Communication Action Groups: Promoting Broader Discussion of Reproductive Health

CEDPA/Nepal

cedpa
1400 16th Street, NW, Suite 100
Washington, DC 20036 USA
Ph: 202-667-1142 Fax: 202-332-4496
cmail@cedpa.org • www.cedpa.org

Introduction

Sex and sexuality are topics rarely discussed in Nepal, even between husbands and wives. The Centre for Development and Population Activities (CEDPA) and its partners are successfully challenging this traditional communication barrier.

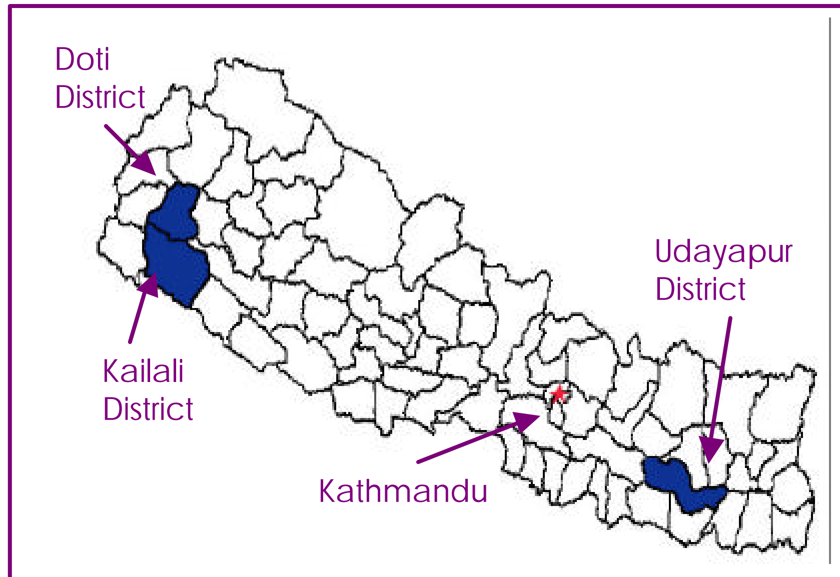
In 1993, CEDPA began providing support to the Nepal Red Cross Society (NRCS) in order to make family planning services accessible to women in rural Nepal. Today the project provides reproductive health services to 27,491 women and girls in 85 Village Development Committees (VDCs). CEDPA works with and on behalf of women and girls in partnership with a variety of government agencies and non-governmental organizations. CEDPA's support aims to contribute to achieving national goals as outlined in His Majesty's Government of Nepal policies and planning documents.

In 1993, the ACCESS Project operated in five districts to provide non-clinical family planning services through local volunteers using a community-based distribution (CBD) approach. For clinical services, clients were referred to the nearest government health facility. When the ACCESS Project was phased out in 1998, CEDPA supported the NRCS under the ENABLE Project. Through the REWARD Project (*Reaching and Enabling Women to Act on Reproductive Health Decisions*), the NRCS offers expanded services, provided by auxiliary nurse-midwives (ANMs), including clinical family planning, safe motherhood, child health and referral services in selected VDCs. The REWARD project also works toward creating an enabling environment that supports and strengthens women's decision-making abilities. In partnership with community groups, the NRCS staff undertakes community mobilization activities that promote the empowerment of women.

CEDPA's Mission:
Empowerment of women at all levels of society to participate as full partners in development.

Overview of the Communication Action Groups (CAGs)

In 1996, the REWARD Project identified a need for effective interventions to increase women's communication about reproductive health among themselves and with their husbands. Project staff formed women's groups, called Communication Action Groups (CAGs), in three rural districts: Doti, Kailali, and Udayapur (see Map). The project provides group leaders with training on communication, leadership, group dynamics, condom use, condom negotiating skills, and HIV/AIDS and sexually transmitted infections (STIs).



Districts Where CAGs Are Active

A CAG consists of 12 to 20 married women of reproductive age from households in a cluster within the target community. Typically, all households in a cluster were represented. In the three districts, there are 495 active CAGs, with a total of 9,900 group members. These groups met monthly to discuss a variety of issues (see Box). Initially, group leaders received four days of basic training on reproductive health and family planning from NRCS staff. Refresher trainings are also conducted. Group leaders facilitate discussions and share what they learned in REWARD trainings.

> ***Discussion Topics***
>
> - Reproductive health and family planning
> - HIV/AIDS/STIs
> - Use of condoms
> - Delaying marriage
> - Delaying first birth
> - Immunization
> - Safe motherhood
> - Use of clean home delivery kits
> - Cleanliness
> - Encephalitis prevention
> - Treatment of diarrhea
> - Vitamin A supplementation

Objectives of the Study

This study was designed to evaluate the effectiveness of the CAG program so that achievements and problems could be identified and program activities strengthened. Specifically, it investigated women's ability to communicate about reproductive health issues with each other and with their spouses.

The specific objectives of the study were to:

- Document CAG processes, i.e. number of meetings, types of activities conducted and effectiveness at mobilization;
- Examine the level of awareness of CAG members about reproductive health issues, including family planning, STIs and HIV/AIDS;
- Evaluate the level, type and content of communication about reproductive health issues among CAG members; and
- Evaluate the level, type and content of communication about reproductive health issues by CAG members with others, including community members, leaders, husbands, and family members.

Methodology of the Study

The evaluation study was conducted in three REWARD project districts. The quantitative portion consisted of surveys with 949 CAG leaders, members, husbands of members, and community leaders. Study findings are summarized in the report "Evaluation Study of the Effectiveness of Communication Action Groups to Enable Women to Communicate on Reproductive Health Issues" (Valley Research Group, 2002).

The qualitative information was gathered by NRCS staff through 25 focus group discussions with CAG members, leaders, husbands of members, roving educators, depot holders, and field workers. The transcripts of these interviews are documented in "Communication Action Group Study: Final Reports on Focus Group Discussions in Three Districts of CEDPA" (Sharma). The quotes throughout this report are taken from the focus group discussions and are labeled by VDC and district.

This report summarizes the findings of both studies and presents major conclusions.

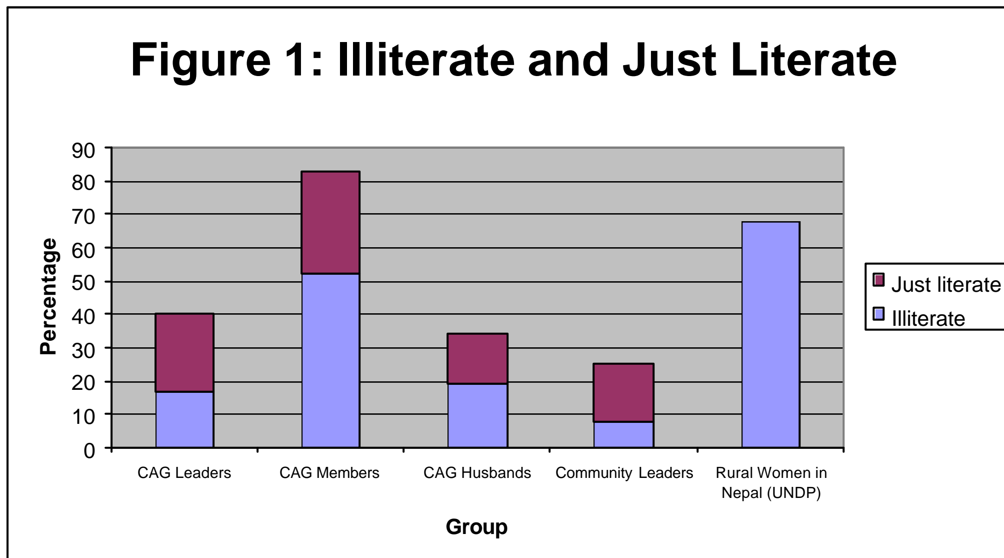
Demographics and Dynamics of CAGs

> *"We joined the group so to learn about things that we did not know and ultimately share what we learn with the community."*
> (CAG members, Bauniya VDC-6, Kailali)

CAG members ranged in age from 15 to over 50 years. Eleven youth members between the ages of 15-19 were included in the survey. The mean age of all members was 32—a little older than the CAG leaders, whose mean age was 30. Husbands of CAG members had a higher mean age of 36. Both CAG members and leaders have been involved with a CAG for a mean of four years.

The vast majority of CAG members, leaders, and husbands work in agriculture. In terms of ethnicity and caste, CAG leaders were slightly more likely to be from higher castes than members.

CAG leaders were more literate than members. While 52 percent of CAG members identified themselves as illiterate, only 17 percent of CAG leaders did so. Husbands of members were 19 percent illiterate. When compared with Nepal's female illiteracy rates overall, CAG members and leaders are doing well (see Figure 1).



CAG members chose leaders who were patient, educated, practical, easy to communicate with and unbiased. Members expected that after receiving training, CAG leaders would be able to "…*increase awareness about personal hygiene and healthy environments, and be able to communicate clearly and accurately."* (CAG leaders, Ranagaun-8, Doti). Some of the CAGs invited respected community members to attend meetings in order to gain support and understanding from them.

Most CAG meetings were held once a month at a member's or leader's house. Members of a CAG in Doti explained, *"We have arranged a bell to ring at the time fixed for the meeting. After hearing the bell, our family members encourage us to hurry up."* (CAG members, Pachanali VDC-3, Doti). Agendas for each meeting were usually formed around issues raised by the leaders, members and NRCS staff. Topics were decided according to the seasons and the diseases that were prevalent at that time.

One Doti CAG member explained the meeting process, "*After all members gather, the person with knowledge of the day's topic stands up and gives a presentation. When she finishes, participants ask questions about points they do not understand. So, there is an exchange of thoughts and knowledge. We keep minutes of every meeting. If someone is not able to attend the meeting, we tell her about the meeting later."* (CAG members, Ranagaun, Doti).

In addition to discussions about health and women's issues, many CAGs have established money savings programs. Monthly dues are collected from each member and the money is made available to members and leaders as low-interest loans when families face hardships, want to start a small business, or need to pay a child's tuition or a hospital bill. Savings programs were cited by many as essential functions of the group and seemed to be one of the main reasons that many husbands support their wives' participation in CAGs. A group of husbands of CAG members in Kailali said, "*Another important thing about our community group [in addition to health education] is its savings program. It is a big help when we have financial problems."* (CAG husbands, Joshipur VDC-6, Kailali).

Another comment from Kailali portrayed the savings program as a direct cause of increased attendance. CAG members noted, *"In the first year [of the group], we conducted only discussion meetings, but in the second year we started a savings*

program. After money was collected, other women joined the group"(CAG members, Bauniya-6, Kailali). The programs were viewed as assets to the communities, "*We do not mind having to repay the money borrowed from the group. We are happy to have the program. There is a feeling of brotherhood and friendship in the community."* (CAG members, Joshipur-6, Kailali).

Despite the many positive comments regarding savings programs, both CAG leaders and members reported that financial issues were the top problem facing their groups, possibly because they want more established and larger savings programs.

The CAGs work within a system of community health providers that include depot holders, fieldworkers, and roving educators:

- Depot holders are centrally-located female volunteers who distribute pills and condoms from their homes. They serve as mentors and supervisors to the CAGs.
- Fieldworkers are paid NRCS staff, mostly male, responsible for monitoring health activities at the VDC level. They recruit new family planning clients and distribute pills and condoms door-to-door.
- Roving educators play a vital role in increasing awareness among men of HIV and STI transmission and protection. They are male-to-male peer educators and are mostly volunteers. They work throughout the district—at tea stalls, bus stops and local festivals.

All three groups work with the CAGs to provide support and to make sure that information is being properly disseminated and understood. Both CAG members and the community health workers have commented on the effectiveness of a network of people providing similar services. The depot holders and roving educators from Tijasi VDC (in Doti) commented that CAGs make their work easier. *"When information comes from several sources, members of the community are more inclined to accept it. If only one person were involved in this work, it would be harder to make the community accept the information."*

Leaders in communities where the CAGs operate were surveyed to obtain their impressions of CAGs' activities. The majority of community leaders interviewed were men (62 percent) with a mean age of 38 years. Most community leaders are social workers, teachers, and political leaders. They did not seem to be from higher castes than CAG members or leaders. Not surprisingly, they had the lowest illiteracy rates at only 8 percent and were the most educated with 47 percent having received School Leaving Certificates (SLC) or further education, compared with 27 percent of CAG leaders and 4 percent of CAG members. Community leaders are valuable resources for advice and support to CAGS. The vast majority of community leaders reported that they had provided support to and had participated in CAG activities but had not attended the meetings. Many CAG leaders sought the advice of community leaders in organizing and maintaining smoothly running groups including help in resolving disputes, increasing participation at meetings, and effectively conveying information.

CAG Members and Leaders: A Change in Self-Confidence

> *"Before we were like birds inside a cage, but now we have developed wings."*
> (CAG members, Bhum/Rasuwa-Bhantabari, Udayapur)

Both CAG leaders and members reported feeling more involved in household decisions and in activities outside the home. They feel they have more control over their lives since they joined a CAG. *"Now we are able to make decisions. Before we had to ask family members for permission before doing even small things like selling a hen. Before we treated men as the head and they treated women as the tail. But now we are wiser. We can make decisions that affect our children such as sending them to school. We have convinced many other women to join the group. Now we believe that women can be strong."* (CAG members, Jalpa/Chilaune-6, Udayapur).

With 67 percent of CAG members and 90 percent of CAG leaders reporting that they are more involved in household decision-making, it is obvious that they feel important shifts in control have taken place. Interestingly, only 19 percent of husbands of CAG members reported that their wives could make their own decisions since they joined a CAG. Overall, the husbands' perceptions of the changes in their wives were much lower than the members' own perceptions.

In some aspects, though, husbands saw more changes in their wives than the women saw in themselves. Since joining a CAG, women have experienced life changes; they have developed communication skills, especially the capacity to speak out about reproductive health. In addition, their awareness of the importance of personal hygiene and sanitation has increased. Husbands reported seeing more changes in their wives than the women saw in themselves. While only 3 percent of CAG members reported having changed their personal sanitary practices, 25 percent of husbands reported having seen this change in their wife. Thirty-eight percent of husbands felt that their wives were more able to participate in community discussions, while only 6 percent of CAG members felt they had gained that skill.

CAG leaders reported being more active in the community than members did (80 percent versus 52 percent). Their natural leadership qualities, the ones that got them elected as CAG leaders, as well as the trainings they received and the experience attained working with CAG members, may have made the transition towards independent decision-making easier. However, only 7 percent of these same CAG leaders reported an increase in communication capacity. These reported changes are noteworthy in that the purpose of the CAGs was to increase women's ability to communicate. While members and leaders reported feeling more able to make decisions and participate more outside the home, their estimation of their own communication skills, even with regard to reproductive health, was much lower than expected.

The perception that communication skills have not increased could be attributed to the gender communication divide that almost all focus group participants mentioned. A group of husbands from Doti explained, "*Women cannot communicate as easily with male members of the community as they can with their husbands or female friends. Discussions among the same sex are more lively and fruitful than when men and women are together"* (CAG husbands, Pachanali, Doti).

Husbands reported that they rarely talked about condoms and other family planning methods with women outside the family. Even male roving educators commented that it was sometimes awkward to talk about reproductive health with women. The Doti husbands said, "*If a couple is not able to make a decision about using family planning methods, the husband consults with his friends and the wife with hers. Then they decide"* (CAG husbands, Pachanali, Doti).

CAG members reported the same thing. Although, they could talk about reproductive health issues with their female friends and with their husbands, they were unable to

discuss such things with other men. Doti CAG members said that they used male field workers to help communicate with male community members. A group of Kailali field workers and depot holders remarked that, "…w*omen CAG members talk differently to men than women who are non-members*" (Field workers/Depot holders, Joshipur-6, Kailali). The inability to communicate freely to everyone in the village was likely the reason that CAG participants did not recognize an increase in their communication skills.

The focus group discussions revealed that women are proud of their progress and are very confident about their accomplishments and their places in society. *"The CAG meetings and functions like Condom Day*[1] *have really helped us move ahead in life. Before we were scared to even go to a meeting because many people told us not to get involved in such things and we worried what society would say. Now we are learning many new things and feel secure"* (CAG members, Jalpa/Chilaune-6, Udayapur).

Husbands: A Change in Support

> *"We feel proud that our wives are CAG members."*
> (CAG husbands, Basaha-9, Udayapur)

In communities where sex and sexuality are rarely discussed openly and women have little say, if any, in the use of family planning methods, a husband's support for his wife's participation in a CAG is a mark of progress towards more empowered women. As this study found, not only did men support their wives, they have taken interest in what their wives are learning and are putting this knowledge into practice.

Gaining support of husbands has sometimes been a long process. Members in Udayapur explained, *"In the early days, we were afraid to attend a meeting because our husbands got angry. They said we went to show our independence. But even then we never missed a meeting. Now we are learning many things and we enjoy attending meetings. Our husbands and children have become more understanding and have started to support us"* (CAG members, Jalpa/Chilaune-6, Udayapur).

Although the vast majority of husbands are supportive of CAG activities, 14 percent of CAG members said they did not receive any support from their husbands while only 2 percent of husbands said they did not provide it. Support in this context is defined as the husband looking after the house and children while his wife is at a CAG meeting and providing moral support and advice to his wife in CAG-related matters. A group of husbands said that after they realized the benefits of their wife's participation in the groups, they began providing support and encouragement. *"We have been helping them in all possible ways. We benefit from their knowledge and feel they should be active in community activities. If our parents criticize our wives, we explain the importance of their activities and support our wives."* (CAG husbands, Pachanali, Doti).

Husbands in Udayapur praised their wives and the work that they have been doing. *"They have worked well for the community and in turn for the country."* (CAG husbands, Basaha-9, Udayapur). Husbands in Kailali supported their wives' independence. *"They have the right to make decisions and we should give them the*

[1] Condom Day is a nationwide celebration organized by a consortium of organizations. It features street theater, speeches, fairs, competitions and condom distribution and education with the goal of raising awareness of condom use and benefits.

chance to do so." (CAG husbands, Joshipur-6, Kailali). Before the formation of CAGs, some husbands had probably heard of STIs and family planning methods. Their wives' involvement in CAGs has now provided the knowledge on how to prevent HIV/AIDS and STIs and which family planning methods work best for them.

Families: Communicating Lessons Learned

> *"Before, we were embarrassed talking to our husbands about condoms but now we talk to them about condoms and we use condoms."*
>
> (CAG members, Pachanali-3, Doti)

The issues that were most frequently discussed with husbands and family members by CAG participants were safe motherhood, reproductive health, family planning, HIV/AIDS and child immunization. Most leaders and members talked to their husbands about family planning and reproductive health. This was followed by comfortable discussions with sisters-in-law and mothers-in-law. More than twice as many CAG leaders were comfortable talking to their mothers-in-law as were members. This distribution is consistent with the expectation of the types of communication CAGs would provide.

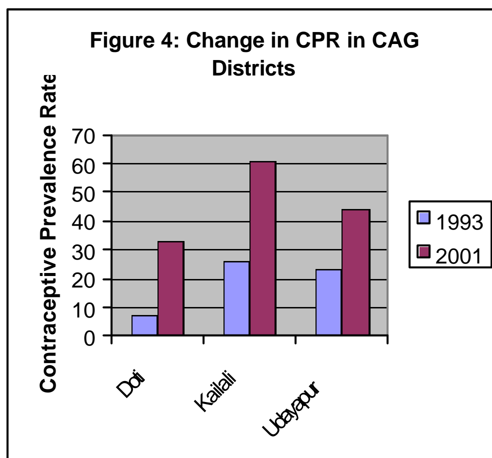
Members also reported talking to their adolescent children about sex, HIV/AIDS, STIs and the menstrual cycle. Due to the apparent difficulty in cross-gender communication, mothers talked to daughters and fathers talked to sons. *"We can tell our husbands to use condoms, but we are not able to tell our sons and daughters-in-law directly about the use of condoms. Therefore, we advise them to attend CAG meetings in order to get information."* (CAG members, Bauniya-6, Kailali). Nevertheless, all generations are benefiting from increased reproductive health information.

One of the original goals of the CAGs—to increase women's communication with their husbands about condom use—appears to have succeeded. Three in five (61%) CAG members talked to their husbands about condom use as compared with the national percentage of less than half (DoHS 2001). Many CAG husbands interviewed said that they had never thought seriously about using family planning methods before the group was formed but now have increased discussions about condoms and reproductive health. "*Since our wives joined a CAG there have been a lot of changes in communication about condoms and reproductive health issues. After a meeting, our wives come home and tell us what they had learned. Before, our wives were too shy to talk about reproductive health and family planning methods, but now they can talk about these things more than we can. Now, we talk about things that we had never discussed before: pregnancy, postnatal care, safe motherhood kits and danger signs during pregnancy."* (CAG husbands, Basaha-9, Udayapur).

Husbands had slightly different impressions of how often they talked about condoms and who initiated discussions. Husbands of members reported having slightly higher rates of discussions on condoms than their wives reported (70 percent of husbands verses 61 percent of wives). Two in five (44%) husbands said they had started discussions and gave their wives credit only 56 percent of the time (See Figure 3). Leaders initiated discussion regarding condom usage with their husbands more often than members, 87 percent to 76 percent respectively. Members in Kailali said, "O*ur husbands are comfortable when we initiate talking with them about condoms"* (CAG members, Joshipur-6, Kailali).

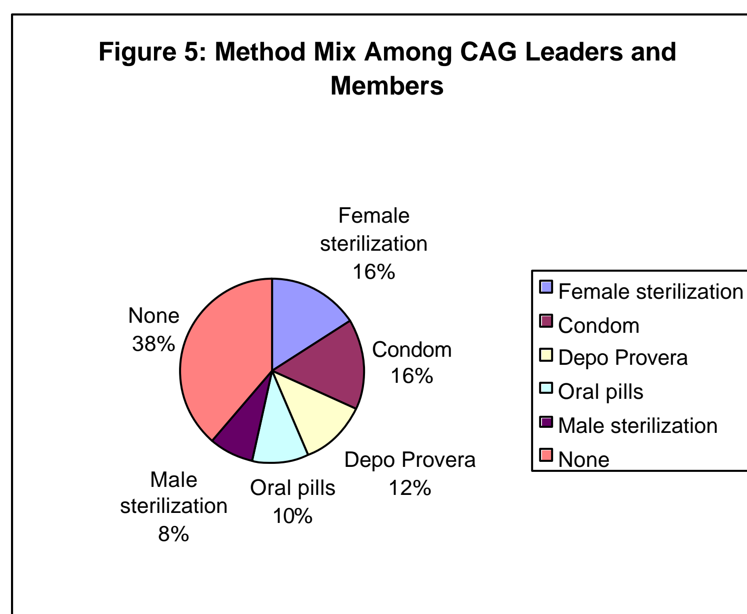
Thirty-nine percent of CAG members said they had not talked about condoms with their husbands. About one-third of this group had not done so because they had already undergone a permanent method of birth control. Other reasons couples listed for not talking about condoms included a dislike of condoms, a previous decision about birth control, and the belief that birth control was not necessary. Nine percent of CAG members reported being too embarrassed to talk about condoms with their husbands, while only two percent of husbands said this prevented discussions from happening.

CAG Members and Leaders: A Change in Behavior



The contraceptive prevalence rate for women in rural Nepal is 33 percent. The nationwide condom use rate is only 3 percent (DoHS, 2001). In this study, 61 percent of CAG members reported using a modern family planning method. A 1993 study conducted by the Nepal Red Cross Society reported that the contraceptive prevalence rates for the three districts in which CAGs operate was 23 percent for Udayapur, 7 percent for Doti, and 26 percent for Kailali. District rates are now 44 percent, 33 percent, and 61 percent respectively (see Figure 4). The surge in contraceptive use could be associated with the education and negotiation skills received from the CAGs.

More CAG leaders than members use condoms (23 percent compared to 15 percent). CAG leaders also have better contraceptive usage rates overall: 70 percent used a family planning method. The most common methods of contraception for CAG members and leaders were condoms and female sterilization (See Figure 5). Male sterilization, Depo Provera and oral contraceptive pills followed.



Community: A Change in Support

> *"The men and women of the community respect us. Some have treated us like gods after we solved their problems. Therefore, we have benefited personally."*
>
> (CAG leaders, Ranagaun-8, Doti)

According to CAG leaders, members, husbands and other community workers, communities that once strongly opposed the operation of CAGs now accept the groups and make use of the information provided. An overwhelming majority of CAG leaders and members said that they received moral support and advice from the community. Only 3 percent of leaders and 6 percent of members reported not having received any support from their communities.

A group of leaders in Doti described the transition in their community "*They looked down upon us and treated us as if we were immoral. Also, some men used to beat their wives for helping us. We encouraged the women in our community to resist the superstitions and negative influences. There is less negativity these days."* (CAG leaders, Ranagaun-8, Doti).

Many members said that things were easier now and that they have been getting more community respect being CAG members. "*Before, people in the community were unwilling to take our advice. They seemed to find fault with it. Now people recognize the importance of the things we say and respect us for it."* (CAG members, Ranagaun-8, Doti). One group cited the savings programs as a reason for community support. *"[S]ince the CAGs started a savings program, many people have been benefiting from CAG membership. Through loans they are able to seek and pay for medical care. Also, they have been able to start businesses with loans from the CAGs and have begun poultry and livestock farming from the money saved."* (Field workers/Depot-holders, Joshipur-6, Kailali).

As communities become more accepting of women's involvement in the CAGs, adherence to conservative values that kept women from decision-making roles and held back progress towards a better-informed society has loosened. CAGs find that their work coincides with and contributes to the creation of "…*an educated and capable society. People are moving towards development. People are now aware of the fact that they can benefit from knowledge."* (Depot-holders/Roving educators, Tijasi, Doti).

Despite such progress, CAG members receive less support from the community than they would like. There are still conservative beliefs and taboo discussion topics that challenge the CAGs. Although community leaders were aware that their communities could be more supportive of group activities, some CAG members reported encountering resistance from less-educated members of the community. Overall, though, the CAGs have become more and more accepted, and many have witnessed great changes in their community's attitude toward their work.

Community: Communicating Lessons Learned

"There is no shame in talking openly about condoms in our village."
(CAG members, Jogi Daha-6/ Purva Tole, Udayapur)

In general, a supportive community allows CAG members and leaders to communicate messages on reproductive and other health issues more easily. In addition to the radio, community members receive reproductive health information from field workers, health volunteers, maternal/child health workers, and health post employees. Almost all CAG leaders indicated that the CAGs were instrumental in creating public awareness of reproductive health issues. CAG members were a little less convinced, but both groups reported the topics most often communicated to both family and community members were issues of safe motherhood, reproductive health, family planning, HIV/AIDS and child immunization. Successful communication of these topics is due to "*…the things that we discuss in the meetings are our own problems. CAGs have made a positive impact in our village."* (CAG members, Jogi Daha- Udayapur).

A group of Doti field workers explained, *"Since women face a lot of problems, the more knowledge they have the easier their lives become. Some of the women regret that they did not have this information earlier or when they had their children."* (Field workers, Gobghat-4, Doti).

Very few CAG members and leaders reported having problems in communicating the messages within the gender-defined communication channels. Nine in ten (89%) members said they communicated messages whenever the opportunity arose; their reports suggested that the conversational environment is open and that communication is easy. CAG members said, "*We give information and communicate with community members at appropriate times, like when we go to collect firewood, when we go to fetch water, while cutting grass or at a social gatherings."* (CAG leaders, Ranagaun-8, Doti). Another group reported, "W*e take out a few hours from our daily routine and household work and then we promote communication (visiting each others' houses)."* (CAG members, Bauniya-6, Kailali).

Some CAGs established a system whereby one member of the group shares the things she has learned with at least five members of the community. In this way *"those who have information share it with others and it transfers from one person to another. Ultimately everyone knows it."* (CAG members, Pachanali-3, Doti).

As a whole, CAG leaders communicated messages more often than members and equally with community members and with family. CAG members communicated slightly more with their own families then with the community. The training that

leaders received could explain their higher levels of comfort with communication outside their family unit.

Skills learned at CAG meetings allowed CAG members and leaders to develop a variety of methods to teach the community about reproductive health and family planning issues. A CAG group in Doti worked with people who did not understand the issues by listing out the positive and negative sides to each issue. Members also used flip charts and other educational tools during CAG meetings to teach community members. Furthermore, members came to realize that people take different amounts of time to accept the messages conveyed and gave examples of what they were explaining in order to help convince people. *"Sometimes non-members express interest in the CAG and initiate a topic about which they want information. We answer all their questions and spread this information throughout at the appropriate time."* (CAG members, Pachanali-3, Doti).

Negative attitudes toward family planning were rarely cited as barriers to relaying information. Instead, the main problems that members faced were that people misinterpreted the information or did not believe what they were told. Participants also reported that many people made fun of them. A group of leaders in Doti explained how they mitigated the conflict that arose when negative attitudes were encountered. *"When we hear about these problems, we meet [the person causing the problems] wife and tell her to make him understand. In a few cases, we meet the person directly and make him understand the benefits of using condoms and the problems he might face by not using them. Such cases do not happen again after we make things clear."* (CAG leaders, Ranagaun-8, Doti).

CAG members, leaders, husbands, and community leaders all had suggestions on ways to improve upon the way the information is disseminated. Members requested training on behavior change and on specific health topics. (Currently, leaders are the only CAG participants who receive formal training.) CAG leaders, as well, expressed interest in having members trained. CAG members and leaders also requested that the roving educators and depot holders provide them with more information and updates on methods. Husbands suggested that social workers, teachers and other community members be involved in CAG discussions. The main request, though, when asked what would improve CAGs' ability to communicate, was for literacy classes. "*Though we now know a little about safe motherhood, family planning methods, sterilization and record keeping, we are not educated. We would be really happy if they could run adult literacy classes for us."* (CAG members, Jogi Daha-6/Purva Tole, Udayapur).

Community: Change in Behavior

> *"Everything has changed in our society. Women know many new things, especially about themselves."*
>
> (CAG members, Pachanali-3, Doti)

In focus group discussions, members of the CAG communities listed many behavioral changes that have taken place in their villages. People have started to pay more attention to their health and hygiene, and many village residents have built latrines. *"Our community has changed in many ways. People have stopped using the roadsides as latrines. They have started making latrines at their homes. Also, they give their children oral rehydration solution when they suffer from diarrhea and take them to the health post if they are seriously ill."* (Field workers, Gobghat-4, Doti). This awareness of hygiene is essential in reducing child deaths from diarrhea and other

diseases. Parents and pregnant women also learn the importance of immunizations and encourage family members and other community members to take proper care of themselves and their families. Gardens have been planted so that people now have access to fresh vegetables.

CAGS are raising community awareness about safe motherhood. "*Many pregnant women used to die, because they could not get proper treatment. But now women know how to find healthcare facilities in their communities and are able get proper treatment and care during pregnancy from ANMs [auxiliary nurse-midwives]"*[2] (CAG members, Pachanali-3, Doti). Women previously forced to sleep on the ground when they were pregnant now sleep in a bed. One group in Kailali said that women previously too shy to show their pregnant stomachs now get regular checkups, are conscious of the position of the baby and of their own health. Trained birth attendants supervise more births. And, other contributing factors to maternal and infant mortality such as very young mothers, are being reduced as well. Many groups reported that their villages now allow women to marry only after they are 20 years old. In addition, couples now practice birth-spacing, have begun to use family planning after having two or three children and are less likely to discriminate against female children,

Study participants reported that reproductive health and family planning discussions have increased. Because some of the CAG project areas have high populations of migrant males, education about STIs and HIV/AIDS is essential to the health of the entire community. CAG members educate migrant men about the importance of using condoms during every sexual encounter to protect both themselves and their wives against disease. A group in Doti reported that if men continued to refuse to use condoms, at least a woman could protect herself against pregnancy: *"If the husband refuses to use condoms, the wife goes to the depot holders for Depo Provera."* (Field workers, Gobghat-4, Doti). Some CAG members acknowledged the need, though, for shared responsibility in decision-making regarding contraception.

One group of field workers and depot holders in Kailali said, *"Before we did not know about over-population, breast-feeding or Condom Day. Now, we celebrate Condom Day and similar activities and involve others members of the community in the programs, too"* (Field workers/Depot-holders, Joshipur-6, Kailali). Doti field workers attributed the changes within the community to awareness campaigns and the counseling provided by the CAGs. The discussions that take place within the CAGs and their support networks are clearly communicated to and accepted by the communities.

Conclusions and Recommendations

Communication Action Groups have increased discussion of family planning and other health topics among couples, families and communities, according to reports from CAG leaders, members, husbands of members, and community leaders. Since their inception in 1996, CAGs have become well-accepted by community residents, who now see them as an important source of health information.

CAG members report that participation in the CAGs has increased their self-confidence in expressing their opinions, making decisions, becoming involved in activities outside the home, and speaking in public. More than two-thirds of CAG leaders and members report that they have become more involved in household decision-making since joining the CAG. Half of the CAG members and four in five

[2] CEDPA/ENABLE's REWARD project engages ANMs.

CAG leaders said that they had become more active in their community. Husbands observed changes in their wife's ability to participate in community discussions. They also detected improved hygiene practices that could reduce child illness.

The CAGs have contributed to increased communication between couples about contraception, including condom use. Three in five CAG members have talked with their husband about condom use – an important topic in this area with high migration rates. Parents also report discussing sex, HIV/AIDS, STIs, and menstruation with their adolescent children.

The more open discussion of family planning appears to be linked to increased contraceptive use. Between 1993 and 2001 contraceptive prevalence rates have more than doubled in the three districts where CAGs are operating.

The CAGs' savings credit program helped women to gain initial approval from their husbands to join a CAG. Subsequently husbands and community members came to appreciate the benefits of the loans, which enabled families to pay for medical care and to start businesses. Over time, husbands have become more supportive of their wife's participation in the CAG. They also take an interest in what their wife is learning and help to put this new knowledge into practice.

Most CAGs continue to have strong participation and community involvement. However, some have developed financial problems. And, some have been affected by low attendance due to various factors, including dislike of the leader.

The CAG members, husbands of members, and community leaders overwhelmingly favored continuation of the CAGs. To increase their effectiveness in educating others, CAG members requested more training on reproductive health issues such as condom use and dual protection, later marriage, and prevention of girls' trafficking. They would also be very interested in attending literacy classes.

Based on the study findings, public and private agencies interested in promoting improved reproductive and child health in remote rural areas should consider encouraging formation of women's support groups and linking them to literacy and credit programs. This integrated approach helps to change women's self-concept and provide them with the skills and resources to improve their lives and make a contribution to their communities. The CAG methodology can be extended to other areas of Nepal as well as to other rural areas where women have little access to health information and few outlets to express their views.

References

Sharma, Bishnu K. "Communication Action Group Study", Unpublished report.

DoHS (2001). Department of Health Services, Ministry of Health, His Majesty's Government of Nepal.

Valley Research Group (VaRG) July 2002. "Evaluation Study of the Effectiveness of Communication Action Groups to Enable Women to Communicate on Reproductive Health Issues", Unpublished report. Kathmandu, Nepal.