



WE CAN
END POVERTY
2015 MILLENNIUM
DEVELOPMENT
GOALS

The UN High-Level Plenary Meeting on
the Millennium Development Goals

MDGs Success Stories from Asia and the Pacific

Accelerating Achievement of the MDGs

ENDPOVERTY
2015
millennium campaign

A stylized white outline of a globe is centered in the background. Several white arrows of varying sizes and directions are overlaid on the globe, pointing in various directions, suggesting movement and progress. A prominent red rounded rectangle is positioned in the center, containing the title and subtitle text.

MDGs Success Stories from Asia and the Pacific

Accelerating Achievement of the MDGs



CONTENTS

Foreword and Acknowledgements	iv
--	-----------

Key Highlights of the Case Studies	v
---	----------

Citizens' Tracking and Monitoring of the MDGs 1

Citizens' Tracking of Social Security Schemes in Orissa, India.	2
Citizens' Monitoring of Local Government to Eradicate Poverty.	4
Monitoring of Health Projects in the Philippines	6
Citizens' Participation in Constitution Making	8

Targeting the Poor and the Marginalised 11

Reaching the Ultra Poor through Innovative Financial Services	12
Grow to Feed – Improving Food Security	14
Improving Access of Rural Women for Safe Delivery	16
Improving the Poor's Access to Reproductive and Maternal Health Services	18
Paediatric AIDS Community-based Care and Support in India	20
Including the Excluded: Life-Saving Vitamin A Supplements for Children in Bihar, India	22
Improved Sanitation in Cambodia	24
Free Bus Fare for Education	26

Institutional Support for the MDGs 29

Pro-Poor Planning, Budgeting and Monitoring – P3BM	30
National Response to HIV/AIDS.	32
The Gender and Development Code of Ifugao as a Tool for MDG progress	34

FOREWORD AND ACKNOWLEDGEMENTS

With 5 years remaining until 2015, we are at the critical junction for achievement of the Millennium Development Goals (MDGs). Marking the 10th anniversary of the Millennium Declaration, heads of states will once again gather at the High Level Plenary Meeting on the MDGs to be held in New York in September 2010, to review the progress so far and develop a concrete plan of action for the next five years. Urgently needed now is that we take stock of our achievements as well as challenges in the past so that the lessons learned will lead to accelerated progress towards achievement of the MDGs.

This publication is a compilation of success stories and good practices from Asia and the Pacific, collected by the United Nations Millennium Campaign as its contribution to the MDG Review process. It presents fifteen short case studies which feature innovative and successful initiatives from the region which have made tangible impact on the MDGs. Each case study attempts to answer the following three questions – (i) what has worked?; (ii) why?; and (iii) how can it be scaled up or replicated effectively?

The case studies in this publication were selected from over 80 cases submitted by our partners – UN, government, and civil society organizations – in response to a call for success stories. The final selection and analysis was done by the Millennium Campaign's Asia and the Pacific Regional Office, by working closely with its national coordinators and their local partners. Particular attention was given to bringing out innovative approaches to effectively addressing the issues of inequality and marginalization, which is a significant challenge in our region, despite the overall considerable progress in attaining many of the MDGs. Further, promoting accountability and transparency by supporting citizens' participation in the development planning, budgeting, and monitoring is another issue which the Millennium Campaign strongly advocates as a key determinant of accelerated achievement of the MDGs by 2015.

We hope that these case studies will serve as a powerful evidence that we have achieved so much and made visible difference in so many people's lives which will lead to a renewed conviction that such achievements can be expanded even further with the right amount of resources and political commitment to reach the remaining unreached.

We would like to express our gratitude for the valuable contributions made by many people involved in the process of collecting, analyzing, and compiling the case studies from different countries. Contributions were made from government institutions, civil society organizations, UN agencies and other development organizations. This publication would not have been possible without such support from all our partner organizations.

Special thanks to the Asia and the Pacific team of the UN Millennium Campaign. Nanako Tsukahara led the conceptualization, collection process, and synthesis, while working closely with Shafqat Munir Ahmad on the final compilation and editing. Kallyaphorn Jaruphand and Uraikul Jetsongkul provided valuable support in collection and compilation. The national processes of collecting and refining submissions were made possible by the Millennium Campaign's national coordinators and their team – Monisha Biswas (Bangladesh), Mary Sok (Cambodia), Agnes Ali (Fiji), Mandira Moddie (India), Wilson Siahaan (Indonesia), Seema Rajouria (Nepal), Eileen Kolma (Papua New Guinea), and Dulce Saret and Rhea Alba (Philippines).



Minar Pimple

*Regional Director, Asia and the Pacific
United Nations Millennium Campaign*

KEY HIGHLIGHTS OF THE CASE STUDIES

The case studies are presented in three sections based on the main characteristics of these featured initiatives – (i) Citizens' Tracking and Monitoring of the MDGs; (ii) Targeting the Poor and the marginalised; and (iii) Institutional Support for the MDGs.

In our view, these themes are among the key factors for ensuring *accelerated achievement of the Millennium Development Goals in an equitable manner*. With only five years remaining until 2015, the current discussions in the development community tend to focus on how to speed up the rates of progress which the countries have been experiencing by learning from the past successes and challenges. This publication also aims to contribute to these discussions, but with an added emphasis on citizens' involvement in the processes of achieving the MDGs as well as prioritizing MDG achievement for the poorest and most marginalised whom many development interventions find hard to reach.

(I) Citizens' Tracking and Monitoring of the MDGs

Many countries have already put in place appropriate policies and strategies which target poverty reduction and achievement of the MDGs, and on many occasions expressed and re-affirmed their political commitment to meeting the Goals by 2015. At the same time, there is a growing realization that the real difficulties in achieving the MDGs are in translating those policies and strategies into effective service delivery on the ground, and that significant improvements need to be made in the area of implementation rather than policy formulation. There is a need for more accountability and transparency in government service delivery. Given the urgency to meet the MDGs in an inclusive manner for all segments of population, it is crucial that the citizens themselves take active part in assessing, tracking and monitoring MDG related essential services at the local level.

In the State of Orissa in **India**, rural poor households are participating in real-time tracking of the delivery of social protection entitlements by using a mobile phone-based monitoring system. In **Bangladesh** and **the Philippines**, participatory citizens' monitoring initiatives have also contributed to effective local planning of development projects, better use of funds for MDG priority areas that matter to the community, and increasing transparency and accountability. These examples show that if combined with government ownership and adequate capacity development and empowerment support, communities can be highly effective agents in the development planning and budgeting as well as tracking and monitoring of their own MDG entitlements. **Nepal's** case is a unique example of crafting a new constitution which is based on demands and priorities of every segment of the population through carefully designed bottom-up approaches to participatory and inclusive consultation processes.

(II) Targeting the Poor and the Marginalised

One of the persistent criticisms of the MDGs is the fact that the achievement is shown at the aggregated level hence it often masks existing disparities within a country. At this final stretch of the MDGs timeframe, conscious efforts must be made for reaching out to the poorest and the most marginalised and delivering their MDG entitlements first. Otherwise, there is a high risk of focusing on what is easily achievable at the expense of further neglecting these voiceless people. Development experiences indicate that it is difficult to effectively target the poor and the marginalised and improve their socio-economic status in a sustainable manner. The eight cases included in this publication offer unique lessons and innovative approaches in this regard that could be useful for development practitioners in other countries.

Microfinance for Ultra Poor in **Bangladesh**, which quickly reached 1 million ultra poor households and improved their livelihood with the right targeting and flexible credit conditionality, has successfully demonstrated that the ultra poor are credit worthy and can attain meaningful level of self-sufficiency, contrary to the common belief. The two cases related to improving access of rural poor women to reproductive and maternal health services – in **India** and **Cambodia** – provide good practices on bringing the essential services closer to the poor and the marginalised not only through financial support but also by establishing emergency transport system and sub-health centers for 24 x 7 delivery services in remote villages. In particular, it is noteworthy that the Indian scheme was based on the identification of remaining pockets of low institutional delivery which existed even after introduction of financial incentives. Another example of financial incentive mechanisms for enhancing the poor's access to basic services is the free bus fare for education scheme introduced by the **Fiji** government.

In **India**, a combination of government commitment, effective targeting of the excluded children, and cost-effective strategies has enabled the State Government of Bihar's vitamin A supplementation programme to reach 94 percent of children in the target age group. Another successful initiative targeting the excluded children is the Paediatric AIDS Community Based Care and Support Programme implemented by a civil society organization in the Indian State of Andhra Pradesh, which helped reduce mortality among children living with HIV from 2.08% to 0.97% in three years. Children are imparted education on self care and treatment adherence through innovative board games and culturally acceptable means of communications.

Cambodia's Community –Led Total Sanitation initiative is a community-level rapid solution to improving sanitation and health conditions in rural villages by introducing indigenous and low-cost methods of building latrines by community people themselves. The System of Rice Intensification also offers a successful model of low-cost and environmentally sustainable rice farming which has improved agricultural productivity and livelihood of poor farmers in rural Cambodia. Both cases offer insights into how to bring visible improvements for the rural poor with their ownership and participation.

(III) Institutional Support for the MDGs

The government is the primary duty bearer to deliver the MDG related services in order to achieve the Goals. It is critical that the government plays a leading role in implementing the national level development strategies, plans, and policies as well as in localizing the MDGs into sub-national plans backed up by appropriate budget allocations.

Local governments, parliamentarians and NGOs in **Indonesia** have been equipped with easy-to-use and practical tools for MDG-based pro-poor planning, budgeting and monitoring. The success of the initiative is attributed to the strong political will and commitment by the local leadership and the interventions designed purely based on the local needs and local planning and budgeting cycle. **Cambodia** is one of the few least developed countries that are on track to meet the MDG 6 on HIV/AIDS, by embarking on a national comprehensive programme to scale up HIV prevention, treatment, care and support for people living with HIV. The remarkable results have been achieved by the strong political commitment and leadership, collaboration among relevant national programmes, together with substantive external financial support and a vibrant civil society response. In Province of Ifugao in **the Philippines**, the first-ever provincial Gender and Development Code was passed which promotes gender-responsive policies, ensures integration of gender concerns in public programmes and projects, and includes provisions for mainstreaming interventions addressing violence against women. It has led to a steady increase in reported cases of gender violence which was traditionally a major challenge due to the conservative culture in the province.



A stylized graphic of a globe with several curved arrows pointing in various directions, rendered in a lighter shade of red than the background. The globe is positioned behind the text.

Citizens' Tracking and Monitoring of the MDGs

Key Highlights

- Efficacy of Livelihood entitlements of 46,000 households in 47 Gram Panchayats (lowest unit of governance) in 2 blocks of Keonjhar district are being monitored monthly.
- 1,321 poor and socially excluded households have gained access to public distribution of food through citizen tracking.
- 876 widow and old people have access to monthly pension and social security.
- 12,300 families get timely and appropriate wages under MGNREGS.
- Out of 33,331 TPDS cards in 32 GPs, 4,298 TPDS cards were identified as duplicate and 1,364 as bogus/ghost cards. These cards were already seized by Panchayats and action was taken, many more in waiting. *Rough estimates suggest leakages of INR. 25 million annually in the 2 blocks from TPDS rice alone.*
- Public officials in 32 Gram Panchayat responded towards service delivery and intimated properly the beneficiaries regarding entitlements.

➊ Actual PDS uptakes by households are captured at PDS rice distribution points on a real-time basis and reported every month by village volunteers using mobile phones. Reports are shared with community and Government for action.



Basic Facts about the Initiative

- Country: India, Orissa
- Title: Tracking of TPDS, Pension and MGNREGS Entitlements in Orissa using mobile phones
- Implementing Agency: Concern Worldwide India
- Intended Outcome and Relevant MDG goals: Goal 1 (Eradicate extreme poverty and hunger). Livelihood Security of 46,000 households through Citizen Tracking
- Target Groups: Resource poor tribal people and women.

Tracking Entitlements for Rural Communities (TERComs) is a mobile-based monitoring system for tracking the efficacy of important social protection delivery of entitlements to rural poor. Village Volunteers are monitoring the entitlements under three major social protection schemes on real time basis at service delivery points and sends the delivery acknowledgment to central server through mobile. Reports on these entitlements are generated monthly and shared with community and Government for action and remedy. This citizen tracking has strengthened the service delivery mechanism at district level, adopted a policy for central reporting of closing stock of TPDS and helping poor in demanding livelihood entitlements to check loss of residual entitlements not claimed by the beneficiaries dealt by citizens.

The Development Context

- Despite unprecedented economic growth, India continues to be home to one-third of the world's poor, ranking 128th out of 177 countries on Human Development Index. It is the world's second most populous country with estimated population of 1.13 billion (2007). 323 million people, or 28.6% of the population, live below poverty line.
- The Government of India has sought to introduce a series of Social welfare schemes and programmes to provide minimum support for its poorest citizens. However, the outreach of such schemes has been quite weak due to widespread exclusion and malpractices.
- Orissa is one of the poorest states in India and regularly suffer from natural catastrophe leading to further suffering by the vulnerable and resource poor. A staggering 18.5 million people (49% of the population) earn less than 10 rupees (0.16 Euros) a day.
- Women's Organization for Socio Cultural Awareness (WOSCA) in Keonjhar district in northern Orissa took up the initiative to track the efficacy of three important social protection schemes – Targeted Public Distribution System (TPDS), Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and the Madhubabu Pension Yojna (pension for elderly people) – in two blocks of the district using a mobile phone based information collection and management system. The initiative is being supported by Concern Worldwide since August 2008 under its Governance and Livelihood programme.
- Keonjhar is one of the most backward districts of Orissa with 44.52% of tribal population, 76.96% of people living below poverty line and 44.73% of literacy. The two blocks mentioned above are considered as the most inaccessible blocks of the district.

Analysis of Success Factors

What has worked?

- Increase in entitlement due to increased awareness among community by sharing live information through women groups, establishment of citizen tracking mechanism at community level and community empowerment factors worked well.
- Real time information management system created through this initiative at Block and GP level helped government in distributing entitlements.

Why it has worked?

- An effective mechanism for removing institutional imperfection through informed stakeholder dialogue and ensuring benefits to the poorest of the poor.
- The proactive data collection by citizens and information dissemination helped in checking corruption and residual loss of TPDS entitlement, leakages and black marketing in TPDS.
- Better compliance of all procedures and mechanisms laid down in TPDS, MGNREGA at the grass root level removed forgery in 2 Blocks and facilitated access to eligible beneficiaries for availing benefits from pension schemes. This initiative has made public officials vigilant and alert at service delivery points and thereby streamlining the process chain.
- Regular interface with the technical persons made volunteers adopted the technology.

What challenges have been faced and overcome?

- Initially, the initiative faced with reluctance of district administration to recognize the value of tracking process. The government was defensive, rather than taking proactive remedial actions when gross irregularities in the officially approved list of entitlement uptakers were revealed. Mass sharing of entitlement information with community and seeing the actual benefits helped overcome this significant challenge.

Key Recommendations for Scaling Up

- The potential gains from citizen tracking using technology are well established now as it is beneficial to both the community and the government in terms of efficient service delivery and management. The flow of resources and funds becomes easier to manage and leakages could be reduced and inefficiencies removed. Under-performers would not be able to hide and government can monitor its personnel more effectively. Thus, there is dire need to scale up the initiative.
- There is a great potential that this pilot can be adopted by the government and scaled up across the whole state of Orissa and other states in India for monitoring health and primary education programs. Factors like community empowerment, sharing concept with government at the beginning, constant engagement with elected representatives and sharing progress indicators with community need to be tackled strategically.
- Social factors such as local tradition, rituals, festivals, and social group dynamics need to be integrated in community sharing and data triangulation plan for greater success.
- Women involvement is a positive factor to keep community motivation high in spite of all hurdles in pilot testing period.
- Option for Public-Private-NGO partnership can be explored while scaling up and bringing political will to perform proactively.

Story from the Field

"I discovered myself in Below Poverty Line list after 13 years on 12th April 2010, subsequently applied for ration card and started availing 35 kg rice per month on subsidized rates. Now I am able to save 350 INR from my earning through my entitlement which I can use for medical emergency. This was made possible because of tracking of entitlements at service delivery points by local village volunteers and increased timely response of local authority. This has brought economic security to my old age and hope for housing support through Indira Awas Yojana," said Jahaji Naik, 59, a Widow and single women of Kamargoda Village, Orissa.

Source



Concern Worldwide is an Irish development agency operating in India since 1999 having its country office in the state of Orissa. Concern works with its local partners addressing the issues of Governance and Livelihoods, response to HIV and AIDS, Disaster Mitigation and Maternal & New Born child health. Concern is implementing this particular project with three local NGO partners Viz. WOSCA, PRAKALPA and CYSID in Keonjhar district of Orissa, India.

Citizens' Monitoring of Local Government to Eradicate Poverty

Key Highlights

- Effective Citizens' Monitoring through Participatory Planning Meetings at the lowest geographical units Union Parishad (UP), give citizens an opportunity to decide about allocations in their respective local government budgets and select development projects that suit their needs.
- The process provides better access to basic services- roads and bridges- connecting them to markets, schools and clinics.
- 5 million people benefit from 3,000 schemes completed every year. 85,000 people play an active and direct role in planning and implementation process as employees getting salary for their work.
- Financial capacity and viability of a total number of 369 local government units have been increased with more block grants and trainings on planning and budgeting.
- As many as 4,662 cumulate Participatory Planning Sessions were conducted for local level budgeting and planning.

🔗 Citizens attend a participatory planning meeting in one Para (village).



🔗 Budget is allocated for a road construction and people from the community are working on the project.



Basic Facts about the Initiative

- Country: Bangladesh
- Project: Local Governance Support Project – Learning and Innovation Component (LGSP-LIC), 2007-2011
- Implementing Actors: Ministry of Local Government, Rural Development and Cooperatives of the Government of Bangladesh, UNDP and UNCDF
- Funding Partners: UNDP, UNCDF, EU, DANIDA
- Intended Outcome and Relevant MDG goals: All Goals with focus on Goal 1 (reducing poverty), as the project aims to build capacities of Union Parishad (UP), the lowest tier of local government structure in Bangladesh, to deliver basic services for MDG entitlements.
- The project benefits both communities and local government institutions through taking local communities on board while deciding on budget allocations and development schemes. It improves efficiency and accountability of service delivery at local level.
- The project team works with local government institutions to strengthen participatory planning, service delivery and financial management through piloting performance-based grants to the elected UPs. Open meetings of local government officials with community are organized to take decisions on budget, development planning, and allocations for development activities.
- This process of citizen monitoring ensures transparency and accountability of local government and other local level institutions to see quality standards work in development projects.

The Development Context

Rural areas in Bangladesh often lag behind rest of the country in development indicators and MDGs achievement. Less than two percent of total public spending is allocated for delivery of services at local level. The local institutions have limited financial capacity and human resources, despite strong legal provisions, to fulfill their responsibilities.

The Government of Bangladesh is committed to improving local governance, and is working through a national Local Governance Support Project to improve service delivery and access to basic facilities in the country.

Analysis of Success Factors

- Financial resources are independently managed by local government institutions.
- Decisions on budget allocation and planning for development are made in consultations with relevant communities.
- More than 3,000 schemes are implemented every year.
- 96% of the funds are used for labour costs to be paid to workers from the community.
- About 83,000 people work to complete the project they make in the interest of the community.
- Participation rate in decision-making process is increasing: 37% of the community attends Participatory Planning Meetings in the project areas as compared to 18% in other local government bodies that does not fall in the project areas.
- Awareness of the people about their role and rights towards local government institutions is very high (70%), more than the one perceived in areas that are not in the project's locations (30%).

A Story from the Field: A Participatory Planning Meeting at the Para Level

In 2009 and 2010, Ward Development Committee of Gaznaipur in Nabiganj Upazila in District of Habiganj, successfully engaged community in decision-making process through participatory planning meetings at the Para (village) level. The citizens in such meetings did hold local governments to account and prioritized local development projects such as construction of roads to increase market access and culverts to reduce occurrence of floods. They also started computer training for youth.

Muhammad Bachu, 25, hailing from Gaznaipur village is one of those who have benefitted from construction of road linking community to markets and a wide range of services that helped raise their incomes and create opportunities for them. *"Since we were given chance to decide what to prioritize to improve our lives, we opted to construct road to get access to market to sell our products. This access saves my time and increases my income as now I can quickly get raw material and send my handloom woven clothes for sale. Before construction of the road in our village, it has to be a nightmare to travel, particularly in rains that used to flood and block our pathways and hence our finished goods used to have struck up at home. We have a watchful eye as citizen at local level decision making,"* he said.



Key Recommendations for Scaling Up

- Participatory monitoring by citizens well-informed of their rights and responsibilities enhances transparency and accountability of local government and other local level institutions and improve prioritization and quality standards of development projects.
- Local Government needs to enhance its finances, especially sources of income.
- High participation rates in planning meetings are essential for local government decision-making to benefit from plurality of voices and greater community ownership of local level development efforts.
- Chances of external factors limiting participation of community should be minimized and new methods ensuring more participation introduced so that the process could be more inclusive.
- Refresher courses and trainings on participatory planning and financial management need to continue to ensure that communities take part in monitoring of local institutions and local officials follow procedure and respond promptly.

Source

Local Governance Cluster (UNDP and UNCDF Bangladesh joint project)

IDB Bhaban – 1207, Dhaka, Bangladesh
Tel: 0088 2 8150088 ext. 1808
Email: lgc.bd@undp.org
Website: www.undp.org.bd

Key Highlights

- The Participatory Monitoring for Health Project established a process on how to scrutinize, monitor, and evaluate government services through fact-finding and data analysis.
- It was able to identify key dysfunctional areas in drug procurement in hospitals, such as the criteria in purchasing essential drugs and the efficiency of the drug procurement system. These issues were raised to the local government level through a series of dialogues.
- Through this initiative, standards for transparency in the allocation and utilization of public funds have been established.
- The Participatory Monitoring project aims to improve transparency in the utilization of provincial funds allotted to municipalities and barangays for infrastructure and health projects. One of its major components is drug procurement analysis, which involves (a) scrutiny of processes and documents in the procurement of drugs for public hospitals in the province of Isabela; (b) understanding why emergency purchases had been done after procurement has been done; and (c) detect if possible cases of corruption had been committed. The other one is barangay infrastructure monitoring, which monitors public infrastructure projects as they are undertaken to avoid fund leakages and to identify inefficiencies in the process.
- Capacity-building trainings were conducted – on monitoring skills, on key concepts of good governance, accountability, participatory monitoring, and on provincial procedures related to infrastructure and health projects – to enable the citizens of Isabela to monitor the funds intended for their health sector.
- Through the series of trainings, “grassroots leaders” were produced who are committed and trained to monitor and identify problem areas and propose solutions.

Basic Facts about the Initiative

- Country: Philippines, Province of Isabela
- Title of Initiative: Participatory Monitoring for Barangay Infrastructure and Health Projects in the Province of Isabela
- Implementing Organization: International Center for Innovation, Transformation and Excellence in Governance (InciteGov), in partnership with the Government of Isabela and the People’s Alliance for Justice, Democracy and Good Governance (PAJDGG)
- Intended Outcome and Relevant MDG goals: Introduce monitoring and evaluation of end-users to village-level infrastructure and health projects (Goals 4,5 and 6)
- Target: Barangays and district hospitals in Isabela Province

The Development Context

The province of Isabela, the second largest province in the Philippines, is known for its strong political culture. Elected leaders are very influential, thus realization of projects and reforms greatly depend on who’s in office. InciteGov took the opportunity to promote accountability and good governance when governor Padaca sought their help to train citizens in the participative monitoring of funds and government services.

Corruption and the misappropriation of funds are two of the main reasons why the Philippines is still off-target in some indicators. Participatory monitoring empowers the citizens to protect the funds intended for their welfare, and is a critical mechanism for promoting accountability and good governance, key factors for achieving the MDGs by 2015.

Analysis of Success Factors

- Leadership and vision. The political culture of a region or area is crucial in implementing a participatory monitoring initiative. The support that former Governor Padaca extended to the project encouraged community participation, and provided access to relevant data.
- Development of grassroots leaders. The framework used in participatory monitoring developed empowered citizen leaders capable of replicating the initiative. The impact of a project can be expanded when people are equipped and passionate in enforcing social accountability and good governance.
- Right to Information. With the support of former Governor, the team was able to access pertinent information and documents to complete the analysis. Many people were reluctant to disclose information because they feared that disclosing too much data might jeopardize their system, including — and especially — their jobs.

🔍 Drug procurement team analyzing documents and data they gathered in the district hospitals with the help of Rep. Dina Abad.



Key Recommendations for Scaling Up

- A combination of political commitment from the government and proper capacity development of citizens is required for effective participatory monitoring to improve transparency in the budget utilization at the local level.
- Push for an ordinance that would ensure sustainability of the monitoring initiative which will not be affected by changes in government.
- Replicate the Participatory Monitoring Trainings model (particularly mentoring and problem solving sessions) to other *barangays* (villages) and elevate initiative to the municipal level to widen reach and gain more influence.
- Establish a clear-cut monitoring and evaluation mechanism to measure the impact of the project in longer-term.

Source

International Center for Innovation, Transformation and Excellence in Governance (InciteGov)

Unit 110 Prestige Tower, F. Ortigas Jr. Road, formerly Emerald Ave. Ortigas Center, Pasig City, Metro Manila, Philippines
Tel.: +632 914 4059
Fax: +632 634 1334
Email: paoladeles@incitegov.org
Website: www.incitegov.org

Contact person:

Paola Deles

Reference:

Terminal Report: Participatory Monitoring for Barangay Infrastructure and Health Projects in the Province of Isabela.

Citizens' Participation in Constitution Making

Key Highlights

- The suggestion and feedbacks provided by Dalits, Indigenous communities, women, Madheshi and youth from 3,915 Villages (VDCs) and 48 municipalities of Nepal, for the new Constitution acknowledged and included in the reports of the Constitutional drafting Committee.
- 1303 local facilitators (51 % female and 49 % male) trained to conduct *Loktantrik Sambad* (Democratic Dialogue).
- Nearly 300,000 people including women, dalits and marginalised communities and municipalities were reached through the Democratic Dialogue programme with the help of 98 local consortium partners of 18 CSOs in every district.

🗣️ A village facilitator conducting a Democratic Dialogue programme.



Basic Facts about the Initiative

- Country: Nepal
- Project: Support to Participatory Constitution Building in Nepal (SPCBN)
- Implementing agency: UNDP Nepal
- Intended outcome and relevant MDG Goals: Cross cutting - economic, cultural and social rights of the Nepali people
- Target group: The people of Nepal who are exercising their right that their voices to be heard while the country is writing a new participatory people's Constitution, with emphasis on traditionally excluded groups of the population.

The Development Context

- In Nepal's current political context, peace building and restructuring of state mechanism are main priorities for the Constituent Assembly (CA). Inequality and disparity based on socioeconomic and geographic factors are among the biggest hurdles that block development and hamper peace efforts.
- While Nepal has made impressive progress in reducing poverty, the disparity between rural and urban still persists. Urban poverty was estimated at 10%, while rural poverty at 35% in 2004. It has come down to 8% and 22% respectively in 2009. The disparity is also high among caste, gender and ethnic groups. The persistent level of economic disparity has its consequential effect on other sectors such as education, health and environment.
- The persistent political instability and growing food insecurity are major challenges and obstacles towards progress on MDGs in Nepal.

Analysis of Success Factors

- Working through local resources including facilitators is key to make the Democratic Dialogue programme more participatory.
- Especially women are accepted well by communities.
- The facilitators were trained on 11 thematic reports of the constitutional committee and on how to conduct dialogue programmes.
- Effective civic education, appropriate education materials, and good documentation.

Story from the Field

Ms. Muni Das, 34, hailing from Janakpur of *Dalit* community (*Tatma* Caste) was hired as a local facilitator for this community. She faced many problems while conducting the Dialogue as the people were politically motivated, in a male dominated society, and specific socio-cultural context.

After proper training, she however successfully managed democratic dialogue to ensure that the voices of *Dalits* and *Dhanusha* are heard and their constitutional needs are met.

"Orientation training on facilitation skills and understanding thematic reports of the constitution committee conducted by the project made me capable of successfully holding the dialogue programme," Muni said.

Key Recommendations for Scaling Up

- Participatory constitution building which includes voices of the poor and the marginalised ensures justiciability and enforceability of MDGs as rights recognized by the country's very basic law – a constitution.
- Such inclusive and participatory programme should be conducted for all communities in order to promote the local people's ownership of the new constitution.
- If we want to bring voices of certain communities while drafting a constitution, we should hire facilitators for local communities who can explain for them constitutional technicalities.
- If facilitators are oriented properly on draft constitution contents, they can take the message to the public and the public can give a real feedback and can monitor the process of constitution making.
- Civic education is necessary for awareness of the people to set the agenda for public debate on constitutionalism
- Minimum guarantee of education, health and livelihood, and clear guarantee of fundamental rights is given in accordance with universal human rights.

Source

Support to Participatory Constitution Building in Nepal, UNDP

UN House, Pulchowk, Kathmandu, Nepal
Tel & Fax; 097-5010058/60/64 (Fax No: 5010081)
Email: sita.gurung@undp.org
Website: www.ccd.org

Contact person:

Sita Gurung

Reference:

The MDGs through Socio-Economic Rights
www.endpoverty2015.org/publications





Targeting the Poor and the Marginalised

Reaching the Ultra Poor through Innovative Financial Services

Key Highlights

- The Microfinance program of Palli Karma- Sahayak Foundation (PKSF) for the poorest of the poor provides flexible terms coupled with non-financial services.
- The initiative was started with 19 Partner Organizations (POs) covering 19 Sub-districts of 17 Districts in 2002. Now 102 POs are operating in about 456 poverty-stricken Sub-districts of 62 districts.
- A total of 1 million ultra poor households have been brought under the program, the largest outreach of its kind in the country.
- USD 252.46 million has been disbursed.
- The program successfully demonstrated that the ultra poor are credit worthy and can attain meaningful level of self-sufficiency.

An impact study (2008) summarizes the impact of the program as below

- More than 28% of the participants enjoy three full meals compared to 24% of the non-participants of the program village and 11% of the non-participants of the control village.
- Around 23% of the participating households were found above the poverty (cost of basic needs, CBN) line compared to 20% of non-participants in the program village and 12% of non-participants in the control village.
- Occasional starvation during monga (seasonal deprivation of employment) was reduced by 5%.
- 55% of households moved to higher level of consumption rationing during 2008 monga.

- Many ultra poor women come out of poverty through undertaking tailoring as an income generating activity.



Basic Facts about the Initiative

- Country: Bangladesh
- Title of the initiative: Microfinance for Ultrapoor Program
- Implementing organization: Palli Karma- Sahayak Foundation (PKSF)
- Intended outcome and relevant MDG Goals: MDG Goal 1 (eradicate extreme poverty and hunger). The main objective of the program is to increase income level of the ultra poor through generating self and wage employment.
- Target groups: Ultra poor

The Development Context

- It is estimated that 40% of the 140 million people in Bangladesh live below poverty line. 25.1% of the poor live in extreme poverty, often described as hardcore poor having access to less than 1800 calories per head per day. Therefore, poverty alleviation and employment generation are top priorities in the development agenda of the Government of Bangladesh (GoB).
- Palli Karma-Sahayak Foundation (PKSF) was set up by the Government of Bangladesh in 1990 to undertake nation-wide microfinance programs for poverty alleviation through employment generation. Reaching a significant number of absolute poor with financial services in a sustainable manner and on a massive scale is certainly a big challenge.
- Bangladesh's average annual poverty reduction rate till 2005 was 1.34% whereas the required percentage was 1.23. The poverty gap ratio has showed a dramatic change. It has decreased to 9 from 17 (baseline 1991). However, a large number of ultra poor need to be pulled out of abject poverty, which is a main challenge towards achieving MDGs entitlements.
- Microfinance is recognized as a powerful instrument to address poverty, especially in Bangladesh context. Although microfinance has reached well over one third of all rural households, it has yet to reach a significant population of the ultrapoor, the bottom 15-25% of the population.

Analysis of Success Factors

- Unlike mainstream rural microcredit, the project had some inbuilt flexible features addressing size of loan, repayment schedule and easy access to savings. These features allowed the ultra poor to access credit tailored to their individual needs.
- Recognizing the intrinsic need to provide low cost credit for the ultra poor, PKSf reduced service charge from 4% to 1% for its partner organizations and 12.5% to maximum 10% (flat rate) for the ultra poor borrowers. This has significantly encouraged both the partners and ultra poor borrowers to benefit from the program.
- The program also provides nonfinancial services such as cash for work, capacity building activities, health service, insurance, and technical services in addition to the flexible credit design.
- Competent and experienced partners and appropriate target areas helped the success of the program. Only those areas that were poverty stricken, remote and geographically vulnerable and those that lack government and NGOs facilities were selected.
- To target the ultra poor, PKSf used various useful tools including rapid and participatory rural appraisals, focus group discussions and wealth ranking exercise. The program targeted vulnerable segments of society such as beggars, former sex workers, day laborers and women headed households. The targeting design allowed for flexibility to adopt any technique that deemed appropriate based on targeting performance feedback.
- The capacity building of partners' staff to target the poor and undertake activities has been an integral part of the program that really helped achieve the targets. Special courses were designed which included process of targeting ultra poor, location of poverty pockets and process of identifying targeting errors.

Story from the Field: Hanufa Begum's Struggle for Survival

"I have earned BDT 62,000 (US\$885) in current crop season by selling cash crops-onions and chilies- thanks to microcredit scheme that has totally changed our life and now other villagers have started thinking positively about the scheme," said Ms Hanufa Begum.

Hanufa lives in Mudafat Village of Manushmara Union in Chilmari Sub-district of Kurigram District, Monga hit area known for hunger in a part of the year. She lived with her husband and a daughter on char land (silt land) where scope for cultivation was extremely limited. She didn't own any asset such as cultivable land. Her husband had to go to the city for daily wage job.

With her husband's meager income, it was difficult for them to live and could hardly have three meals. Hanufa joined Mudafat Chandramolika Samity (a credit group of a PO) and took a loan of BDT 10,000 (USD 142) for a year. She leased 30 decimals of land to cultivate rice and high value crop such as onion and chili. Both husband and wife got training on spices farming under the project.

They got 259 KG of rice, 1,295 KG of onion and 1,000 Kg of chili from the land they leased out of the microcredit. They consumed rice at home while sold other cash crop earning six times higher the credit they got.

"With our income, now my family is growing healthier, my only daughter goes to school; we can eat regularly, and dress well. My husband does not need to migrate anywhere for work and we are now saving to buy some land. I am sure we would own our own land to cultivate," said Hanufa.

Key Recommendations for Scaling Up

- PKSf's institutional mechanisms which were established by a parliamentary act play a major role in enabling the expanded reach of credit to the ultra poor and the most needy.
- Coordination and collaboration among government, NGOs, private sector, development partners, civil society, and other stakeholders are essential for scaling up such flexible microcredit programs to support ultra poor come out of abject poverty.
- Credit schemes targeting ultra poor must have flexibility in credit conditionalities.
- Local context, proper targeting of ultra poor and areas of work need to be clearly defined.

Source

Palli Karma-Sahayak Foundation (PKSF)

E-4/B Agargaon Administrative Area,
Sher-E- Bangla Nagar, Dhaka-1214,
Bangladesh
Tel: +880-2-90140056-9
Fax: +880-2-9126244
Email: pksf@pksf-bd.org
Website: www.pksf-bd.org

Contact person:

AQM Golam Mowla, DGM

Reference:

Report of the Household Income and Expenditure Survey 2005



Key Highlights

- By 2009, 112,552 households in all provinces have adopted SRI.
- SRI farmers' output was 92% higher than the ordinary practice.
- On average, gross profits per hectare increased from \$120/ha with conventional methods to \$209/ha with SRI methods, as yield increased by 41% from 1,629 kg/ha to 2289 kg/ha.
- The amount of chemical fertilizers has been reduced by more than 50%.
- The amount of seeds has been reduced by 70-80%.
- 13% of farmers interviewed have stopped using pesticides and 7% have stopped using chemical fertilizers on rice and other crops.
- SRI enabled a \$23/ha saving in variable costs such as seeds and mineral fertilizer, and an increase of \$66 in the income coming from higher yield.

Basic Facts about the Initiative

- Country: Cambodia
- Title of the project: System of Rice Intensification (SRI)
- Implementing agency: Adopted by the Ministry of Agriculture, Forestry and Fishery and supported by NGOs and donors
- Intended outcome and relevant MDG Goals: Goal 1 on poverty and hunger, as well as 4, 5 and 7 by ensuring nutrition to the family members especially children and women and helping to improve the soil through greater root growth and the nurturing of soil microbial diversity.
- Target groups: Poor farmers in rural areas who livelihood solely depend on paddy rice cultivation.

SRI is a methodology for increasing the productivity of irrigated rice by changing the management of plants, soil, water and nutrients, with the goal to create optimal conditions for growth in roots and tillers. As root growth increases, there will be more tillers and more grains per plant. Evidences show that SRI produces more and cost less, therefore helps to provide food security and the surplus products can generate income for the farmers.

First started by a Cambodian NGO (now called Cambodian Center for Study and Development) in 1999, the practice is now strongly supported and integrated into national plan and strategy such as National Strategic Development Plan, Strategy for Agriculture and Water, and Strategic Framework for Food Security and Nutrition.

The Development Context

- Main agricultural practice in Cambodia is family-based and rain-fed system. Food shortage is usually faced by many families that have small or little access to land and have no alternative income generation activities. As the population increases while the soil fertility decreases we need improved cultivation technique to help poor farmers secure their food.

 Farmers planting SRI crops



Analysis of Success Factors

What has worked and why?

- Simple techniques, accessible/affordable, economic, and immediate result.
- Interest, commitment and willingness of the farmers to apply the techniques, which helps to strengthen the ownership of the experimentation.
- Technical support and follow up from technical department, donors and government to help the farmer along the process.

What challenges have been faced and overcome?

- Labour intensiveness, poor soil fertility which require farmers to use chemical fertilizers, and long-term flooded area.
- In particular, external labourers who are not trained about the SRI techniques just use the traditional way of rice cultivation. To overcome these challenges more training now are focused on these hired labourers.

Story from the Field

"When I heard about SRI, I didn't believe it at first, and my wife was against it, but the CEDAC people took me on a tour of other SRI farmers and I decided to take a risk."

"I planted a small crop of rice as an experiment using the SRI method. I am so happy to see my farm now produces double the amount of rice it used to."

Mr. Ros Mao Chorm, Tramkork district, Takeo province, Cambodia.

Key Recommendations for Scaling Up

- The initiative for availing locally available, low-cost, simple techniques for increased agricultural production leading to enhanced food security can be replicated effectively in other rice-producing countries, by looking into proper institutional support mechanisms.
- Implementing and supporting SRI dissemination program which ensures that all rice farmers can understand and apply the techniques is essential for nation-wide expansion.
- Implementing and supporting a nationwide community-based seed selection program to ensure that all farmers have access to good quality, locally-produced seeds.
- Promoting a nationwide soil fertility management program, especially the promotion of green-manure cultivation during the early wet season, cultivation and use of nitrogen-fixing trees, and making and using compost.
- Development of small and medium-scale irrigation facilities and participatory irrigation management, especially for the purpose of supplementary irrigation in the wet season.
- Development of local production of appropriate implements for SRI production, specifically soil-aerating mechanical hand weeders and roller-markers or other tools for enhancing SRI crop establishment in a labor-saving way.
- Development of better storage, milling and marketing capacities.

Source

SRI Secretariat of Department of Rice Crop/GDA/MAFF

54B, St 656, Sangkat Teuk Laak 3, Khan Toul Kok, Phnom Penh, Cambodia

Tel and Fax : (855) 23 996 255

Mobile Phone : (855) 17 959 727 / 016 777 080

Email : kea_ipm@hotmail.com and ratanasky@camintel.com

Website : www.foodsecurity.gov.kh/sri

Contact person (if appropriate):

Mr. Kong Kea and Mr. Heang Rattana

Key Highlights

This initiative is built on a two-pronged strategy to improve rural women's access to institutional deliveries.

Operationalizing Sub Centres for 24 x 7 safe deliveries

Mapping of the existing health facilities in Guna district was done and based on needs, 12 new centres were identified and operationalized as 24x7 safe delivery centres. Out of these eight were sub centres which were upgraded to provide above services. The aim was to provide 24x7 safe delivery centre at every 20- 25 km thus improving accessibility and reduction in travel time with increased service utilization.

- 8,500 deliveries conducted at Sub centres in 2 years.
- 63% of beneficiaries were from marginalised and excluded communities Schedule Tribe (ST) 49 %, Schedule Caste (SC): 14%)
- Increase in institutional deliveries in the district from 29% in DLHS 2 (2002-04) to 50.4% in DLHS 3 (2008) and to 94% in 2009-10 (District data)
- 10% reduction in District hospital share of institutional deliveries from 35 % in 2006-07 to 25 % in 2009-10.
- Scaled up under NRHM to more than 300 Sub centres in the State.

Emergency transport system with 24 x 7 Call Centre

The model has two key components, fleet of vehicles and a call centre to coordinate this fleet. 22 vehicles were pooled and placed at different delivery points. On receiving the call the operator diverts the nearest vehicle to the village and also informs the nearby delivery centre to be prepared for incoming patient thus reducing delay.

- 19,000 pregnant women transported in last two years.
- 30% of total deliveries in the district being transported.
- 50% beneficiaries from marginalised groups (S.C : 23%, ST : 28%, Other backward classes : 42%)
- Being scaled up under NRHM in 44 out of 50 districts.
- 21 call centres functional as of June 2010 with 44,000 beneficiaries in 2009-10.

Delivery Room Sub Health Centre, Shivpuri: Auxiliary Nurse and Midwives (ANMs) trained in skilled birth attendance, essential equipment, emergency transport vehicle, solar power back up and running water supply were ensured.



Basic Facts about the Initiative

- Country: India / Madhya Pradesh
- Title of the initiative: Improving Access of Rural Women for Safe Delivery : Twin Initiatives for Reaching the Unreached
- Implementing agency : Department of Public Health Govt of Madhya Pradesh (MP) and UNICEF
- Intended outcome :
 - Improvement in institutional delivery rate in remote villages
 - Improved access of excluded communities to institutional deliveries
 - Reduced travel time and delay in reaching safe delivery centres
 - Reduced congestion at District hospital and First Referral Units (FRUs)
- Relevant MDG Goals: Goal 5 (Improving Maternal Health), Reducing Maternal Mortality by three quarters from 1990 to 2015 (Indicator: Proportion of births attended by skilled health personnel)
- Target Groups: Pregnant women from remote villages with predominantly marginalised population having difficult access to institutional delivery.

The Development Context

To achieve MDG-5 Government of India in 2005 launched a large conditional cash transfer scheme 'Janani Suraksha Yojna' (JSY) under which women are given incentives to give birth in an institution. Financial incentives incorporated under JSY helped to bring clients to Health centre for Institutional delivery but it also raised challenges for institutions to keep pace with increasing delivery load. Road access to safe delivery centres from far flung villages has been difficult for pregnant women to have safe deliveries in spite of financial incentives provided by JSY. This was resulting in pockets of low institutional delivery thus hampering JSY objectives. Moreover, there was increasing load of normal deliveries coming to First referral units affecting quality of care.

An attempt was address this situation in 2007-08 in Guna District where District health society, UNICEF and Government of M.P. piloted twin initiatives of setting up emergency transport system linked to 24 x 7 call centre and operationalization of Sub Centres for 24 x 7 delivery services in remote villages.

Looking at the success of these need based innovations in improving access of rural women of marginalised communities for institutional delivery and its relevance in context of Madhya Pradesh which has fourth highest MMR in the country (335 per 100,000, Source: SRS 2006)) Government of Madhya Pradesh decided to scale this up State wide with necessary provisions made under NRHM plan for 2009-10 and 2010-11.

Analysis of Success Factors

What has worked?

- Investment in need based intervention to address demand
- Providing service delivery near community
- Investment in training, human resources and infrastructure
- Review visit by key decision makers in the Government, donors and partners as they in their feedback decided to replicate the initiative

Why it has worked?

- Being need of the community
- Community and Panchayat participation
- Proactive district administration
- Ownership by the State
- Advocacy efforts were backed up with hand holding by UNICEF during scale up
- Mainstreaming under NRHM

What challenges have been faced and overcome?

- Ensuring adequate delivery load comes at these centers
- Ensuring adequate space to keep pregnant women
- Ensuring detection and timely referral of complicated cases

Story from the Field

Guna district is located in the Western part of Madhya Pradesh bordering Rajasthan and Uttar Pradesh. It has population of 976,596 with majority of the population (75%) living in rural area. The Schedule Caste (S.C.) and Schedule Tribe (S.T.) population accounts for 15.70% and 14.69% of the district's population. Till 2006 delivery centres were located along highway far from remote villages making access difficult.

Mapping of Delivery Centres in Guna District

* New Centres started in 2007-08, Pre Existing Centres in 2006



Key Recommendations for Scaling Up

- Introduction of these measures effectively addresses the three delays leading to maternal mortality (recognizing the problem, taking pregnant women to health facilities in time, and getting skilled birth attendace) by supplementing the conditional cash transfer programme.

Sub Centres for 24 x 7 safe deliveries

- Mapping of Health Centers targeting pockets of low institutional delivery.
- Provision for delivery room to be inbuilt in design of sub centre building in identified areas.
- Ensuring minimum 2 ANMs and one Staff nurse/Lady Health visitor at these centers.
- Training of above staff in skilled birth attendance.
- Monitoring and early identification of complications by regular use of Progress of labour chart.
- Provision of maintenance funds for these centers in District plans.

Emergency transport system with 24 x 7 Call Centre

- Minimum three vehicles per block to ensure timely response.
- Fleet of vehicles can be outsourced on a monthly rental.
- Provision for running cost of vehicles and call center to be made in District action plans.
- Training of drivers in First-Aid.
- Involvement of village level functionary is important to ensure adequate utilization.
- Call Centre can also be used for Pregnancy registration and immunization monitoring.

Source



UNICEF has been working in India since 1949. The largest UN organisation in the country, UNICEF is fully committed to working with the Government of India to ensure that each child born in this vast and complex country gets the best start in life, thrives and develops to his or her full potential. UNICEF uses its community-level knowledge to develop innovative interventions to ensure that women and children are able to access basic services such as clean water, health visitors and educational facilities, and that these services are of high quality. At the same time, UNICEF reaches out directly to families to help them to understand what they must do to ensure their children thrive.

Improving the Poor's Access to Reproductive and Maternal Health Services

Key Highlights

The findings of a review conducted in several selected villages and health facilities reveal significant improvements after 3 years.

Increasingly the poor has utilized the reproductive and maternal health services and the risks to maternal death are reduced.

- Number of women delivered at health centres increased from 282 to 2,156 in 2008 and 2009 respectively.
- Number of safe delivery increased from 544 in 2008 to 884 in 2009.
- Number of beneficiary increased from 59,568 in 2008 to 94,492 in 2009.
- There were no poor people coming for the consultations for birth spacing at the beginning. However, in late 2009, there are 1,326.
- There was only one woman receiving IUD insertion service in 2008. There were 42 in 2009.
- Triple -increase for men or women consulting for STD at HCs, 3,176 in late 2009.

After losing her first child at home during delivery, her second child was saved by midwife at health centre. This was made possible by the support from UNFPA discretion fund to safe delivery.



Basic Facts about the Initiative

- Country: Cambodia
- Project: Equity Fund helps the poor access to reproductive and maternal health services
- Implementing institutions: UNFPA, RHAC and Ministry of Health
- Intended outcome and relevant MDG goals: The UNFPA-supported intervention will contribute to promoting reproductive and maternal health and to reducing maternal death. Women 's reproductive rights is promoted, especially venerable groups could exercise their reproductive rights (MDG 3 and 5)
- Target groups: Women in 5 operational districts of three provinces.

The UNFPA's supported Health Equity Funds for Reproductive Health has been executed by the Ministry of Health and managed by an NGO namely Reproductive Health Association of Cambodia (RHAC) in an effort to reducing maternal mortality rate in the 5 operations districts. The poor are able to access to reproductive and maternal health services, where they are hampered by limited access to the services due to financial difficulty. They have been able to exercise their reproductive rights and access to better health care and safer practices through the support.

The Development Context

Current situation, relevant MDG achievements and gaps status

- Even though Cambodia has made great strides towards achieving the MDGs 4, 6 and 9, the number of people living in extreme poverty remains high, about 4 million.
- MDG Goal 5 is not on track and Cambodia seems to have slow progress in achieving Goal 3.
- Women continue to face gender disparity in decision making and access to reproductive rights and services remain challenging. There are still 461 deaths out of 100,000 live births in the last ten years (2008 census).
- Further, the socio-economic gap between rich and poor has not narrowed down, rather widened.
- The unmet need for family planning is high, 25.7% (CDHS 2005) in the rural area which doubled their risk to the limited accessibility to services.

Key challenges and obstacles towards progress of MDGs

- Though Health Equity Fund has been practiced in Cambodia several years ago and that health policy exempt user fees for the poor, the government subsidy accounts for only 10 to 15% of the hospital's total monthly income.
- The HEF service package varies, while some cover cost of services, other covers food and travel allowances which depends on development partners' mandate.
- There are only 51 referral hospitals and 120 health centres have health equity fund package.

Analysis of Success Factors

What has worked and why?

- The poor were identified by community-based agents and selected by NGO partner together with commune councilors based on agreed standard by the ministry of planning.
- System for referral from health centre to referral hospital has been established and that staff of NGO partner were proactive boost up the financial clearance process.
- Financial commitment from development partner with proper monitoring and evaluation system.

Challenge faced and overcome

- There was delay in pre-identification which affected the use of RH services. Also some errors in identification of the poor led to dissatisfaction among health staff and community people.
- There is some barrier to the poor in using non-RH services given limitation of government subsidy in the non-Equity Fund package health facilities.

4 key lessons useful for the replication within the same country or another country

- The similar support should also consider for the non-reproductive health services to the most vulnerable group.
- The issue of sustainability in the case of discontinuation of funding support from development partner needs to be addressed.
- The information on the services covered by the Equity Fund should be clear by health providers, community-based agent and community leaders.
- Pre-identification of poor households needs to be accurate and consistent. Therefore, the involvement from local authorities and external monitoring are critical.

Voices from the Field

"Without the support from Equity Fund, my family would debt for accessing to services."

Ms. Suong Sopha, Kg Preah village, Chhnok Trou, Kg Chhnang province

"Without equity fund, women could not exercise their rights to reproductive health and maternal services, they do not know if their rights is guaranteed through this system – but now they better understand and come for services."

Mr. Chub Cheng, EF Coordinator in Siem Reap province.

"Commune council helps identifying the poor and referring them to health centre for services – women now know their rights"

Ms. Duch Marin, Commune Chief, Yeang Commune, Siem Reap province

Key Recommendations for Scaling Up

- A conditional cash transfer scheme such as this makes visible impact in improving the poor's access to health services, if it is combined with appropriate coordination among responsible actors and public outreach campaign.
- Develop strategies to conduct health information campaigns for the poor rural population in order to promote reproductive health services, maternal health and introduce change in health seeking behaviors.
- The regular system to receive feedback from the community is encouraged for problem solving.
- Encourage and follow up with the local authorities such as commune councils and village chiefs to have referral mechanisms from community to health centre and further to referral hospitals.
- Encourage collaboration among community, health centre, operational district and referral hospital levels and investigate to eliminate the practice of informal charges and gift-giving.
- Strengthen the capacity and the involvement of the commune council to the pre-identification list is up-to-date by working closely with health staff and community members.

Source

Reproductive Health Component – Support to Health Sector Support Project, Ministry of Health through Equity Fund programme (UNFPA-Cambodia)

P. O. Box 877, Phnom Penh, Cambodia

Tel: +855-23-215519, +855-23-216295

Fax: +855-23-211339

Email: unfpa.cmb@unfpa.org

Website: <http://cambodia.unfpa.org>

Contact person:

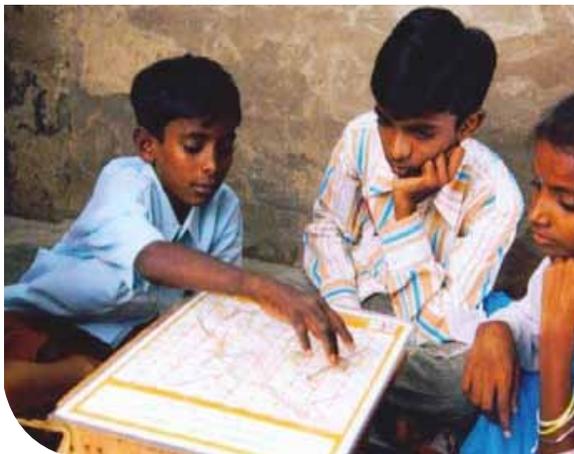
Sok Sokun (sok@unfpa.org),

Sophanara Pen (sophanara@unfpa.org)

Key Highlights

- Improved HIV testing among children exposed to positive mothers from 137 to 2048 within 3 years (2006- 2009) in Andhra Pradesh-piloted a model in India.
- Reduced mortality among children living with HIV from 2.08 to 0.97% within 3 years.
- 104 social safety nets increased adherence to treatment among orphan children living HIV from 30 % to 98 % within three years evident in reduced morbidity with increased CD4 levels from 230 to 679 (on ART) and 320 to 428 (not on ART).
- Scaled up from 7 sites to 22 sites in Andhra Pradesh within three years.
- Evidence of child mortality among infants (below 18 months) born to HIV positive mothers led to advocacy for HIV testing through PCR.
- Increased compliance and adherence among parents living with HIV with improved treatment access behaviour.
- VMM experience in paediatric care and support were translated into development of a Paediatric Counselling module for National AIDS Control Organisation (NACO) to train counsellors in child-friendly counselling.
- Advocacy with state government led to provision of concession to travel to ART centres in public transport.

- Children living with HIV being educated on self care and treatment adherence through Snake and Ladder board game.



Basic Facts about the Initiative

- Country: India, Andhra Pradesh
- Title of the initiative: Paediatric AIDS Community-based Care and support Programme
- Implementing agency: Vasavya Mahila Mandali (VMM)
- Intended outcome and relevant MDG Goals: Improved life span among children living with HIV on treatment with 100% adherence. MDG goal 4 target 1: Reduce child mortality from 120 to 42 per 1000 live births.
- Target groups : Children Living with HIV and AIDS

The Development Context

- The estimated number of children living with HIV and AIDS in India is 202,000 as per UNAIDS estimates. About 56,700 HIV infected children are born every year. Half of HIV positive children die undiagnosed before their second birthday as they are not tested by PCR test, which are expensive in private sector and just initiated in public health sector.
- HIV is multi folding vulnerability to poverty hence caregivers could not bear cost of medicines, travel and trauma due to morbidity and mortality of parents and reduced adherence levels leading to increased opportunistic infections. In 2006 HIV prevalence among Ante natal clinic attendees in Andhra Pradesh was around two per cent. With the 'political will' Asia's first paediatric HIV and AIDS treatment initiative spearheaded in India by the National AIDS Control Organisation (NACO) with support of Clinton HIV/AIDS Initiative that provided free child specific dosages of lifesaving antiretroviral (ARV) drugs.
- Under-Five mortality, going by the present trend, can come down to nearly 70 per 1000 live births by 2015 against the target of 26.67 per 1000 live births. Currently the status in Andhra Pradesh state is 63.2 in 2005-06 from 91.2 in 1992-93. However, the rate of decline is more pronounced in case of male as compared to female.
- Girl children are given less care for health, nutrition and education by families in a patriarchal society in India. Due to increased morbidity among the mothers living with HIV, they cannot take care of their children. Clinton Foundation through VMM has withdrawn the support for travel, nutrition and follow-up for treatment of children that made the poverty stricken families to invest on the health of the child living with HIV.

Analysis of Success Factors

What has worked and why?

- VMM outreach workers provided education, treatment and treatment adherence to community based support groups working with children living with HIV, children from HIV affected families and caregivers. This led to peer support for taking medicines and it also helped reduce stigma and discrimination.
- VMM workers accompanied orphan children and sick caregivers to ART centre for refilling of medication and bereavement counseling. They also promoted deliveries in institutions.
- Improved adherence with culturally acceptable age specific take home messages among low literate population in resource poor setting.
- Improved nutrition food habits led to reduced opportunistic infections in addition to medication.
- Improved supply of medicines at public ART centres led to continuity in medication.
- Sensitized health care professionals who provide timely services at testing and ART centres.
- VMM with communities developed nutrition recipes book in vernacular became popular.
- VMM has developed a close link of HIV and TB treatment as the co infection is about 40-60%.

Challenges faced and overcome

- Stigma and discrimination at family and community level.
- PCR test for infants below 18 months is not available in the public sector for early identification of HIV to reduce deaths below 18 months.
- Lack of travel concessions by government for public road transport for child with caregivers.
- Intervention among children is different and rather difficult compared to the intervention methods among adults.

Key Recommendations for Scaling Up

- Multiple levels of interventions involving all key actors in HIV/AIDS care, treatment, and counseling, with emphasis on child-friendly means of communications can yield visible impact.
- National AIDS Control Organisation (NACO) needs to design child centric community-based care and support programmes to ensure continuity of adherence levels in existing five states and to scale up them across India.
- Polymerase Chain Reaction (PCR) test for children below 18 months to be available at primary health centre (PHC) level in par with the existing scale up of ICTCs in India.
- Pediatric AIDS care should be mainstreamed into reproductive health and child care (RCH) so that child benefits from other health services as well.
- Pediatric HIV testing should be integrated into the existing Integrated Child Development Scheme (ICDS) services where the mothers will be counseled for testing of their children below 5 years.
- All families should be provided with support to access Public Distribution System by availing ration cards and where eligible, Below Poverty Line (BPL) cards.
- Double nutrition provision for sick children needs to be strictly implemented through ICDS programme where the children living with HIV will get supplementary nutrition.
- Institutional deliveries need to be promoted from 53.6 per cent to above 90 per cent so that the children born to HIV positive mothers can be protected to reduce child mortality from HIV/AIDS.
- Travel concessions on public transport for people living with HIV (including children) and caregivers to travel to ART centres in Andhra Pradesh to be replicated in all states.

Source



Vasavya Mahila Mandali (VMM) is a women managed secular NGO established 40 years ago with the vision to promote comprehensive social, economic and political development for women and children in vulnerable situations, thereby empowering communities in Andhra Pradesh to improve their quality of life, and build a better India. VMM works for reduction of stigma and improving the quality of life through community mobilisation and reached to about 75000 children affected/living with HIV and 'gender' is cross cutting among all the interventions. Empowerment of the women in vulnerability is at forefront of VMM by improving their socio, economic status with dignity and self reliance. VMM has promoted Technical Resource unit to capacitate human resources on mother and child care.

Including the Excluded: Life-Saving Vitamin A Supplements for Children in Bihar, India

Key Highlights

- Sufficient supplies made available by the State Government machinery using their own resources.
- 13.4 million children (9-59 months) reached with vitamin A supplements in 2009.
- 94% of eligible children in Bihar reached with two doses of vitamin A in the calendar year 2009 - protecting them against vitamin A deficiency.
- Emphasis on traditionally excluded children living in hard-to-reach areas and children belonging to socially disadvantaged groups as undernutrition and mortality rates are significantly higher among these groups.
- A combination of cost-effective strategies used to cover maximum number of eligible children – supplementation with routine measles immunization, dedicated bi-annual rounds, use of additional sites for supplementation.

 A child receives vitamin A supplement in Bihar, India (© UNICEF India)



Basic Facts about the Initiative

- Country: India, Bihar
- Title of Initiative: Vitamin A Prophylaxis Programme
- Implementing Agency: Government of Bihar, India
- Intended Outcome and relevant MDG goals: Prevention of vitamin A deficiency and reduction in child mortality (MDG 1 - target 2 and MDG 4 - target 5)
- Specific target group: 9-59 month old children in the state of Bihar

The Development Context

- In India, vitamin A deficiency (VAD) is prevalent among children below 5 years of age. Vitamin A deficiency significantly weakens the immune system, increases infectious morbidity and leads to preventable child mortality. Global evidence shows that in areas where vitamin A deficiency is prevalent, preventive vitamin A supplementation (VAS) can reduce child mortality by an average of 23%. This is why vitamin A supplements are often referred to as *drops of life*.
- The policy of the Government of India is to provide twice yearly preventive VAS to all children 9-59 months old, through the primary health care system and the Integrated Child Development Services (ICDS) programme. UNICEF is supporting the efforts of state governments, including Bihar, to increase access to and coverage with vitamin A prophylaxis beyond the coverage levels achieved through routine immunization and immunization catch-up rounds using bi-annual VAS strategy and additional sites for supplementation. The goal is to reach all eligible children twice a year with VAS - with particular emphasis on children who are traditionally excluded from the delivery of essential health and nutrition services - and ensure that over 90 percent of eligible children benefit from this essential nutrition intervention.
- Vitamin A deficiency has long been a problem of public health significance in the state of Bihar. The state has high poverty and under-five mortality rates (85 per 1,000 live births). Despite continued efforts, the coverage of VAS among children less than 3 years in Bihar was only 26%.
- The Bihar government is ensuring universal vitamin A coverage for eligible children. The coverage data for 2009 indicates that Bihar's vitamin A supplementation programme reached 13.4 million children, protecting 94 percent of children in 9-59 months age group.

Analysis of Success Factors

- Inclusion of excluded children in the programme as result of district level planning. More than 11,000 health centres and 80,000 child development centres and over 3,400 additional temporary sites deliver vitamin A supplements with help of trained volunteers from community.
- All village-based frontline health and nutrition workers and volunteers in the 38 districts of Bihar were trained to administer preventive vitamin A syrup to children and to counsel mothers on how to improve vitamin A content of their children's diet.
- Team work and strong coordination at all levels translated into engagement and motivation of functionaries of two government flagship programmes – Integrated Child Development Services (ICDS), and National Rural Health Mission. They worked together to identify areas and communities that were not reached with VAS earlier due to long distances from the health center, poor connectivity due to lack of motorable roads, absence of health or ICDS centre, and communities predominantly belonging to scheduled castes, scheduled tribes or minorities, and not receiving any nutrition-health services.
- Adequacy of supplies, information and communications used to be the crucial factor for success of the program in reaching out to maximum number of eligible children. An intense IEC effort helped create awareness among community members regarding importance of VAS at district, block and village levels, and motivated them to ensure that the eligible children received supplement.

Key Recommendations for Scaling Up

- Ensuring continued government commitment to the programme with evidence-based advocacy efforts by development partners, and strengthening of collaboration and convergence among government departments involved in programme implementation.
- Strengthening co-ordination among key partners (government departments, international development agencies, and local non-governmental organizations) for VAS, especially for:
 - adequate supply of vitamin A to be administered during the bi-annual rounds and also during routine immunization;
 - adequate number of staff for supplement administration;
 - adequate real-time monitoring and supervision of dosage administration by supervisors and representatives of partner organizations;
 - appropriate record keeping and sufficient monitoring formats; and
 - correct semester-wise reporting of coverage with the inclusion of children covered through routine immunization.
- Using temporary additional sites for better coverage of children residing in hard-to-reach areas.
- Strengthening data management system and feedback mechanisms to improve availability and quality of data to support decision making for the programme, especially for the excluded and most vulnerable segment of the population.
- Intensifying comprehensive efforts to ensure bundling of bi-annual VAS with deworming and nutrition-health education.

Source



United Nations Children's Fund is a driving force that helps build a world where the rights of every child are realized. UNICEF was created to work with partners to overcome the obstacles that poverty, violence, disease and discrimination place in a child's path. UNICEF upholds the Convention on the Rights of the Child. We work in 190 countries through country programmes and national committees to assure equality for those who are discriminated against, girls and women in particular. We work for the Millennium Development Goals and for the progress promised in the United Nations Charter. We believe that we can, together, advance the cause of humanity.

Key Highlights

An evaluation of CLTS conducted in 2009 revealed significant improvements after three years:

- Since 2006, 828 villages in 10 provinces have implemented the CLTS approach, without outside financial or material support.
- Approximately 30 per cent of these villages have reached "Open Defecation Free" status.
- 67 per cent of all households implementing CLTS have sourced materials from their villages to build latrines, making CLTS a cost-effective and efficient approach to improving rural sanitation.
- 91 per cent of households are satisfied with their current latrines and 94 per cent believe their villages now have better sanitation as a result of CLTS.
- Improved safety for women and girls who no longer have to go some distance from their houses where they may be exposed to indignities and potential sexual violence.

📍 A boy in front of a latrine under a UNICEF-supported CLTS program in Sralau commune, Kampong Thom, Cambodia (© UNICEF/CBD/Thomas Billhardt).



Basic Facts about the Initiative

- Country: Cambodia
- Initiative: Community-Led Total Sanitation (CLTS)
- Implementing agency: The Ministry of Rural Development with support from UNICEF, Plan International and other NGOs
- Intended outcome and relevant MDG Goals and targets in focus: CLTS will improve access to basic sanitation in rural areas in Cambodia and therefore contribute to halving the proportion of people without access to basic sanitation by 2015 (MDG 7)
- Specific target groups/beneficiaries: men, women and children at the village and community levels

CLTS is an innovative approach to achieving better sanitation, which motivates people to build their own sanitation infrastructure without depending on subsidies from external agencies. Communities are supported by trained facilitators to analyze the sanitation situation of their villages and to engender commitment and create action plans towards stopping open defecation by building simple and affordable toilets. The approach was first introduced in South Asia.

The Development Context

- Less than 1 in 4 Cambodians has access to latrines and hand-washing facilities, one of the lowest rates in Southeast Asia.
- Lack of sanitation, coupled with poor hygiene practices result in high incidences of diarrhoeal diseases that account for one fifth of the deaths of under five children, and an estimated 10,000 overall deaths annually.
- While only 9.8 per cent of households had access to hygienic sanitation facilities in 1998 this figure had risen to 23.3 per cent in 2008 (General Population Census).
- This shows a reasonable gap of 6.7 per cent from Cambodia's MDG target of 30 per cent. However, this is a more challenging gap of 30 per cent from the MDG target of 53 per cent.
- Even if Cambodia meets the MDG target, 47 per cent of the rural population would still be without access to improved sanitation.

Voices from the Field

"Building a latrine is not difficult, just dig the hole about 1.5 to 3 meters deep, then put the wooden slab a bit higher than the soil level, build the wall and roof, you can have a latrine already. We have to build cover as well to prevent flies from going inside and the smell from coming out." Elderly lady in Prey Norkor village, Otdar Meanchay.

"It is important to continue to remind people of the need to stop open defecation, we are lucky that there are many women in my village who are keen to assist." Mrs. SOUNG Chanthan, CLTS facilitator from Kok Roveng village, Chhrey commune, Prey Veng District, Prey Veng Province who has been nicknamed "grandma toilet" in her village.

Analysis of Success Factors

What has worked and why?

- Community participation that is equitable. By triggering an urgent need for community action to eliminate the health dangers of open defecation, villagers actively participate in building latrines. All villagers have been given the same opportunities to participate and learn from the process.
- A cost-effective approach. Dry pit latrines cost very little if materials are sourced from the villages.
- Effective behaviour change among rural families. Communities are fully informed through awareness raising about negative effects of open defecation.
- Sustainability of improved sanitation and hygiene practices, by putting in place some key elements for sustainability such as cleaning and maintenance of latrines, monitoring mechanisms and behavior change.

What challenges have been faced and overcome?

- The need to develop alternative low-cost durable latrines that utilize indigenous materials and skills, to improve the durability of dry-pit latrines against flood and constant use.
- The number of latrines in most villages does not yet match the number of households. CLTS needs to be scaled-up more widely and to be reinforced with sanitation marketing to make a lasting impact on the sanitation situation in the country.

Key lessons that will be useful for replication

- Communities are willing and able to build their own latrines without subsidies, but this requires good and intensive facilitation skills and encouragement.
- CLTS will not be sustainable in flood-prone villages. These areas do not suit unlined dry-pit latrines, which are the basic latrine that is being built by villagers in CLTS villages.
- CLTS has been more effective in villages not covered by on-going subsidized sanitation programs.

Key Recommendations for Scaling Up

- Low-cost indigenous solutions such as this initiative could be a 'quick-win' intervention to accelerate the MDG achievements, with particular emphasis on ensuring its longer-term sustainability and impact.
- The physical conditions of rural villages need to be properly assessed to ensure suitability of CLTS.
- There is a need for cooperation and collaboration among government and non-government organizations in sourcing talented facilitators and developing appropriate design technologies of latrines.
- The participation and roles of women in village structures and activities should be increased. Evaluation findings indicate that women benefit most by successful CLTS implementation in villages and therefore should play a key role in the CLTS process.
- Sanitation and hygiene need to be integrated and prioritized in local development plans, to ensure sustained support for sanitation and hygiene activities in villages especially when open defecation free status has been attained.
- Scale-up awareness-raising and education on sanitation and hygiene in the target villages.
- Effective monitoring mechanisms and maintenance need to be in place as well as trained facilitators and focal points with good monitoring skills to respond to issues and problems that villages or villagers face during CLTS implementation.
- It is important to establish and strengthen a community monitoring mechanism in order to sustain the achievement of Open Defecation Free status.

Source

United Nations Children's Fund (UNICEF)

Cambodia Country Office
P.O. Box 176, Phnom Penh, Cambodia
Tel: +855 23 426214
Fax: +855 23 426284
Email: unicef_phnom_penh@unicef.org

Contact person:

Hilda Winarta (hwinarta@unicef.org)

Key Highlights

- Targeting low income families unable to afford to send their children to school, the government introduced in September 2009 the free bus fare initiative to ensure that parents send their children to school without incurring extra cost.
- A survey conducted in late 2009 shows a direct correlation between students' fluctuating attendance rate and bus-fare increases.
- 10 million Fiji dollars (5.2 million US dollars) was set aside in the 2010 national budget for this scheme, in addition to providing tuition-free education.
- The scheme has benefitted 490 out of 600 schools on Viti Levu, Vanua Levu, Levuka, Taveuni and Rotuma.
- In addition to this Free Bus Fare scheme, the government has also pledged to provide free textbooks to all students, starting with primary schools.
- 7.4 million Fiji dollars (3.85 million U.S. dollars) has been allocated for the Family Assistance allowance along with a monthly 30 Fiji dollar (15.60 U.S. dollars)-food voucher programme for poor families. Such assistance is expected to benefit around 20,000 people.

Basic Facts about the Initiative

- Country: Fiji
- Title of the initiative: Free bus fare to allow full attendance to school
- Implementing agency: Ministry of Education
- Intended outcome and relevant MDG Goals: Achieve Universal Primary Education-MDG 2
- Target group: Low income families

The Development Context

- Fiji has made significant progress towards providing access to basic education, including addressing the issues of gender parity and equality.
- The primary net enrolment rates increased from 95.98% in 2005 to 96.01% in 2006, yet, student retention and dropout remain challenges for the country. The growing number of drop-outs from primary school is attributed to educational costs such as text books and bus fares.
- The repercussions of the global financial crisis have had an impact on education as well. School dropout rates have worsened with about 15 percent of children not surviving through the full eight years of primary education, while about 74.9 percent did not complete secondary education.
- Due to the rising cost of fuel prices and other commodities, many parents who lived below the poverty line could no longer afford to send their children to school. In most cases, children could only attend classes twice a week thus missing out on important learning.



Analysis of Success Factors

- Government commitment to Education for All, based on the recognition of the poor families' needs and their economic difficulties compounded by the recent financial, food and fuel crises.
- A special committee was set up to develop a set of objective eligibility criteria for the bus fare scheme.
- The scheme is only applicable to students whose parents' collective salaries were less than US\$8,000, and only within an 18km distance or three stages of fares. In order to qualify, parents are required to provide proof of income level.

Key Recommendations for Scaling Up

- A package of effective interventions including a low-cost 'quick-win' measure like this scheme can make immediate and longer-term visible impact on the MDG acceleration on the ground at multiple levels.
- For government to continue to subsidize transportation programmes to allow students to complete full course of primary education rather than early drop outs.
- Nutrition and environment also need to be recognized as contributing factors to early drop outs.
- Resource allocation to early childhood centres and subsidise early childhood centres to cater for enrolment of those children who cannot access nor afford to attend pre-school, as early childhood development is emphasized as a holistic part of the education system.

Story from the Field

Thirteen year old Varaniseese Likuyawa eagerly prepares herself for school daily knowing that she now does not have to walk to school which is four kilometers from her home village of Vuisiga in Naitasiri. Having had to walk to school in the early part of her childhood, Varaniseese would miss going to school whenever it rained heavily as the roads would be all muddy and soggy.

"Before I used to miss school a lot and when my teachers asked me questions in class, I didn't always understand. When they started the carrier, my mum told me that I had to study harder, because I used to be behind in my work when I don't attend school. Ever since the carrier has been taking me to school and home, I am now able to concentrate more on my school work and give better answers to the teachers," she said.

School headmaster, Mr Penijamini Ratabanusu applied for the free bus fare initiative in January and got the approval from the Ministry of Education around February. "The kids are more awake and they pay more attention than they used to. Before they used to be cold after walking in the rain and they get tired. Now the children are more attentive and they are better equipped to learn," he said.

Source

Ecumenical Centre for Research and Advocacy (ECREA) is a Non Government Organisation (NGO) based in Suva, Fiji Islands. It was founded in 1990, with the aim to address the social, religious, economic and political issues that confront Fiji.

189 Rt. Sukuna Rd, GPO Box 15473, Suva, Fiji Islands

Tel: (679) 3307 588

Fax: (679) 3311 248

Website: www.ecrea.org.fj



A stylized graphic of a globe with several curved arrows pointing in various directions, rendered in a light red color against a darker red background. The globe is composed of several curved lines representing latitude and longitude, and the arrows are positioned around it, suggesting movement or progress.

Institutional Support for the MDGs

Key Highlights

The impact of the P3BM initiative is seen as follows:

- Budget allocations for MDG related development sectors in the 18 districts increased by an average of 17%.
- In 2010, the share of “direct development expenditure” (versus indirect mainly for administrative costs) in the 18 districts averaged at 60% compared with 48% in 2009.

Such impact has been made possible due to the following achievements since the P3BM’s inception in July 2008.

- Over 1,000 government officials, local parliamentarians and local NGOs trained on MDG Score-carding, Poverty Mapping, and MDG-based Budget Analysis using Pivottable.
- Data forum and common database established in 5 districts.
- Legally backed by the decree of regents, the P3BM tools including the MDG Scorecard, Poverty Map and Budget Analysis used to advocate planning and budgeting issues in the Multi-stakeholder Consultation Forum for Development Planning (*Musrenbang*) regularly conducted in the 18 districts and three provinces.
- Facilitation of the development and revision of district-Mid Term Development Plans (RPJMD) using the MDG targets and indicators so the Plans become more realistic and measurable.
- Using the common P3BM framework, healthy dialogues between the local government and the local parliament in planning and budgeting.
- *Practical manuals* and regular newsletters on P3BM published and disseminated widely in the country.

Basic Facts about the Initiative

- Country: Indonesia, 18 selected districts in the provinces of West Nusa Tenggara, East Nusa Tenggara and Southeast Sulawesi.
- Title of the initiative: Pro-Poor Planning, Budgeting and Monitoring (P3BM).
- Implementing agency: UNDP Indonesia in partnership with the Ministry of National Development Planning and local authorities of the selected provinces and districts.
- Intended outcome and relevant MDG Goals: Goals 1 to 7 with a special emphasis on Goal 1 (Eradicate Extreme Poverty and Hunger).
- Specific target groups: Local government officials, local parliaments and local CSOs. As the initiative is on planning, budgeting and monitoring, it is directly linked to policy-making processes and policy documents such as the Five-year Mid-term Development Plans, Annual Development Plans, Annual Budget Documents.

An Example of P3BM Tools: MDG Scorecards

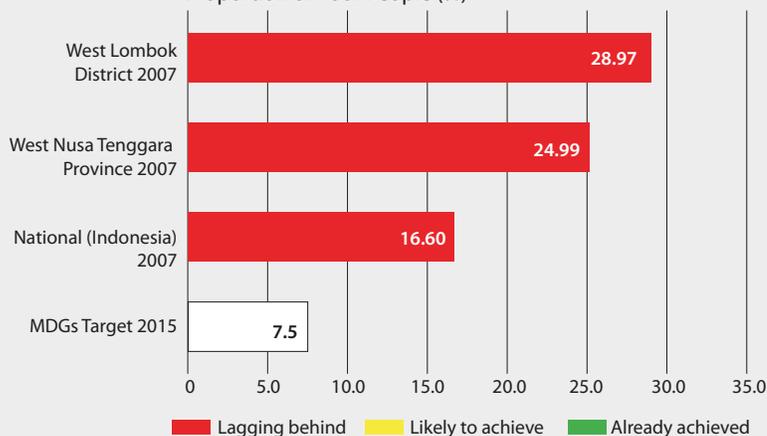
Goal 1: Eradicate extreme poverty and hunger

Target 1A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Proportion of Poor People (%)



Percentage of poor people in this district far higher than those of provincial, national and global targets



Source: National Statistic Agency 2007

The Development Context

Starting in 2001, the Government of Indonesia has decentralized responsibility for development sectors to autonomous district governments while significantly increasing funding allocations from the national budget to provincial and district governments. Since then fiscal decentralization has further progressed, and in 2006, provincial and district governments spent 40% of all public funds in Indonesia, a level of fiscal decentralization higher than any other East Asian country except China. Fiscal decentralization offers the potential to improve provision of public services and to support MDG achievement. However, capacity within many district governments to plan, budget and implement programmes is limited and a high percentage (often over 60%) of district budgets are allocated to pay for wages of civil servants and other overhead costs of local government.

Major constraints to improving the effectiveness of poverty reduction programmes in Indonesia have been identified as follows, which provided the basis for developing this P3BM initiative:

- Provincial and District Poverty Reduction Strategies and Plans often lack realistic targets and expected outputs related to poverty reduction or provision of health and educational services to the poor which are backed up by annual budgets.
- Targeting of the poor in poverty reduction programmes is often not carried out in a systematic manner at the local level.
- Capacity building of local communities is not given adequate attention, resulting in local people not participating effectively in planning, implementation, monitoring and evaluation of programmes, thus significantly reducing the impact of these programmes on the targeted groups.
- Often poverty reduction programmes lack effective monitoring and evaluation systems in place, including participatory M&E, which has resulted in inadequate level of feedback for improvements in implementation.
- Lack of information exchange and coordination among central and local poverty reduction programmes hamper optimal results in addressing the needs of the poor.

Analysis of Success Factors

What has worked?

- Simple and practical P3BM methodology and tools (MDG Scorecard, Poverty Maps, and Budget Analysis).
- The results of P3BM analysis easily interpreted and applied into the local planning and budgeting processes.
- Cross-fertilization of P3BM methodologies and tools among participating districts and provinces through regional and national training workshops.
- Political commitment by the local government and multi-stakeholder participation.

Why it has worked?

- Strong ownership by the local stakeholders especially local government authorities, evidenced by the cost-sharing arrangements in many districts.
- Strong political will and commitment by the local leadership (provincial governors and district heads).
- Responsive to the need for improved planning and budgeting processes at the local level.
- The pace of the project determined by the planning and budgeting cycles at the local level.
- Active participation of local stakeholders in the training activities which are facilitated by solid and technically capable P3BM team.
- Measurable successes have encouraged different stakeholders at the local level to replicate and build on the achievements.
- Multi-level and multi-stakeholder involvement (national, provincial, and district; governments, parliaments, CSOs, academics and media).

What challenges have been faced and overcome?

- Frequent change of local government staff and local leadership.
- Proliferation of regions (village, sub-district and district) leading towards change of data structure. This has influenced the availability of data needed for the P3BM analysis.
- Political interest in planning and budgeting.

Key Recommendations for Scaling up

- Multi-level and multi-stakeholder involvement in an MDG localization exercise to identify local priorities by using reliable data and tools can significantly contribute to improving implementation of MDG related programmes.
- Formulation of a Presidential Decree or Joint Circular Letter is essential to institutionalize P3BM in the planning and budgeting.
- Distributing *Manuals and Guidelines for Compiling MDG Database and Program Database* to wider stakeholders in the country.
- Disseminating P3BM among the Parliamentary Budget Committee, relevant Ministries and Agencies, and NGO and University Networks.
- Conducting a National P3BM Symposium involving all relevant stakeholders with an aim to formulate an action plan and to institutionalize P3BM at the national level.
- Coordinating with the education and training agencies at central and regional level, and providing TOT for their staff, in order to technically prepare human resources for disseminating P3BM widely.

Source

UNDP Indonesia

Menara Thamrin 8th Floor, Jl. MH Thamrin Kav. 3, Jakarta 10250, Tel: +62-21-3141308, Fax: +62-21-39838941

Key Highlights

The National Response to HIV and AIDS has successfully scaled up HIV prevention, treatment, care and support for People Living with HIV (PLHIV) in Cambodia and generated benefits at the individual, community and health centre level due to a high level of collaboration among all stakeholders. Significant improvements have been documented in the past ten years:

- 100% condom use programme ensured the availability of condoms in all entertainment establishments where sex could be procured.
- Over 90% of entertainment workers and men who have sex with men (MSM) have received HIV and AIDS education.
- At the end of 2009, a total of 37,315 people with advanced HIV infection received antiretroviral therapy (ART), including 33,677 adults and 3,628 children. This is 92.17% of those in need.
- The number of HIV-infected pregnant women who received ART to reduce the risk of mother-to-child transmission of HIV increased from 505 in 2007 to 798 in 2009 (32.24%).
- Survival of PLHIV on ART after 12 months is estimated to be 87.4 % in total (86.7 % of adults and 93.9 % of children).
- The number of health facilities providing Voluntary and Confidential Counseling and Testing (VCCT) has increased from 197 in 2007 to a high of 233 in 2009.

- PLHIV receiving drug counseling at the Battambang referral hospital (© FHI).



Basic Facts about the Initiative

- Country: Cambodia
- Project: National Response to HIV and AIDS (National Strategic Plan II 2006-2010)
- Implementing agency: The National AIDS Authority (NAA) in collaboration with line ministries, UN agencies, development partners and civil society at national and sub-national level.
- Intended outcome and relevant MDG Goals: Contribute to the decrease in HIV prevalence, scale up effective HIV prevention and expand care, treatment and support for People Living with HIV (PLHIV) (MDG 6)
- Specific target groups: People Living with HIV (PLHIV) and most-at-risk-populations (MARPs)

The Development Context

- While 2 % of the population was infected by HIV in 1998, the prevalence has reduced to an estimated 0.7 % by 2010. Due to this, Cambodia is one of the few least developed countries that are on track to meet MDG 6.
- Cambodia has also exceeded its international commitments and its own CMDG target for 2015 and Universal Access target for 2010, since 92.17 % of eligible PLHIV are receiving ART in 2009. This is due to the expansion through the Continuum of Care (CoC) programme established in 2003.
- The epidemic is changing and the response has to pragmatically address challenges and areas which have not received sufficient attention such as maternal and child health and impact mitigation/support to orphans and vulnerable children along with stigma and discrimination and MARPs.
- Stigma and discrimination against PLHIV remains high and creates a barrier to accessing services for prevention, care, support and treatment.
- The epidemic in Cambodia is concentrated among entertainment workers, men who have sex with men and injecting drug users. Although prevention programmes have had significant results, HIV interventions targeting most-at-risk populations have been hampered due to changes in legal and policy environment.
- The national response is highly dependent on external funding with only approximately 10% of AIDS spending covered from domestic sources.

Analysis of Success Factors

What has worked and why?

- Strong political commitment and leadership by the Royal Government of Cambodia in responding to HIV, together with substantive external financial support from various sources and a vibrant civil society response.
- Working in collaboration with different national programmes has contributed to the results.
- The Continuum of Care (CoC) has followed internationally endorsed standards of good practice.
- A culture of learning by doing and a comprehensive approach to capacity building.
- A four-pronged Linked Response approach for Prevention of Mother to Child Transmission (PMTCT) has increased the coverage and quality of services, as well as referral linkages.

Challenge faced and overcome

- A major challenge is the scale-up and more strategic targeting of HIV prevention at most-at-risk populations.

Key lessons useful for the replication within the same country or another country

- The successful implementation requires effective management and strong cooperation among all stakeholders including government entities, civil society, private sector and development partners.
- VCCT services are an integral part of the CoC and serve as key entry points for prevention, treatment and care services.
- The availability of financial and human resources is crucial to sustain the coverage of ART as well as prevention services.

Key Recommendations for Scaling Up

- Development of coherent and comprehensive policy responses supported by strong political commitment by the government and coordinated civil society involvement can be a model for other countries' efforts for making rapid progress in the HIV/AIDS target.
- Strengthen enabling legal, institutional and policy environment in order for the key populations to access prevention, care, treatment and support services.
- Collaboration between government and civil society needs to be strengthened to build on their experiences and extensively involve PLHIV in decision making for mechanism that has implication on service provisions.
- Regular reviews of progress involving all the stakeholders help in detecting what works well and what does not work so well and subsequently in adjusting interventions to ensure that targets are met.
- A wide range of partners need to work together in order to scale up required services. For example: prevention of Mother to Child Transmission and prevention among Most at Risk Population.
- An effective communication strategy is important since awareness on HIV prevention, treatment, care and support can be attributed by intensive programme activities, combined with suitable messages through media.
- A nascent surveillance system needs to be strengthened and scientific information need to be used consistently by key stakeholders to guide the response and advocate change.
- Increase domestic funding in order for the response to be sustainable.
- The contributions of the HIV health sector response needs to be recognised and maximised in order to strengthen health systems in general with the aim of addressing other concerns (e.g. maternal and new born health, sexual and reproductive health, tuberculosis, paediatric care, laboratory services and infection control).
- Stigma and discrimination against people living with HIV needs to be addressed with the goal of elimination.

Source

National AIDS Authority (NAA)

Building 16, Street 271 and corner Street 150, Toeuk Laark 2,
Tuol Kork, Phnom Penh
Tel: (855) 23 883 540
Fax: (855) 23 885 129
Website: www.naa.org.kh

Contact person:

Dr. Teng Kunthy, Secretary General of the National AIDS Authority

The Gender and Development Code of Ifugao as a Tool for MDG progress

Key Highlights

- The passage of the Anti-Violence against Women and Children Act of 2004 (Republic Act No. 9262) provides a definition of all forms of abuse and violence within the family and intimate relationships and the penalties for such acts.
- The Anti-Trafficking Act of 2004 (Republic Act No. 9208) seeks to protect Filipino citizens from all forms of human trafficking.
- The two Acts paved the way for the emergence of inter-agency councils in local government units.
- Councils within the Provincial Government, through the legislative branch, passed the Ifugao GAD Code into law in 2007.
- To further address the problem of gender-based violence against women, the Provincial Council against Gender Violence and Trafficking ratified the Code's Implementing Rules and Regulations through Council Resolution No. 01 Series of 2008.
- From 17 cases in 2005, the number of reported cases steadily increased to 21 in 2006, and 55 in 2007, which demonstrated increasing public awareness as well as the efficiency of the reporting system.

Women of Ifugao, Philippines shown above in their traditional skirts, no longer have to play tug-of-war for their rights. The Ifugao Gender and Development Code passed in May 2007 ensures gender-responsive policies are promoted and gender concerns are integrated in public programs and projects. The Code also includes provisions for mainstreaming interventions addressing violence against women.



Basic Facts about the Initiative

- Country: Philippines, Province of Ifugao
- Title of Initiative: Ifugao Gender and Development Code of 2007
- Implementing Organization: Philippine Legislators' Committee on Population and Development (PLCPD)
- Intended Outcome and Relevant MDG goals: To promote gender equality and empower women / MDG 3
- Target group: Women and children in Ifugao Province

The Gender and Development (GAD) Code of Ifugao, passed on May 21, 2007, is a pioneer provincial code led by a multisectoral team focused on issues concerning gender and reproductive health. Among its objectives are to promote gender-responsive policies and to ensure that gender concerns are integrated in public programs and projects. Furthermore, the Code includes provisions for mainstreaming interventions addressing violence against women. Ifugao is the first province in the country to come up with a provincial and municipal GAD Code.

The Development Context

- The conservative Ifugao culture prohibits the open discussion of sex, even in legal cases. Ifugao ethics bans use of words pertaining to reproductive organs, sex, and reproduction. This cultural factor prevents women from discussing in detail how they were harassed, leading to incomplete court testimonies. Victims of rape, young or adult, often deal with injustice as family members themselves try to silence the victims. Others do not even file sexual abuse cases as their families choose to resolve matters among themselves.
- Progress on MDG achievement has been hampered somewhat by the moral and ethical beliefs of Ifugaos. For them, morality has to conform to the will of the gods. An Ifugao who did something deemed unacceptable to the gods faces social ostracism as punishment for his acts.
- Currently, the Code mandates all concerned departments of the local government, including the municipalities and line agencies, to act within 24 hours upon receipt of complaints or reports of violence against women and children.

Analysis of Success Factors

- Women became more involved in referring victims of violence to the proper authorities after the Code was passed, while they had been active agents to address gender related issues in the community.
- The GAD Code had intensified local laws such as the executive order creating the Provincial Council against Gender Violence and the Trafficking and the Reproductive Health Ordinance that embodies an integrated and comprehensive reproductive health care and responsible parenthood focused on the time-honored value of respect for human dignity, people's right and their families.

Key Recommendations for Scaling Up

- Adoption of such codes and other legal mechanisms helps establish objective standards and rules for enforcing gender related rights and entitlements.
- Ensure implementation and monitoring of the GAD Code by the Provincial Government through the Provincial Council against Violence and Trafficking (PCAGVT).
- Recognize the role of women's organizations and the Provincial Social Welfare and Development Office as advisers to these groups.
- Encourage the participation of men in the campaign to uphold women's rights and end gender-based violence.
- Advocate legislation that support issues addressed in the Code, including general health, nutrition, reproductive health, women in governance, violence against women and children, and justice, peace and order.

Source

Philippine Legislators' Committee on Population and Development (PLCPD)

2/F AVECSS Bldg., #90 Kamias Road cor. K-J Street, East Kamias, Quezon City, Metro Manila, Philippines

Tel: +632 925 1800 and +632 436 2373

Email: plcpdfound@plcpd.org.ph

Website: <http://plcpd.org.ph>

Contact person:

Ramon San Pascual, Executive Director

Reference:

- Gender and Development Code of Ifugao, PLCPD
- All About Violence Against Women: An Information Kit, PAD-NCRFW and UNFPA, Manila, 2005

ENDPOVERTY 2015 millennium campaign

UN Millennium Campaign Asia and the Pacific

UN Millennium Campaign Country Offices

UN Millennium Campaign

Asia and Pacific Regional Office
Rajadamnern Nok Avenue,
Bangkok 10200, Thailand
Tel: +66 2 288 2592
Fax: +66 2 288 1052
Email: mc-asia@un.org

BANGLADESH

Monisha Biswas

UNDP Office, IDB Bhaban,
Dhaka-1000
Tel: + 880 2 815 0088 (ext.1244)
Fax: +880 2 811 3196
Email: monisha.biswas@undp.org

CAMBODIA

Mary Sok

Office of the UN Resident
Coordinator, No. 53 Pasteur Street
Phnom Penh
Tel: +855 (0) 23 216 167/216 217
(ext.122)
Email: mary.sok@one.un.org

INDIA

Mandira Moddie

Resident Coordinator's Office,
United Nations Building
55, Lodhi Estate, New Delhi – 110003
Tel: +91 011 46 532 376
Fax: +91 011 24 627 612
Email: mandira.moddie@un.org.in

INDONESIA

Wilson T.P. Siahaan

United Nations,
Jl.M.H. Thamrin kav.3
P.O. Box 2338, Jakarta, Indonesia
Tel: +62 21 314 1308 (ext.226)
Email: wilson.siahaan@undp.org

NEPAL

Seema Rajouria

RCO Unit, UN House, Pulchowk, G.P.O.
Box 107, Kathmandu
Tel: +977 1552 3200 (ext.1507)
Email: Seema.rajouria@undp.org

PAPUA NEW GUINEA

Eileen Kolma

UN House, Deloitte Tower, Level 14
Douglas Street, N.C.D. P.O. Box 1041
Tel: +675 321 2877
Fax: +675 321 1224
Email: eileen.kolma@undp.org

PHILIPPINES

Dulce Saret

UN Coordination Unit, 29th floor,
Yuchengco Tower, RCBC Plaza
6819 Ayala Avenue, 1226 Makati City
Tel: +632 901-0406
Fax: +632 901-0404
Email: dulce.saret@one.un.org

PACIFIC SUB-REGIONAL OFFICE

Agnes Ali

United Nations, Fiji
7th Floor, Kadavu House
414 Victoria Parade, Suva, Fiji Islands
Tel: +679 3300 399 (ext. 203)
Fax: +679 3301 976
Email: Agnes.Ali@undp.org