



**Best Practices in Egypt:
Engaging Community Leaders to Create a Movement for Change**



The CATALYST Consortium is a global reproductive health and family planning activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health of the United States Agency for International Development (USAID). The Consortium is a partnership of five organizations: Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia. CATALYST works in reproductive health and family planning through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality reproductive health and family planning services and healthy practices through clinical and nonclinical programs.

Mission

CATALYST's mission is to improve the quality and availability of sustainable reproductive health and family planning services.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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THE NEED

Reproductive health and family planning (RH/FP) decision making takes place within a complicated web of social influences. When an individual, couple, or family wishes to consider whether to delay marriage and childbearing, avoid female genital mutilation or gender-based violence, or choose to space births and take advantage of RH/FP services, they often rely on others for information, advice, encouragement, role modeling, and assistance. This is certainly true in Egypt, where a variety of community leaders—clergy, community outreach workers, traditional birth attendants, teachers, local civic leaders, the media, and others—have great influence over community attitudes, norms, and practices. With up-to-date knowledge and technical support, these leaders can be powerful forces for positive change.

Community leaders have the potential not only to share accurate information, help create an environment of open dialogue about difficult topics, dispel myths regarding contraceptive use, inform communities on the appropriate use of routine and emergency RH/FP services, and challenge unsafe traditional practices, but also to act as visible role models, embodying recommended behaviors, and mobilize community action in support of clinics and the health of their neighbors. If, on the other hand, these leaders disseminate inaccurate information or persuade others, through their words or actions, not to adopt healthier behaviors, their influence can do incalculable damage.

THE TAHSEEN SOLUTION

TAHSEEN recognized the extraordinary, largely untapped potential of these leaders to act as RH/FP champions for their communities. It therefore, devised a series of activities designed to gather them together, educate them about pressing RH/FP issues, and give them the skills and tools they need to communicate to, and mobilize their communities. Collectively, these leaders:

- **Raise awareness and knowledge** about RH/FP, including recommended RH/FP behaviors (optimal birth spacing, use of routine and emergency postpartum services, use of emergency postabortion services, delayed marriage and childbearing, continued schooling for girls, couple and intergenerational communication about RH/FP issues).
- **Encourage and endorse recommended behaviors** by engaging in open dialogue about RH/FP issues and contribute to the creation of community norms supportive of behavior change.
- **Facilitate community access to services**, for example, by making people aware of the presence of a newly renovated clinic in their vicinity or by mobilizing support for emergency transportation options for women experiencing obstetric emergencies.

- **Mobilize community support for clinics**, for example, by participating on clinic boards. These boards mobilize community and private resources for the clinics. Support is also encouraged by publicly recognizing the good work being done by health providers, outreach workers, clinic boards, the commercial sector, NGOs, youth, and others who are involved in improving the health care that is available to women, men, youth, and children in TAHSEEN communities.
- **Represent community needs to clinics, government officials, TAHSEEN staff, the media, and others**, for example, as members of clinic boards, which monitor quality at clinics, as members of Youth Committees.

To help leaders achieve these objectives, TAHSEEN mobilizes and empowers them through training and other support:

1. **Mobilizing and preparing leaders to reach out to their communities.** Because different people look to different leaders for help and guidance, and because many respond more decisively to information and advice when it is offered from a variety of sources, TAHSEEN involved a variety of leaders—from political leaders to newspaper reporters; from sheiks and priests to student leaders and prominent businesspeople; from NGO activists to agriculture extension workers and literacy instructors; and from physicians to traditional birth attendants and community outreach workers. Each leader has a specific constituency—Muslims, Christians, men, women, youth, pregnant women, engaged or newly married couples, farmers, businesspersons, students, customers, clients, low-literate men and women, and the general public. These leaders were brought together by TAHSEEN for trainings, which improved their RH/FP knowledge (about family planning, contraceptive methods, reproductive stages, gender-related issues) and enhanced their communication, leadership, and community-mobilization skills.

TAHSEEN trained some leaders in sector-specific groups. Religious leaders, for example, needed to be able to refer to scriptural passages that supported birth spacing, while agriculture and irrigation extension workers needed to use analogies to farming in order to explain the importance of antenatal care. TAHSEEN developed specific training packages, for religious leaders (Muslim and Christian who are trained together), community outreach workers, youth, clinic board members, media representatives, literacy instructors and extension workers. These trainings involved curricula and materials developed or adapted by TAHSEEN and its partners specifically for these leaders.

TAHSEEN trained other leaders as part of interdisciplinary teams, to work together on specific interventions in a given locality—for example, in postabortion care, postpartum care, or youth education and mobilization. Leaders were identified by NGOs, political leaders, and others, and could include virtually anybody who showed leadership skills, an interest in improving community health, and an ability to reach key constituencies. Leaders included professionals, women’s group members and NGO outreach workers. In addition, district teams were identified and trained to work on both postabortion and postpartum care. Teams included doctors, district-level public health and education officials, nurses, representatives from the Ministry of Youth and Sports and the Ministry of Social Affairs, Muslim and

Christian leaders, media and NGO representatives, and a representative of the literacy initiative. Interdisciplinary training offered leaders a deeper understanding of a specific issue and its impact on the community, as well as communication, mobilization, and behavior-change skills, and an opportunity to collectively plan appropriate action in their communities.

Finally, TAHSEEN worked with political leaders at the local, district, governorate, and national level to encourage their visible support of (1) recommended RH/FP behaviors, (2) clinics in TAHSEEN communities, and (3) community initiatives. In every TAHSEEN community, the village leader, or *omda*, signed a Memorandum of Understanding with the Governor and a high-level MOHP official. This process allowed for the substantial engagement of local and governorate political leaders and ignited unprecedented civic support. Political leaders encouraged crowds at clinic openings to space their births 3-5 years.

- 2. Supporting leaders as they educate and mobilize their communities.** During trainings, community leaders created action plans for how to best reach their constituencies through one-on-one talks, group presentations, community meetings, door-to-door canvassing, inter-agency networking, classroom lectures, sermons, special events and media work. Following training, leaders went back to their communities and implemented their plans, looking to each other and to TAHSEEN staff and partners for support when needed. In some cases, as with religious leaders, continued support takes the form of six monthly follow-up sessions. In other cases, as with literacy facilitators, support takes the form of additional training, for example on postabortion care. The creativity, leadership, and enthusiasm of these leaders inspire others to consider behavior change and support improved health in their community.

RESULTS

Community leaders are an essential component of the TAHSEEN integrated multisectoral RH/FP model.¹ They, more than any other group or intervention, are responsible for encouraging and facilitating the behavior change that will be necessary if TAHSEEN and its partners are to successfully improve the health of Egyptian women and children. This is especially true in the case of potentially sensitive topics, like gender-based violence, or when it is necessary to challenge long-held traditional beliefs, practices, and misconceptions. So whenever TAHSEEN prepares to introduce a new activity or message, it assembles community leaders who then find innovative ways to bring this new activity or message to the grassroots level. Community leaders also represent their communities in clinics, government agencies, and other groups that wish to be of service, and they guide TAHSEEN's work with their technical expertise and their intimate knowledge of their constituencies. For the first time, religious leaders are initiating public dialogue to recognize the need for postabortion care, youth are informing their peers about healthy behavior, and the media is bringing RH/FP issues into the homes of tens of thousands of Egyptian families. With their energy, their authority, and their willingness to openly address sensitive topics, they gain the support of those they address, which in turns opens the door to lasting change. A few of the accomplishments are outlined below:

¹ The integrated model links reproductive health/family planning to other health and nonhealth services and programs. The model focuses on improving quality of care, mobilizing the community, strengthening referral systems and contributing to long-term sustainability by addressing the needs and barriers to care.

- **Religious Leaders.** By June 2005, TAHSEEN had trained 123 Christian and Muslim clergy in Minia, 70 in Beni Suef, and 61 in Fayoum, in addition to 24 female religious leaders from Minia. These clergy are counseling their followers, including RH/FP messages in their sermons, and leading awareness-raising sessions, often for interfaith audiences. More than half are also active in TAHSEEN committees and working groups (e.g., on postabortion care, postpartum care, or youth education).
- **Community outreach workers.** Since February 2004, TAHSEEN has trained 410 (female) *Ra'aidat Rifiat* and 75 (male) *Mothakef Sokany*, providing them with the skills necessary to counsel clients during home visits and hold public awareness-raising seminars on RH/FP topics such as antenatal and postpartum/newborn care, and adolescent RH/FP. As part of training, outreach workers learned how to understand the needs of and best communicate with specific client groups, such as women and youth. They also learned how to participate in TAHSEEN's data-collection activities.
- **Clinic Board members.** A total of 558 Clinic Board members have been trained in a two-phase training process, and all 53 TAHSEEN clinics in Minia, Beni Suef, and Fayoum Governorates now have functioning Boards. Boards are mobilizing communities to support their clinics. One local government official, for example, donated supplies for maintaining the clinic's garden. Local businesses have agreed to continue funding TAHSEEN's continuing-education program for clinic medical staff in another community once TAHSEEN is longer involved.
- **Media professionals.** Beginning in October 2003, TAHSEEN has been educating and mobilizing radio, television, and print media professionals in a 12-session program to mobilize them, and to build their capacity to report on RH/FP topics. TAHSEEN brings these media professionals together monthly with RH/FP professionals and governorate directors of family planning and maternal-child health to discuss how they might better disseminate health messages in their community. More than 100 media professionals have completed this 12-month program in Minia, Fayoum, and Beni Suef governorates. As a result of this program, 113 television segments, 129 radio segments and 112 newspaper or magazine articles covering RH/FP topics have appeared as of June 2005, and coordinated with the openings of clinics renovated by TAHSEEN.
- **Youth.** Governorate-level Youth Committees, established by TAHSEEN, organized several activities for mobilizing and educating youth. For example, as of June 2005 they gathered a total of approximately 1,672 promising youth leaders from 44 communities to participate in: (1) a six-day program of community service, sporting activities, and RH/FP education, to raise the communities' awareness of RH/FP issues, and (2) structured activities to make their communities aware of services available at their newly renovated TAHSEEN clinics and to facilitate community access to them. These two programs increased youth knowledge of RH/FP, created support for an intergenerational dialogue on RH/FP, and led to increased service use.

Outcome

Caseloads tripled at TAHSEEN clinics

Community leaders have been instrumental in increasing the caseloads in the clinics. They played an active role in educating, encouraging, and inspiring community members to adopt healthier practices, including appropriate use of clinic services. Between the fourth quarter of 2003 and the fourth quarter of 2004, on average, caseloads at the first five clinics to participate in TAHSEEN's program tripled on average (see below).

CLINIC	Total caseload			ANC visits			FP service users		
	Q4 2003	Q4 2004	Ratio Increase	Q4 2003	Q4 2004	Ratio Increase	Q4 2003	Q4 2004	Ratio Increase
Sawada	643	2963	4.6	177	393	2.2	288	440	1.5
Dawedia	527	2557	4.9	55	221	4.0	213	382	1.8
Edmu	1010	3521	3.5	402	862	2.1	332	518	1.6
Nazlet el Amoden	1613	4250	2.6	435	606	1.4	349	672	1.9
Tayeba	2272	5681	2.5	506	597	1.8	733	978	1.3
TOTAL	6065	18,972	3.1	1575	2679	1.7	1915	2990	1.6

