

"We must maximize the impact of investment by integrating efforts across diseases and sectors, by using innovative, cost-effective and evidence-based tools and approaches, and by making financial channels more effective."²⁴

Ban Ki-moon, UN Secretary-General, *Global Strategy for Women's and Children's Health*, UN, 2010



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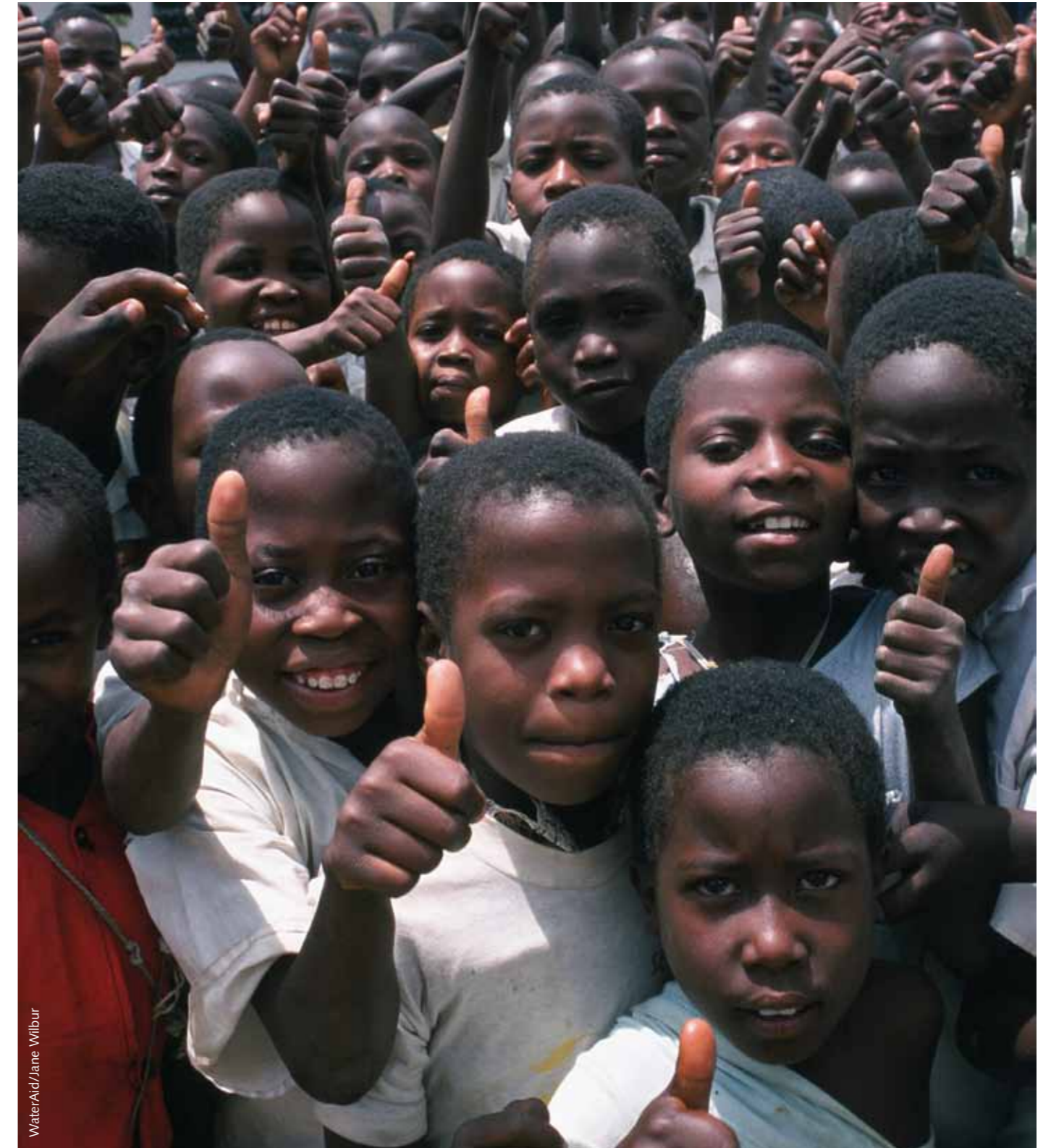
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Join up, scale up

How integration can defeat disease and poverty



WaterAid/Jane Wilbur



“Achievement of the Millennium Development Goals requires mutually supportive and integrated policies across a wide range of economic, social and environmental issues for sustainable development.”

Keeping the promise: united to achieve the Millennium Development Goals, UNGA resolution, 17 September 2010¹



Mothers wait to have their children seen at Webuye Health Clinic in Kenya's Western Province.

Lessons learned:

1. **Community participation is essential for the design of integrated programmes that respond to lived realities, and thus increase programme uptake and sustainable impact**
2. **High-level political leadership enables better focus on needs and resource mobilisation**
3. **Integrated, cross-sector approaches more closely reflect and respond to the determinants of poverty and disease**
4. **High-quality integrated programmes can prove cost-effective for donors and secure efficiencies for policy-makers**
5. **Funding integrated approaches at community level demonstrates what works and generates learnings to inform national plans and scale-up strategies.**

1. UNGA, 2010, *Keeping the promise: united to achieve the Millennium Development Goals*, p9

Executive summary

Despite the extraordinary advances of the 21st century, the devastating impacts of poverty and preventable diseases continue to prevail. While major development efforts are ongoing in countries around the world, the vast majority of those programmes continue to be implemented through segmented divisions and budgets as dictated by institutional structures – such as health, education, nutrition or water and sanitation.

While these divisions can prove useful, they often create artificial divides in the lives of the individuals, families and communities that face the greatest challenges. Today, many stakeholders are recognising that, because the challenges of poverty and lack of access to health, nutrition, and education overlap in people's lives, more effective and lasting solutions may be found in integrated, cross-sectoral programmes. For example, progress in child health can be accelerated through an integrated approach that coordinates a range of interconnected interventions. These include approaches aimed at reducing maternal mortality, solutions for tackling undernutrition, and efforts to address the environmental factors that contribute to poor health, such as lack of safe sanitation, clean water, and hygiene practices.

Today, interest in integrated approaches is increasing. Decision-makers at both the policy and programme levels increasingly acknowledge the importance of tackling poverty issues through integrated strategies and coordinated approaches. High-quality integrated programmes can prove cost-effective for donors, secure efficiencies for policy-makers, and provide more holistic services and greater impact for those who need them most.

At the same time, implementation of integrated approaches poses a challenge for development stakeholders. Myriad factors – for example, policy differences, lack of mechanisms for cross-sectoral and cross-institutional communication and collaboration, capacity gaps, and competition for limited financial resources – create imposing barriers to developing cross-sector approaches. Nevertheless, many governments and institutions are trying integrated approaches that are providing concrete examples of successful practice.

Successful models of integration are responsive to needs at the community and country level and include strong leadership from the responsible government agencies. The following success stories focus on three of the core areas – primary healthcare, clean water and sanitation, and nutrition – that are essential to achieving the Millennium Development Goals. These initiatives, and others like them, are generating important lessons and evidence for national policy-makers, donors and their NGO partners alike.

- In Kenya, the government's new national policy on the control and management of diarrhoeal disease in children was informed by community-level approaches that combined treatment and prevention information and interventions.
- In Zimbabwe, a joint initiative by local government, churches and community representatives tackled hunger, disease and poverty through a programme integrating clean water provision with measures to improve nutrition and incomes.
- In Peru, national-level action by the government to put malnutrition at the top of the political agenda included creating systems and structures to implement a coordinated multi-sectoral strategy. The result was a reduction in child malnutrition.
- In Uganda, the Ministry of Health improved life for people living with HIV by integrating good water, sanitation and hygiene practice into its training and support for people providing home-based care.
- In the Philippines, hand-washing in schools became the focal point of a cross-sectoral initiative integrating education and health promotion in order to reduce disease.
- In Nepal and Ethiopia, government policy scaled up the integration of health and related programmes at national level to improve healthcare for rural communities.

Poverty and disease can be effectively addressed through integrated approaches – bringing together a range of interconnected interventions

High-quality integrated programmes can be cost-effective and efficient, and deliver better results.

Introduction

In September 2010 the UN General Assembly pledged its continuing commitment to the Millennium Development Goals (MDGs). Since the goals were launched in 2000, significant progress has been made in some areas, but more still needs to be done, and faster, if real success is to be achieved in reducing poverty, hunger and disease by 2015.² As governments, donors and policy-makers strive to meet the goals in a difficult economic climate, this report highlights stories of realistic, value-for-money solutions from various contexts.

Interconnected goals, interconnected approaches

This report addresses three of the core areas – primary healthcare, clean water and sanitation, and nutrition – that are essential to achieving the MDGs. Interconnected and mutually reinforcing, these can be best achieved when pursued through integrated strategies and coordinated approaches.

“We commit ourselves to... improving the quality and effectiveness of healthcare services delivery by providing integrated healthcare services through coordinated approaches at the country level, the increased use of common platforms and the integration of relevant services of other sectors, including water and sanitation.”

Keeping the promise: united to achieve the Millennium Development Goals, UNGA draft resolution, 17 September 2010³

What are integrated approaches?

Integrated approaches deliver a range of interventions that address multiple needs through coordination across a variety of sectors and with participation of all relevant stakeholders to achieve common goals.

However, the institutional structure of ‘sectors’ (health, education, water etc) rarely reflects the ways in which poverty, health, nutrition, gender, education and other issues are inter-related in people’s lives. This artificial division into ‘sectors’, while useful for pragmatic reasons such as budgeting and management, creates structural barriers to addressing cross-sectoral issues, such as difference in policies, lack of mechanisms for cross-sectoral and cross-institutional communication and collaboration, capacity differences, and competition for limited financial resources. In addition, many studies suggest the lack of community participation and awareness of integrated programmes as the primary barrier to their uptake, impact and sustainability. Therefore, despite increased recognition of the importance of cross-sectoral approaches, the implementation of such approaches remains challenging for many countries.

Where governments, programme implementers and communities do move towards more integrated solutions, they can more closely reflect and respond to the determinants of ill health and poverty. Increasingly, decision-makers at both the policy and programme levels are acknowledging the importance of tackling poverty issues through integrated strategies and coordinated approaches. Delegates to the UN General Assembly reviewing progress on the MDGs in 2010 emphasised that all the goals are interconnected and mutually reinforcing. In the area of health, for example, they stressed ‘the importance of multi-sectoral and inter-ministerial approaches in formulating and implementing national policies that are crucial for promoting and protecting health’.⁴

2. World Bank, *Global Monitoring Report 2011*

3. UNGA, *Keeping the promise*, p20

4. UNGA, *Keeping the promise*, p20

5. UN, 2010, *Global Strategy for Women’s and Children’s Health*, p4x

6. UN, *Global Strategy for Women’s and Children’s Health*, p5

7. UN, *Global Strategy for Women’s and Children’s Health*, p7

Increasingly, decision-makers at both the policy and programme levels are acknowledging the importance of tackling poverty issues through integrated strategies and coordinated approaches.

To take just one area, achieving progress in child health requires an integrated approach that coordinates a range of interconnected interventions aimed at reducing maternal mortality, tackling undernutrition and addressing the environmental factors that contribute to poor health, such as lack of safe sanitation, clean water, and hygiene practices.

New momentum

As the success stories that follow demonstrate, global efforts to address poverty and health issues will help generate new momentum to achieve key development outcomes in a more effective and equitable way as countries pursue integrated plans, policies and strategies, and as donors and policy-makers actively promote and support integrated approaches.

The recent global financial crisis and subsequent cuts in aid and public spending have led to increased interest in such approaches among development stakeholders. High-quality integrated programmes can prove cost-effective for donors, secure efficiencies for policy-makers, and provide more holistic services and greater impact for those who need them most.

Learning from others

In practical terms, however, the best ways of achieving improved outcomes through integration are not always clear. In this context, concrete examples of successful practice can be a source of both information and inspiration. At the same time, experience has shown that successful approaches to integration are those tailored to the specific needs and circumstances of the community and countries in which they operate, and those that secure active participation of communities in programme design and implementation.

Action Against Hunger, Action for Global Health, End Water Poverty, PATH, Tearfund and WaterAid have worked together on this report to highlight some successful examples from around the world of integrated programmes that address the interconnectedness of poverty issues. These projects have generated some challenging and exciting insights into the possibilities that an integrated, cross-sectoral approach to tackling poverty offers.

Coordinated action, integrated delivery

In 2010, setting the tone for the UN’s Global Strategy for Women’s and Children’s Health, Secretary-General Ban Ki-moon emphasised the importance of integrated delivery of health services, noting that the strategy ‘requires that all partners unite and take coordinated action’.⁵ He explained: ‘This means scaling up and prioritising a package of high-impact interventions, strengthening health systems, and integrating efforts across diseases and sectors such as health, education, water, sanitation and nutrition. It also means promoting human rights, gender equality and poverty reduction.’⁶

The experiences reflected in this report underscore the value and potential of taking coordinated and integrated action across the full range of objectives that make up the MDGs.

“We have to do a better job of building nutrition outcomes into programmes across all relevant sectors. So water, sanitation, hygiene programmes, health programmes and agriculture programmes... should all be cross-linked.”

Dr Rajiv Shah, Administrator, US Agency for International Development June 29, 2010 at Statesmen’s Forum, Center for Strategic and International Studies, Washington, D.C.

“Integrated care improves health promotion and helps prevent and treat diseases such as pneumonia, diarrhea, HIV/AIDS, malaria, tuberculosis, and non-communicable diseases. Stronger links must be built between disease-specific programs... and services targeting women and children (such as the Expanded Programme on Immunization, sexual and reproductive health and the Integrated Management of Childhood Illness).”

Ban Ki-moon, UN Secretary-General, *Global Strategy for Women’s and Children’s Health*, UN, 2010⁷

Reducing child mortality: integrating prevention and treatment in Kenya

The challenge

Recent data identifies diarrhoeal disease as the leading cause of child deaths in Kenya.⁸ Lack of access to clean water and sanitation creates high levels of risk for vulnerable children living in poverty – a Kenyan government survey in 2006 found that for up to 21% of those diagnosed with diarrhoea, the disease proved fatal.⁹ As part of its efforts to achieve the MDGs, Kenya's government developed new policy guidelines, published in 2010, with an objective to halve the number of deaths due to diarrhoea among children under five by 2013.

While many initiatives to address diarrhoea focus on one, or only a few interventions, this policy champions an integrated approach that promotes a range of interventions across the prevention to treatment spectrum. Implementation of this approach requires cooperation across the child health, water, sanitation and hygiene (WASH), and nutrition sectors.

The solution

One of the reasons for developing new guidelines was that the country lacked a national policy statement on managing diarrhoeal diseases.¹⁰ The decision to address this gave the government an opportunity to create a policy which embraced recent developments in the field. The resulting document, *Policy guidelines on control and management of diarrhoeal diseases in children below five in Kenya*, launched by the Kenyan Ministry of Public Health and Sanitation in March 2010, outlined an approach based on integrating prevention and treatment of these diseases.

A key aspect of the strategy was the integration of national policy with strong and achievable grass-roots approaches. Experience showed that past efforts to tackle diarrhoea with programmes that focused on only one approach or that relied solely on the help provided by government health facilities had limited success, especially for diarrhoeal and respiratory illness. The policy therefore aimed to improve not just the service available in clinics but also the quality of prevention and care that mothers could provide to their own children.¹¹

In parallel with development of the policy, the Ministry of Public Health and Sanitation worked with the health NGO PATH to run a programme in poor villages in the country's Western Province. This allowed them the opportunity to test and demonstrate the effectiveness of combined interventions at the local level. The programme was able to operate within an existing project funded by USAID focused on HIV/AIDS, TB, reproductive health, and child/maternal health.

The pilot programme, which began in 2008, was distinctive – it used an integrated strategy that included approaches to prevent and treat diarrhoeal disease in the community as well as those delivered through government health facilities. One practical and innovative step that proved beneficial was to restore 'Oral Rehydration Treatment (ORT) corners' in clinics, where mothers have traditionally been able to give their children rehydration therapy – but to make them not just a distribution point for ORT and zinc, but also a place where health staff could educate the mothers about ways of preventing illness, such as breastfeeding, using safe drinking water, adequate sanitation and good hygiene practices.

The success

At the community level, the programme has seen a rise in the number of mothers receiving education on diarrhoea prevention and treatment, and using ORT and zinc treatment. Availability of zinc and oral rehydration salts has also increased along with demand. Of the mothers in the community, a nurse at Lugulu Mission Hospital says, "As community members, once they get the education [at the ORT corners], they are able to teach other people, so that diarrhoea is also reduced by the community."

Work is now continuing at local level to build awareness of the integrated approach, to support the government's efforts to sustain its commitments in the long term and to bring the lessons learned from this project to a bigger scale in implementing the national policy. For one local official there is no doubt about the benefits of the approach. Florence Weke-sa, deputy mayor of Kimilili, Western Province, says, "Do not do this work in silence. Work with local leaders. Shout about it. Make a loud noise." She adds, "Diarrhoea is still here – but it is no longer killing."

8. Countdown to 2015 – Maternal, Newborn and Child Survival: Kenya country profile (2010 data on child mortality causes from WHO Child Health Epidemiology Reference Group). <http://www.countdown2015mnch.org/documents/2010report/Profile-Kenya.pdf>
9. National IMCI Health Facility Survey, November 2006, Ministry of Public Health and Sanitation, reported in Policy guidelines on control and management of diarrhoeal diseases in children below five in Kenya, March 2010, p2
10. Kenya Ministry of Public Health and Sanitation, March 2010, Policy guidelines on control and management of diarrhoeal diseases in children below five in Kenya, p1
11. Kenya Ministry of Public Health and Sanitation, Policy Guidelines, p3

"The Government of Kenya is committed to an integrated, multi-pronged approach to addressing diarrhoeal disease, a major cause of child death in our country. By using all the tools at our disposal, we can save lives now and for years to come."

Dr P. Santau Migiro, Head, Division of Child and Adolescent Health, Ministry of Public Health and Sanitation

Conclusions

- Partnerships with cross-sectoral stakeholders, including government, healthcare workers and clinicians, multilateral agencies and NGOs enabled the project to succeed.
- Funding to demonstrate an integrated approach at community level helped to produce an effective strategy at the national policy level.

Other examples

- **Cambodia:** Ministries of Health and Education partnered with NGOs to implement a WASHED framework (Water, Sanitation, Hygiene Education and De-worming) to reduce roundworm, hookworm and whipworm infections.
- **Benin:** A partnership involving government, the private sector and local NGOs integrated household water treatment and treatment of diarrhoea (with oral rehydration solution and zinc) to reduce child illness and mortality.



Before the ORT corner installation, this paediatric ward in Kimilili could see up to 10 cases of severe diarrhoea per day. High admission numbers meant that patients often had to share beds.



Thanks to the ORT corner and to basic prevention and treatment education, the ward now sees far fewer cases of diarrhoea per day – sometimes none at all.



These children at the ORT corner at Kakamega Hospital will be dismissed in a matter of hours.

Improving health: integrating food security and access to water in Zimbabwe

The challenge

Over the last ten years, political instability and the collapse of Zimbabwe's economy have seen inflation and unemployment soar. The crisis in food supplies and prices has been compounded by a series of disastrous droughts, leaving an estimated one in three children suffering from chronic malnutrition.¹² Lack of access to sanitation and clean water and associated diarrhoeal disease exacerbated the malnutrition further, and between August 2008 and May 2009, an outbreak of cholera in 55 of Zimbabwe's 62 districts claimed over 4,000 lives, according to the Ministry of Health and Child Welfare of Zimbabwe.¹³

Since the Government of National Unity was created in February 2009 the economy has begun to grow, but for the poorest and most vulnerable people the threat of hunger, disease and destitution is still a stark reality. However, in Zimbabwe's second largest city Bulawayo the local government is working with the community and local faith-based organisation Churches in Bulawayo to provide an integrated approach to food security and safe water.



One of 20 nutritional gardens in Bulawayo, Zimbabwe - with land provided by the Bulawayo City Council. Each garden is divided into household plots where families can grow vegetables and medicinal herbs to boost nutrition and health. A total of 983 families now benefit from these gardens.

The solution

In 2008, Bulawayo City Council, Churches in Bulawayo and local community representatives joined forces in a project focused on the city's high-density western suburbs, aimed at increasing the community's resilience to disease and food shortages by improving nutrition and access to water.

The city council provided land for urban agriculture, creating 20 community gardens, each of about 2,500 square metres. Each garden was divided into household plots where families could grow vegetables and medicinal herbs to boost their nutrition and health.

The gardens were located close to water boreholes that had fallen into disrepair. A key aspect of the programme therefore was to restore the boreholes to working condition, to provide a ready supply of safe water for drinking and vegetable cultivation. The project removed debris from 20 boreholes, flushed them out, and installed new pumps.

The local government, Churches in Bulawayo and the community worked closely together at all stages, from planning to implementation. With support from development NGO Tearfund, 20 local communities set up water point committees and each appointed three pump minders per borehole, who then received training in pump maintenance and repairs. The beneficiaries were selected by councillors, residents' association groups and Churches in Bulawayo representatives, with a focus on the poorest and most vulnerable sectors of the population, including child-headed households, widows, orphans, and people living with HIV.

Churches in Bulawayo provided the beneficiaries with initial training on vegetable gardening, and following on from this local councillors arranged for agricultural extension workers to provide support for the beneficiaries in each garden. The beneficiaries followed a permaculture approach, minimising the use of chemical fertilisers and pesticides and using organic manure and pest controls instead.

The process was deliberately depoliticised, to prevent perceptions of any local politician 'owning' the gardens, helping to ensure that the project's sustainability did not depend on any individual's patronage. At the same time, interest and visits by the local member of parliament gave the beneficiaries opportunities to advocate for policy changes on urban agriculture and land tenure.

The success

Once the project was successfully running, beneficiaries could grow enough vegetables to feed their households and sell the excess: at least 80% of the families were eating vegetables with every meal and at least three types of vegetable per week. The local community has also benefited, by being able to purchase fresh vegetables locally at an affordable price. Meanwhile, assessments by the Bulawayo City Council health department indicate a decrease in diarrhoeal diseases and malnutrition, although further monitoring and evaluation would be required to establish the exact impact of the project on health.

A total of 983 families now benefit from the gardens, and 20,000 people have gained access to safe drinking water. Some 90% of the beneficiaries are women, and 15 of the 20 gardens are headed by women.

The project accords equal status to male and female beneficiaries, and gives full rights to child-headed households. Beneficiaries work voluntarily on the vegetable plots of people with disabilities and of children while they are attending school. The vulnerable beneficiary groups, including 118 people living with HIV, have reported they no longer experience stigmatisation and have gained a new dignity through making a contribution to the community with their vegetable sales.

Access to the gardens and rehabilitated boreholes has enabled these communities to minimise their liability to water-related diseases, drought-related disaster and hunger. It has also built a sense of dignity for the beneficiaries and given them a new place in the community. Now other residential areas are asking if they can have similar projects.



One of 20 rehabilitated boreholes, which provide a safe water supply for drinking and vegetable cultivation for the nutritional gardens. Approximately 20,000 people have benefited from the borehole rehabilitation programme.

“Development challenges faced by communities in the Matabeleland region, and Bulawayo in particular, require integrated approaches for sustainable solutions. The positive results from this project have led to an increased demand for it to be replicated in other residential areas.”

Bishop Albert Chatindo, Chairman, Churches in Bulawayo

Conclusions

- Cooperation between government, NGOs, faith-based organisations and communities at the local level can identify achievable solutions to poverty needs that improve many aspects of a community's life.
- Integrating approaches to respond to water and nutrition needs can create an effective community-level strategy to boost food security and health.

Other examples

- **Laos and Cambodia:** Governments partnered with civil society in a maternal health programme encompassing nutrition, water and sanitation, immunisation, reproductive health services, and training for midwives.
- **India and Bangladesh:** Mobilisation through women's groups generated major successes, including a 45% reduction in newborn deaths and a reduction in maternal deaths, as well as a 57% reduction in moderate maternal depression in India; an increase in uptake of health services; a significant improvement in hygienic delivery practices, including use of delivery kits, and an increase in exclusive breastfeeding.

12. Bulawayo 24, 24 April 2011, <http://www.bulawayo24.com/index-id-news-sc-health-byo-3044-article-Malnutrition+in+Zimbabwe+knows+no+class.html>

13. World Health Organization http://www.who.int/csr/don/2008_12_02/en/index.html

Reducing childhood undernutrition: integrating agriculture, housing, WASH, education and cash transfers in Peru



The challenge

Despite steady improvements in recent years, Peru continues to struggle with poverty. As a consequence, child undernutrition remains a significant problem: a national survey in 2009 showed chronic malnutrition affecting 23.8% of children aged under five. The country claims the world's greatest disparities between urban and rural areas, with chronic malnutrition in villages nearly three times higher than in cities. The government has responded to this challenge with a set of integrated policies from national to local and family levels, which has already shown significant results.

The solution

A key factor in the government's response to malnutrition was to give the issue a high political profile. National leaders placed malnutrition at the top of the political agenda, which increased visibility for the issue and the likelihood of adequate resources. This decision in turn was buoyed by a strong civil society advocacy campaign: in the run-up to the 2006 presidential elections, the Initiative Against Child Malnutrition (*Iniciativa contra la Desnutrición Infantil*) persuaded 10 out of 13 of the candidates to sign a public pledge to make child undernutrition a priority if elected.

Following the election, a single government ministry was initially responsible for the programme, but a year later the president appointed the secretary-general of the Inter-Ministerial Commission for Social Affairs, supervised by the prime minister, to coordinate the national strategy against malnutrition. This ensured that the head of the strategy had the power to implement a multi-sectoral response, involving the highest levels of government.

14. INEI (National Statistics and Information Institute), 10 February 2011: <http://www.livinginperu.com/news/14077>

15. Action Against Hunger International, *Undernutrition: what works?* Briefing paper, January 2011, p11

16. Action Against Hunger International, *Undernutrition: what works?* p6

The national plan – called *Crecer* ('Grow') – brought national and local government, NGOs, civil society and private bodies together in a strategy to combat malnutrition and poverty. The plan involved the country's health, education, water and sanitation, housing and agriculture policies, creating a coordinated and integrated inter-sectoral strategy. It also streamlined the country's previous 82 social policies into 26, and consolidated all the previous nutrition programmes into one, focusing efforts and resources on the key objectives of reducing stunting and anaemia.

The main element within this was the *Juntos* ('Together') programme, which provided conditional cash transfers to the poorest communities, enabling families to use financial allowances for specific purposes to improve children's health and nutrition – for example, to buy more vegetables, fruit and other nutritious foods.

Other components in the programme include improving the water and sanitation infrastructure to reduce the rates of water-related disease, supporting and developing agriculture to increase food production, providing care for children and women of child-bearing age, and running literacy and nutritional education programmes.

The success

Between 2007 and 2010 Peru achieved a 4.7% reduction in childhood chronic malnutrition – from 22.6% to 17.9%. The drop was bigger in rural areas (a reduction of 5.6%, from 36.9 to 31.3%) than in urban areas (a reduction of 1.7%, from 11.8% to 10.1%).¹⁴

There are still regions where undernutrition rates remain very high. Nevertheless, by integrating government policy with a multi-sectoral approach, Peru has achieved substantial results in reducing childhood malnutrition.

“It is well known that childhood undernutrition has multiple causes. Indeed, it touches upon a wide range of sectors, including health, agriculture, water and sanitation and education, with the relative importance of each differing according to context. This multi-causality requires promoting a functional multi-sectoral approach in order to enhance policy coherence and coordination.”

ACF International, *Undernutrition: what works*, January 2011¹⁵

A January 2011 study by the NGO ACF International of key policies and practices in Peru and four other countries which have achieved positive results in reducing malnutrition identified the following strategies as key to their success:

- Give a high political profile to the objective, creating political impetus.
- Adopt a multi-sector approach, with policies of coherence and coordination across a variety of sectors.
- Encourage civil society ownership and participation among the people affected by the issue, to improve acceptance and impact of the initiatives implemented.
- Adopt a multi-phase approach, combining short-term and long-term approaches.
- Ensure institutionalised coordination, bringing together long-term, sustained and scaled-up action under a single coordination council.
- Secure continuity of relevant financial investment from host governments and the international donor community.

ACF International, *Undernutrition: what works*, January 2011¹⁶

Conclusions

- Political support at the highest level for integrated responses to poverty enables effort and resources to be focused on key needs.
- Government-level action to create structures for cross-sectoral coordination with multiple stakeholders can facilitate the development and implementation of integrated strategies.

Other examples

- **Democratic Republic of Congo:** Local health ministries, public and private hospitals, and faith-based and non-governmental organisations are partnering to implement a programme encompassing maternal and child health, immunisations, nutrition, and water and sanitation.
- **Bangladesh:** Eleven government ministries work through a coordinating committee to reduce food insecurity in a programme that includes food assistance, economic help to households, clean water supplies, and support to mothers to improve health, hygiene and nutrition within families.

Safeguarding health for people living with HIV: integrating WASH and home-based care practices in Uganda

The challenge

An estimated 1.2 million people are living with HIV in Uganda.¹⁷ AIDS and diseases that accompany HIV-infection (such as pneumonia, diarrhoea and tuberculosis) have reduced life expectancy, depleted the labour force, reduced agricultural production and weakened the health and education services. Adequate nutrition, safe water, sanitation and hygiene are crucial factors in protecting people living with HIV from disease and infection. Lack of access to these necessities puts them and their families at increased risk of diarrhoeal and other diseases.

As part of its efforts to improve living and health conditions for people living with HIV, the Ugandan Government has taken a leadership role in integrating water, sanitation and hygiene (WASH) services with its national HIV programme.

The solution

In January 2008 the Ugandan Ministry of Health embarked on a programme of building good water, sanitation and hygiene practice into its training and support for people providing home-based care for people living with HIV. In collaboration with the USAID Hygiene Improvement Project, the NGOs AED and PLAN Uganda, the Uganda Water and Sanitation Network (UWASNET) and the National Working Group on WASH Integration into Home-Based Care in Uganda, the Ministry set up a working group and a pilot programme to test the effectiveness of the approach. The working group had representatives from 26 organisations, including the Ministry of Health, international NGOs, local NGOs, and regional and local home-based care organisations.

The result was the publication in 2010 of a training manual for care providers, and a set of practical guidelines on key ways to improve hygiene. The aim was to give home-based care providers the tools and information they need to improve the quality of their care, with a focus on how to transport, store and serve drinking water safely, how to safely handle and dispose of faeces and menstrual blood, and how and when to wash hands.¹⁸

The informational materials were designed to be accessible and useful for care givers with low literacy levels, with 'how to' illustrations, pictorial counselling cards and assessment tools. The working group ensured that the advice in the guidelines was practical and appropriate by running an eight-week community-level pilot project in Kampala and Mukono and holding workshops in October 2009 for 47 master trainers from 23 home-based care organisations. This project did local research to identify small practical actions that would help families and other carers to avoid the risks posed by poor hygiene practices, then tested and refined the actions before including them in the guidelines.

During the pilot programme, families responded positively to ideas such as simple homemade 'tippy tap' devices, which helped them to reduce the amounts of water needed for hand-washing. Client and community volunteer Charles Byamukama says, "I used to have at least one bout of diarrhoea a month, but since I improved my hygiene at home I can go for more than three months without it." Carers also welcomed the idea of using ash as a freely available resource for hand-washing, especially where soap was scarce.

The interactive training approach kept the participants engaged, and they left with specific new skills to use in the home – for example, how to change bed linen without having to get the person out of the bed. The training also helped people to develop a positive attitude to WASH practices, so they were more willing and able to tackle difficult and normally taboo issues such as hygienic handling of faeces and menstrual blood – tasks that they regularly had to undertake but had never been trained to do.

The success

This programme has generated keen interest in integrating WASH into home-based HIV care at national policy and local implementation level. The potential for success is high, especially if the activities can be integrated into all existing programmes. The 23 partner organisations involved have integrated WASH into their home-based HIV care programmes, and opportunities exist to ensure that all community-level health workers acquire the skills to do the same. The government has urged all agencies and organisations involved in providing home-based and palliative HIV care to integrate WASH practices into their programmes, ensuring the longer-term sustainability of the approach.



Regis Sicheuunga, who is HIV positive shows her grandchildren how to wash their hands

Conclusions

- The Ministry of Health's integration of water, sanitation and hygiene approaches into home-based care at the level of national policy – and urging all implementers to do the same – made the approach sustainable.
- Successful piloting at community level can stimulate support for cross-sectoral strategies both locally and nationally.

Other examples

- **Ethiopia:** Local governments supported land and water access for a USAID urban gardens programme for HIV-affected individuals, integrating community gardens, water and sanitation, health, and finance and enterprise in 20 cities across Ethiopia. To ensure land access for the gardens, city-level government offices of health, agriculture, and trade and finance in Addis Ababa partnered to complete a comprehensive urban agriculture policy for Addis Ababa, which may serve as a model for other cities.
- **Democratic Republic of Congo:** A local faith-based consortium runs a programme that empowers communities to help reduce sexual violence through establishing community protection committees and HIV/AIDS awareness. This is integrated with health, water and sanitation programmes in order to reduce vulnerability to violence and improve maternal and child health.

17. UNAIDS, 2009 estimate, <http://www.unaids.org/en/Regionscountries/Countries/Uganda/>

18. Uganda Ministry of Health, USAID, UWASNET, PLAN Uganda, Improving Water, Sanitation and Hygiene (WASH) Practices of Ugandan Home Based Care Providers, their Clients and Caregivers in the Home: Participant's Guide. <http://www.hip.watsan.net/page/4043>

Improving child health: integrating health and education programmes in the Philippines

The challenge

Diarrhoeal and respiratory diseases kill 82,000 children each year in the Philippines.¹⁹ Yet simple hygiene practices can provide valuable protection: for example, hand-washing with soap has been shown to reduce incidence of diarrhoeal disease by over 40%.²⁰ The UNICEF/WHO seven-point plan for eradicating diarrhoea²¹, published in 2009, identifies this practice as one of the five key elements of prevention.

Government structures can be an obstacle to tackling disease, but in the Philippines a novel cross-sectoral initiative has given a fresh impetus to efforts to prevent diarrhoea.

The solution

Using the country's schools as a channel for educating children about the risks of poor hygiene and enabling them to acquire good hygiene habits – such as washing their hands with soap – had been part of the government's approach for some years, but it was not always clear where primary departmental responsibility lay for promoting and resourcing what was both an educational and a health initiative.

In 2009, government at national and regional levels and the local NGO Fit for School worked together to create a more coordinated approach to running and funding an effective hygiene education programme in schools. The result was a Memorandum of Understanding signed in May 2009 by the Department of Education (DepED), the League of Provinces of the Philippines and Fit for School, Inc. This agreement laid out the roles and responsibilities of each organisation as part of the government's Essential Health Care Programme (EHCP). Fit for School acts as a watchdog in monitoring and evaluation and promotes the exchange of best practice among the various implementing schools, divisions and regions.

The EHCP is distinctive in that it tackles key health issues among state elementary school children through an inter-sectoral collaboration approach that integrates health, education, water and sanitation. In practical terms, it has introduced a system where children wash their hands with soap and brush their teeth with fluoride toothpaste every day at school. In addition, it strengthens the national de-worming programme for all children twice a year. Persuading schools to take part in Global Handwashing Day gives an extra boost to the campaign.

The programme targets school children aged 6–12, requiring schools to organise supervised group hand-washing and tooth-brushing activities at least once per day. There are 16 million children in the country's state elementary schools, and now more than one million of them, in more than 4,000 schools, are practising these basic hygiene behaviours.²² What the children learn also has a further impact on their families and communities.

One year into the coordinated programme, the results were encouraging: school absenteeism in the intervention group was 30% lower than in the control group, the number of children with below-normal body mass was 20% lower, and the increase in oral infections was 40% lower.

The success

The EHCP offers simplicity of design, ownership and participation, affordability and scalability, institutionalisation, and a high return on investment for Filipino children. Initial indications are that the initiative is having a lasting impact. Inter-sectoral collaboration in the education and health sectors and at policy level is changing and increasingly built into local budgeting as a key to improving hygiene at the individual, family and community level. In 2009 it was decided that the Philippines would mark Global Handwashing Day on 15 October each year.



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'I am very proud of Fit for School and the Essential Health Care Programme. It helps us to make progress on a number of the MDGs where the Philippines are falling short of the targets. It has become such a success for our country because of the 'three S's': simplification, scalability and sustainability. Apart from the very tangible benefits for our children it has resulted in better cooperation between health and education.'

Brother Armin Luistro, Secretary of Education, Philippines

Conclusions

- Overcoming departmental divides at government level with a cross-sectoral strategy can facilitate more effective action on health issues.
- Securing both local and national buy-in for an integrated programme can enable affordable, scalable and high-impact interventions.

Other examples

- **Nicaragua:** The Health and Education Ministries and local authorities are working with young people to improve sexual and reproductive health in an approach that includes improved health services and health data collection, and programmes at schools and youth clubs.
- **Zimbabwe and South Africa:** A strategy based on community education via community health clubs ensures integrated and sustainable development by promoting hygiene, monitoring for epidemics such as cholera, monitoring child growth and development, and supporting people living with HIV.

19. Department of Health, Philippines, cited by Fit for School Inc, <http://www.fitforschool.ph/handwashing.html>

20. *ibid*

21. UNICEF/WHO, 2009, Joint report 'Diarrhoea: Why children are still dying and what can be done': http://www.unicef.org/health/files/Final_Diarrhoea_Report_October_2009_final.pdf

22. <http://www.globalhandwashing.org/philippines>

Scaling up: building integrated approaches at national level

The challenge

Two developing countries – Nepal and Ethiopia – have extensive health needs, especially in poor and remote rural areas where access to clinics and other facilities is limited. Resources have to be stretched, but where strategies lack coordination their impact is reduced.

Both countries, however, have taken innovative steps to build more effective coordination by scaling up integration of health and related programmes at national level.

Nepal

An independent survey found that the health and sanitation sectors in Nepal were hampered by a lack of institutional coordination, which was damaging efficiency. To build better cross-sector linkages, the Ministry of Health and Population (MoHP) organised a workshop in 2009 with support from the NGO WaterAid and the World Health Organization (WHO), bringing together senior figures from the health, education, local development, and WASH sectors. Following these discussions, the health sector designated a focal point to coordinate with WASH sector organisations on a number of health-related aspects of WASH: the result was improved coordination and communication.

In the same year an outbreak of diarrhoeal disease that caused 346 deaths underlined the difficulties stemming from lack of clarity about areas of responsibility for taking action. The health sector focused on providing treatment to save lives, while the WASH sector focused on preventative measures. This event highlighted the need for closer integration and for strategic as well as responsive action. As a first step, in 2009 all public health professionals at district and regional levels received orientation on WASH issues during a regional workshop conducted by the MoHP, WaterAid in Nepal, UNICEF and WHO.

Strategic coordination

At a national level, the latest stage of the Government's health strategy – the Nepal Health Sector Support Programme II – came into operation in 2010. This five-year strategic plan includes plans to prioritise WASH as a cross-cutting theme within the health sector. The practical implications of this include: promoting hygiene and sanitation through the existing institutional infrastructure; mainstreaming promotion of hygiene and sanitation in other essential healthcare services; establishing a water quality surveillance system and promoting use of safe water; including WASH in health education to promote behaviour change, and strengthening inter-sectoral collaboration and coordination.

Further work now needs to be done on mainstreaming WASH in other health programmes (e.g. reproductive health, child health, epidemiology, HIV, nutrition, behaviour change, communication, and training of health staff) and to improve links between health and WASH and across programmes.

Ethiopia

One woman dies every 25 minutes in Ethiopia from complications related to childbirth – mostly in rural areas, far from any clinic.²³ In response to this and other challenges in rural areas, in 2004 the government launched the Health Extension Programme (HEP). This expanded the national health programme to include community-based services – the aim being to improve access to essential health services at village and household level, with a focus on sustained preventative actions and increased health awareness, and to establish an effective way of shifting healthcare resources from the urban to the rural population.

The HEP is a package of basic and essential promotional, preventative and curative health services. It empowers communities to make informed decisions about their own health by equipping them with appropriate skills and knowledge. Its goal is to create a healthy society that will play an active part in poverty reduction.

Cross-sectoral healthcare

To implement the HEP, the government constructed a comprehensive network of primary healthcare units, with a health post in every village of 5,000 people linked to referral health facilities. Each health post is staffed by two health extension workers, both of whom are female community health workers trained in delivery of the programme's 16 essential health packages. These cover four major areas:

- family health services (maternal and child health, family planning, immunisation, adolescent health and nutrition)
- hygiene and environmental sanitation (excreta disposal systems, solid and liquid waste management, water safety, food hygiene, personal hygiene)
- disease prevention and control (HIV, TB, malaria, first aid)
- information, education and communication

More than 31,000 health extension workers are now trained and deployed in the country's 15,000 villages and in more than 12,000 health posts. A study has shown that the HEP has improved access to various preventative and treatment services in rural communities and facilitated an improvement in health and hygiene practices at the local level.

23. UN News Centre, 25 May 2011. <http://www.un.org/apps/news/story.asp?NewsID=38503&Cr=maternal&Cr1=>



FMOH Ethiopia



Miguel Alvarez

Conclusions

- Bringing together leading figures in all relevant sectors can improve cross-sectoral communication and coordination and promote closer integration of services.
- Where resources are limited, integrating programmes at local level can expand the reach of national services.

“Health sector involvement in WASH promotion initiatives in the last two years has been encouraging: now this process needs to be institutionalised through to community level, and we need to build coordination with other ministries.”

Badri Bahadur Khadka, Director, National Health Education, Information and Communication Centre, Ministry of Health and Population, Nepal

Lessons learned and recommendations



The initiatives described in this report show real-world examples of how to make integration work and why it's so important to do so. Successful models of integration are responsive to needs at the community and country level and include strong leadership from the responsible government agencies. The experiences and lessons learned from these case studies suggest the following recommendations for policy-makers:

1. Community participation is essential for the design of integrated programmes that respond to lived realities, and thus increase programme uptake and sustainable impact

- Engage communities in assessing needs and priorities, and in designing, implementing and evaluating integrated approaches

These case studies demonstrate the positive benefits associated with prioritising community participation in programmes' design and implementation, including improved coverage, increased impact, and community ownership and therefore increased sustainability of projects. Communities can show what 'integration' means in real life, supporting and informing decisions made by policy-makers on integrated programmes. Community participation and leadership contribute to the development of policies and projects that are aligned with their priority needs, and improve acceptance and impact among affected populations. National governments that create opportunities for participation of affected communities in the design, implementation and monitoring of projects are better able to ensure that responses are based on real needs, reflect how people live, are sustainable in the long-term, and remain accountable to the community.

2. High-level political leadership enables better focus on needs and resource mobilisation

- Ensure political support at the highest levels for integrated responses to identified needs
- Sustain political support by creating a mechanism that will promote and help facilitate coordination and communication among different sectors and ministries; delegate and be specific about the roles and responsibilities of each agency or ministry.

The integrated projects described here benefited from established mechanisms of coordination and strong political support. Establishing a framework that clearly defines the responsibilities and the roles of each agency, institution, and ministry will facilitate coordination and communication as well as a strong leadership at a national, regional and district levels. Successful projects have also shown the need for training and budgetary support across relevant departments to strengthen and sustain capacity for cross-sectoral coordination.

3. Integrated, cross-sector approaches more closely reflect and respond to the determinants of poverty and disease

- Include cross-sectoral indicators in evaluation frameworks for tracking within sector plans – such as health, water, sanitation and hygiene and nutrition
- Encourage and formalise coordination with other relevant ministries and ensure these ministries, as well as relevant civil society organisations; make joint decisions across sectors.

As monitoring and evaluation powerfully influence priorities in how projects are implemented and where those responsible invest the most time, resources, and effort, governments can promote more integrated and coordinated approaches by adopting indicators that measure efforts across health, water, sanitation, and nutrition even within sector-specific plans.

4. High-quality integrated programmes can prove cost-effective for donors and secure efficiencies for policy-makers

- Develop multi-year plans to finance integrated programming and ensure sustainability
- Identify ways to provide more flexible funding to partner countries in support of their priorities, and to fund multi-sectoral approaches.

Because integrated programmes provide multiple services through one delivery platform, they can more effectively leverage infrastructure investments and reduce duplication of effort by disparate providers. Additionally, these programmes make it far easier – and therefore more likely – for families to access the services they need.

Sustained multi-year financial commitments and plans, rather than short-term projects, by governments and donors enhance policy coherence, coordination, and likelihood of success. A key determinant of success has been donors' willingness to provide more flexible funding to partner countries in support of their priorities, and to fund multi-sectoral approaches, supporting the inclusion of cross-sectoral indicators in national plans. Flexible funding also reduces the high burdens of separate monitoring, evaluation, accounting, and reporting that result when countries have to patch together multiple disease- or intervention-specific grants from myriad sources. These stories have shown the importance of donors' support for multi-sector approaches in countries, of encouraging coordination across national ministries, and calling for participation of relevant ministries as well as relevant civil society organisations in the national planning process.

5. Funding integrated approaches at community level demonstrates what works and generates learnings to inform national plans and scale-up strategies.

- Support the integrated programming under way in low-income countries, specifically through funding pilot programmes to inform planning and policy-making at the national level.

As these examples illustrate, designing effective programmes can involve a degree of trial and error to learn what mix of interventions can deliver the most impact, what mechanisms of coordination are both efficient and effective, and what resources are needed to ensure success. Donors and national governments can support integration by funding and shaping pilot programmes that will be proving grounds for taking integration to scale. Lessons learned during the pilot efforts can inform policy at all levels, from local to national programmes.



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DAI (page 13)
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