical examples of this progression, beginning with UCI. In Juba (Sudan), the programme started with immunization in 1984, oral rehydration therapy was added in 1984-86, and nutrition will be included in 1986-87. This is the gradual broadening to a Child Survival and Development programme on the way to a Primary Health Care programme. The case states that this progression was intentional - a rare example of forward planning which worked. This case is also striking for its careful monitoring and evaluation system, built in from the outset. Colombia began with a national UCI campaign which has led to a national CSD programme aiming at eventual universal coverage of the population. It is well financed and broadly supported by a variety of government, international and voluntary agencies. Colombia is also the one country represented in this issue which is predominantly urban; with 73% of its 28 million inhabitants living in urban areas.

As the other cases indicate, there is not always such an orderly continuum. In Somalia, for example, a PHC programme was already in place, but the immunization coverage in Hargeisa and Mogadiscio was incredibly low - 15%and 19% of under-fives respectively. The immunization campaign was an opportunity to expand this coverage to 77% and 74% respectively, and invigorate the Primary Health Care system at the same time. This was done through high political commitment, effective social mobilization and broad involvement of community leaders, the party structure and student nurses. Bangkok is a somewhat different situation, where Primary Health Care was introduced to achieve equity for the urban poor who were not being adequately served by the predominantly private health delivery system. Within the PHC context, one goal is to increase immunization coverage with DPT, OPV and BCG from 80% to 100%. The Basic Minimum Needs approach of the programme operates through the PHC network and includes water and sanitation, early childhood development and eventually will include drug abuse, childhood disability and street children. Thus, it is moving toward the Basic Services model.

Olongapo City, on the other hand, is an Urban Basic Services (UBS) project which was begun by a local college with UNICEF assistance. It emphasizes PHC, uses health volunteers as community workers and is now run by the city Health Officer. (This is much like the Colombo (Sri Lanka) project which has health wardens at the base and is part of the office of the Chief Medical Officer for Health of the Colombo Municipal Government). The India cases and that from Mexico are comprehensive UBS projects which include PHC and CSD as important components. They also have convergent supporting activities such as water and sanitation, pre-schools and income-generating activities. The Mexican project has, in addition, a preventive emphasis in relation to street children.

These projects demonstrate that the participatory and comprehensive urban basic services approach provides a natural context for introducing and sustaining the CSD and PHC initiatives. Examples in India are the three towns in Kerala where every child under one has been immunized, and in Visakhapatnam where 86% of all children under one have been immunized. One clue to the effectiveness of the UBS approach in India is the concept of neighbourhood

development planning based upon community volunteers who work with small units of twenty or twenty-five families. This effectiveness has led the government of India to incorporate urban basic services into its current Five Year Plan.

The results reported in the Mexican case indicate significant progress across a wide range of CSD/PHC interventions from the promotion of breastfeeding through immunizations, to family planning, pre-natal and post-partum check-ups to preventive dental care. The heart of the project is its emphasis upon systematic community participation in every phase of the process, from need definition to evaluation.

Some Learnings from the Cases

1. There is a natural inter-connection among UCI/CSD/PHC/UBS and there are no clear lines between them.

2. Universal Child Immunization can be the entry point for a broader PHC or UBS programme, or it can be a component emphasized within an existing PHC or UBS programme.

3. Where a PHC/UBS system is already in place, with community workers and volunteers at the base, it can be an effective context for achieving Universal Child Immunization and CSD goals, and for sustaining the new practices which have been introduced.

4. The PHC/UBS approach naturally incorporates non-governmental organizations as part of a total participatory service system.

5. The PHC/UBS approach contains the realistic promise for attaining the goal of "health for all" in poor urban areas within the foreseeable future.

6. The Urban Basic Services approach broadens the traditional narrow health focus of Primary Health Care to include such components as water and sanitation as well as a strong emphasis upon community organization, all of which are part of the Primary Health Care approach.

7. UBS also permits some modest activities to be undertaken which address the basic problem of poverty through income-generating activities for women and nutrition projects.

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Senior Urban Advisor

1) NAME OF PROJECT: JUBA TOWN AREA COUNCIL ORAL REHYDRATION AND VACCINATION PROJECT

2) TARGET POPULATION: The infant and child population and the pregnant and lactating women in Juba.

3) TIME FRAME: 1984-1987

4) IMPLEMENTING AND CO-OPERATING AGENCIES:
   i) Juba Town Area Council Health Department (JTAC);
   ii) Directorate of Health and Social Welfare;
   iii) Adventist Development and Relief Agency (ADRA);
   iv) UNICEF.

5) COSTS: US$ 359,600 for the four-year period.

6) SOURCES OF FUNDS:
   i) US$ 11,900 provided by UNICEF as noted funds for the start-up of the immunization component (1984);
   ii) US$ 65,700 provided by the IMR Fund to cover project expansion and introduction of the oral rehydration therapy component (1984-1986);
   iii) US$ 200,000 committed through a USAID Child Survival Grant for the incorporation of a nutrition component (1986-1987);
   iv) US$ 62,000 provided by ADRA for counterpart staff costs and project support;
   v) US$ 20,000 are forthcoming from the JTAC for salaries of project staff (70%) and for related service expenditures (30%).

7) OBJECTIVES:
   i) To provide Juba's infant and child population and pregnant and lactating women with easy access to immunization, oral rehydration, growth monitoring, nutrition education, nutrition rehabilitation and basic diagnostic services through the establishment of community-based Primary Health Care centres in each of the town's seven councils;

ii) To familiarize Juba's population with the benefits and availability of these CSD services through the establishment of a regular programme of health education throughout the city;

iii) To strengthen inter-level co-operation in the government between the Regional Directorate of Health and the Municipal Health Authorities in planning for and evaluating the introduction of Primary Health Care services in the urban areas;

iv) To promote an inter-departmental approach at the local government level for the promotion and delivery of basic health services, with particular emphasis on CSD components;

v) To involve community representatives directly in project planning, implementation and monitoring processes and thus, establish a link through which the felt needs of the community can be translated into further government-supported self-help activities.

8) OUTPUTS (BY THE END OF 1987):

i) A minimum of 80 percent full immunization coverage of children under one and of pregnant mothers;

ii) One hundred percent (100%) access to oral rehydration therapy, growth monitoring, immunization, nutrition education, food supplements and basic diagnostic services;

iii) Full and accurate knowledge on proper preparation of oral rehydration salts and regular use of ORS sachets in the treatment of dehydration associated with diarrhoea by a minimum of 80% of Juba's households;

iv) A significant reduction in the number of infant tooth extractions being performed as a means of treating acute diarrhoeal attacks as compared with the baseline data gathered in January 1986;

v) A significant reduction in the incidence of moderate to severe malnutrition, as compared to the baseline data gathered in January 1986;

vi) A significant improvement in parental knowledge concerning appropriate weaning and feeding practices as compared with the baseline assessment of knowledge levels obtained in January 1986;

vii) The full institutionalization of the Oral Rehydration and Vaccination Project management, and of its financial, administrative and evaluative functions within the Juba Town Area Council.

9) PROJECT IMPACT INDICATORS:

i) Reduction of infant and child mortality rates in general, and specifically of those attributable to diarrhoeal diseases, immunizable diseases and malnutrition;

ii) Data series on 500 households in Juba, checking children under six periodically over the course of the project's development;

iii) Data gathered in the seven community health centres on the number of diarrhoea cases treated with Oral Rehydration Solution, the number of immunizations given, the number of children enrolled in supplemental feeding programmes, the number of children being checked regularly for growth monitoring, and the number of patients being treated for other essential endemic health problems.

10) BRIEF DESCRIPTION: JUBA TOWN AREA COUNCIL ORAL REHYDRATION AND VACCINATION PROJECT

Background

In Juba, capital of the Equatorial Region of South Sudan, seventy percent of the estimated 100,000 people reside in congested and unsanitary slums or squatter areas. Eighty percent of the households consume untreated water directly from the Nile or polluted streams. Seventy percent do not have access to toilet facilities.

Before the project activities started, medical assistance could only be obtained from the Juba hospital, a handful of expensive private clinics or one religious clinic. Since only the latter could provide drugs regularly and at a reasonable cost, most people were dependent upon the limited supply available at the private pharmacies. Many could not afford the monopolistic prices being charged by these pharmacies. Full immunization coverage of children under two stood at a mere 8%. Sixty percent of the people had no idea that immunization services were being offered. Oral rehydration therapy was little known and even less frequently used. Evidence from a UNICEF-funded survey demonstrated that 32.5 deaths per thousand live births were attributable to diarrhoea attacks within the first 6 months of life alone.

It was in the light of this situation that the Juba Town Area Council, the Regional Directorate of Health and Social Welfare (EPI Department) and UNICEF came together in 1983 to plan the Oral Rehydration and Vaccination Project (OR/V Project). The Project was designed to lay the foundation for urban PHC through the gradual and phased introduction of GOBI-FF and other maternal and child health interventions. These services were to be delivered through seven community health centres located throughout the town.

Active community and local government involvement was sought in developing the Project and monitoring its impact and effectiveness. In addition, close inter-sectoral co-ordination was established between the Public Health Department and other services under the authority of the Juba Town Area Council's executive branch.

Project Planning and Management

With impetus from UNICEF, a central planning group was convened in 1983 to broadly outline a strategy for the introduction of Primary Health Care services in Juba Town. The group comprised regional and local government officials from health and other service sectors and representatives from NGOs and from UNICEF. This group formulated a common inter-sectoral strategy based on the promotion and delivery of immunization, growth monitoring, oral rehydration therapy, food supplementation and nutrition education. It was envisaged at that time to introduce a basic diagnostic, educational and prescriptive service, capable of dealing with the most essential health problems, once the initial GOBI services would be effectively delivered.

Once drafted, the preliminary plan was reviewed by the Town Council sub-committee on health. The details of the project proposal were then presented to a full session of the Council in a three-day seminar and the

final amended plan of operations was ratified. The project was subsequently introduced to the target communities in a series of community meetings and one-day seminars convened by the elected counsellors. The meetings and seminars were attended by traditional, civic, religious and political community leaders. After assessment of the communities' needs, interests and level of commitment, a plan of action was drawn up.

The OR/V Project leader is the Chief Public Health Inspector of the Town Council who insures co-ordination between the executive and legislative branches of the Council through the Chief Executive Officer.

A Project Review Committee, chaired by the project leader, provides a forum for co-ordinated planning and evaluation between the Public Health Department and other co-operating departments. Technical assistance is forthcoming from the Directorate of Health, UNICEF, and ADRA (see diagram on page 6).

Project Implementation

1. Health Centre Activities: Each of the seven community health centres is staffed by a minimum of four paramedical officers: a health visitor who is the Centre Director, and three midwives or nurses. All four have undergone an intensive training programme on immunization, growth monitoring and oral rehydration therapy conducted by ADRA and the Directorate of Health. This original training programme followed a "see how it's done, do it yourself, then teach your fellow student" approach. It consisted of two weeks of in-class theory and practical demonstration, followed by one month of practical experience in the ADRA clinic in Juba, where the trainees worked in each position on a rotating basis, under intensive supervision. Once established in the seven community health centres, the paramedical staff are supervised jointly by ADRA and the MCH staff from the Regional Directorate of Health.

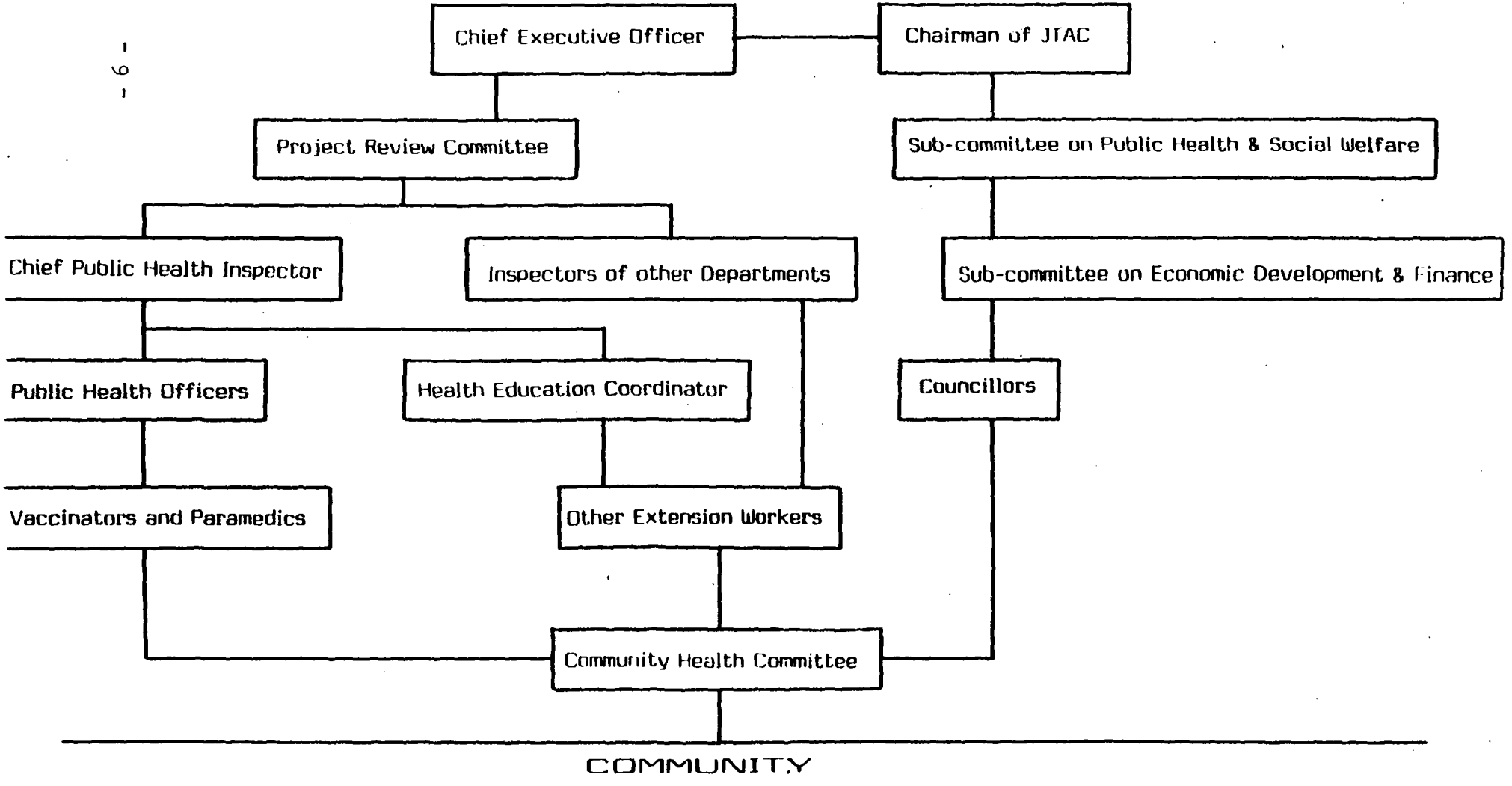
When nutrition activities are introduced in 1986, all paramedical staff working in the community health centres will undergo specialized training in nutrition. Again, practical experience, under close supervision, will be gained at the nutrition rehabilitation and education unit of the ADRA clinic.

Day-to-day operations of the health centres are determined by the needs of the patients. All patients are registered. They receive a "Road to Health" card and are weighed, screened and assigned to the Immunization, Oral Rehydration Therapy or Nutrition Stations. Once the full diagnostic and prescriptive services are introduced in 1987, patients will also be referred there if necessary.

a) Immunization Station: Immunizations are administered by one of the paramedical staff who also explains the side effects and the need to return for successive doses, records the immunizations on the "Road to Health" card and registers the child or the mother on a tally sheet. Similarly, records are kept for all health interventions undertaken, and are compiled in a monthly report.

JUBA TOWN AREA COUNCIL ORAL REHYDRATION AND VACCINATION PROJECT

PLANNING AND IMPLEMENTATION ORGANOGRAM



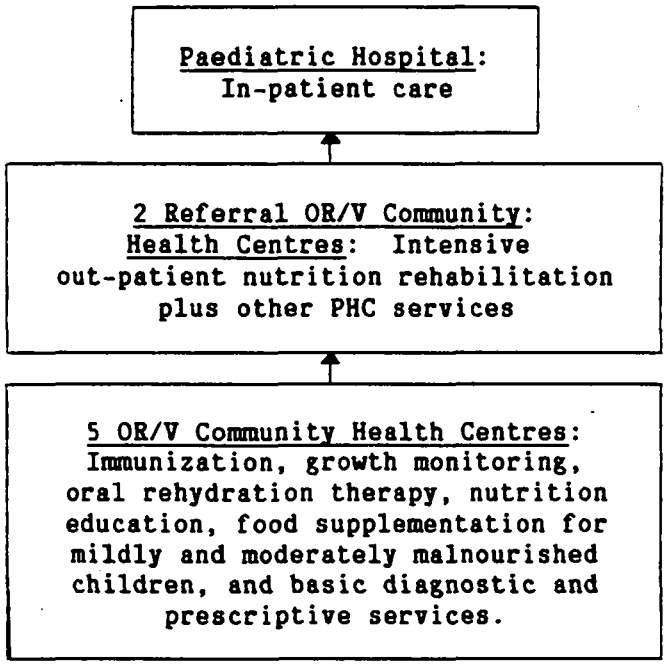
b) ORT Station: Diarrhoea cases are referred to this station where the severity of the dehydration is assessed, a rehydration schedule is established for moderately and mildly dehydrated children and rehydration is initiated under the centre's supervision. Mothers are taught how to prepare and administer the oral rehydration salts. They also participate in health education discussions and presentations on disease prevention, sanitation, birth spacing and family planning.

Severely dehydrated children, or those with serious complicated factors, are referred to a privately operated paediatric hospital in Juba.

c) Nutrition Station: In five of the health centres, a nutrition station will provide nutrition education and/or supplemental feeding to children identified as below 80% weight for age. Mothers will be taught how to use locally available foods to prepare a balanced and nutritious diet for their children. A demonstration garden is being set up at each centre to take advantage of the water run off from the handpumps located in the compound. In addition, attempts will be made (with the help of the extension workers undertaking promotional activities in the residential areas) to identify households with malnourished children and to assess the more obvious causes of malnutrition (i.e., poverty, lack of knowledge, etc.), so that remedial action can be initiated, either directly through project resources or with assistance from other departments working under the Town Council.

Severely malnourished children, recorded as 60% of weight for age or below, will be referred to two specially designated health centres for intensive out-patient treatment and rehabilitation. Extremely malnourished children exhibiting additional serious complicating factors will be referred to the Juba paediatric hospital for in-patient treatment and rehabilitation.

2. Referral system: The seven community health centres are designed to meet the essential health needs of the population in their immediate neighbourhoods. In addition, two of them will serve as out-patient nutritional rehabilitation facilities for severely malnourished children who do not exhibit signs of other serious medical complications (see 1.c above). All cases involving serious complications or, in the case of severe dehydration, requiring intravenous therapy, are referred to the privately operated paediatric hospital in Juba. In such cases, the cleaner is sent on a bicycle to the hospital where an ambulance is on standby. In the meantime, initial assistance is administered at the community health centre. The following diagram depicts how this referral systems works:



3. Community-Based Health Education: The promotional and educational activities undertaken by the OR/V Project are conducted with the co-operation of the department of Youth and Sports and the department of Social Welfare and Education, working under the Juba Town Area Council. Twenty six volunteer extension workers from these departments serve as "health educators" in the communities where they live. The OR/V project organized for them one and a half months of in-service training in the use of low-cost and traditional communication techniques. This will be useful in disseminating essential messages concerning the GOBI elements in the simplest terms possible. The course followed the syllabus and task-oriented teaching approach laid out in the Expanded Programme on Immunization Health Education Trainers Manual (Ed. C. Schwabe, 1984).

By training extension staff already employed by other departments, the OR/V Project has fostered a convergence of service delivery throughout Juba, building upon the rapport these extension workers had already established with their communities.

The twenty six volunteer health educators are supervised by a health education co-ordinator working for the Project. A regular series of group events (dramas, songs, exhibitions and discussions) are run each month in schools, churches, community organizations, and in the residential areas themselves. In addition, as mentioned above, the volunteers assist the paramedical staff working in the community health centres by identifying particularly "at risk" households for targetted advocacy and follow-up.

4. Monitoring and Evaluation: A comprehensive monitoring and evaluation system is built into the OR/V Project. A major baseline household study was conducted in Juba Town in January 1986 to provide the following information:

a) Immunization coverage rates of infants and pregnant mothers.

b) Knowledge levels and parental attitudes towards immunization, diarrhoeal diseases (including the prevalent practice of infant tooth extraction in acute diarrhoea cases), oral rehydration therapy, and nutrition (including taboos).

c) Infant and child morbidity and mortality rates, overall, and as particularly attributable to immunizable and diarrhoeal diseases.

d) Anthropometric measurements of all children under six and comparison of these data with ILO/UNFPA 1983 information on the same households.

e) Detailed retrospective expenditure analysis of basic goods and services to establish absolute and relative budget shares across income deciles.

f) Data on demand for various types of health services (i.e., traditional, modern, preventive, curative, public, private), including quantity required, price paid (both in cash and in terms of opportunity cost of time expenditure), and variations by income levels.

g) Communication channels through which information and health education messages flow to target audiences.

A post-project follow-up survey will be undertaken at the end of 1987 to measure the impact of the Project on the parameters listed above.

A comprehensive monthly monitoring protocol is currently being designed. Records are now being compiled at each community health centre on attendance rates, age of patients, number of patients treated with oral rehydration salts, immunized, weighed and measured, or provided with food supplements. Lessons learned during the pilot phase of the Project on communication channels and the relative effectiveness of alternative media will also be incorporated. In addition, 30 random sample surveys will be undertaken by the Project to collect detailed information on specific areas of interest and to assess the mid-term impact of the various health interventions.

All surveying and monitoring activities undertaken by the Project are conducted either by the volunteer health educators or by the paramedical staff working in the health centres. This makes it possible for them, who are directly involved in service delivery and advocacy, to learn about the problems of the community members and assess the deficiencies of the Project. In addition, it ensures that they serve as advocates and not just as information collectors.

Project Constraints

1. Overlapping jurisdiction: the respective jurisdictions of the various levels of government dealing with planning and delivery of health and other basic services in the urban context of Juba, seat of the Regional Government, have not yet been clearly delineated. Despite the introduction of the OR/V Project, and the clear mandate provided by the Local Government Act of 1981, the Juba Town Area Council has encountered considerable difficulty in playing the leading role as planner and administrator of basic services in the city. This was due both to institutional deficiencies at the Town Council level and to reluctance on the part of regional health authorities to delegate responsibility for administering project development.

The jurisdiction problem has led to difficulties in co-ordinating on-going health projects and hence, new project initiatives are not always designed to complement existing efforts. It has also caused considerable problems in terms of control of Project staff. Though their salaries are paid by the Town Council, technical staff (i.e., paramedics and extension workers) look to their "Mother Ministries" at the provincial or regional level for supervision and accountability. This has led to very poor control over staff both in terms of work ouput and quality of performance.

2. Institutional weaknesses: the legislative branch of the local government is very weak and inexperienced; hence, efforts by the OR/V Project to initiate supporting legislation which would formalize and legalize Project initiatives have not been successful. Elected counsellors (some of whom do not reside in the areas they serve) perceive their only role as being distributors of essential commodities. In most cases, it has been fruitless to utilize these counsellors as intermediaries to gain access to the communities. To compensate for this deficiency, greater reliance is now being placed on informal leaders, teachers, extension workers and church networks.

3. Project Finance: The institutional weaknesses of the local government have meant that the Town Council has played no role at all in formulating the OR/V Project budgets. This is critical, given that the development of a project of this kind necessarily implies additional demands on the Council's resources, particularly for recurrent costs. Thus, the Council is now supporting the expansion of the delivery of health services in the town without assessing whether or not it can realistically afford or sustain these services when external resources come to an end.

To some degree, the OR/V Project is based on the understanding that the Municipal Authority will not be able to fully meet the recurrent costs of the expanded urban Primary Health Care system being developed. This is why the baseline evaluation included a household expenditure study and a demand analysis. The Project expects to establish the effective household demand for public and preventive health services across income groups, and determine whether a progressive structure of user fees can be introduced. The Project is also trying to economize where possible, for example, through the establishment of inter-sectoral linkages and through the use of appropriate technologies and low-cost and traditional communications media. Finally, the Project is exploring the possibility of organizing an annual Easter Immunization Football Cup in Juba, the proceeds of which would go to the Project.

4. Project Implementation: Past reliance on a separate cadre of vaccinators caused many problems. Because of their low status, poor pay, and limited career options, the vaccinators proved to be very unreliable. The credibility of the Project, in the eyes of the mothers and community at large, was constantly being compromised as vaccinators would not come for scheduled immunization sessions.

The OR/V Project has solved this problem by integrating the immunization activities into the Primary Health Care package and by relying on the paramedical staff to administer the vaccinations along with the other GOBI-FF and PHC services.

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1)	NAME OF PROJECT:	SUPPORT PROJECT FOR THE IMPLEMENTATION OF THE NATIONAL CHILD SURVIVAL AND DEVELOPMENT PLAN (CSDP) OF COLOMBIA
2)	TARGET POPULATION:	3.6 million families: i) 3,686,000 children under five including 795,000 children under one; ii) 801,000 pregnant women.
3)	TIME FRAME:	1984-1989 (for the overall plan)
4)	IMPLEMENTING AND CO-OPERATING AGENCIES:	i) Government of Colombia; ii) The Colombian Red Cross; iii) Catholic Church; iv) WHO; v) UNFPA; vi) PAHO; vii) UNICEF.
5)	COSTS:	US$ 429.8 million including US$ 2 million from UNICEF
6)	SOURCES OF FUNDS:	i) Government of Colombia; ii) UNFPA; iii) PAHO; iv) UNICEF; v) Bi-lateral aid.
7)	OBJECTIVES (by 1989):	General i) Reduce the infant mortality rate from 57 to 40 per 1,000; ii) Improve the nutritional status of mothers and children; iii) Reduce the incidence of developmental disorders.

Specific

i) Reduce neonatal mortality from 23 to 17 per 1000;

ii) Reduce child mortality due to acute diarrhoeal diseases from 23.2 to 11.6 per 10,000;

iii) Reduce child mortality due to acute respiratory diseases from 12.5% to 7%;

iv) Expand immunization coverage to cover 80% of children under five;

v) Decrease overall malnutrition in children under five from 19.4% to 15%;

vi) Educate about 750,000 pregnant women and 1,190,000 families about child development;

vii) Train 350,000 "health scouts" (health workers);

viii) Reach 1,500,000 families with health education;

ix) Set up 5,000 centres for distribution of ORS and promotion of oral rehydration therapy (ORT).

7) BRIEF DESCRIPTION: CHILD SURVIVAL AND DEVELOPMENT PROJECT

Background

The 1983-86 National Plan of Colombia "Towards Equity in Health" aims at covering the entire population of the country with a package of services for mothers and children, through a community-based project. Of the total population of Colombia, approximately 3.7 million are children under five years of age and pregnant women are estimated at 1,000,000. The infant mortality rate has gone down to 57 per 1000 in the last three decades. The main causes of child mortality are perinatal diseases, gastro-intestinal infections and acute respiratory infections.

In 1984, the highly successful immunization campaign encouraged the Government to draw up the National Child Survival and Development Plan. The plan emphasizes the development and use of low-cost techniques such as oral rehydration, growth monitoring, expanded immunization, pre-natal checkups, health education and identification, referral and monitoring of "at risk" cases. It involves care of pregnant women and those of child-bearing age. It also seeks to control diseases such as malaria that may increase morbidity or mortality among children. Promotive and preventive aspects of health care and education, involvement of the family and the community, use of low-cost and proven strategies and co-ordinated resources are the underlying concepts of the programme. Thus, the government and the non-government sectors have joined in a synergistic effort.

Strategy

1. Social mobilization to involve the community and community-based organizations; training, for this purpose, of a large number (350,000) of health workers.

2. Development of "risk criteria" for early detection of "at risk" children and mothers.

3. Identification of mothers and children "at risk" through trained community workers.

4. Focus mainly on children below five years of age and on pregnant women;

5. Use of mass media on a large scale, and in particular, innovative use of interpersonal education through games and arts to provide information on the main risk factors to health;

6. Provision of adequate support to the health workers through the national health service.

Project Activities

1. Peri-natal Mortality Control: The main causes of perinatal complications are deliveries attempted by non-medical personnel whose training did not include identification of "high risk" pregnancies. Hence, this activity includes: training of traditional midwives and community health workers in identification of "at risk" and "high risk" delivery cases and referrals to health centres, use of a health card system, recording of deliveries and follow-up on the newborn child's development.

2. Acute Diarrhoeal Disease Control: Gastro-intestinal infections are one of the main causes of child mortality. The main activity is to promote the use of oral rehydration salts and hygiene education through 5,000 centres.

3. Acute Respiratory Infection Control: The main components of this programme are making timely care available through the primary health system, and promoting family awareness and education.

4. Malnutrition Control: The overall malnutrition rate is 19.4% for children under five and an additional 19.7% can be considered "at risk." The basic activity is supplemental nutrition for children and pregnant women, broadened nutrition education, early stimulation of malnourished children, eradication of intestinal parasites and implementation of an information system to record and monitor the children's nutritional status.

5. Psycho-affective Deprivation Prevention: The aim will be to educate families in the use of simple stimuli and play for cognitive and psycho-social development. Also, community education programmes promoting the need to provide psycho-affective attention to children are being developed.

6. Child Immunization: The aim is to cover 80% of children under five through the expanded immunization programme.

7. Related Activities: Other activities include the development and production of educational materials, promotional materials for radio and television, training materials for community workers (health cards, training manuals, audio-visual training aids), and the provision of supplies for immunization and other health related programmes.

Project Co-ordination

Each agency involved in the programme has been assigned a specific target for each project activity, such as training of health workers, setting up of centres for the distribution of oral rehydration salts, community education, production of health cards, early detection, etc. Separate fiscal allocations have been made for each activity and the progress is being monitored every six months.

The Government of Colombia has overall responsibility for the project, mainly through its Ministries of Health and Education. There is a co-ordination committee consisting of representatives of all the governmental and non-governmental agencies involved in the project. This committee meets every six months to assess progress and approve the timetable for various

activities. In addition, technical executive committees for each area of work, consisting of the implementing agency, the Ministry of Health and UNICEF, co-ordinate and supervise activities and follow-up. Finally, the organization of co-ordinating committees is promoted at the departmental, municipal and local levels, including representatives of the different organizations involved in the execution of the activities at these levels.

Financial allocation and release of UNICEF funds is made through the Foundation for Higher Education. Supply of materials is handled centrally and in kind so as to achieve economies of scale and uniformity.

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1)	NAME OF PROJECT:	ACCELERATED CHILD IMMUNIZATION PROJECT, SOMALIA (This project has two sub-components, one focused on urban centers and the other on rural areas)
2)	TARGET POPULATION:	i) Total under-five population of the country or approximately 750,000 children. ii) Total population of women of child-bearing age, or approximately 870,000.
3)	TIME FRAME:	1985-1989
4)	EXECUTING AND CO-OPERATING AGENCIES:	National i) Ministry of Health; ii) Mayor's Office, Mogadiscio; iii) Regional Health Authorities; iv) Nursing Schools; v) Ministry of Information. International i) Save the Children Fund (UK); ii) WHO; iii) UNICEF.
5)	COSTS AND SOURCES OF FUNDS:	The main funding input is from the Government of Italy through UNICEF (US$ 3.46 million).
6)	OBJECTIVES: (Urban Sub-component)	Medium Term i) Increase vaccination coverage of children and mothers in two urban centres; ii) Develop the capacity to manage and organize accelerated EPI activities in urban areas. Long Term i) Sustain vaccination levels so that succeeding groups of newborns can be vaccinated through regular urban health services; ii) Create public demand for vaccination services; iii) Establish quantifiable targets for reduction and elimination of immunizable diseases.
7)	OUTPUTS:	Total number of children with full immunization status in Hargeisa: 14,000; in Mogadiscio: 68,000.

8) BRIEF DESCRIPTION: ACCELERATED CHILD IMMUNIZATION PROJECT, SOMALIA

Background

As part of the urban primary health care activities in Hargeisa, the second largest city in Somalia, the regional health authorities approved in late 1984 an ambitious plan to vaccinate all children under five in the city against the six common childhood diseases. Hargeisa has a registered population of 120,000; although unofficial estimates put the figure much higher. The under-five population at that time was estimated to be approximately 18,000. Prior to the campaign, only 15 percent of the children were fully immunized even though free immunization had been available through the regular MCH services.

During the first round of the campaign in January 1985, 15,000 children were immunized. Although an epidemic of cholera in a refugee camp adjacent to the city disrupted initial operations for the second round, the campaign eventually continued and succeeded in providing full immunization status to 14,000 children, or almost 77 percent of the child population of the city. It was estimated that 93 percent of the children were fully protected against measles.

Encouraged by these results, senior officials of the Ministry of Health and the Mogadiscio Mayor's Office decided to organize a similar, larger campaign in the capital city. After intense preparations, the first round was launched on 3 July 1985. 55,000 children under five were immunized, representing 86 percent of the pre-registered eligible child population. On completion of the three rounds, almost 68,000, or 74 percent of the under-five population, had achieved full immunization status for all six antigens. Before the campaign, surveys had indicated that only 19 percent of the children in Mogadiscio had completed the full series of immunizations.

The success of these efforts have stimulated similar campaigns in urban centers around the country and greatly increased the general public awareness of the importance of child immunization. While these accelerated activities continue in urban areas, regular immunization for rural communities is also being provided through the primary health care system. As a result of these combined efforts, an additional 10 percent of Somalia's under-five population were also fully immunized.

Organization

1. Community Mobilization: In both Hargeisa and Mogadiscio, there are no house numbers, or street names. Except for the central residential areas, the settlement pattern is unplanned and unorganized. The only form of organization that exists is that of the Party, which is based on the following units:

Tabella: a collection of about 50 houses
Laanta: a collection of 3-22 tabellas
Xaafad: a collection of 2-5 laama
Waax: a collection of 2-5 xaafada

At each level, there is a party-appointed leader. In both cities, these party/community leaders were used extensively in pre-registering children, promoting the campaign and assisting with operations. This community network was, without any doubt, the main reason for the success of the social mobilization element of the campaign. This was confirmed by the fact that during the second round, when political leaders of Hargeisa and Mogadiscio were involved in other activities, the number of vaccinations dropped dramatically.

2. Personnel and Training: In Hargeisa town, EPI regular staff received help from students undergoing nursing training. Each batch of 30 students received one week of theoretical and practical training through the MCH centres. The four-day vaccinating week allowed them to pursue their normal studies 2 days a week. Batches were rotated every 2 weeks so that normal work was disrupted to a minimal extent. MCH staff also received refresher training prior to the campaign. By the end of the campaign, 7 teams consisting of 4 students each, 1 MCH nurse and 1 teacher responsible for the registration of children were operational, supervised by a small Regional PHC team of national staff and 3-4 UNICEF technical staff.

In Mogadiscio, 2,500 political and community leaders were given short orientation courses on the operational aspects of the campaign. Vaccinations were given by 530 trained student nurses working in 62 vaccination centres around the city. Each vaccination site was staffed by four student vaccinators. The sites were open from 7 a.m. to 6 p.m. and required two shifts of vaccinators during the day. A small army of national service students visited a total of 150,000 houses to register the children and urge parents to come to the centres. A fleet of buses was used each morning and evening to carry all the personnel between pick-up points and the vaccination centres.

3. Pre-Registration: In Hargeisa, it was decided, after the second round of the campaign at which attendance was the poorest, to pre-register all children. A system was designed in order to maintain coverage after the campaign. This consisted of a Family Form on which the names of all children under five and all pregnant women were recorded, as well as their vaccination status. These forms were gathered into tabella registers which were used at vaccination sites, and then subsequently held at the local MCH centre, where they are still being used. This registration was a major exercise, involving a team of schoolteachers hired and trained for the purpose, working in conjunction with party officials. Despite all the efforts involved, it proved vital to achieve high coverage, as well as good follow-up.

Benefitting from the experience in Hargeisa, all eligible children in Mogadiscio were identified and listed in 'neighbourhood notebooks' before the first immunization round by the community leaders. During immunization sessions, names were ticked-off when the children appeared at the centres. A daily examination of these notebooks by programme monitors identified those areas showing low response and permitted same-day follow-up on defaulters.

4. Monitoring: In Mogadiscio, an interesting feature of the monitoring process was the daily feedback of information to the EPI/HQ from all vaccination centres. These data were immediately computerized to give

cumulative and percentage vaccination rates for each of the 13 districts of the city. This information was passed on to the political leaders and broadcast each morning on the radio. This feedback information generated considerable friendly rivalry between districts.

Furthermore, cluster surveys were conducted after the first and third rounds in each district, using standard WHO methodology. Results from these surveys allowed the campaign managers to pinpoint strong and weak districts in order to strengthen communication or operational inputs.

Political Commitment

Political commitment was high in Hargeisa where the Party 'machine' worked hard at all levels, and particularly at the tabella level. Tabella leaders devoted much time and effort to find unvaccinated children identified from the lists of names derived from their pre-registration Family Forms.

An extremely important element in the Mogadiscio campaign was the publication of a Presidential Circular underscoring the importance of child immunization. This circular was widely publicised and distributed to all political and community leaders involved at the local level. The President's presence at the inauguration of the campaign provided a major stimulus for the population to come forward to the EPI centres. The President's personal commitment also ensured full participation of the Party, the Somali Women's Democratic Organization and the Ministries of Health, Education, Interior and Information.

Social Mobilization

Communication support was a common and crucial component of both campaigns. In each case, a communication strategy was developed in conjunction with the implementation plans. Posters, handbills and attractive car bumper stickers were distributed through various channels before and during the different rounds. Undoubtedly, the use of radio broadcasts in both cities was the most important communication support to the campaigns.

In Hargeisa, a series of educational programmes on vaccination were broadcast in the week preceding the campaign. To supplement these programmes, mothers were interviewed during the campaign on their views and concerns about immunization. In addition, a vaccination song was recorded by a popular local band and played frequently over the radio and by loudspeaker vans travelling around the city. Celebrities, including eminent sheikhs, recorded broadcasts encouraging mothers to vaccinate their children.

Much of the real social mobilization occurred because of the strong Party structure. Routine and special meetings at all levels, including the popular orientation meetings, were charged with spreading the message, and also with generating a competitive spirit among tabellas, laanta and waax.

Evaluation

In Hargeisa, a standard WHO EPI coverage survey was carried out after the fourth round which showed the following figures:

DPT/OPV/I	DPT/OPV/II	DPT/OPV/III	Measles	BCG
97%	91%	79%	91%	85.8%

These figures are very encouraging, particularly in the light of the nomadic nature of the population.

In terms of solid reduction of disease incidence, no reliable figures are available. However, it should be mentioned that during the cholera epidemic which occurred after the second round, there was also a very severe measles epidemic in the Gannat refugee camp located within the town limits. Up to 600 children were reported to have died of measles and related causes in the camp. In the town, however, no single death was reported.

A standard WHO 30-cluster survey conducted in Mogadiscio in 1984 had shown that most children who were being vaccinated were over one-year-old and therefore often already immune, and that full immunization rates for one-year-old children were very poor. The aim of the campaign was, hence, to complete full immunization of children over one so that the regular MCH services could focus on infants and their mothers.

The campaign was evaluated in two ways: coverage achieved and reduction in disease incidence.

In terms of vaccination coverage, the Mogadiscio campaign was highly successful. A series of WHO standard cluster surveys conducted at the district level after the third round showed the following results:

DPT/OPV/I	DPT/OPV/II	DPT/OPV/III	Measles	BCG
96%	91%	78%	91%	89%

These encouraging results seem to be reflected in declines in disease incidence. Figures from Benadir Hospital, the only children's hospital in the city, showed only one measles case - in an unvaccinated child - in the six-month period starting in October 1985. However, a careful epidemiological assessment is required to see if early declines in measles are followed by declines in other diseases, notably polio, for which declines in recorded incidence are not to be expected so rapidly.

No mass campaign can claim success unless it strengthens the infrastructure in order to maintain the coverage attained during the campaign. Great progress has been made in strengthening vaccination services for mothers and newborns at Benadir Hospital, where more than half of the city's births take place. However, the children who get their first dose of BCG and polio vaccines at Benadir Hospital must be followed up to complete the series; preliminary data from a still incomplete survey of infants in Mogadiscio suggest that only half of those surveyed are following the prescribed schedule for following doses.

Maintaining coverage in urban areas

Sustaining demand for vaccinations after the campaigns is essential for maintaining high coverage. One of the main disincentives affecting Somali mothers in the two cities was found to be the walking distance to the vaccination centre. The observation was particularly relevant for areas on the periphery of the city. In order to ensure that mothers have less distance to walk in the future, the health authorities are planning to establish satellite EPI/ORT units linked to the existing MCH centres. Staff at each centre will supervise 3-4 satellite units staffed by local TBAs and student nurses.

In Hargeisa, a system whereby BCG is given to all babies born in the hospital is working efficiently. An outreach system covering 16 new outreach points is also working well. Uptake on this service is still not optimal, but a model system of birth (and pregnancy) registration at the tabella level is currently being developed, using the Family Form system. Once this is working in the trial area, it will be expanded to the whole town.

Communication support will also be maintained after the campaigns. One innovative example of this strategy has been the production of a musical drama which incorporates themes on child survival. The musical is extremely popular and will be shown in all districts of Mogadiscio during the mid-1986 before travelling to all towns of the country undertaking EPI accelerated activities.

UNICEF Somalia, in association with SCF (UK), has printed an EPI module entitled 'Raise and Maintain Urban Vaccination Coverage'. This booklet has been developed on the basis of the experience of the Mogadiscio campaign and deals with the general concern of expansion of EPI activities in the city.

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1)	NAME OF PROJECT:	PRIMARY HEALTH CARE IN BANGKOK
2)	TARGET POPULATION:	Approximately 120,000 in 7 congested communities and 140,000 residents of two peri-urban districts of Bangkok
3)	TIME FRAME:	Pilot stage: 1982-1986
4)	IMPLEMENTING AGENCY:	Health Department of the Bangkok Metropolitan Administration (BMA)
5)	COSTS:	Supplemental funds for PHC provided by UNICEF have been approximately US$ 120,000 (as of the end of 1985).
6)	SOURCE OF FUNDS:	i) Health Department, BMA ii) WHO iii) NGOs iv) UNICEF
7)	OBJECTIVES:	i) Render better and appropriate health services to low-income people; ii) Promote collaboration among government, NGOs and community health facilities and workers to achieve health for all by the year 2000; iii) Involve the people in planning and management of community health services through health volunteers.
8)	PROJECT IMPACT INDICATORS:	A survey of the 4 initial target communities was made in 1982 and comparative data will again be collected at the end of 1986 to determine project output and impact. Absence of disaggregated data for project areas needs to be rectified in future programming.

9) BRIEF DESCRIPTION: PRIMARY HEALTH CARE IN BANGKOK

Background

In Bangkok, the overall health resources seem to be adequate, but because they are mainly provided by the private sector, they are not equitably distributed. Although there are already 56 fully staffed district health centres, the present health care delivery system fails to fully meet the basic health needs of the urban poor. The people in congested areas live near medical and health facilities, but like their rural counterparts, they endure conditions of poverty, poor environmental sanitation, and ill health. Those living in peri-urban areas have limited access to essential health and medical care.

Realizing the inequity of the health situation, it was decided to include this Primary Health Care Project in the second BMA Health Development Plan (1982-1986) specifically to help redress this situation. The project aims to render better and appropriate health services to the people, particularly those with low income, and to promote collaboration among existing health facilities through primary health care to attain health for all by the year 2000. To achieve full coverage, it is necessary to stimulate, convince and support communities and individuals to help themselves; to develop appropriate attitudes and skills among all levels of health personnel, especially those working in the community; and to involve the people of disadvantaged communities in planning and managing community-based health services.

In January 1984, at a follow-up meeting to assess the progress of the Primary Health Care Project, the BMA administrators agreed to direct urban development along the line of the national social development strategy through the use of Basic Minimum Needs (BMN) indicators. BMN indicators are tools designed for every five-year period to establish and measure social development targets and achievements. They have been developed by the National Economic and Social Development Board for use in rural development projects. The BMA spent the months of May until December 1984 on the adaptation of the rural BMN indicators to suit the Bangkok urban situation. Thus, 33 out of the 52 indicators are now being used in Bangkok. Therefore, the BMN approach has been gradually applied in community development by the BMA since 1985. UNICEF co-operation with this approach started at the beginning of 1986.

Organization and Operation of the PHC Project, 1982-1985

The PHC project is directly administered by the Health Department of the BMA which has well-trained and well-equipped medical teams in the 56 District Health Centres. Each center has one or more doctors, nurses, midwives, public health nurses, and usually a dentist and a social worker. The public health nurses frequently visit communities to monitor and guide the work of the PHC volunteers. They are the main health personnel involved in the training of and referrals from the volunteers and in information collection. They are also the key link between the government health services system and the people of the communities. This basic PHC strategy has been adapted to fit the varied conditions in each type of communities:

1. In peri-urban villages, the well-established rural PHC methods were used with only minor modifications. Village Health Communicators (VHC) were selected using a sociogramme technique for each group of 8-15 families. VHCs were trained for disseminating health information and became the contact point for their group. After 12 months of service in their communities, one Village Health Volunteer (VHV) was selected from among each group of 10 VHCs to receive additional training on simple diagnoses, treatment, referral and management. The VHVs were provided with basic medical kits and can treat minor ailments. VHVs also set up and manage the drug co-operative of the village; make referrals to district health centres and hospitals; and organize immunization or other campaigns.

2. The improved congested community (slum) is an organized community in which the infrastructure has been improved, land tenure is secure, and established community committees have been elected. In these communities, Urban Health Volunteers (UHV) are chosen by the community committee on a basis of one per 20-30 families. Their training and tasks are similar to those of the VHVs. However, they receive additional training in environmental sanitation and drug abuse, which are more serious problems in these communities. The direct links with the community committees are very important and make it possible for UHVs to be involved in general problems of community development.

3. The BMA has also recently begun work in unimproved congested communities which are not legally recognized residential areas and have no recognized community organization. As a result, many government services cannot be legally provided in these areas and infrastructure and housing improvement is restricted by the land owners. In these communities, UHVs must be given special training in order to function also as community organizers. PHC activities are dependent on the creation of an effective community organization and on other services and infrastructure not currently available. Therefore, the health volunteer is expected to become a multi-purpose community development worker.

Results

Reports from BMA have shown the following achievements of the PHC Project:

	1982-1986 Target	As of September 1985 Achievement (overall PHC Project of BMA)
Trained health volunteers:		
Congested areas	420	484
Peri-urban	565	235
Trained health communicators (peri-urban)	5,650	2,774
Drug co-operatives (peri-urban)	-	17
Water jars (peri-urban)	-	128% *
Latrines (peri-urban)	-	110% *

*Some households have more than one latrine and several water jars.

Constraints

Lack of tenure security in the unimproved congested communities discourages permanent construction and BMA cannot make physical improvements in these areas without the permission of the land owner.

Economic pressure often limits the performance of volunteers and self-help activities among temporary labourers.

Health personnel have to change their role and attitude from sitting in their office waiting for patients to going out and working with people in the communities. Because of the great availability of hospitals and health facilities, health professionals often think that there is no need for PHC.

The PHC pilot project demonstrated the effectiveness of PHC in urban areas. However, it has also shown that PHC alone cannot solve all environmental sanitation and other social problems of these poor communities. Therefore, a broader strategy of Basic Minimum Needs (BMN) was introduced through the PHC network which had been established to co-ordinate government, NGO and community actions.

Organization and Operation of the Project - 1986

Structurally, the BMN development approach is under the Office of Policy and Planning of the BMA and is executed through the "Bangkok Community Development Committee", chaired by the Permanent Secretary of the BMA. Administratively, there is a two-prong concept in the implementation of this development approach. The District Chiefs head the implementation teams in their districts while the various departments provide the supportive services.

UNICEF assists the BMA in applying the BMN approach in the development of 7 congested communities in the inner zone of Bangkok and 16 villages in the suburban areas. The approach includes processes by which needs that are identified reflect the real needs of the community and which strengthen self-reliance among community members. To enhance self-reliance further, UNICEF will also provide grants for the establishment of community health development funds. These funds are designed as a tool to maintain community participation and create local credit to enable community members to cater to their development needs, especially in the field of child health and development. The BMN approach also supports co-operation with NGOs in the solving of community problems. In this way, it is hoped that community needs which are outside the capacity of the BMA and UNICEF will be met by NGOs.

Future trends of UNICEF assistance

In 521 congested communities in Bangkok, BMA is currently able to cover about 10% of the population with its development efforts. UNICEF is assisting BMA for development work in 7 of these communities. Although, in 1986, UNICEF is gearing its assistance towards the BMN development approach, it still emphasizes the assistance in the field of health. Early childhood development will be included for those communities which are ready to establish day-care facilities in homes or centres.

Immunization will be another area of concentration of UNICEF assistance for Bangkok. However, the assistance is not to be confined to the project areas, but will be aimed at the entire infant population of Bangkok. Immunization, like all health services in Bangkok, is not delivered only from BMA but also from other government and private institutions. To increase the immunization coverage in Bangkok for DPT, OPV, BCG from 80% to 100% and for measles from 30% to 50%, the BMA needs to strengthen its monitoring capability - to monitor all vaccinations in Bangkok, irrespective of service points. In 1985, work has been initiated to merge and modify record systems which are being used. As a result, a health record booklet has been designed for common use by all sectors. UNICEF will be assisting the BMA to expand usage of this health booklet. Apart from this, social mobilization is another important area of UNICEF assistance to increase coverage. A major effort in social mobilization will be included in the national UCI efforts from which Bangkok will also benefit.

Since the BMN approach encompasses a broader area of social development, UNICEF will need to determine the extent of its assistance. Examples of possible new areas are: drug abuse, street children, abandoned children, and childhood disability. Since there are a large number of NGOs working independently in these communities, BMA should play a co-ordinating role. Presently, the Health Department has organized annual meetings with NGOs for experience sharing. Perhaps, support should be provided to strengthen BMA in this role so that the wealth of resources available in Bangkok could be better mobilized for the benefit of the poor communities.

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1)	NAME OF PROJECT:	COMMUNITY-BASED PHC SERVICES FOR LOW-INCOME COMMUNITIES IN OLONGAPO CITY
2)	TARGET POPULATION:	Low-income families in three depressed barangays* in Olongapo City
3)	TIME FRAME:	1983-1987
4)	IMPLEMENTING AGENCY:	Olongapo City Health Department (Project was initially implemented by an NGO, Columban College)
5)	COSTS:	$216,860 for five years
6)	SOURCES OF FUNDS:	i) UNICEF; ii) Local Counterpart (Columban College and Olongapo City Government).
7)	OBJECTIVES:	Long Term Goals i) Achieve full participation of community members in providing health and nutrition, water and sanitation, community livelihood, education and other basic community services through collective and concerted action promoting self-reliance and self-sustenance; ii) As a demonstration project, provide an experience and basis for future policies and plans for the city government and other social service agencies to develop, strengthen and expand basic services in other similarly situated communities; iii) Contribute towards the development of a national approach and broad-based capacity to expand delivery of community-based services in low-income urban areas with emphasis on the need for strong community organization and community participation.

* The Barangay is the smallest political unit of a city.

Service and Output Objectives (by end of 1987):

i) Training of two hundred (200) community health and nutrition workers to provide health and nutrition education to mothers and extend simple preventive and curative health care;

ii) Equipment and adequate staffing of three (3) community health centres;

iii) Improved community health situation as shown in: lower infant mortality rate, decreased incidence of child illnesses, improvement of nutritional status of 1,796 children, lower post-partum mortality rate, effective functioning of community health programme, improvement of personal and community hygiene and sanitation, and proper waste and garbage disposal;

iv) Participation of at least 80% of families in target areas in income-generating activities;

v) Organization of community groups with skills for baseline information gathering, community planning, monitoring and evaluation of community projects in health and nutrition, water and sanitation, education, livelihood and community development in general;

vi) Development of a data base on abandoned and street children; evaluation of existing programmes and services and recommendations for alternative actions;

vii) Production of documentation/publications, community profiles, progress reports, evaluation and monitoring systems, community studies (e.g., health situation, livelihood, etc.).

8) BRIEF DESCRIPTION: COMMUNITY-BASED PHC SERVICES IN LOW-INCOME COMMUNITIES IN OLONGAPO CITY

Background

Olongapo City lies 127 kilometres north of Manila and is located at the southernmost tip of Zambales Province. With a current population of more than 200,000, the city continues to experience the basic problems of economic instability and social impermanence due to its dependence on the presence of a US Naval Base in Subic Bay. The "rest and recreation" industry has remained as its primary economic activity which rests on a foundation external to its own system. Consequently, the city suffers from various urban problems: poverty, unemployment, malnutrition, inadequate public facilities and social services, poor housing and impermanence of land tenure, drug abuse, increasing number of abandoned and street children and other related social problems. These problems have been found to be more pronounced in the depressed barangays of Cabalan, Pagasa and Kalaklan.

As a direct response to the problems and needs articulated by community groups in these barangays, Columban College initiated this project with UNICEF assistance and in co-operation with the city government, the local MSSD office (Ministry of Social Services and Development), a number of NGOs and the communities themselves.

In a span of only 2-1/2 years, Columban College was able to demonstrate effectively an alternative, community-based approach to providing child-focused PHC services. In November 1985, the project was turned over to the City Government, specifically to the City Health Department, to facilitate the institutionalization of the approach within the local government's development programme and to prepare for the eventual expansion of the project to other depressed communities.

Project Components/Activities

The project is an urban basic services programme which stresses community-based approaches and supports strong community participation in providing basic services to children of low-income communities. The project has the following interrelated components, all focused towards providing better opportunities for child survival and development.

1. Community-based health programme, with emphasis on maternal and child health and nutrition: Community groups identify health needs, participate in planning a community health programme, select appropriate community members to be trained as health volunteers and nutrition workers, and work with the city health office for expansion of preventive and medical services.

2. Seminars on responsible parenthood and family life: Families participate in seminars on such topics as responsible husband-wife relationships, responsible parent-child relationships, and responsible family-society relationships. This component seeks to offset the largely destabilizing influence of the "rest and recreation" industry on the city's families by promoting family and community solidarity.

3. Situation study on abandoned and street children: This component seeks to find out who, how many, and where the city's abandoned and street children are, in order to develop some alternative approaches to dealing with their problems.

4. Community livelihood projects: Because unemployment is the priority problem in these communities, this component calls for identifying the most feasible economic activities; organizing community members for livelihood projects, training them for business, and assisting them in the initial phases of production, credit and marketing.

5. Continuing community research, planning, monitoring, evaluation and documentation: Running throughout the project period are activities on the community level to assess the situation of families and children, plan appropriate actions to respond to community needs and to evaluate the impact of community actions.

Organization and Operation of Project

The daily work is performed by four full-time staff members, each responsible for the following components:

a) Community-based health and nutrition is handled by a community nurse;

b) Community livelihood projects, by a staff member with training in agriculture, and in animal husbandry;

c) Situation study on abandoned and street children and seminars on responsible parenthood, by a person with a background in humanities/social sciences, guidance and counselling;

d) A staff member with studies in sociology is responsible for community research, planning, monitoring, evaluation, documentation and organizing.

All four staff members work as a team. Until the project turnover to the city government, the project team was co-ordinated by a group of volunteer college administrators and faculty of Columban College. The role of co-ordination is now in the hands of the City Health Officer.

The project team and project co-ordinator are supplemented by a project advisory group headed by the City Mayor which provides general policy directions and guidelines to ensure that project activities remain consistent with project objectives and likewise fit within the overall city development goals and plans. It is comprised of representatives from various local government agencies, NGOs, church sector, and the barangay chairman of the three target communities.

Project Strategies

Over time, the project has evolved the following strategies:

a) Stimulating and facilitating active involvement of the community in:
   - identifying community needs and arranging them in order of priority;
   - planning, implementing, monitoring and evaluating projects;
   - generating internal and external resources.

b) Inter-agency co-ordination/collaboration in basic services provision to priority groups of children and their families.

c) Reliance on indigenous, volunteer community workers in the provision of basic services.

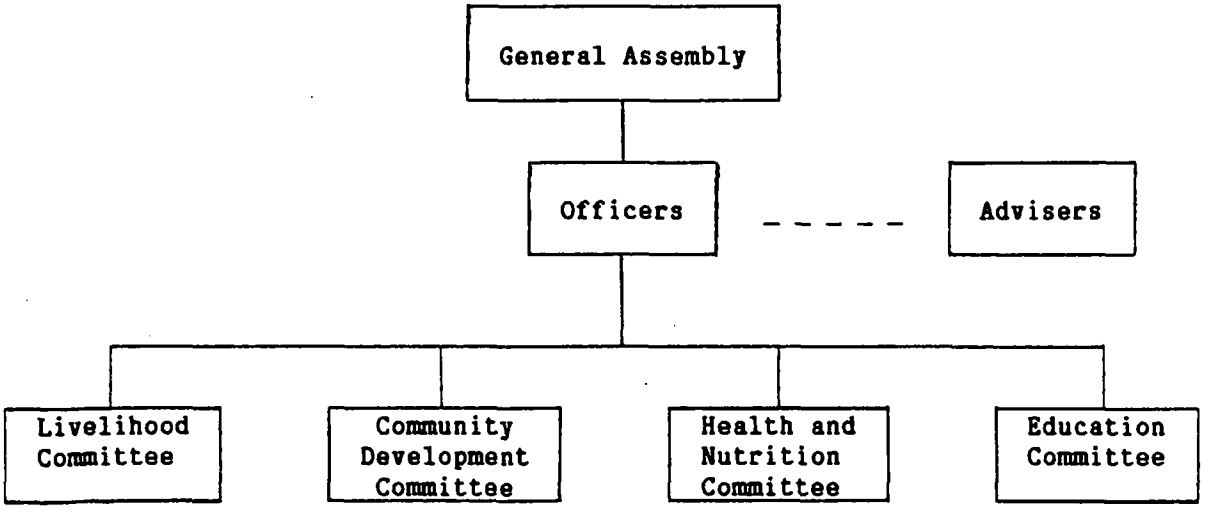
d) Use of appropriate technology adapted to local community realities and needs.

e) Enhancing capabilities of the barangay council (lowest political-administrative unit) in social planning and development activities.

Project Accomplishments/Results/Constraints

a) Seven (7) purok* associations have already been organized in the communities and are now actively participating in planning, implementing, monitoring and evaluating activities in health, nutrition, non-formal education, community livelihood, and community development in general. All these activities result in the improved situations of children in the target communities.

   The organizational structure evolved by the people themselves, with the facilitation of the project staff, is shown below:



*A purok is a sub-division of a barangay - a neighbourhood.

b) One hundred eighty nine (189) barangay health workers/volunteers have been jointly trained by Columban College and the City Health Office with UNICEF support. Equipped with the necessary knowledge and skills and motivated by a sense of service and concern for children, the barangay health workers conduct the following activities: community health surveillance, child-growth monitoring, promotion of breastfeeding, immunization campaign, mothers' classes, promotion of herbal medicine and setting up of herbal gardens and backyard vegetable gardens. They respond to house calls, attend to home deliveries, assist at the health centre, refer cases to the city public hospital, and promote environmental sanitation. Primary health care committees have been formed in the barangays. With trained community health workers/volunteers and actively functioning PHC committees, the health and nutritional status of children has significantly improved. Immunization coverage has reached 83.28% to 94.39%. However, due to the pervasive influence of commercialized drugs and infant formulas, promotion of herbal medicine and breastfeeding needs further intensification.

c) Livelihood activities meant to help augment the family income improved the quality of food served on the family table. Community meetings are conducted to organize community credit groups which identify and screen loan beneficiaries, assess and monitor community livelihood projects, collect repayments and build up their seed capital through fund-raising activities. The community credit groups themselves define the criteria for selecting the loan beneficiaries, the types of livelihood projects that can be supported by the group, the roles and responsibilities of beneficiaries and the members of the screening committee. Training in small business management and community credit scheme has been conducted. Other skills-training provided by the Ministry of Social Services and Development and the National Cottage Industries Development Authority, which have benefitted a significant number of families, include: vinegar-making, fresh water fish culture, goat raising, hog fattening, poultry raising, wood lamination and silk screen processing and food preservation. These training activities are financed by the community members themselves or by different agencies in the city. However, due to the prevailing national economic crisis, the biggest problem encountered has been the slow repayment of loans.

d) A situation study on abandoned and street children in the city has been conducted using participatory action-research. The study reveals that economic poverty is the primary reason for children going to the streets. Other causes are socio-psychological factors such as unfavourable home conditions, irresponsible and uncaring parents, fathers abandoning their families, desire to be free and independent, and the attraction of money from street activities - especially when there are US navy ships in port. The participatory and action-oriented methodology used for the study led to the formation of a working committee on abandoned and street children composed of representatives from government, NGOs, the church sector, professional groups and community groups. This working committee now

meets regularly and has come up with some suggestions for alternative interventions to address the realities and needs of the abandoned and street children. Two projects are now being planned: the development of community-based networks to serve abandoned and street children/training of community volunteers; and the establishment of a drop-in centre/temporary shelter for street children with the following services: subsidized meals, counselling, non-formal education, alternative recreation, dignified work/income opportunities and other services which may evolve as the street children themselves begin to take active part in running the drop-in centre.

Conclusions

The Olongapo project experience to date has demonstrated that the Basic Services Strategy, with its strong emphasis on community participation and organization, can address the needs of urban poor children effectively. However, certain issues need to be seriously studied. For instance, a more deliberate and systematic provision of basic services to urban poor communities is hampered by two interrelated and reinforcing factors:

- the absence of land tenure security, particularly in squatter settlements;
- the pervading policy notion that the provision of basic services to urban areas is a major factor that triggers accelerated migration to the cities, thus leading to formation of squatter settlements.

On the one hand, these factors have tended to stifle efforts to generate community initiatives to work collectively for permanent improvements in their areas (housing improvements, drainage canals, toilet and sanitation activities) because of the constant threat of demolition and eviction. On the other hand, city governments are also constrained from responding to the demands for basic services in these areas because of the legal impediments arising from existing policy. This requires critical review. Meanwhile, the health and nutritional status of children in these poor urban settlements continues to deteriorate, further aggravated by the current economic crisis.

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1)	NAME OF PROJECT:	URBAN BASIC SERVICES PROGRAMME IN INDIA
2)	TARGET POPULATION:	380,000 slum dwellers in Visakhapatnam (State of Andhra Pradesh); Cuttack (State of Orissa); and Alleppey District (State of Kerala)
3)	TIME FRAME:	1982-1986
4)	IMPLEMENTING AND CO-OPERATING AGENCIES:	i) Government of India ii) Municipal Councils iii) Medical Colleges iv) Voluntary Agencies
5)	COSTS AND SOURCES OF FUNDS:	UNICEF commitment: US$ 1,170,000 over five years. (Approximately US$ 0.60 per capita per annum)
6)	OBJECTIVES:	To reduce child/mother morbidity and mortality through provision of municipal health, water, sanitation and education services on a participatory basis.

7) BRIEF DESCRIPTION: URBAN BASIC SERVICES PROGRAMME IN INDIA

Introduction

Since 1976, UNICEF has been co-operating with the Government of India in extending basic services to the urban poor, particularly to women and children, in some selected towns and cities. 42 towns have been covered and 250 more will come under the programme in the next few years. This paper deals with two of these towns - Visakhapatnam (State of Andhra Pradesh) and Cuttack (State of Orissa) - and a district - Alleppey (State of Kerala) where the Urban Basic Services (UBS) programme has been in operation for over three years.

Programme Start-up

In 1979, using its own funds, the Municipal Corporation of Visakhapatnam initiated an Urban Community Development project patterned after the Hyderabad project. The pilot efforts were successful and the State Government and the Municipality decided to expand the programme to cover the entire slum population of the city. With UNICEF's assistance, this expansion started in July 1981.

The Urban Community Development project in Cuttack was set in motion in April 1982 as a result of several surveys revealing the desperate plight of the city's poor.

The third project is different from the other two in that the planning unit is a district and not an individual town. The project is being implemented in three towns - Alleppey, Shertallai and Kayamkulam - in the district of Alleppey. In Kayamkulam, where the programme started first, there had already been an integrated development programme focusing on the physical infrastructure of the town as a whole. UNICEF co-operation enabled the town authorities to pay concerted attention to the city's poor families, and to provide them with facilities to improve the health and education of their children. In 1981, after two programme planning workshops, the Basic Services programme in Kayamkulam was extended to the other two adjacent towns.

Programme Management

The management styles and set-ups differ from one project to the other because of the conceptual and operational variations found in each of them. In Visakhapatnam and Cuttack, the monitoring mechanism was established only at the State and Municipal levels. Alleppey, being a district programme, needed a monitoring link at the district level; thus, a District Committee co-ordinates planning and implementation in the three towns.

The project work is carried out by Municipal staff specifically enlisted for the purpose. In the first two towns, the Chief Executive Officers monitor the programme through a monthly project review meeting convened to consider the reports of the project staff and the general implementation progress. This meeting is also attended by some representatives of voluntary agencies who assist the project and the heads of the Municipal Health and Engineering Departments. In the Alleppey district project, the programme is reviewed every two months through a Review Committee headed by the District Co-ordinator. UNICEF attends all of these meetings.

Objectives and Performance

The UBS programme is a joint venture between the Government and the disadvantaged urban communities through the mediation of municipalities, voluntary agencies and UNICEF. Its purpose is to promote and protect the emotional, social and physical development of children and mothers in the disadvantaged areas. In order to achieve this, the programme has the following specific objectives:

1. Extend child care and health services, water and sanitation facilities, and provide training in income-generation skills to mothers; in order to help reduce substantially child morbidity and mortality.

In pursuance of this objective, Visakhapatnam has immunized 86% of all children under one with DPT, BCG and Oral Polio, in a population area of 500,000. This was done in collaboration with the State Medical College. The achievement is noteworthy because of the commitment shown by all persons involved despite the lack of adequate supplies and equipment. The city has also trained over 5,560 women in child care and nutrition, particularly, in home-based diarrhoea management. Over 800 women have also been trained in income-generation skills such as spinning, weaving and tailoring. 500 latrines have been constructed, which now creates a demonstration effect throughout the area.

In Cuttack, an extensive campaign to increase the public awareness level about immunization has been conducted using a wide range of audio-visual and other support communication material. Private organizations such as the Rotary Club and Textile Mills have joined in the campaign. The continuous drought situation in the State, which is an annual phenomenon, has caused severe cold-chain difficulties. However, public education programmes continue unabated. As a result, immunization coverage has increased, though still not achieving the "herd immunity" level. Over 2,000 children are being regularly monitored with growth charts and health check-ups. 116 tubewells have been installed and one caretaker for each of these tubewells has been trained. 10 community latrines and over 1,200 individual latrines have been provided to the area and 1,000 more units are to be constructed before the end of 1986. 42 out of the 45 schools adjacent to slum areas have been provided with latrine facilities. Women's income-generation activities are also being carried out.

In the three towns of Alleppey, all children under one have been immunized. Training in diarrhoea management, child care and nutrition have been provided with the help of the Kerala Agricultural University and the Medical College. 30 handpumps and over 30 standposts now improve the water supply to the poor areas. 1,740 individual household latrines have been constructed. Over 200 families benefit from income-generation activities such as Coir making and goat rearing.

2. Develop the full growth potential of children by improving the provision of early childhood learning opportunities.

The main component of this activity is the provision of balwadis (pre-schools) and creches. In Visakhapatnam, 33 new balwadis and 5 creches

have been established. These are in addition to 99 other pre-schools provided through the Integrated Child Development Scheme supported by UNICEF. In Cuttack, 45 pre-school centres provide early learning stimulation to over 1,350 children. The teachers have been trained and teaching material has been provided. In Alleppey, 154 pre-school centres and 3 creches are functioning.

Almost all these pre-schools are community supported. The municipality provides only a stipend and training to the pre-school workers.

3. Raise the level of social consciousness of the urban poor through non-formal education in order to increase their capacity to prioritize and plan to meet their own needs, particularly those of women and children, with or without outside help.

To meet these objectives, the concept of neighbourhood development planning through community volunteers has recently been developed. This method of micro-level programming and implementation had already proved its efficacy as a tool to obtain people's involvement and municipal participation. The system relies on volunteers selected by small neighbourhoods of 20 to 25 families. They are trained by the project staff in community organization and development work. Most of the volunteers are women. Contrary to early fears, the local bodies have found the volunteer committees to be very co-operative and effective in expediting project implementation.

In Visakhapatnam, the women volunteers have constructed, with the support of the whole community, many large but low-cost and unsophisticated community centres in their own localities, which can accommodate about 100 people at a time. The project budget was used only to provide timber and rafters amounting to about US$ 50 each. These centres are utilized to run pre-schools, sewing classes, adult literacy classes and community meetings. In Cuttack, 14 adult literacy centres, 10 of which are for women, have been organized by the project. Neighbourhood committees are being formed and the communities have agreed to eventually take over the responsibility of paying the stipends of the pre-school workers.

In all these projects, community members voluntarily provide free labour for common activities such as occasional cleaning up of the community, cleaning of drains and repairing of pathways.

The community organizers and the project staff continue to support and strengthen the capacity of the people through education and motivation. They provide information to the communities about the available governmental and non-governmental facilities and services and help them follow the procedures and processes to seek access to these facilities. As a result, bank loans have been obtained by many community members for shelter improvement and self-help housing. In Visakhapatnam, over 3,000 self-help houses have been constructed by slum dwellers with the facilities made available to them. In Cuttack, women have been educated to approach the banks for small loans for income-generation purposes.

4. Improve the capacity of the municipality and voluntary agencies to effectively launch and manage child specific programmes for the urban poor.

In every project town, UNICEF has helped the local bodies to hire project staff and train them. UNICEF has provided the initial salaries for two to three years, with the understanding that the municipalities would take over the financial responsibility for the staff and programme thereafter. UNICEF has also provided office equipment and other supplies, including vehicles, for the efficient running of the programme. Technical assistance and consultancy services have been utilized to prepare feasibility studies and situation analyses which have proven very useful for advocacy and mobilizing the necessary political and administrative will to improve the situation of the urban poor. It is the first time that these local bodies have attempted an integrated primary health care programme in urban poor areas with a systematic methodology. The knowledge and experience gained thereby have strengthened the municipal system in its belief that urban basic services is a comprehensive and valid strategy for the development of poor areas.

Constraints

The main constraint encountered by these projects was the lack of interest at the political level in the initial stages, until the projects gained momentum and started showing results. There is now in all three areas a strong political and administrative will and commitment to ensure success and expansion of the programme.

The difficulties in cold-chain maintenance also impeded the immunization efforts. Efforts are being made to resolve these difficulties.

Conclusion

The UBS programme has proved its efficacy and validity in reaching the urban poor with the facilities and services of the municipal system. Non-governmental agencies and the urban poor themselves are now respected participants in the municipal service delivery system. The participatory mechanisms utilized in the programme have strengthened the urban poor's capacity to seek, receive and maintain the services and facilities. People's initiatives and innovative alternatives flourish. The experimentation in Alleppey led the Government of India to decide on the district as the planning unit for future UBS implementation.

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1)	NAME OF PROJECT:	INTEGRAL PROGRAMME FOR COMMUNITY PARTICIPATION IN BASIC SERVICES IN COATZACOALCOS AND MINATITLAN (VERACRUZ STATE, MEXICO)
2)	TARGET POPULATION:	Coatzacoalcos: Initially 1,200 members of poor shantytown families, especially mothers and children, in one pilot colonia (Playa de Oro) and later on, in 9 other colonias (2,000 families or 14,000 persons); Minatitlan: 1,500 families or 9,000 persons in two urban and seven rural communities.
3)	TIME FRAME:	1983 -
4)	EXECUTING AND CO-OPERATING AGENCIES:	i) State Government; ii) Federal agencies; iii) Municipalities; iv) University of Veracruz; v) Central, State and local DIF (System for Integral Development of the Family); vi) UNICEF.
5)	COSTS AND SOURCES OF FUNDS:	UNICEF share is approximately US$ 210,000.
6)	OBJECTIVES:	i) Promote and strengthen community organization in the shantytown colonias of Coatzacoalcos, with a view to improving their living conditions; particularly in the areas of primary health care, health education, environmental improvement, provision of water and sanitation services, nutrition, formal and informal education and promotion of social services; ii) Support the operational co-ordination of the activities of the central government, federal agencies, municipalities and UNICEF, within selected geographical areas, in order to improve and extend existing services and their benefits to the population.

7) BRIEF DESCRIPTION: INTEGRAL PROGRAMME FOR COMMUNITY PARTICIPATION IN BASIC SERVICES IN COATZACOALCOS AND MINATITLAN (VERACRUZ STATE, MEXICO)

Background

The project is a modified continuation of the original one which was initiated in the same area in 1979, with the support of UNICEF.

In 1982, the number of poor people in Coatzacoalcos and Minatitlan was estimated at 130,000 (43% of the total population). Of these:

- 1/3 earned less than the minimum salary;
- 1/5 were underemployed, unemployed or involved in petty crimes;
- 3/4 were without permanent jobs;
- 1/2 or more than half were not provided with social security;
- 2/3 were totally or practically illiterate;
- Between 45 and 49% of the population were under the age of 14 years and a rate of economic dependency of 1/4 forced children and women to work.

In this general context, the project identified the following groups as being at risk:

a) Children from 0-6 years who suffer from (a) high rates of morbidity and mortality due to diarrhoea, gastro-enteritis, respiratory problems, parasites and malnutrition; and (b) absence of attention in their early childhood aggravated by the fact that most parents work outside the home.

b) Children from 7-14 years who often enter the labour market in conditions unsuitable for their age. Many of these children work and live in the street. Some of the problems they face include truancy and dropping out from school, lack of recreation facilities, adoption of anti-social behaviour influenced by gangs of youngsters and use of addictive substances such as industrial glue.

c) Abandoned mothers: approximately 17.4% of families were headed by mothers who had been abandoned.

Community Organization and Participation

Using a participatory methodology, UNICEF, together with co-operating agencies, has systematically promoted community participation in diagnostic and project formulation processes. The implementation of that methodology led to the identification of needs and the choice of priority actions in the colonias through continuous people's involvement.

Diagnosis of overall life conditions has been carried out in three communities and the water, drainage and health situation has been evaluated in seven others. The communities have participated in the collection of information; in the definition of priority objectives; in the design and implementation of projects, including the selection of their health workers; and in the negotiation of solutions to their problems (e.g., land ownership, drainage, education). In addition, the different technical groups at the

local level which have been trained in the methodology, have acted as "loud speakers" at other levels. Even though it has not been systematized yet, the experience obtained has enriched the existing methodology of participatory planning.

Basic Services

Primary health care has been initiated with community health workers selected by each community. In 1984, 19 health workers were trained in the two cities and in the rural areas of Minatitlán. Ten additional health workers were trained at a later stage in the urban area of Coatzacoalcos to provide services for the 9 other colonias. The project now reaches 18 communities.

The services provided at the local level by PHC Promotors include the following:

a) for 4,150 children under six years old - growth and development monitoring, nutrition, immunization, oral rehydration, de-worming and treatment of common illnesses;

b) five to six-year-olds are provided with pre-school education;

c) six to fourteen-year-olds receive oral rehydration, de-worming, preventive dental care and treatment of common illnesses;

d) for 4,000 mothers - pregnancy check-up services, anti-tetanus vaccines, breastfeeding promotion, post-partum check-ups, treatment of common illnesses and family planning.

In the El Palmar community of the City of Minatitlan (600 children from 370 families), the emphasis has been placed on the testing of different diagnostic instruments for children's development. For this, the Portage Guide for Pre-School Education, which is a system of continuous evaluation of children's development, is being used.

After a feasibility study, a community-based local health information system was established in May 1984 in the pilot colonia of Playa de Oro for programming, monitoring and evaluating the project. It gathers data on the various aspects of health care mentioned in a) to d) above. Similar systems were later established in the other 9 colonias. It is hoped that this information system can be adapted, with pertinent changes, in other UNICEF health projects in Chiapas, Veracruz, Guerrero and Jalisco.

Another significant feature of the project is the reorientation of the role of health promotors from promotion to delivery of basic health services to mothers and children.

As far as Pre-School Education is concerned, the Project has made considerable progress in 1985. Emphasis has been placed on the design of new interventions aimed at strengthening the relationship between growth and development. On the other hand, efforts are being made to define better the content of pre-school education in marginal urban areas. Changes in the

physical environment, in the relationship between children and teachers, in family participation in the socializing process, and the introduction of stimuli for the development of children's creativity, are being pursued. The Project has also been instrumental in defining the teacher's role as well as the remuneration system and co-ordination of pre-school programmes at local level. The results of the search for a new pre-school education model will be shared with the System for the Integral Development of the Family - UNICEF's project counterpart - and the Public Education Secretariat. It is hoped that these institutions can adapt their present pre-school services to a less formal as well as more integrated approach to pre-school education.

Other convergent activities include home vegetable gardens; nutrition education (i.e., food preparation); assistance in child upbringing; supplementary feeding through the Programme of Family Feeding Assistance (PASAF) integrated in the Central and State DIF Programmes; basic sanitation; introduction of drinking water facilities and the study of the relationship between development and environmental sanitation. Project development in both cities has been possible, thanks to the growing community involvement and reciprocal interaction between PHC components and pre-school activities.

Results

In 1985, MCH activities were evaluated in the urban community of Playa de Oro of the City of Coatzacoalcos, the urban communities of El Palmar and Miguel Hidalgo, and the rural communities of San Cristobal, Boca de Oro, El Chiflido, La Soledad, El Monal, Enrique Rodriguez, and La Arena in the City of Minatitlan. This represents the total urban population of Coatzacoalcos and Minatitlan and more than 50% of the rural population of Minatitlan. Data related to the population and services generated by the project information system were examined at first. Then 10 promotors, 214 of the project families, and 45 students from the University of Veracruz carrying out social services in the project communities were interviewed. Thirty (30) representatives and technicians from national executing agencies, i.e., the Medical Unit of the Municipal DIF, and from the Faculties of Medicine, Odontology, Nursing and Social Work of the University of Veracruz, also participated in the evaluation designed by UNICEF.

The evaluation methodology, its implementation, results and conclusions, were documented in detail and showed that the project covers close to 100% of the infants, children 1-14 years old and mothers with the above-mentioned health services. Specific results include:

a) promotion of breastfeeding among 100% of the mothers;
b) the percentage of children under six years old with "normal" nutritional status increased from 23.9 to 38.4 in one year of work;
c) the vaccination levels for children under six reached 71.3% against tuberculosis (BCG), 61.3% against diphtheria, tetanus and whooping cough (DPT), 65.0% against poliomyelitis and 76.3% against measles (as of May 1985);
d) 60% of all children received de-worming treatment on two occasions during the year;
e) health education covered 100% of all families;
f) 56% of all women who head families are using some method of family planning (ligation, pill, and intra-uterine device);

g) 90% of pregnant mothers have pre-natal check-ups;
h) 75% of all pregnant mothers received tetanus toxoid;
i) 1.8 check-ups were carried out on each mother during the immediate post-partum period (28 days);
j) 1,358 children in schools located in the project communities were given preventive dental care and instructions (brushing technique, use of dental floss, application of flouride);
k) 35 workshops were held between October 1984 and September 1985, and about 60 teachers, 300 mothers and 800 children were trained.

The evaluation also showed the importance which the community attributes to the new health services offered by the promotor. She has played a functional role in the closer relationship which has been observed between local government and political leaders on the one hand, and the communities on the other. These achievements have been possible, thanks to a reorientation of existing community and health resources, more than to the donation of additional funds.

Problems Related to Scaling Up

In spite of the fact that criteria for scaling-up have been considered since the beginning of the project, the necessary know-how to ensure institutional change in favour of the poor is being incorporated very slowly in the normative framework of the corresponding national agencies. However, the project generated an inventory of elements necessary for such institutional change. The methodological process and achievements have been systematized and organized in a graphical format so as to facilitate communication with other sectors and the public.

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