GOING BEYOND THE ‘HEALTH ONLY’ APPROACH

USING CONTACTS BETWEEN FAMILIES AND THE PRIMARY HEALTH CARE SYSTEM TO PROMOTE THE ALL-ROUND DEVELOPMENT OF YOUNG CHILDREN

Judith L. Evans, Viorica Berdaga and Lilia Jelamschi

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The Moldovan Experience

Judith L. Evans, Viorica Berdaga and Lilia Jelamschi

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For further information, please contact:

Deepa Grover
Regional Adviser - Early Childhood Development
UNICEF - Regional Office for Central and Eastern Europe and the Commonwealth of Independent States
E-mail: degrover@unicef.org

Lilia Jelamschi
Project Officer - Early Childhood Development
UNICEF - Moldova
E-mail: ljelamschi@unicef.org

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Almost all young children and their mothers come into contact with PHC services in the Republic of Moldova. These contacts represent an excellent opportunity to provide guidance, counselling and advice with respect to the all-round health and development of young children. In Moldova, these contacts were used in a systematic and comprehensive way. Many positive results were registered, a significant one being that the new mother and child health (MCH) programme explicitly mentions parenting education as one of the strategies to be pursued.

A number of the former Soviet countries have similar health systems. The detailed documentation of the Moldova example holds many lessons for these countries. Additionally, it serves to showcase how working with existing infrastructures and resources can result in sustainable solutions to complex needs. The Moldova experience represents a model to be emulated. This case study will be of use to governments - especially ministries of health - UNICEF programme staff, as well as partners and other stakeholders who are involved in early childhood development initiatives.
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Executive Summary

The Moldovan health system needs to be applauded for ‘going beyond health only’ in their provision of PHC. Many other countries recognize the importance of health reform but have not realized the importance of addressing the whole child; psychosocial development is generally marginalized, if it is addressed at all. The Republic of Moldova is a very good example of how the health system has stepped in to help parents and families to promote this critical aspect of the young child’s development.

This story describes an initiative, undertaken by UNICEF in the framework of its Cooperation Programme, in partnership with the Government, other UN organizations and NGOs, which has contributed to the design and delivery of PHC in the Republic of Moldova. The main goal of the UNICEF Early Childhood Care and Development (ECCD) Programme in the Republic of Moldova is “to attain the highest achievable standards of health, nutrition, and psychosocial development in children under the age of seven, by improving access to and quality of basic health-care services. The main objectives are: (a) to promote cost-effective and efficient MCH services; (b) to contribute to the development of an accessible, qualitative and sustainable primary health care; (c) to increase access to and improve quality of early childhood development practices in families and communities”.

The main accomplishments to date include: (a) institutional and policy changes in the area of mother and child health (MCH); (b) capacity-building of health-care providers on quality clinical care and parent education; (c) development of the capacity of health-care managers to identify, prioritize, and analyze MCH problems, and to select and implement appropriate interventions; (d) strengthening of supervision, monitoring and evaluation systems; (e) improvement of family practices and increased demand for basic social services.

The fact that UNICEF has had a consistent approach and has allowed the initiative to evolve (through carefully planned stages that have been developed along the way as a result of feedback and monitoring) has provided strong underpinnings to the effort.

1 The word ‘initiative’ is being used rather than ‘project’, as the effort involves a long-term commitment to improving maternal and child health and development, rather than a short commitment as implied within a project focus: this has been the cross-cutting strategy throughout the process.

2 This is the story from a UNICEF consultant’s point of view. While a number of people from government, the universities, colleges, and PHC facilities were interviewed, they have all been part of creating and implementing the initiative.

INTRODUCTION
"If the young child is surrounded by supportive and positive influences it is likely that he/she will survive and thrive. These outcomes, surviving and thriving, are, to a very large extent, dependent upon how well-equipped families, especially primary caregivers, are to care for, respond to and manage the needs of young children from birth onwards."
Grover, 2005

In the Republic of Moldova, a young mother-to-be is on her way to the local health clinic for her fifth prenatal check-up; she is due to deliver in the next month. Her husband is with her. In advance of this check-up the mother begins to think about what will happen after the baby is born and she has some questions about whether or not to breastfeed the baby and for how long. After her check-up, she and her husband sit with the doctor who says that everything looks fine in terms of the pregnancy. The doctor asks if the parents have any questions and the young woman begins with her list of questions about breastfeeding. The questions are answered by the doctor and the nurse who are meeting with the parents, and the parents are given a pamphlet with more information on breastfeeding. They leave reassured by the medical staff that all is well and they can see the importance of breastfeeding.

A month later the baby is born. The father stays with the mother during the birth - although he is somewhat squeamish about doing so - and now the mother has a five-day stay in the hospital where she and her baby are in the same room together. During that time there are many opportunities for the mother to get support from the nurses as she starts breastfeeding. When she and the baby leave the hospital the mother is feeling confident about how to care for the infant.

On the second day after the woman returns home she is visited by the doctor and a week later the nurse from the public health clinic is scheduled to visit her. The mother is awaiting the visit because she has many questions and she knows the nurse will listen to her and give her good advice. One of the things the mother wants to talk to the nurse about is the fact that the baby wakes many times during the night and is fussy during the day. The grandmother has advised the young mother to give the infant some tea - it always worked for her - but the young woman is not sure that this is right, given the information she received from the hospital.

The nurse arrives and watches as the young mother breastfeeds her child. She helps the mother adjust her position slightly. The nurse assures the young mother that her breastmilk is best and emphasizes that the infant should not have any other foods,
This vignette is one of many that could illustrate the way in which the PHC system in the Republic of Moldova is providing support to families, from pregnancy into the early childhood years. The restructured health-care system focuses on the basic needs of women and children, but goes beyond to attend to a broad definition of health. This structured continuity of care is designed to equip families to respond to, and support the development needs of their infants and young children in a holistic way.

An important dimension of the vignette is that the holistic approach to child survival, growth, development and protection is being provided through the PHC system. This story describes an initiative, undertaken by UNICEF in partnership with the Government, other UN organizations and NGOs, which has contributed to the design and delivery of PHC in the Republic of Moldova, where steps have been taken to enhance the role of health personnel in PHC clinics, with the ultimate goal of changing parental behaviour in order to stimulate children’s overall development.5

The activities comprised in the initiative are linked to other reforms and changes underway throughout the whole health system. As the initiative started, actions were taken to shift from a predominantly curative system to one that favours health promotion, disease prevention and broader child development issues. Emphasis was given to focusing on the ways the relationship between PHC staff and families could be oriented towards dialogue rather than prescription only. This involved being more open to questions raised by families and engaging in direct dialogue around child health issues. Once that was underway, a much broader focus on overall child well-being - encompassing health, nutrition and other supports for children's development - was put into place.

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1 See footnote 1.
2 See footnote 2.
ACCOMPLISHMENTS WITHIN THE INITIATIVE
Focusing on the core story, there is already much that can be learned. As the initiative has evolved, a wide variety of activities have set processes in motion that have moved it forward. But before looking more closely at the processes, it is important to briefly mention some of what has already been accomplished.

1. **National indicators.** This initiative is part of a larger PHC reform, the impact of which can already be seen in relation to MCH key indicators. According to the figures quoted in the *Common Country Assessment*, the infant mortality rate (IMR) declined from 19.2 deaths per 1,000 live births in 1990 to 14.4 deaths in 2003. The under-five mortality rate (U5MR) dropped from 25.2 deaths per 1,000 live births in 1990 to 17.5 in 2003 and the maternal mortality ratio (MMR) from 53.2 deaths per 100,000 live births in 1990 to 23.5 in 2004. The decreases in perinatal causes of deaths have been attributed to the National Perinatal Care Programme, which is a part of this initiative.

2. **Perinatal outcomes.** The analysis of perinatal mortality and morbidity rates revealed a positive trend downwards. In terms of health-care practices during pregnancy, early rendering of antenatal care had increased to 69 per cent in 2004, as compared to 57 per cent in 2003; the use of home-based perinatal care record had reached 85 per cent in 2004 versus 59 per cent in 2003; care during delivery and psychosocial support by health-care personnel 63 per cent in 2004 against 46.7 per cent in 2003; and free access of relatives to the maternity wards 81 per cent in 2004 versus 68.8 per cent in 2003. For postpartum and neonatal care, early breastfeeding had reached 95 per cent in 2004 versus 81 per cent in 2003; and skin-to-skin contact 95 per cent in 2004 versus 75 per cent in 2003.

3. **Family outcomes.** Positive changes in family practices have been documented by a series of studies, surveys and evaluations. The analysis of interviews conducted among pregnant women and families with children less than five years of age reveals an increase in the percentage of those who recognize danger signs during pregnancy (59 per cent in 2004 versus 21 per cent in 2001). Knowledge of at least two danger signs in the health of young children has increased to 82.9 per cent against 73 per cent; 55 per cent of mothers now exclusively breastfeed their children until three months of age (versus no cases of exclusive breastfeeding in 1996); 81 per cent of mothers breastfeed their children until six months of age and 60 per cent until 12 months of age (versus 58 per cent and

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29 per cent in 1996); all children are given supplementary food at the age of six months. There are also improvements in the use of iodized salt, from 34 per cent of the population consuming iodized salt in 2000 to 58 per cent in 2003.

4. **Policy impact.** Parent education has been included into the Basic Benefit Package of Health Services of the National MCHC Programme, into the National Perinatal Care Programme, and into the Health Family and Community Practices Plan of Action, covering key child-care practices beyond health, nutrition, and immunization.

5. **Training.** The pre- and in-service training of PHC providers (doctors and nurses) has been enhanced to include parent education, in general, and a greater understanding of child development, in particular. In essence, training focuses on issues reaching beyond clinical care, i.e., providing psychosocial support during pregnancy; planning and organizing antenatal care courses for pregnant women and their families; counselling on danger signs during pregnancy and on nutrition and hygiene issues; and preparing for parenthood.

6. **PHC practice.** Positive changes have been achieved in the practices of health-care providers. It is reported that 60 per cent of PHC workers trained in IMCI/CD include parent education in their work with families, counselling them in the area of child development.

7. **PHC/parent relationship.** The staff/parent relationship has changed. Medical staffs seek to engage the parent into a conversation about the child, rather than simply giving out information. As one doctor explained, "It is no longer a one-way street. The conversation now goes both ways." She was referring to the fact that rather than simply prescribing what families should do in a given situation, it is now her responsibility to ensure that families understand what they are being told and to encourage them to ask questions.

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"Multiple Indicator Cluster Survey 2000, op. cit."
LESSONS LEARNED
What makes the initiative work? Some of the key ingredients within the development of the initiative are related to the fact that, from the beginning, the goal was to create a sustainable change in the health system through a long-term commitment, rather than adopting a ‘project’ approach. The keys to the successful evolution of the initiative so far include:

1. Advocacy with decision makers: making strategic use of data and evidence which suggest that parent education has the potential to meet national goals, such as reducing child mortality and morbidity rates and improving child development.

2. Building on the existing PHC system as opposed to creating new structures, with the aim of integrating family education on early childhood development into the health-care system.

3. Building on well-accepted and successful programmes and initiatives in the health sector - mainly the National Perinatal Care Programme and the IMCI initiative - as strategic entry points for family education programmes with an important component of child development (i.e., beyond health and nutrition).

4. Adopting a comprehensive approach to the change process, working at all levels and including all stakeholders. This involves revising national policies, standards and job descriptions; capacity-building of health providers; communication; setting up supervision, monitoring and evaluation systems.

5. Involving key people in the initiative - decision makers and technical staff at the national level have participated since the beginning.

6. Working in partnership throughout the initiative: partnerships have been based on what government, donors, UN organizations, and NGOs do best, with partners coming and going, depending on the evolution of the activities.

7. Creating monitoring and evaluation systems that people can use themselves to watch their own progress.

The story that follows provides details on each of these elements. But first it is important to provide some background on the initiative.
BACKGROUND
The Republic of Moldova is a small landlocked country neighbouring Ukraine to the East and Romania to the West. On 27 August 1991, Moldova became a Parliamentary Republic. Since then, the country has faced numerous political, economic and social challenges. As a result, “Moldova’s living standards and human development indicators still rank amongst the lowest in Europe, even in comparison with other transition economies.”

The Republic of Moldova is a country of nearly 4 million inhabitants, the majority of whom live in rural areas. In 1990, there was an almost equal distribution between rural and urban populations. Since then, there has been a movement from urban to rural areas. By 2003, the urban population had dropped to 39 per cent of the total population. (It should be noted that the change in the proportion of rural/urban population is partly due to the change in the definition of ‘urban’ after the administrative reform of 2002.)

A trend that has an impact on population numbers involves significant migration to other countries in search of employment and expanded opportunities. The census data (1995) indicate that every fifth person from rural areas and every tenth from urban settlements has left the country in search of employment. According to official figures, an estimated 10 per cent of the population has left the country in search of employment, whereas unofficial figures are higher and suggest that 15 to 20 per cent of the population had migrated by the end of 2004.

The migration also worsened the attrition rate among health-care workers, thus threatening the ability of the health system to meet the needs of the population. Between 1995 and 2001, the number of doctors in urban areas declined by 5.6 per cent, while the number in rural areas dropped by around 25 per cent. The decrease in the number of nurses in rural areas was more dramatic, with a decline of 37 per cent as compared to 19 per cent in urban areas.

There is evidence that household income increases when family members are able to work abroad. However, while family income may be rising, the result of migration is that children are deprived of parental care. “A recent survey of 1,844 children from 25 rural settlements reported that an astonishing 81 per cent had at least one parent working abroad.”

Another data source, the Moldova Demographic and Health Survey conducted in...
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2005, reported that 31 per cent of children lived with only one or neither parent and 7 per cent without both parents, whereas 3 per cent of children were orphans, with one or both parents having died.

In terms of those left behind, the one in five children classed as poor in the Republic of Moldova are of particular concern. Extreme poverty among young children is especially acute: “Thirty-three per cent of children under the age of five do not receive adequate food to meet their proper health and development needs. Mirroring the national poverty profile, this situation is most serious in rural areas.”

Thus, there is a large percentage of the population living in poverty - in both urban and rural areas. The challenge has been to create a mechanism to reach these families and communities and to provide them the best possible support to meet young children’s health and development needs. One way to achieve this in the Republic of Moldova is through PHC. Before continuing with the story, it is important to step back and look at why there is a focus on working with families in a preventative care approach.

\textsuperscript{17} Common Country Assessment 2005, op. cit., p. 10.
A focus on families

“Parents and other caregivers determine the amount and quality of the food their children consume, and the degree of protection they receive against illnesses, accidents, injuries and stress. Families are the first in the chain of command when it comes to putting into action the health provider’s advice - ranging from taking the child to be immunized, to managing and treating simple health conditions at home, to seeking help if the child’s condition needs attention that is beyond their capacity, and to comforting the child who is in physical or psychological distress.”
Grover, 2005

Infants are very dependent on those who around them promote their survival, health and overall well-being. During the early years, children are the most malleable and the most vulnerable. “Evidence from the fields of physiology, nutrition, health, sociology, psychology, and education continues to accumulate, indicating that the early years are crucial in the formation of intelligence, personality, and social behaviour. Children are born with physical, social, and psychological capacities, which allow them to communicate, learn, and develop. If these capacities are not recognized and supported, they will wither rather than flourish.”

The first year of life is most crucial in terms of a child’s physical growth; children who falter during this period are exposed to the risk of delayed or debilitated cognitive (mental) development. This process is affected not only by the child’s nutritional and health status, but also by the kind of interaction the child develops with the people and things in his environment. That is where parents and families have an important role to play.

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It is the family who is entrusted with the responsibility of ensuring children's rights and needs. During the early years, young children spend the great majority of their time within the family setting, with relatives creating the human and physical environment within which they are growing and learning. Thus, logically, it is during the early years that it is most important that the family gets appropriate support.

In addition to the fact that it is logical to work with parents of young children, research has demonstrated the impact of the family focus on young children's health and development. For example, in relation to infant mortality, a recent Lancet series on newborn health stated that a combination of universal - i.e., for all settings - outreach and family community care at 90 per cent coverage averts 18 to 37 per cent of neonatal deaths.

Another research project that highlighted the importance of families was conducted in the late 1990s. The World Health Organization commissioned a review of programmes that were effective in improving the health, the nutrition, and the psychological development of children in disadvantaged circumstances. The review led to the conclusions that the most effective programmes have the following characteristics:

- They focus on the children who are in the 'critical window' of life - improvements before birth and during the first two to three years of life have the greatest impact on the child's future growth and development;
- They focus on children who are most at risk - the greatest improvements were seen in children who were impoverished and undernourished;
- They involve parents and other caregivers in improving childcare;
- They combine several interventions: for example, to promote good nutrition, strengthen mother-child interaction, stimulate psychosocial development, and improve the child's health.

Why is the 'combining of several interventions' (a holistic approach) so important? The answer begins with an understanding of what it means to be healthy. According to the 1978 Alma-Ata Declaration, Health for All by the Year 2000, health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. While the health-care system has historically focused on 'the absence of disease or infirmity', there is an increasing awareness of the need to focus on prevention as well. And

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while there are clearly measures that families can take to keep the child healthy, it turns out that those measures do not relate only to hygiene and safety, they also relate to how the child is cared for.

Care includes much more than keeping the child safe and free from harm. Care encompasses the ways in which adults (parents and other caregivers, including older siblings) interact with the young child throughout the day. It does not require a special set of activities. It involves paying attention to what the young child is doing, attending to the feeding process to ensure that the right kind of foods are being given and that the child eats in a supportive environment, talking to the child, and showing love and affection. The context within which the child is being raised impacts on the kinds of care required and received.  

If we accept these findings, how do we reach parents/caregivers? What do we want them to know and how do we bring that knowledge to them? What skills and behaviour are we looking for? Who can best work with families to create a caring environment within the home? The health system is an obvious partner. In the Republic of Moldova, the primary reason for using PHC as the main channel for family education was the availability of a well-developed infrastructure and the high coverage by health-care services of pregnant women and families with young children - over 98 per cent. Another reason was a high level of trust in health professionals, particularly among young mothers. Existing PHC services provided multiple opportunities for family education in the health-care centres and via the outreach work of health-care providers, especially nurses. (See Box 1 for a description of the structure of health services in the Republic of Moldova.)

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**BOX 1 The structure of health services in the Republic of Moldova**

In order to achieve national coverage of parent education and counselling activities, UNICEF advocated for the use of the extensive network of the country’s PHC facilities and their personnel. The organization of the PHC services mirrors the territorial and administrative structure of the country, with its 32 raions (counties), 2 municipalities and 1 autonomous region. At the raion and municipality levels, the network of PHC facilities is organized around the raion/municipal centre for family doctors. This central PHC facility has a managerial and coordination role for all PHC facilities in the respective raion/municipality. The described PHC infrastructure covers the entire population of the Republic of Moldova.

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*Evans, J. L., ‘Working with Parents to Support Children from Birth to Three Years of Age’, lead article in the Coordinators’ Notebook, No. 24, 1999.*

*TAU Gagauzia (Transnistria is not included).*
with essential health services ensuring over 95 per cent coverage for immunization, antenatal and postnatal care, child growth and development monitoring. Within the PHC approach, the health system provides families with a continuity of care (from pregnant women to families and young children) that allows them to gain a whole array of knowledge and skills in support of their children's well-being.

According to the national regulations, a family doctor (assisted by three nurses) serves a population of 1,500 to 2,000 people. However, due to the high attrition rate, most of the rural facilities are understaffed. Nevertheless, provision of MCH services represents a priority for PHC workers and is carried out routinely.

The coverage (and frequency) is high: thus, during the first year of life, the child is seen by the health-care provider six to seven times. This is true for virtually all the families in the country.

A typical family doctor's office is provided with basic equipment and furniture, including for storing the medical records. Recently, there has been an addition to these expected items: improvised toys and educational materials for parents. When the mother brings the child for regular check-ups, the doctor can show her how to play with the child using these toys. Similarly, while waiting, parents can read booklets on child feeding, security, literacy, and disciplining.
WHAT HAS SET THE PROCESS IN MOTION?
There are a number of variables that appear to have contributed to the evolution of the initiative. They include:

1. **Addressing national priorities:**

   *Making strategic use of data and evidence which suggest that parent education has the potential to meet national goals, such as reducing child mortality and morbidity rates and improving child development.*

   In setting this initiative in motion, UNICEF looked at some of the MCH indicators to help guide the decision on how to best support the government in meeting national goals. In essence, the main reasons for introducing the IMCI initiative were high infant and under-five mortality rates due to avoidable conditions, especially at home. The high mortality rates were explained by the inadequate access to and quality of PHC services, the inadequate referral to higher levels of care, and poor family knowledge about children's illnesses, hence the delay in seeking medical help. As summarized in the *Common Country Assessment*,23 perinatal conditions, respiratory diseases, congenital malformation and injuries represent major causes of infant and under-five mortality rates. While improvements have been reported,24 there are still many illnesses, causing deaths, which could be prevented or cured. The high level of child mortality at home (23 per cent of all infant deaths) arises due to avoidable causes (more than half of all deaths) and could be explained by the families/parents' inadequate child-care knowledge and practices, and their failure to recognize danger signs and to seek help.25

   If diseases that contribute to U5MR have avoidable causes that appear to be explained by the lack of knowledge and skills on the part of families, what is the most appropriate way to reach parents and work with them? Given developments in the Republic of Moldova in relation to the health reform process, including the improvement of PHC services, activities that would strengthen PHC seemed like a logical entry point for UNICEF.

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24 The decrease in perinatal cases of deaths could be attributed to the National Perinatal Care Programme. The decline in congenital malformations and respiratory diseases could be explained by nationwide immunizations campaigns against rubella, introduction of universal supplementation of all pregnant women with folic acid, and expansion of the IMCI strategy.
The right to health is enshrined in the Constitution of the Republic of Moldova and guaranteed through free provision by the State of basic health-care services. The Moldovan Government is committed to reaching the Millennium Development Goals (MDGs). To achieve these goals, the Government has given priority to "ensuring health for all on the basis of principles of accessibility, accountability, co-participation and cost-efficiency, and increasing the quality of public health, epidemiological safety, food safety and prevention of epidemics".26

In a recent review of the health sector reform in the Republic of Moldova, Atun noted the problems being faced by the country, which "... inherited a health system based on the Soviet Semashko Model characterized by centralized planning; hierarchical administrative organization; a very large provider network dominated by hospitals and tertiary provider units; parallel health systems for line ministries and large organizations; poorly developed PHC level fragmented by tripartite delivery model which provided services separately for adults, men and children, as well as a large number of vertical programmes delivered by narrow-specialists; absence of family physicians at PHC level which lacked gate keeping function; a surfeit of hospitals and human resources concentrated in the capital Chisinau; an inequitable resource allocation system based on historic activities and inputs - and favoured large hospitals in urban centres at the expense of rural areas; line-item budgeting of provider units and salary-based payment systems which encouraged inefficiency and discouraged improved performance; strict care delivery protocols not based on current evidence which encouraged excessive referral to secondary care level; highly curative and disease-focused services (partly attributable to the nature of medical training) with limited health promotion or prevention, and a system which allocated users to doctors and prevented them from exercising choice or meaningfully participating in the health production process."27

In other words, the health system was neither efficient nor cost-effective. Therefore, a major reform was required. The Government did not shy away from the task and was one of the first Commonwealth of Independent States (CIS) to begin health-care reform. In 1995, the Law on Protection of Health was adopted,28 establishing the platform for subsequent laws

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26 Ibid., p. 15.
27 Atun, op. cit., p. 5.
and decrees related to the reform of the health system. The health reform strategy focused on four major areas: 1) organizational and structural changes; 2) modifications to the financing system; 3) reform of the education and training system for medical staff; and 4) pharmaceutical reform. The most important changes brought by the Ministry of Health, and used as opportunities to promote family education, were the introduction of family doctors in 1997 and of the mandatory health insurance in 2003.

The health-care reform is comprehensive and complex. Clearly, UNICEF could not address all the areas to be reformed, but was aware that it had a comparative advantage in relation to different foci in the reform, particularly those related to the development and implementation of PHC. And, in fact, UNICEF has been a part of the organizational and structural changes, which include the development of PHC and the reform of the education and training system for medical staff. UNICEF chose these areas because they had the added advantage of strengthening and broadening family education as part of the health-care system.

Internationally, UNICEF has considerable experience with a variety of activities that address preventable diseases and support families in providing appropriate holistic care to infants and young children. Thus, UNICEF chose as its primary entry points: a) perinatal care; b) the implementation of the Integrated Management of Childhood Illness (IMCI) initiative - a proven best practice to make medical staff and families more aware of danger signs related to the most common childhood illnesses, and c) the monitoring of child growth and development, with a focus on enhancing families' ability to support all aspects of child well-being (not only the health and safety of the child), through the Care for Development (CD) approach. UNICEF started by building on what existed.

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29 Atun, op. cit., pp. 37 and 38.
3. Building on well-accepted and successful programmes and initiatives in the health sector:

Building mainly on the National Perinatal Care Programme and the IMCI initiative - as strategic entry points for family education programmes with an important component of child development (i.e., beyond health and nutrition).

The National Perinatal Care Programme

The National Perinatal Care Programme focuses on improving access to quality prenatal, childbirth, and postnatal care. Some of the main principles of the perinatal care reform are: family-centred care, involvement of women in decision-making and overall de-medicalization of care. Key perinatal care technologies implemented in the Republic of Moldova include the organization of prenatal classes for pregnant women and their families, partnership during pregnancy and birth, skin-to-skin contact, early and exclusive breastfeeding, rooming-in, and relatives’ free access to maternity wards. All these have resulted in a greater interaction between health-care professionals and families and in improved family knowledge and skills in comprehensively caring for neonates.

In terms of the birthing process, family members - fathers or mothers of the women who are delivering - can be present; there is rooming-in during the time the mothers are in the hospital (five days); they get support and advice in initiating exclusive breastfeeding; there are opportunities for parent education regarding feeding, play and communication with the infant and young child. Both medical staff and parents have responded positively to these changes.

Box 3 gives an overview of the communication strategies undertaken in relation to perinatal care. The specific objectives were: “To prompt, by the end of one year, 80 per cent of possibly pregnant women ... to visit a family doctor at a government health centre immediately (within a week of having missed their period for three weeks) to determine whether they are pregnant or not, and, if they are pregnant and have decided to continue the pregnancy, then to adopt the following micro-behaviours: (a) to begin taking folic acid, (b) to begin taking iron supplements, and (c) to take prompt action on any of the danger signs during their pregnancy.”

Communication activities proposed in the COMBI Plan for Antenatal Care should be seen as an integral part of broader activities implemented under the National Perinatal Care Programme in the Republic of Moldova, such as:

- development of national perinatal care guidelines, standards, and protocols;
- development of perinatal care training modules for pre- and in-service training of health-care providers;
- training of health-care professionals working in the area of perinatal care;
- training of perinatal care managers;
- strengthening of the national perinatal care monitoring and evaluation system, etc.

The main purpose of the COMBI Plan is to support and enhance the effectiveness of perinatal care activities and strategies and, thus, to contribute to the further reduction of maternal and perinatal mortality.

1. **Overall goal**

To contribute to the overall goal of the National Perinatal Care Programme of reducing maternal and perinatal mortality in the Republic of Moldova.

2. **Behavioural objective**

To prompt, by the end of 2006, 80 per cent of possibly pregnant women to visit a family doctor at a government health centre immediately (within a week of having missed their period for three weeks) to determine whether they are pregnant or not, and if they are pregnant and have decided to continue the pregnancy, then to adopt the following micro-behaviours:

(a) to begin taking folic acid during the first 12 weeks of pregnancy;

(b) to begin taking iron supplements at least for two months during their pregnancy, and

(c) to take prompt action on any of the six danger signs during their pregnancy.

In order to achieve the desired behavioural changes at the individual, family and community levels, the COMBI Plan makes use of a blend of five communication interventions: administrative mobilization; media; interpersonal communication; community mobilization; and point-of-service promotion - through a variety of channels.

The interpersonal communication is the most important component of the COMBI Plan. Thus, the key messages promoted under this campaign are expected to reach all the villages of the Republic of Moldova.
and all the women who plan a pregnancy or who are already pregnant, via a number of channels, and namely:

2,700 family doctors and 6,000 nurses from all PHC facilities of the country

From January to June 2006, PHC workers will be promoting the campaign messages and distributing communication materials during home visits in their catchment area and during consultations at health centres. Though all families are to be informed, special attention will be given to families with pregnant women and/or families with women who plan a pregnancy.

The health workers will be motivated to convey the campaign messages through an appeal from the Deputy Minister of Health, continuous monitoring of the campaign activities by local authorities and the raion hospital board, and the Thank You Certificates that will be distributed to all health assistants at the end of the campaign. It is worth mentioning that the campaign activities - namely the education on health issues - have already been included in the tasks of the PHC personnel and are monitored by the Ministry of Health and Social Protection and the National Company of Health Insurance.

A range of informative materials for families and pregnant women (leaflets, guidelines for mothers-to-be, posters etc.) will support the health workers’ activities.

All teachers (class masters) and approximately 250,000 students from grades 8 to 12 throughout the country

Students from grades 8 to 12 will have a special hour dedicated to MCH issues. After the course, they will be asked to convey the acquired information to their families, friends and neighbours. In addition, the teachers will be encouraged to conduct educational courses for parents on the topics promoted under this campaign.

Media professionals - from TV, radio and newspapers

The behaviours promoted under the National Communication Campaign will be widely reflected in the mass media through special radio and television programmes and advertisements, repeated broadcast of a documentary on MCH, television and radio advertisements, special reportages etc.

Representatives of local NGOs, counsels and young people, and over 100 Peace Corps volunteers

Priests of approximately 1,200 Moldovan congregations

Up to now, under the interpersonal communication component, over 30 training courses for health and education professionals have been conducted, covering over 3,000 participants. The administrative mobilization process has involved the development of an information note to the Prime Minister and an administrative mobilization plan followed by high-level
advocacy meetings with the Prime Minister’s cabinet in order to seek the involvement of the Prime Minister in the National Communication Campaign. Following the meetings, the Prime Minister issued an appeal to the central and local public authorities, requesting the active participation of line ministries, presidents of raion executive committees as well as mayors in the implementation of the COMBI Plan for Antenatal Care.

40 meetings for all raion councils and mayors’ offices were organized (838 mayors and representatives of local community councils received orientation on the COMBI Plan for Antenatal Care)

The mayors have a special role in the National Communication Campaign. In their capacity of community pillars, they will mobilize all actors at the local level, encouraging them to carry out the campaign activities.

Materials produced for the National Communication Campaign include:

- leaflets for pregnant women, for women who plan a pregnancy, and for their families (1,500,000);
- posters (three posters for each health centre);
- memoranda for PHC workers, teachers, and local public authorities;
- The Future Mother’s Guide for all pregnant women;
- a behavioural documentary on care during pregnancy for the general public;
- two television and two radio call-in shows (planned);
- two press conferences (planned);
- ‘Thank You Certificates’ for doctors (planned);

In order to evaluate the effectiveness of the campaign, a monitoring and evaluation plan has been developed.

The Integrated Management of Childhood Illness (IMCI) initiative

The IMCI initiative is an integrated approach for addressing the main causes of childhood morbidity and mortality and for improving child survival, growth and development through improving case management skills of the health system and PHC workers, as well as family and community practices. (See Box 3.)
BOX 3 Integrated Management of Childhood Illness (IMCI)

Every year, 10.5 million children in developing countries die before reaching their fifth birthday, many during their first year of life. Seven in ten of these deaths are due to acute respiratory infections (mostly pneumonia), diarrhoea, measles, malaria, malnutrition and HIV/AIDS, or a combination of these.

In response to this challenge, WHO and UNICEF have developed the Integrated Management of Childhood Illness (IMCI) initiative as a broad strategy to reduce the main causes of child mortality and morbidity in developing countries. The initiative, which was launched in 1995, encompasses interventions to prevent illness and reduce deaths from the most common childhood illnesses and to promote child health and development.

Source: http://www.afro.who.int/whd2005/imci/
Last updated 7 April 2005.

According to the IMCI concept, changes at the level of the PHC system must be complemented with matching changes in the family and community practice. This is an especially valid approach for the Republic of Moldova, where a study conducted in 2000 revealed that parents did not know when a child's condition was critical enough to seek the help of a doctor. Also parents lacked knowledge on child development issues and failed to understand their role in stimulating the child's cognitive and psychosocial development. This was evidenced in the UNICEF-sponsored ECCD baseline study which indicated that only a few parents talk to, read to, and play with their children. In addition, the perinatal care evaluation (Ministry of Health, 2004) of the pilot project indicated that the weakest components of IMCI were family and community practices. Something needed to be done. Thus the initiative focused on strengthening and enriching family education/counselling, going beyond health, nutrition, and immunization to include a broader understanding of child development. The initiative has the following two primary goals:

1. To change parental behaviour so that parents seek medical help when appropriate and provide adequate care in the home to prevent diseases from reaching a crisis point. Families have to understand that it is their duty to ensure the child's health, and that they have to take on this responsibility. While, for people raised in the West, this may seem a strange objective, it is critical in

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31 Multiple Indicator Cluster Survey 2000, op. cit.
32 Government of Moldova, United Nations Children's Fund, ECCD Baseline Study for Moldova Family Knowledge, Attitudes, and Practices in the area of Early Childhood Care and Development and Developmental Status of Young Children (0-7 years) in Moldova, 2003. According to this study, 20 per cent of parents do not read to their children; 44 per cent of families have no books for children; 12.3 per cent of parents never play with their children; and 8 per cent of families have no toys.
the former Soviet countries where 'parenting' roles used to be taken on by the State.

2. To change doctors' approach to childhood illnesses. Doctors do not only have to address the child's immediate needs, they also have to educate families about how to adequately boost the child's overall development. For some doctors this has required a shift in the role of medical staff and families.

A tool created to complement the basic IMCI approach is the Care for Development (CD) package (see Box 5), which is designed to help families go beyond identifying danger signs related to children's illnesses. Families are provided with guidance on how to support the child's overall development through appropriate care practices and on how to stimulate his intellectual capacity.

**BOX 4  Care for Development (CD)**

The intimate relationship between physical growth and psychological development is particularly evident in the first years of life. This helps explain why prenatal and early childhood nutritional interventions can also have an impact on psychological development. Likewise, early psychosocial stimulation programmes to improve cognition (one aspect of psychological development) may also have effects on physical growth. The most significant fact, though, is that children who benefit from combined nutrition and stimulation programmes perform better than those who receive either type of intervention alone.

Building on the IMCI counselling process and the delivery system developed to implement IMCI is an efficient way to implement CD.

**Key features of IMCI-CD**
- Based on the model of IMCI nutrition counselling
- Improves the knowledge and skills of mothers and others who care for children
- Strengthens active and responsive feeding to improve nutrition and growth
- Introduces activities to improve interaction with children, to stimulate growth and learning, and to promote responsive care for the child's health
- Recommends specific play and communication activities to help children move to the next steps in their development
Counselling families on how to support the development of their children is one of the strategies that are emphasized in the IMCI initiative. A counselling approach focuses on what caregivers can do to respond to the needs of children. It provides guidance on activities to stimulate physical growth and intellectual and social development, and helps families solve problems in providing care for their children.

Another way in which the initiative builds on what exists is creating support materials for both doctors and families that sustain the new approach. Boxes 6 through 8 list the materials that have been produced through this initiative.

**Training materials**

**BOX 5**  **Materials developed to support the (re)training of medical staff**

- Dr. C. Landers’ book *Developmental Paediatrics* translated into Romanian (This book was introduced to the paediatric faculty at the occasion of a workshop where all participants received a copy);

- Antenatal care training module for PHC professionals;

- Guidelines for psychosocial support to pregnant women (2003);

- Early childhood development training module for nurses (2005);

- *Mother’s Agenda* (a booklet on care and development, with a more recent component on child safety (2000, 2003, 2004, 2005));

- Early childhood care and development: family education - the curriculum and training module for pedagogical colleges and universities, as well as for nursing colleges (2004, 2005);


Revision of forms

Forms have been revised in line with desired goals in working with parents and families. As the initiative 'revised' forms that were already being used, there was no need to get approval for new forms - although the revisions were substantial. (See Box 6.)

BOX 6  **Forms revised to facilitate positive child outcomes**

**Form 112 revised - Child’s medical record kept in PHC facility by the family doctor**

The form, revised and enriched with reference growth charts, is structured to reflect the IMCI approach to physical examination, parent education and the planned follow-up. The form also features a matrix of what to look for/talk about during each visit to the family doctor or nurse. Medical staffs have to check the box in the matrix for each topic they talked about, and sign the form.

**Form 113 revised - Pamphlet for parents**

Parents are also given a pamphlet entitled Mother’s Agenda. It includes information on child development and on what family members can do to support the child’s overall development. There is emphasis on:

1. nutrition
2. feeding
3. immunization (immunization chart)
4. Care for Development (communication: talking to the child, reading to the child and playing with the child)
5. danger signs in relation to the identification of illnesses for which medical services should be sought
6. safety
7. hygiene

Materials for parents

BOX 7  **Materials to support adult/child interaction**

A series of 12 booklets for parents have been developed and used in selected regions. The booklets are accompanied by a facilitator’s manual on how to use these with parents. Some of the titles are *Play: An adventure in learning, Fun with books, Keeping your child safe* etc.;

Two booklets for parents have been published: *How to communicate with children* and *How to play with children*, CNETIF, 2004;

*The Guideline for Pregnant Women* (2002, re-printed in 2006);

*Mother’s Agenda*, a booklet on care and development, with a more recent component on child safety (2000, 2003, 2004, 2005);


4. Adopting a comprehensive approach to the change process, working at all levels and engaging all stakeholders:

This involves revising national policies, standards and job descriptions; capacity-building of health providers; communication; setting up supervision, monitoring and evaluation systems.

It is necessary to establish strong vertical and horizontal links and simultaneously work at policy, strategy and operational levels - at policy level to create an enabling environment, at strategy level to institutionalize changes, and at operational level to create shared ownership, to reduce resistance, to share lessons and to develop a critical mass of professionals in order to implement policies and change. Without linkages, policies will not be adopted and local-level initiatives and innovations have no impact on informing central policies and cannot diffuse horizontally to other regions.33

To embed new activities into a system requires that actions be taken at all levels. The initiative has been supportive of the development of new policies, such as the National Insurance Plan/Basic Benefit Package, standards, protocols, and regulations (Programul Unic de Asigurari in Sanatate). The implementation, in 2004, by the Government of Moldova, of the Basic Benefit Package of health services previously developed and piloted with UNICEF’s technical support, ensured free access of pregnant women and children to essential MCH services - antenatal care, essential obstetrical and neonatal care, child growth and development monitoring, immunization, IMCI, including free provision of essential drugs.34

As noted earlier, one of the strategies within the overall health reform has to do with changing the curriculum in academic institutions offering pre- and in-service medical training, including the State Medical and Pharmaceutical University, the Medical College (that trains nurses) and the School of Continuous Medical Education for Nurses. This was done through integrating the family-focused approach into training. And it involved the re-training of current personnel within PHC facilities. The inclusion of family-focused curriculum into pre-service training of medical staff has had significant impact on the success of the initiative, and is one of its most innovative aspects.

The story of the strategy for implementing the IMCI-CD initiative (IMCI-Care for Development) speaks to this innovation. When IMCI was to be implemented within the PHC system, choices had to be made about who would get the initial training. The choices were strategic

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33 Atun, op. cit., p. 113.
in terms of the people who ultimately became involved in the initiative.

In 1998, the chief-paediatrician from the Ministry of Health attended an initial introduction to and training in IMCI at a workshop in Indonesia. Subsequently, the Republic of Moldova decided to adopt IMCI and three key people went for training. This included a representative of the Ministry of Health (still part of the Ministry and very much involved in IMCI training), a member of the Medical University (still at the University and involved in IMCI training) and an individual from the first raion (geopolitical district) where the approach was to be pilot tested. This combination worked - there was representation from different levels and all those chosen were high enough in their respective organizations to be able to initiate changes - as long as they remained linked to one another. And they did.

Once these three people were trained, an extensive training of trainers scheme was put into place that resulted in a very strong team of 40 trainers who work within the Medical University (about two thirds of the trainers), the Medical College and the School of Continuous Medical Education for Nurses - the key institutions responsible for both pre- and in-service training of medical professionals within the country. A few trainers come from raions where IMCI was first introduced. It was a good move to begin with university staff as they are very influential in terms of pre-service training. Their WHO/UNICEF certification in IMCI gave them additional status, even though they are already a high-ranked group.

While maintaining their previous positions, these trainers are called on by the Ministry of Health to provide training in IMCI throughout the country. Each training lasts approximately two weeks (12 days for the basic IMCI training, out of which two days are allocated to CD). In addition, a separate four-day workshop on CD was developed for nurses.

By the end of 2006, it is estimated that 60 per cent of the PHC providers in all but two autonomous regions will have been trained in IMCI - a critical mass according to WHO. CD is increasingly being spread through in-service
training of medical staff. However, there will continue to be a need for refresher training, and supervision and monitoring in IMCI implementation.

What about other stakeholders, like families and the general public? They are also critical actors in maintaining and sustaining the initiative. As a result of IMCI training and other reforms, PHC centres are shifting their behaviour to be more supportive of parents. The challenge is to find ways to support parents as they modify their behaviour. As indicated in the Multiple Indicator Cluster Survey of 2000, one in four parents cannot name at least two danger signs requiring immediate medical help. Clearly considerable work needs to be done to reinforce understanding and change behaviour.

In order to carry out their more proactive role, parents need the support of others in their community. A strategy known as Communication for Behavioural Impact (COMBI) at the family and community levels has helped the wider public to understand how to support families’ and young children’s well-being. For this purpose, COMBI complements activities promoted through the health-care sector by involving other actors at the national level (from the education sector and the media) and at the community level (local authorities, educators and religious leaders). In 2005, national campaigns through the COMBI Plan were underway. (See Box 8 for a summary of the COMBI strategy for the period March 2005 to February 2006.)

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**BOX 8** Summary of communication for behaviour impact interventions for ECD (COMBI ECD)

1. **Overall goal**
   To contribute to improved cognitive and socio-emotional development of children by implementing a communication and social mobilization programme that will prompt children’s caregivers to adopt early stimulation practices.

2. **Behavioural objective**
   To increase promoted behaviours: hugging from 48 per cent to 90 per cent, talking from 80 per cent to 90 per cent, playing from 45 per cent to 80 per cent, reading from 37 per cent to 60 per cent.

3. **Communication strategies**
   Administrative mobilization, public advocacy and public relations used to put the particular behaviours on the public and administrative/programme management agenda through meetings/discussions with various instances of the government/community leaders; through memos to all staff in the ministries of

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35 Multiple Indicator Cluster Survey 2000, op. cit.
education and health; through mobilization of regional/local public authorities; through the use of celebrity spokespersons. The administrative mobilization process involved the development of an information note to the Prime Minister and an administrative mobilization plan followed by high-level advocacy meetings with the Prime Minister's cabinet in order to seek the involvement of the Prime Minister in the National Communication Campaign. Following the meetings, the Prime Minister issued an appeal to the central and local public authorities, requesting the active participation of line ministries, presidents of raion executive committees as well as mayors in the implementation of the COMBI ECD Plan.

A special event with extensive media coverage was organized in collaboration with the private sector. As a result, over 6,000 books were collected and distributed to 10 villages - five books per family with children (1,000-1,200 families).

40 meetings for all raion councils and mayors' offices were organized. As a result, 838 mayors and representatives of local community councils received orientation on the COMBI ECD Plan. The mayors have a special role in the National Communication Campaign. In their capacity of community pillars, they will mobilize all actors at the local level (teachers, local NGOs, PHC workers, religious leaders), encouraging them to carry out the campaign activities.

Community mobilization: community meetings, distribution of materials, point-of-service promotion, monitoring and evaluation.

The interpersonal communication is the most important component of the COMBI ECD Plan. Thus, the key messages promoted under this campaign are expected to reach all villages and all families with children less than five years of age.

PHC workers (2,700 family doctors and 6,000 nurses):

Home visits as part of child growth and development monitoring

Support to parents during consultations at health centres

Organizing parenting classes (linked to media)

Link to IMCI-CD, ECD training of nurses, National MCHC Programme (family and community practices)

Pre-school teachers (5,000 teachers from rural areas):

Home visits of families with young children (two to three years of age)
In connection with promoting greater public awareness of the importance of the first three years of life, in 2005, a one- or two-day course was offered in each raion to which key people within the raion were invited (mayors, council members, teachers, and other community counsels and young people, and over 100 Peace Corps volunteers; priests of approximately 1,200 Moldovan congregations.

Media/press activities: Press conferences/releases, TV/radio spots, TV/radio talk/call-in shows, radio fillers, feature articles (monthly);

Out-door promotion: Street banners, posters;

Materials to be produced: Leaflets for parents, leaflets for schoolchildren; Guide for young parents (produced and distributed);

As of now, under the interpersonal communication component, over 30 training courses for health and education professionals have been conducted covering more than 3,000 participants; representatives of local NGOs,
5. Involving key people in the initiative -

decision makers and technical staff at the national level have participated since the beginning.

"It takes a team focusing on common goals to achieve success."

Director, Maternal and Child Health, Ministry of Health and Social Protection

Stories always have characters. And this story is no exception to that rule. One of the keys to making this initiative work is the people who have been involved. Regardless of multiple changes in the system and at high levels within government, there has been a solid core of individuals, from different agencies and organizations, who have been passionately involved in moving this initiative forward. These individuals come from different settings - from the Ministry of Health, from the State Medical University, and still others working with UNICEF, or with Step by Step. Each has a different motivation behind his/her involvement. Each of them is well respected, trusted and, in his/her own way, willing to push the system. They are high enough in their own organization to make things happen, and their organizations have the necessary authority to undertake changes.

From UNICEF’s point of view, the key in terms of people’s involvement has been:
(a) recognizing, identifying and selecting 'champions' to promote the initiatives, i.e., people who can make a difference;
(b) having a mix of decision makers and technical people; (c) motivating people by providing for incentives - not necessarily monetary, e.g., sending them to international conferences and providing them with speaking opportunities to present the country’s experience; (d) giving those involved credit for the success of the initiative. Not incidentally, the UNICEF Representative has been in place for five years. She has participated in the initiative from the beginning and has provided support to her staff throughout the process.

It is worth mentioning that all the core individuals who have been involved in the initiative were actors of change in their own workplace before they came together to support the development of this initiative.

A snapshot of a few key individuals

As early as 1993, a doctor of the faculty of the State Medical University began to question the Russian perspective on what constituted pathology. She began to explore what the World Health Organization (WHO) had to say about health and understood the importance of the Alma-Ata Declaration and the broad definition of health. The more she explored, the more she realized the importance of the environment in influencing child outcomes and looked for ways to integrate a more holistic perspective on children’s growth and development into the preparation of health professionals.
Another individual who was involved from early in the initiative is currently responsible for the operation of a 200-bed orphanage. Watching children under her care, she saw that giving the children appropriate food and keeping them warm and safe was important. But even when these things happened, children did not thrive. She observed how these young children did develop when they were provided with attention and care. She concluded that a single element was not sufficient to support a child’s development; all the pieces needed to be in place. She was also concerned because many of the children in the orphanage were not true orphans. Many were social orphans, i.e., children whose parents feel they cannot provide for them at home and therefore send them to the orphanage to be raised. She believed that these parents would be motivated to keep their children at home if they understood more about the importance of the parent-child relationship and could witness its impact on the child’s development. She could see the value of educating parents on child development issues, and that the logical place to start this education was the parents’ first contact with the medical system.

During the reform of the health-care system, the lady responsible for MCH issues in the Ministry was exposed to alternative ways of setting up the health system and to the value of investing in preventative care. She was a key person in the introduction of IMCI to the country. In fact, she was the first to be trained in IMCI.

None of these people would describe themselves as the ‘leaders’ of the initiative. In fact, all are quite humble about their involvement, stating that what they are doing is simply facilitating the process that has been set in motion. They understand the importance of their role, but see it in relation to the role many others have played to keep the initiative evolving.
The Director of MCH describes partnerships as critical for such a large-scale initiative. She understands that different partners have different roles to play. For example, the role of the Ministry of Health and Social Protection is to coordinate in a general way and, through the development of policies and strategies, to provide support to universities, colleges and PHC centres, all of which are part of the Ministry, as they are the ones who are conducting training and monitoring activities. And the PHC centres have the responsibility for implementation. Partnerships are forged at each step of the process.

The medical staffs, who have already been trained and who have been working in a more collaborative way with parents, see how the initiative has changed their partnership with families:

- “It’s not one-way. We used to tell parents what to do and then we asked if there were any questions. We didn’t really expect them to ask any questions, and they would say ‘no’ and that was the end of the conversation. We did not take the time to find out if they really understood what they were being told to do. Now we encourage mothers to ask questions. We ask parents questions to be sure they have understood what we are telling them.”

- “I’m not afraid of children anymore.”

- “Now we are clearer in terms of what we are looking for.”

UNICEF (with funding from a variety of sources), the Ministry of Health and Social Protection, WHO and the World Bank have been at the core of the partnerships forged through this initiative. But there have been others involved in substantive ways as well.

Who are some of these partners? In the Republic of Moldova there are very few NGOs working in the social sector, and even fewer who focus on young children and their families. Those few have been supportive in this effort. For example, Step by Step has been an important and ongoing partner in developing materials for families. Step by Step has been involved in the translation into Romanian of Dr. C. Landers’ book *Developmental Paediatrics* (this book was introduced to the paediatric faculty at the occasion of a workshop where all participants received a copy); in writing and producing a series of 12 booklets for parents (accompanied by a facilitator’s manual on how to use the booklets with parents); in creating alternative supports to be used in community-based resource centres for parents (such as play groups for children 0-3 years old, and weekly programmes for children 3-5 years old); and in working with UNICEF in the development and
implementation of the COMBI strategy. Radda Barnen financed the development of one of the publications for families; Associazione Italiana Amici dei Bambini (AiBi), an Italian NGO, supported the Strengthening Parenting Practices in Families with Young Children Project; and the National Centre for Early Childhood Development has produced booklets for families - one on play and the other on communication. They also conducted the ECCD baseline study for UNICEF.

Needless to say, UNICEF provided the underpinnings for the initiative. (See Box 9 for a description of the role that UNICEF had played and continues to play.)

**BOX 9  UNICEF’s role**

“Always be looking for the next step - never think of the effort as finished. Maintain flexibility along the way.”

UNICEF staff, 2005

UNICEF has been a key partner in the effort. Its role is: (a) to support the generation of evidence (studies, assessments) in support of family education for ECD and to use data for advocacy and programming purposes; (b) to bring international experience and models from which the Republic of Moldova can learn and develop its own model; (c) to facilitate the building of partnerships and to bring together various inputs, thus leading to strong intersectoral cooperation and to a more holistic approach to the child; and (d) to engage in fund-raising and fund-leveraging to expand the initiative geographically.

UNICEF is able to play a lead role because it is well-known and respected, not only internationally, but at the national level. UNICEF has provided the underpinnings for the initiative in terms of its clear and consistent vision of and its belief in the initiative, which keeps the process moving. There appears to be a consensus within the UNICEF office on the connection between the activities carried out and the objectives to which the initiative is heading. As the activities planned involve different interests within the office at different times, it is hard to tell when one project begins and when it ends. This is part of remaining flexible.

UNICEF is able to bring together human and financial resources in such a way that those involved feel ownership for activities. It has the capacity to provide incentives that keep people involved - for example, sending staff members to regional and international conferences so that they can share what is happening in the country and learn from others.

UNICEF has provided strong support to the project thanks to the fact that it has had a consistent approach and has allowed the initiative to evolve (through carefully planned stages that have been developed along the way as a result of feedback and monitoring).

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36 ECCD Baseline Study for Moldova Family Knowledge, Attitudes, and Practices in the area of Early Childhood Care and Development and Developmental Status of Young Children (0-7 years) in Moldova, op. cit.
7. Creating monitoring and evaluation systems
that people can use themselves so that they are able to watch their own progress.

"Listen to what people say - hold regular feedback and problem-solving sessions."
UNICEF team (Moldova) 2005

A variety of surveys, reviews and studies have been conducted that will help track the progress of the initiative. In 2000, UNICEF conducted a Multiple Indicator Cluster Survey (MICS), designed to provide critical information about the health and well-being of people in the Republic of Moldova. Two years later, in 2003, UNICEF conducted a child-rearing study that yielded important information about infant and young child feeding practices and some of the behaviours that need to be addressed through ongoing work with families.

As a result of partnerships, it is possible for the initiative to be advised by studies, reviews and research conducted by any of the partners involved. For example, the Republic of Moldova was included as one of the case studies in a Review of Experience of Family Medicine in Europe and Central Asia, that aimed to show the ways in which different countries in the region were defining and implementing family medicine. Atun’s review provided a different perspective on the initiative and put Moldova’s efforts in the context of what other countries are doing. In his review he notes that, despite its resource-constrained environment, the Republic of Moldova has achieved significant milestones with PHC reforms. This finding was reflected in the Common Country Assessment 2005:

"Infant and under-five mortality indicators have improved since 2001, following a period of stagnation during the 1990s. This trend can be explained by improved access to, and quality of, essential MCH services...The introduction of the Basic Benefit Package of Health Services in 2003 and Compulsory Health Insurance in 2004 facilitated the free-of-charge access for pregnant women and children to health services and essential drugs. Immunization rates exceed 95 per cent for the main antigens; coverage with antenatal care and the proportion of births attended by qualified staff is almost universal. In addition, large-scale implementation of training activities for health workers coupled with recent equipping of PHC facilities contributed to improved quality of care."

As important as these documents are in monitoring various aspects of the initiative, and placing its progress within a national or even international framework, they do not specify the extent to which the doctor/parent constrained environment, the Republic of Moldova has achieved significant milestones with PHC reforms. This finding was reflected in the Common Country Assessment 2005:

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37 Multiple Indicator Cluster Survey 2000, op. cit.
38 ECCD baseline study, op. cit.
39 Atun, op. cit.
relationship has changed and the extent to which families have internalized the information they receive through a dialogue. Nonetheless, Atun notes that there is evidence from his recent research “that the new model is welcomed by the users and health professionals, both of whom identify many benefits of this approach. What is a highlight for some is the ‘user-centeredness of the model’ - parents have a choice of doctor and are encouraged to ask questions”.41

Clearly, throughout the process, the advice to ‘listen to what people say - have regular feedback and problem-solving sessions’ has been followed. This has happened, as new activities have been created along the way that has moved the initiative forward. There are plans to continue to build the initiative, based on an ongoing assessment of what has been accomplished, what needs to be strengthened, and openness to new avenues to be explored.

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41 Atun, op. cit., p. 7.
THE FUTURE
The initiative has had a strong beginning. Data from various reviews and surveys, as well as anecdotal evidence, would suggest that the Republic of Moldova is on the right track in promoting PHC on such a large scale, and that there are already positive outcomes for medical staff and families.

At this point, the story could continue along several different paths, depending on what happens within the environment that surrounds the initiative. The story will be influenced by ongoing changes within the health-care reform, and the impact of these changes on the lives of all the people involved - from politicians and those who deliver health care to families. National political, economic and social developments will also influence the course of the initiative, as will actions at the international level.

**Challenges related to ongoing changes in the health system**

While not being able to foresee what all the possible influences on the story might be, there are some elements in the immediate environment that may well have a bearing on how it develops. For example, the story will certainly be influenced by decisions related to the funding of health care. If funding decreases, which is likely if the economic situation within the country does not change, it is hard to know whether the current share between preventative and curative care will be preserved. At the present time, the chief doctor from the raion hospital is responsible for the total health budget of the raion. These administrators influence the allocation of health funds, although they need to follow national guidelines. It is reported that PHC receives currently about 28 per cent of the budget across the raions (in the Soviet era only 8 per cent went to preventative care), but this could decrease (or increase) over time, depending on the level of national funding for health care. Thus, the funding (and the policy related to that funding) could either take the initiative off course, or strengthen it. But regardless of what happens within the structure of the health-care reform, the human factor is paramount.

**The challenge of maintaining the commitment of key people**

We have seen that the vision and commitment of key people have been at the core of the initiative. We have seen the value and the importance of high-level individuals who have remained consistent and persistent - in UNICEF, in the government and in key NGOs. This could change. It is hoped that others would continue the effort, but it is not clear what would happen if some of these people moved on to other endeavours.

**The challenge of shifting roles within PHC**

We are also seeing the potential for shifts in personnel within the PHC system. There is continuing debate on exactly how each PHC clinic should be staffed. If this shifts over time there will be repercussions in the ways services are offered in the PHC clinics. (See Box 10.)
While there are debates about how the PHC clinics should be staffed (which has implications for training and supervision), a critical issue will be the morale of medical staff within the clinics. The initiative seems to be full of elements that allow people to develop and thrive, while at the same time there are demoralizing aspects of the healthcare system in general that influence people's commitment to changes.

As was noted earlier, there has been a rapid rate of migration of health personnel from rural to urban areas or abroad, thus leaving rural areas underserved. With medical personnel continuing to leave the rural areas, there is a risk of increase in the MMR, IMR and U5MR, despite the spread of the IMCI-CD approach. A key question is: Can the healthcare system create incentives for medical personnel to return to rural areas? This will need to happen if rural areas are to benefit from PHC.

In addition to not wanting to work in rural areas, many doctors are tempted to migrate to another country in search of better opportunities. Morale is low among doctors.

BOX 10  **Ongoing debates about staffing**

The question is: should midwives be reinstated as specialized nurses within the PHC system? Under the Soviet system there were midwives, who were nurses with special training. They played an important role in preventing maternal and infant mortality. As a part of the shift to the new PHC system, the 'midwife' specialization was eliminated, with all nurses being accorded equal status (previously midwives were paid more than other nurses), although unofficially they continue to play the role of midwives. There is now some pressure to reinstate them.

It is significant that, at the time of this decree, the Minister was an obstetrician/gynaecologist. Since the elimination of midwives, the Head of MCH has been arguing that this specialization is still needed. She has been working to reinstate midwives and has made this argument to a series of Ministers of Health. The following Minister of Health was approached to reinstate the midwives, but his answer was: If an obstetrician/gynaecologist did not see the need for a midwife, who was he to say there should be one. Midwives were not reinstated under his watch. A third Minister of Health was approached. In this instance, his advisors disagreed with the idea of reinstating midwives, so it did not happen. Most recently, the Ministry of Health and the Ministry of Social Protection were combined. The current Minister of Health was the Minister of Social Protection. He is now being approached on the issue of specialization of nurses. While the advisors still say no, the lobbying continues.

Note: While putting together the case study, yet another minister has been appointed. He is the Rector of the Medical University.
A doctor beginning his/her career earns about USD 60/month. The fact that doctors who have developed specializations are now required to become family doctors within the PHC clinics and can no longer practice their specialization, coupled with a lack of incentives for them to receive additional training, results in low morale among staff within the PHC centres. If doctors are to be retained, there need to be incentives to encourage them to continue.

While morale may be low as a result of low pay and lack of incentives, the initiative has nonetheless had a positive influence. One of the informal indicators of positive progress is the fact that many doctors and nurses have found greater job satisfaction in their new roles. Some of this has to do with a better understanding of children’s growth and development, leading them to no longer being afraid of children. Another positive element has been seeing parents as people and working with them as partners rather than being distant from them.

But, here is another twist and turn in the story. There is a fear that the role of doctors and nurses has changed too much. As the dialogue is opened up between doctors/nurses and families, medical staff may be getting more than they bargained for (and certainly more than they are trained to handle). In general, the counselling and communication skills of medical staff need to be developed further. Their limited counselling skills hinder the most basic health promotion and disease prevention activities.

An emerging issue is that medical staffs at PHC centres are the first ‘officials’ that many families meet. One of the consequences of being the first point of contact when families are under stress is that, at least informally, staff within the PHC clinic feel that they are being called on to be therapists and social workers, since there is no place else that families can turn to for this service. This is not a role for which they have been trained, nor should health providers be the ones to provide comprehensive assistance. They must be backed up by appropriate services to which health providers can direct the families facing problems.

**Challenges related to working with parents**

As noted in UNICEF’s *Annual Report 2004*, parent education does not fall under the direct responsibility of any sector. While it is an activity that takes place within health, education, and social protection, it is not a priority within any of these ministries. In addition, the job descriptions for service providers within the health, education and social protection sectors do not explicitly spell out their responsibility vis-à-vis parent education, nor is there earmarked financing at the system level to carry out parent education.

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A bigger challenge, however, is that the education sector, which has primary responsibility for children's cognitive and intellectual development, does not have access to families until the child reaches school age, 'thus loosing the opportunity to intervene at the most appropriate time. For example, parents are contacted by the education system when the child is over three years of age, while playing and reading to a child should start during the first months of life'.

One of the most interesting elements that may well influence the progress of the initiative is the culture around parenting within the society. In Soviet times, 'parenting' was taken on by the State, which provided crèches and ongoing childcare where children were attended to for the majority of the day so that both parents could work. Children were kept safe, clean and fed, and their health was monitored within these centres. Parents had little or no responsibility for the basic care of the child. They were not given any information about child development and they had no understanding of the impact of interacting with the child in ways that supported its development.

In essence, the State was responsible for the child. With little or no responsibility for the child, parents had no reason to talk with other parents about their children - to share common concerns, to learn how other parents were handling situations, to celebrate milestones. As a result, there is no history of parents talking to other parents about issues related to raising children. The expectation is that knowledge comes through a hierarchal structure; this structure is still in place, despite the attempt to open up a dialogue between medical staff and parents. Even though under the IMCI-CD approach parents are encouraged to ask questions, they only ask questions to doctors and nurses, not to other parents. Creating ways for parents to support other parents would certainly lead to changes in parental knowledge and behaviour.

In PHC clinics, parents are asked to stay in a room known as the well-child room for about an hour after the child is immunized to be sure there is no reaction. These rooms are pleasantly arranged with a clean and pressed table cloth covering the table. There are some reading materials for the mother. There are copies of the booklets for parents produced by Step by Step, as well as the various books for families produced within this initiative. On the walls, there are pictures on breastfeeding produced and distributed by UNICEF a few years ago. These rooms provide a space within which parent groups could meet under the auspices of the health staff, or in peer groups where informal conversations could take place.

Ibid.
GOING BEYOND THE 'HEALTH ONLY' APPROACH USING CONTACTS BETWEEN FAMILIES AND THE PRIMARY HEALTH CARE SYSTEM TO PROMOTE THE ALL-ROUND DEVELOPMENT OF YOUNG CHILDREN

SAREA IODATĂ. O ALEGERE SĂNĂTOASĂ.

UNICEF

GOING BEYOND THE 'HEALTH ONLY' APPROACH USING CONTACTS BETWEEN FAMILIES AND THE PRIMARY HEALTH CARE SYSTEM TO PROMOTE THE ALL-ROUND DEVELOPMENT OF YOUNG CHILDREN
In summary, this story is not only about ultimate outcomes, although these are important. This story is about setting in motion processes that are anticipated to lead to healthy outcomes for mothers and children. The telling of the story has allowed us to identify what to look for in the process of an initiative. Rather than relying solely on long-term outcomes to declare the value of activities, the story challenges us to identify and document the indicators of progress along the way, such as the kinds of policies that are in place and the activities that are likely to influence policy changes, the extent to which systems are open to change, the availability of tools that can be used to build on what already exists within a system, the level of commitment to the effort of key decision makers, the extent to which people are being trained in a way that enhances their knowledge, attitudes and behaviours, the extent to which meaningful partnerships have been created that are based on the strengths of each organization/agency involved, the presence of a monitoring and evaluation system that provides periodic feedback on progress, and the extent to which this feedback is used to make changes in current activities and/or to create new activities.

So, is the Moldova initiative a 'model' for other countries in the region? Yes and No. Countries within the CIS have taken different paths since independence. Each of them has lessons to learn. For example, while reforms in the health-care system were pioneered in the Republic of Moldova, they have not necessarily been achieved earlier than in other CIS countries. Nonetheless, Moldova is seen as a country where innovations can be introduced and where they have a high likelihood of being implemented. For example, the Republic of Moldova was recently chosen by WHO as a country where the Safe Motherhood approach is being piloted.

The country has several characteristics in favour of its being able to move ahead nationally in relation to the implementation of innovations. First, it is a small country where it is possible to envision going to scale. Second, it has a responsive and responsible Ministry of Health willing to engage in reforms. Third, there is a cross-sector alliance for early childhood concerns.

According to the UNICEF Annual Report, this cross-sector alliance was “strengthened during the National ECCD Conference where over 100 policy and decision makers at the national and raion level, as well as professionals working in health, education, and child protection, gained a better understanding of the main problems facing young children, and of ECD concepts. The National ECD Alliance was consolidated during the Conference Resolution and distributed to the Government, the Parliament, and donors.”

One sign that the Republic of Moldova does have something to offer is that there are people within the country whose knowledge, 

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Ibid.
skills and experience are valued by others in the region. For example, WHO uses Moldovan experts to conduct training on immunization and IMCI in other countries. Similarly, Moldovan perinatal care experts are known and valued in the region, and the National Perinatal Care Centre has been designated as WHO Collaborative Centre.

Clearly, the Republic of Moldova is accumulating experience in the introduction of psychosocial support for infants and young children through the health sector, a unique accomplishment in the early childhood field. This experience is invaluable and of great interest to those who are struggling to work more closely with the health sector in order to reach families with young children and to provide them with the appropriate knowledge and support that will lead to better mother and child outcomes.
Bibliography


Evans, J. L., *Working with Parents to Support Children from Birth to Three Years of Age*, lead article in the *Coordinators’ Notebook*, No. 24, 1999.


*Moldova Demographic and Health Survey*, 2005.


