"TOGETHER FOR BETTER HEALTH, FOR US, BY US"
April – June 2012 Report

INTRODUCTION

I. PREPARATION PHASE

1. Main aims and plans

This grant adds a health component to OvidiuRo (OvR) educational program ***Fiecare Copil in Gradinita*** (Every child in preschool)[1], by allowing communities in the project to determine the most pressing health needs of its preschool children and to use their grant allocation to meet these needs, under OvR consultation and monitoring.

In Romania, the specific objectives of the grant, over the three years, are to:

- Create awareness and provide parents with tools for behavior change to **prevent outbreaks of infectious diseases** and other health-related issues that affect school attendance;
- Ensure children in the project benefit from required vaccinations and regular **check-ups**;
- Facilitate closer collaboration with local **health mediators and/or GPs**;
- Enable impoverished parents to purchase **medicines**, vitamins, and hygiene supplies;
- Encourage mothers' gynecologic check-ups and use of **contraceptives** for family planning.

First year plan:

- April – July 2012 – set up project team, call for proposals from the 20 FCG communities, evaluate applications, negotiate budgets, create monitoring and reporting tools;
- July – August 2012 – meetings in each community; health and hygiene education activities within summer programs for 5 and 6 year olds;
- September 2012 – June 2013 – direct health interventions by local teams; collaboration with Public Health Departments, NGOs, National Roma Authority, Ministry of Health etc.

2. Identification of target group

In Tarlungeni comuna, Brasov county, 130 impoverished children will be supported through the health grant

The funding was open to all 20 communities that are implementing the ***Fiecare Copil in Gradinita (FCG)*** project – out of these, 18 applied to the health minigrant.

FCG components:

1. **Leadership of local authorities** and a proactive Local Action Group;
2. **Door-to-door recruitment** of children at risk for school drop out;
3. **Teacher training** in modern methods and strategies for working with disadvantaged children;
4. **Parent engagement through incentives** for children's daily attendance in preschool.

Mini-grant target group is the same as for FCG:

- Children 3-6 years old from impoverished families (determined by income per family member less than 35€ per month, substandard living conditions, and low education level of parents.
- Parents of these children (and indirectly their siblings and other close relatives)

[1] ***Fiecare Copil in Gradinita (FCG)*** ensures preschool attendance of impoverished 3-6 years old children by provision of conditional cash transfers in the form of food coupons worth of 12 euros per month, if children attended daily.

3. Implementation strategy

Application process: Each community filled in an application identifying the main health needs of children, the types of interventions to be done and resources needed, and describing the local health infrastructure (number of GPs, existence of health mediator, distance to medical clinic etc.). Requests were analyzed based on: gravity of problem and number of children in each community, coherence of the application and validity of the suggested solutions, cost-efficiency report and the self-sustainability of interventions.

Budget: The communities were not given a budget limit because we wanted the local teams to identify the real needs of the children and their families, and then to prioritize them. Most teams requested hygiene kits, vitamins and parent education activities; only a few went into medical interventions, such as medical tests or support for hiring a health mediator. (This is mainly because school directors, who are FCG local coordinators and who wrote the applications, do not collaborate much with GPs, as school medical cabinets do not exist in rural areas. One of our goals is to improve communication through this grant). The total request was over 80k euros, double our grant amount – indicating a huge lack in current medical services.

Funding priorities: The OvR team visited each community to discuss the proposal with parents, GPs, HMs, mayors, and the proposed local coordinator. Based on this discussion the OvR grant manager, FCG community coordinator, and GSK's CSR manager identified the following priorities:

1) **Prevention activities:**
    a. Basic **analysis** for children, in September (throat swab, stool exam);
    b. Fund for parents to buy prescribed **medicines** that are not free;
    c. Educating parents re mandatory **vaccinations**;
    d. **Vitamins**;
2) **Access to healthcare** activities:
    a. Funding **transportation** costs – so that children can be seen by specialized physicians;
    b. Encouraging GPs to make weekly **visits in isolated communities**;
3) Support for **health mediators**;
4) **Health education** and distribution of personal and home hygiene products;
5) **Family planning**.

1) PREVENTION ACTIVITIES

Medical Tests: During community visits we learned that practically none of the impoverished children we support has ever had a routine medical test – although these are mandatory for preschool registration. These test are not widely available for free and poor parents don't afford them, even when they are aware of their importance, and usually the school principals „close their eyes" and allow children to register without the tests. Although not all communities asked for this activity to be funded, we decided to finance basic medical tests (throat swab and stool sample) for all children in the project.

Medicine: Even when diagnozed, parents often cannot afford to buy the prescribed medicines. For acute infections, the medicine must be purchased within 24 hours or the prescription expires. Most medicine for children is free, and when it is not, the costs are usually small, but for impoverished parents with several children they are a hurdle to timely care.

Immunization: While the state says that over 90% of children should be immunized, the average in our communities is 70%. A few communities had vaccination rates are as low as 50% and one (the extremely impoverished Roma settlement in Ponorata, Maramures county) had 20%. Despite the fact that vaccines are available free of cost, parents' ignorance about the importance of vaccines and their fear of common side-

effects prevents some from immunizing their children. The project encourages doctors and health mediators to communicate more effectively with the parents on this issue.

Allocation per child for basic prevention: 2 eur for monthly „Fruit Day" and for providing soap and toilet paper (usually lacking in state schools) accompanied by activities to encourage washing hands.

2) INCREASED ACCESS TO HEALTHCARE SERVICES

Transport: More than half of the children live in villages that are kilometers away from the medical clinic, with no public transport available (none of the parents in the project have cars – only a few who own a cart, a horse or a bicycle). In Floroaia Mica, a neighborhood in Intorsura Buzaului town, Romania's coldest area, parents must walk with their children 5 km round trip to get to the clinic, sometimes at below -20 degrees Celsius, while the medic only visits the community for emergencies or to see new-born babies. In Ocolna, Dolj county, the children live 10 km away from the village where there is a GP – they hitch-hike or walk. Even where the medic is close, some pharmacies are only open a few hours a day or even twice a week, so parents must go to the next town to buy medicines – which they often don't do because of trip costs. Thus, many children are not properly treated, and very few ever make it to the specialized eye doctor, dentist or speech therapist, although many should. The most common health problems of children are atsma and ongoing respiratory infections, sight and hearing problems caused by untreated infections, and parasitosis. The grant will cover transportation costs of children to medics and mobilize GPs to give weekly consultations in isolated communities.

3) SUPPORT HEALTH MEDIATORS INVOLVEMENT

According to the law, City Halls can request the Health Ministry to pay for a health mediator; still 10 of the 18 FCG communities do not have one, and most mayors told us they are not allowed to hire new people anyway[2]. On the other side, the existing HMs have unclear roles since now they are hired by City Halls (doing a lot of social, rather than health-related work), but report to the Public Health Departments. Even so, health mediators are very important, especially in isolated villages. The grant will facilitate the training and temporary payment of 5 health mediators. Our strategy is to cover the part-time salaries of the HMs, while the City Hall commits to make all necessary steps to obtain funding and have the position unblocked by the ministries in charge.

4) HEALTH AND HYGIENE EDUCATION OF CHILDREN AND PARENTS

Lack of proper hygiene is one of the main issues teachers have to fight with daily, and the main source of recurrent diseases. It's vital that parents understand the severe implications that lack of hygiene has for the children. As the amount requested for hygiene kits was way too high for our budget in this grant, we are supplementing it from other in-kind donations. So far, GSK Romania donated 1400 sets of tooth paste, tooth brushes and cups for the children, and we obtained shampoo and detergent from Procter & Gamble. We are approaching other companies for soap, bleach, towels etc., and are planning to meet with representatives of all Public Health Departments in the counties where we work, to obtain the anti-lice solution, which is free but not widely available – in order to allow for the GSK financial grant to be used mainly for medical interventions.

5) FAMILY PLANNING

An important intervention, but which unfortunately cannot be financed on large scale at this point, is birth control. Natality rate among the poorest Romanians (mostly Roma) is three times higher than the average national rate. Despite common opinion that poor families want to have more babies in order to benefit from the state allowance of 45 euros per child per month, for the child up to age 2, our observations show that many women do not want more children, but either they are not aware of birth control methods, or these are too expensive. Right now, in Romania the only free contraception method (besides condoms which are very little used in poor communities) is one type of birth control pill, which doesn't fir for all women and is not stable (the type changes every few months according to what funds are available). In order to benefit from free birth control pills through national health programs, women must have a hormonal test, which costs over 50 euros.

[2] Since 2010, the Romanian Government introduced, as crisis measure, restrictions for public institutions to hire new people. The rule is that for each new person to be hired, seven other must have quit, retired or been fired. This absurd rule made it difficult for authorities in Araci to hire a new health mediator when the previous one left to work in Sweden, for example, and it keeps being an obstacle in hiring new health mediators. These positions can be unblocked with a good justification, but it is a long and beaurocratic process.

During the first year of the grant we will cover the cost of birth control interventions in three communities where such programs have already been started, so women already had their tests done or can have them done for free, and where the GP is willing to conduct such programs.

II. IMPLEMENTATION PHASE

1. Highlight (3 months of implemented period)

Community visits to identify needs – In May, OvR team visited all the communities and had in depth discussions with all involved, in order to identify the health needs of impoverished children and to understand how the health system in rural Romania really works. We identified a few key points in which this health grant can produce visible results. It is now clear that the first year of the project will be a pilot year that will focus on having in each community (1) a clear evaluation of the children's health situation, (2) a functional local group focused on solving health needs, and (3) an efficient monitoring system. Besides the activities that will be common for all communities, we chose to fund other punctual interventions, as proposed by the local teams, in order to see what works and what doesn't and to collect as many "lessons learned" as possible (such as installing showers and washing machine in one community where lack of hygiene is a big issue, providing vitamins in winter months in another, financing vaccins that prevent reccurent respiratory diseases, or a logoped to come regularly to work with the children in other communities, and co-financing a fountain to be built in one village where water is contaminated and children are always sick because of that).

High enthusiasm for the project – double launch, with wide media coverage *(see media report attached)*:

- April 23, Tarlungeni village, Brasov county – the grant was introduced to local communities through a mix of media event (national and local press), family visits and discussions among 25 GPs, health mediators, directors of local Public Health Departments, and school directors. The event promoted the grant and gave local teams a clear idea about the funding priorities and possible project activities.
- June 6, Bucharest – Pascal Prigent, GSK Romania General Manager, Leslie Hawke, OvR President, and two school principals spoke to the national media, health authorities and NGOs about the health needs coverd by the project. Connections to be followed-up this summer were made with Sastipen, the Roma NGO that trains health mediators, the National Agency for Roma, and the National Public Health Institute. We are exploring training/mediation sessions for local community members with Mariana Buceanu, an experienced trainer of mediators and public institutions employees.

2. Problem solving

So far, the main problem seems to be the big difference between how things should work based on existing laws and regulations, and the reality in these communities. For example, GPs in one "comuna" (an administrative area formed of a few villages) should do medical check-ups in each village, once per week – if the population is higher than 50 people. However, in reality these medics only go to isolated villages in emergency cases or to visit new-borns, and then they don't have time to consult other people in the village.

The health mediators can be hired by City Halls, with funding from Public Health Departments. Still, mayors don't understand the system or don't have the will to fight beaurocracy, so many communities that badly need a health mediators, do not have one. Also on paper, the HM is responsible for a wide range of useful interventions in the community; in reality, with two supervisors who are not communicating between them, it is common that HMs don't perform their tasks as much or as well as they should.

If we really want to improve the children's health state, rather than preach about what should be done, but is not, we must use the first year of the grant to fill in the gaps in each community – while lobbying for the law to

become practice. For example, we will temporarily pay for the salaries of health mediators, although they should be paid by the Health Ministry, while conditioning the City Halls to start hiring procedures, and we will stimulate local GPs to go weekly in isolated communities, by paying them extra for the hours they spend there consulting people – while trying to find a better solution through Public Health Departments.

3. Time line for next 3 months

July – August:

- Project planning visits in each community (communication of final costs approved, finalize local project teams, set-up logistics, agree monitoring and evaluation procedures)
- Training for 5 health mediators (with the support of Sastipen NGO, authorized in training HMs)
- Pilot health education activities with children aged 5-6 during summer schools in 14 communities
- Pilot training in one community, for the "health action group"
- Weekly GPs visits in three isolated villages

September:

- Basic medical tests for all children in the project
- 5 trained HMs start working (hired by local communities, with funding from the health grant)
- 3 GPs continue weekly visits in isolated villages
- Health education activities for parents and children
- Other direct interventions (transport, support with medicines, etc.)
- Networking with public authorities, NGOs and other stakeholders

III. ASSESSMENT PHASE

1. Risks and changes within the project

- **Political instability** – 2012 is electoral year in Romania (local elections in June, Parliamentary elections in November). In addition, the Government was changed in April following protests. Political instability makes it common for school inspectors, heads of public health departments, mayors and even school directors to be suddenly revoked from these positions. In one community that applied for the health grant, the vice-mayor who was our strong supporter, has just been replaced, the school principal became school inspector and the new school director is not interested in our project; the whole project team somehow disassembled. We will meet the new people to see if we can continue our project here, but we are not very optimistic based on signals received. Besides the risk of stopping the project (which makes our investment so far punctual and short-term), this also affects our lobby efforts, as officials we talk to one day are gone the next and the situation will continue to be unstable until the end of the year.
- **Budget limits** – the financial needs related to health in our communities are much higher than the amount we have at our disposal through this grant. This is due to the extremely bad health infrastructure, and a general lack of funding in the Romanian medical sector. We are trying to supplement the GSK health grant with in-kind donations or OvR's contribution.

2. Improvements and results

a/ **Monitoring and evaluating** – we are now creating monitoring tools, such as the activity card inspired from the Bulgarian team, which we will adapt to GPs and HMs, narrative and financial report forms and other project management tools to help teams keep track of activities, results and costs.

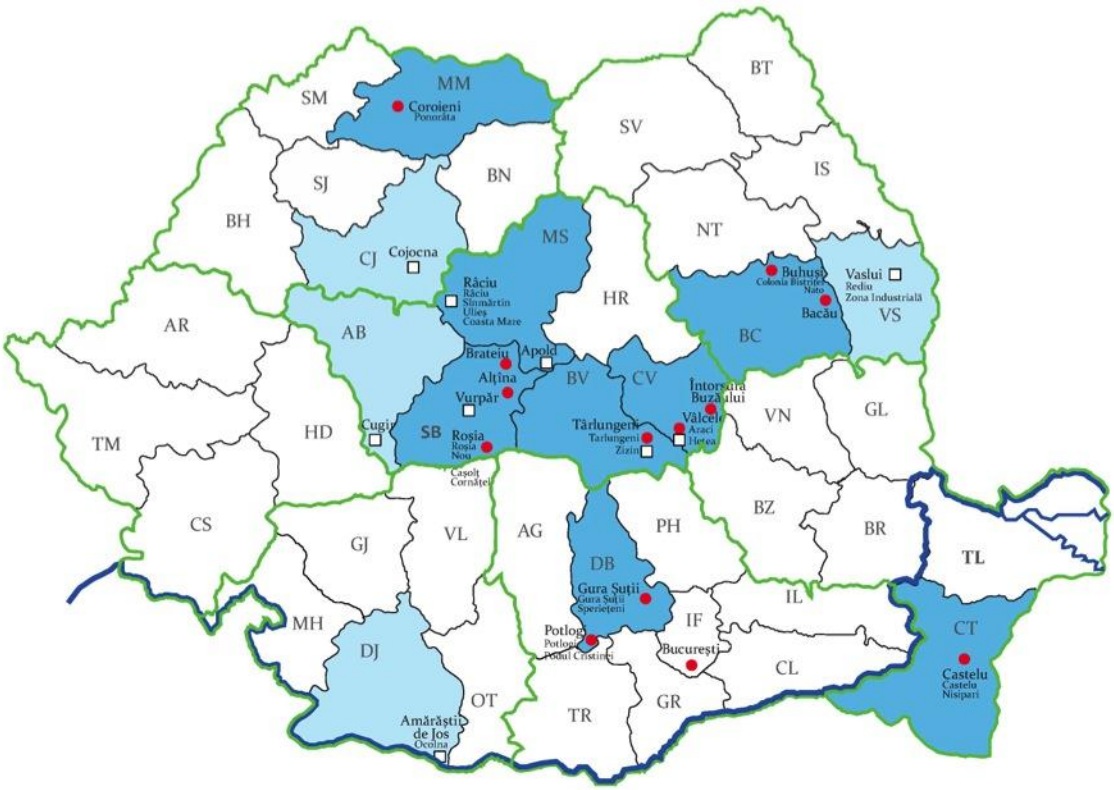
b/ **Programme staffing, local ownership and empowerment**

- On OvR side, the program is managed by Alina Seghedi, and supported by Iolanda Burtea as project assistant and Timona Cioinea, accountant. Besides these three positions that are budgeted for, the health grant is supported by our four FCG program managers who have the oversight on each community, and by our PR team, for promotion events and media relations.
- In communities, the project is coordinated in most cases by the existing FCG local coordinator (usually the school principal or a teacher), but there are also communities in which the coordinators proposed

are the health mediators or employees of the City Hall's social department. The local project teams are formed by GPs, nurses, HMs, teachers, mayor, school principals, and indirectly school mediators and social workers. We will try to involve experts from the County Public Health Departments, as well as the Roma expert in the Prefectura (the representatives of the National Agency for Roma in each county).

IV. ATTACHMENTS

1. List of regions involved in the program



Tărlungeni (Brașov), Araci & Întorsura Buzăului (Covasna), Râciu & Apold (Mureș), Roșia, Vurpăr, Alțîna & Brateiu (Sibiu), Cojocna (Cluj), Cugir (Alba), Coroieni (Maramureș), Amărăștii de Jos (Dolj), Potlogi & Gura Șuții (Dâmbovița), Buhuși (Bacău), Vaslui & Castelu (Constanța).

2. Interim Financial Report – see attached Excel document

3. Project in the media/Media monitoring – see attached media report