ENABLE's Contributions to the Reproductive Health Field

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ACRONYMS AND ABBREVIATIONS

ACCESS	Access to Family Planning through Women Managers
AIDS	Acquired Immunodeficiency Syndrome
AMK	Aama Milan Kendra (Nepal)
ARH	Adolescent reproductive health
BLOOM	Better Life Options and Opportunities
CAG	Communication Action Group
CASP	Community Aid and Sponsorship Programme (India)
CBD	Community-based distribution
CBHMO	Community-Based Health Management Organization (India)
CBO	Community-based organization
CEDPA	Centre for Development and Population Activities
COCIN	Church of Christ in Nigeria
CPR	Contraceptive prevalence rate
CS	Child survival
CYP	Couple years of protection
D&G	Democracy and Governance
ENABLE	Enabling Change for Women's Reproductive Health
FBO	Faith-based organization
FGC	Female genital cutting
FLE	Family life education
FP	Family planning
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IFA	Iron folic acid
IUCD	Intra-uterine contraceptive device
JAPC	Jharkhand AIDS Prevention Consortium (India)
KGVK	Krishi Gramin Vikas Kendra (India)
LGA	Local government area
MBD	Market-based distributor
MCH	Maternal and child health
MIS	Management information system
NCWS	National Council of Women's Societies (Nigeria)
NGO	Non-governmental organization
NRCS	Nepal Red Cross Society
ORS	Oral rehydration solution
OVC	Orphans and vulnerable children
PHE	Peer health educator
PLWHA	People living with HIV/AIDS
PVO	Private voluntary organization
REWARD	Reaching and Enabling Women to Act on Reproductive Health Decisions (Nepal)
RH	Reproductive health
SM	Safe motherhood
SMA	Safe motherhood advocate

SMN	Safe Motherhood Network (Nepal)
SMV	Safe motherhood volunteer
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
VOD	Vanguard of Democracy
WRAI	White Ribbon Alliance of India

ENABLE's Contributions to the Reproductive Health Field

Overview of the ENABLE Project

The Enabling Change for Women's Reproductive Health (ENABLE) Project, implemented during 1998-2003, had the overall goal of strengthening women's capabilities for informed and autonomous decision-making to prevent unintended pregnancy and improve reproductive health. Its two major objectives were:

Objective 1: To increase the capacity of NGO networks to expand quality, gender-sensitive, and sustainable family planning, reproductive health, child survival and HIV/AIDS services; and

Objective 2: To promote an enabling environment that strengthens women's informed and autonomous reproductive health decision-making through NGO networks.

The ENABLE Project focused on low-income, marginalized women who had limited access to reproductive health (RH) services due to many factors, including inability to pay for medical services, lack of information about family planning (FP) and maternity services, lack of support from spouses and other family members, distance from health facilities, unfamiliarity with medical care, and family responsibilities. ENABLE worked to bring reproductive health services closer to isolated rural communities and urban slums by collaborating with community organizations to offer local services plus referrals to health facilities.

In addition to assisting individuals, ENABLE worked to change the overall social and cultural climate that influences reproductive health decision making and limits access to health services. The rationale for seeking to create an enabling environment came from CEDPA's experiences during the ACCESS Project, which preceded ENABLE. CEDPA staff observed that increasing access to family planning services was insufficient. One of the key factors preventing women from using family planning is that many women are unable to make their own decisions regarding childbearing and use of health facilities. Many women express a desire to limit or space births, are aware of contraceptive methods and can identify a service site, and yet still do not use family planning.

ENABLE sought to bridge this gap between intentions and behavior by changing the larger social and cultural context for reproductive health services – making contraceptive use more acceptable, ensuring that women and their spouses were well-informed about contraception and other health issues, addressing gender inequities, helping communities to address major health concerns, ensuring that community leaders and health providers were supportive of reproductive health, helping health providers to make services more

client-friendly, and changing social norms regarding reproduction and women's role in society.

The ENABLE Project's Conceptual Framework

The ENABLE Project's conceptual framework takes into account the need to provide quality family planning/reproductive health/child survival (CS) and HIV/AIDS services and to promote an enabling environment for reproductive health (see Figure 1). This process focuses on women within the context of gender, family influences, and community norms. The program strategies enable women to move up the empowerment continuum, evolving from little control to increased control over their reproductive decisions.

The ENABLE conceptual model is based on the premise that empowerment is a process characterized by four progressive stages:

- *Access* – Having the knowledge and means to obtain health care, education, credit, and other benefits;
- *Conscientization* – Being aware of women's reproductive rights and able to recognize gender inequities;
- *Participation* – Being involved in groups and civic activities that directly reinforce one's health and well-being; and
- *Decision-making* – Having the power to determine how to meet one's own needs in reproductive health and other areas.

Movement through this continuum is made possible by a gender-sensitive, enabling program that seeks to go beyond the provision of quality services to empowering women to make informed decisions best for themselves.

The components of the conceptual framework are briefly defined below, following the flow of models as charted in Figure 1, the ENABLE Project Conceptual Framework.

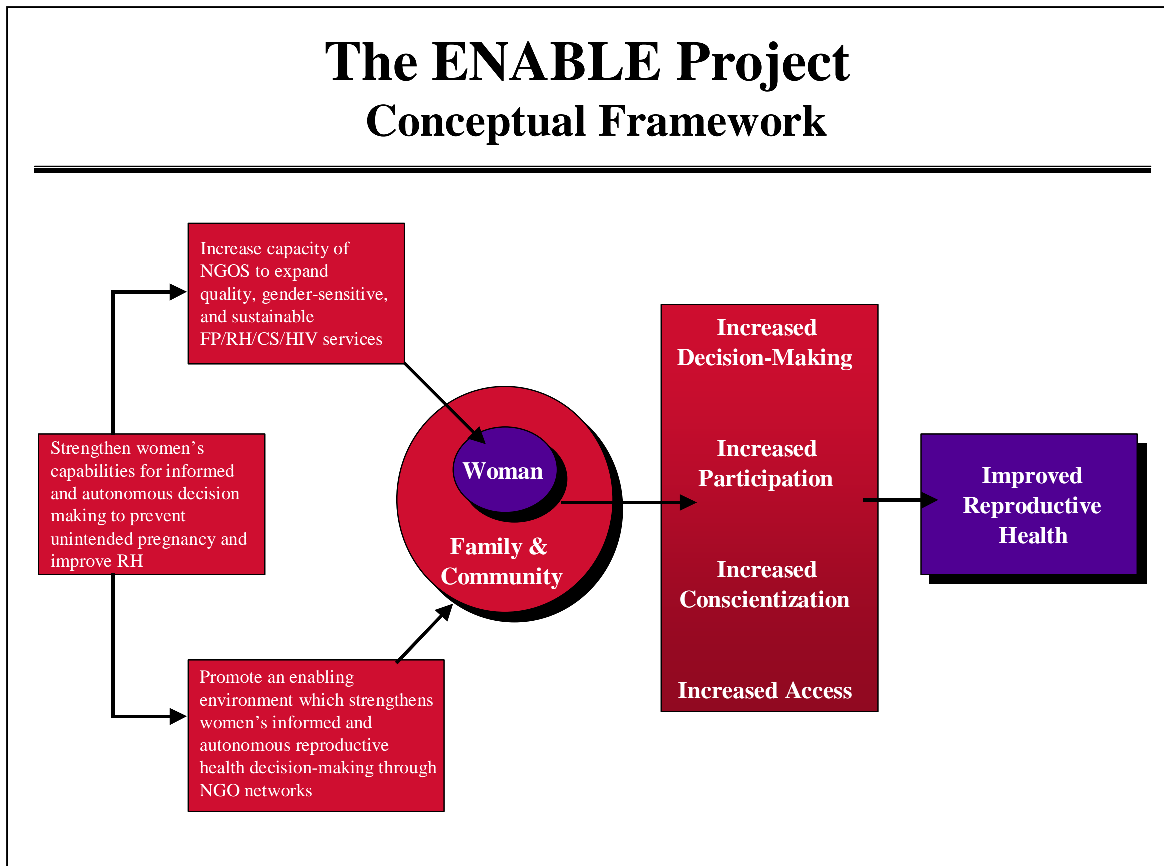
Improving Quality Services Through a Systems and Process Improvement Approach: ENABLE built the capacity of nongovernmental organizations (NGOs) to understand the organization as a dynamic system of processes that create services to meet the needs and expectations of customers/clients. Through training and regular technical assistance, ENABLE helped to strengthen organizations' ability to do continuous quality improvement.

Promoting an Enabling Environment by Reducing Inhibiting Factors and Enhancing Enabling Factors: Individual decision making regarding reproductive health is shaped by family context and community norms. CEDPA and its NGO partners identified and addressed factors that inhibit progress towards women's RH decision-making, such as traditional views regarding women's roles, cultural norms, women's status and education levels, and service availability and accessibility. Gender roles and power dynamics within

the family and community can directly affect use of FP and RH services. Cultural practices and beliefs surrounding RH, sexuality, pregnancy, and birth practices may be particularly strong and resistant to change.[1] CEDPA also identified enabling factors, such as the power of groups and the presence of civil society in many countries, and developed strategies to influence these factors. The inhibiting and enabling factors were addressed at three levels – the individual, the family, and the community – with the objective of creating a supportive environment.

[1] Timyan, Judith et al. 1993. "Access to Care: More Than a Problem of Distance." *The Health of Women: A Global Perspective*. Ed. M. Koblinsky et al., Boulder: Westview Press.

Figure 1. The ENABLE Project Conceptual Framework

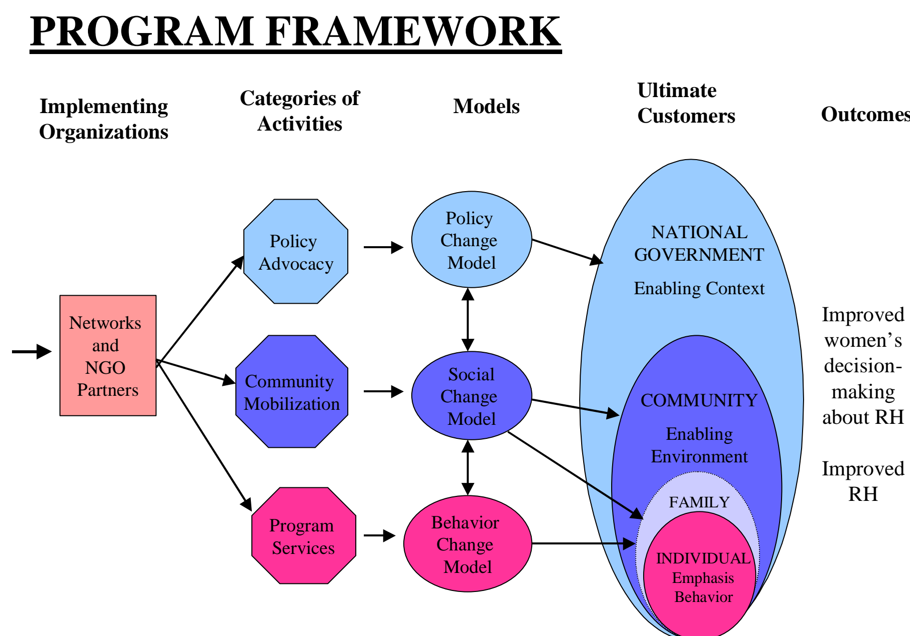


The ENABLE Project Program Framework

In applying its conceptual framework, the ENABLE Project developed a systematic plan of activities (see Figure 2, the ENABLE Project Program Framework). Working through local networks of stakeholder agencies and NGO partners, ENABLE conducted three types of program activities: (1) advocacy for policy change, (2) community mobilization for changes in social norms and health behaviors, and (3) program services. Each of these components had a set of activities that comprise a "model" for policy change, social change, and behavior change. These models were applied at all levels of society: the individual, the family, the community and the national government, with the goal of improving women's reproductive health and their decision making about reproductive health.

ENABLE identified a set of emphasis behaviors that were the focus of individual and family behavior change activities. At the community level, ENABLE sought to create an enabling environment that was supportive to women's RH decision making. At the national level, ENABLE sought to create an enabling context, including changes in policies, laws and practices that adversely affected women's reproductive health or were obstacles to women's use of RH services.

Figure 2. The ENABLE Project Program Framework



ENABLE Project Outputs

Project outputs were organized by ENABLE's two strategic objectives covering provision of reproductive and child health services and promotion of an enabling environment for women's RH decision making. Table 1 summarizes ENABLE project outputs by year, while Table 2 summarizes them by country.

During 1998-2002, ENABLE provided family planning services to more than 300,000 new clients and more than 1 million continuing clients. ENABLE distributed or sold more than 400,000 couple years of protection. Countries with the largest number of family planning clients were Nigeria and Nepal.

ENABLE's community participation and advocacy activities reached more than 56 million people, and behavior change activities reached more than 2 million people. ENABLE also trained large numbers of community workers, staff of local NGOs, service providers, and local leaders in a variety of topics, including family planning, safe motherhood, advocacy, social mobilization, youth-friendly RH services, and NGO management and sustainability.

The ENABLE Project supported a total of 106 subprojects – 15 subprojects in Asia and the Near East and 91 subprojects in sub-Saharan Africa. The five main countries where ENABLE worked are: Ghana, India, Nepal, Nigeria and Senegal. ENABLE also had one subproject in Cambodia and did an evaluation of Egypt's New Horizons Program.

Table 1. Summary of Progress Toward Key Results as Linked to Results Framework, by Year, 1998-2003

SO 1: To increase the capacity of NGOs to expand quality, gender-sensitive and sustainable reproductive and child health services						
Indicators	**1999**	**2000**	**2001**	**2002**	**2003**	**Total**
# of new FP clients reached by community workers	31,816	177,047	48,754	43,959	152	**301,728**
# of continuing FP clients reached by community workers	103,684	330,816	369,178	221,585	169	**1,025,432**
Couple Years of Protection (CYP) distributed/sold	19,300	42,432	337,451	29,068	0	**428,251**
# of community workers trained to provide RH services	9,520	7,361	12,279	9,922	67	**39,149**
# of NGO staff trained to provide youth-friendly FP/RH services	179	2,185	148	13	4	**2,529**
# of NGO staff trained in workshops designed to promote programmatic and financial sustainability	2,514	16,364	1,392	999	0	**21,269**
SO 2: To promote enabling environment through NGO networks an enabling environment that strengthens women's informed and autonomous reproductive health decision-making						
Indicators	**1999**	**2000**	**2001**	**2002**	**2003**	**Total**
# of people reached with behavior change communication activities	202,131	232,549	352,644	1,583,699	112,001	**2,483,024**
# of people reached on community participation and advocacy	342,708	40,741,036	523,444	14,943,720	9,228	**56,560,136**
# of orgs. involved with implementing community participation and advocacy	409	569	281	154	0	**1,413**
# of people participating in non-formal education activities	19,129	10,691	10,357	27,427	572	**68,176**

Table 2. Summary of Progress Toward Key Results as Linked to Results Framework, by Country, 1998-2003

SO 1: To increase the capacity of NGOs to expand quality, gender-sensitive and sustainable reproductive and child health services						
Indicators	**Ghana**	**India**	**Nepal**	**Nigeria**	**Senegal**	**Total**
# of new FP clients reached by community workers	53,223	8,411	42,435	197,385	274	**301,728**
# of continuing FP clients reached by community workers	52,086	68,526	335,394	568,873	553	**1,025,432**
Couple Years of Protection (CYP) distributed/sold	16,365	130,223	218,402	62,872	389	**428,251**
# of community workers trained to provide RH services	865	19,804	12,358	5,572	550	**39,149**
# of NGO staff trained to provide youth-friendly FP/RH services	1,043	1,472	10	0	4	**2,529**
# of NGO staff trained in workshops designed to promote programmatic and financial sustainability	333	16,518	659	3,705	54	**21,269**

SO 2: To promote enabling environment through NGO networks an enabling environment that strengthens women's informed and autonomous reproductive health decision-making						
Indicators	**Ghana**	**India**	**Nepal**	**Nigeria**	**Senegal**	**Total**
# of people reached with behavior change communication activities	90,445	1,237,646	379,455	662,279	113,199	**2,483,024**
# of people reached on community participation and advocacy	52,486	44,354,097	12,106,405	26,569	20,579	**56,560,136**
# of orgs. involved with implementing community participation and advocacy	90	658	616	49	0	**1,413**
# of people participating in non-formal education activities	737	34,815	31,597	0	1,027	**67,176**

ENABLE's Contributions to the Reproductive Health Field

1. Promoting an Enabling Environment

The key elements of an enabling environment are:

- Supportive community norms and values;
- Adequate information to support decision making;
- Accessible, quality health care services;
- Clients' ability to identify health problems and assess personal risk;
- Appropriate policies and service delivery norms;
- Gender equity and women's empowerment; and
- Active involvement of local residents as change agents.

To promote an enabling environment, ENABLE sought to address multiple levels of society: individuals, households, communities, formal organizations such as schools, informal interest groups, political entities at local regional and national levels, and socio-cultural groups. Some of the major strategies that ENABLE used were to:

- Develop partnerships among diverse stakeholder groups;
- Give community groups the tools to create change, often using community volunteers as educators and contraceptive distributors;
- Link RH information and services with other community-based programs such as literacy education and income generation;
- Promote support groups of women and youth;
- Link community-based RH programs with health facilities;
- Train women leaders, advocates and policymakers; and
- Give increasing responsibility for program implementation to NGOs and local groups.

Exploring the Linkages between Participation in Democratic Activities with RH Behaviors

To explore the relationship between women's participation in democracy and governance (D&G) activities and reproductive health behaviors, the ENABLE Project conducted a quasi-experimental study in Plateau State, Nigeria in December 2002 and January 2003. The Church of Christ in Nigeria (COCIN), ENABLE's partner, identified four Local Government Areas (LGAs). One LGA had both D&G and RH interventions, one had only D&G interventions (such as voter education), one had only RH (which consisted of home visits by CBDs and group talks), and one served as the control area. After two years of operation, CEDPA/Nigeria conducted a multi-stage random sample survey of 2,000 ever-married reproductive-age women in the study LGAs.

The study found that women who had been visited by COCIN community-based FP distributors (CBDs) and those who had been exposed to D&G activities were significantly more likely to be using modern contraceptive methods than women with no exposure, holding education constant. Among women with less than a secondary school education, contraceptive use was highest among those in the LGA with combined D&G and RH interventions.

Women who scored high on the mobility empowerment index (which measured women's freedom to go out of the house for six purposes) and on the sexual empowerment index (which measured women's views on situations when a woman can refuse sex with her husband) were significantly more likely to be using modern contraception than other women.

Because modern contraceptive prevalence was relatively low in this area (under 9%), women's intention to use family planning in the future (46%) was also used as an outcome variable. Intention to use FP was significantly higher in the combined D&G and RH area. It was also significantly associated with CBDs' visits and to participation in D&G activities.

This study supports the idea that participation in democratic activities such as encouraging women to register to vote and questioning candidates on their views regarding women's issues does lead to a greater sense of freedom and independent thinking. These elements of women's empowerment in turn are associated with women's current use of modern contraceptives and intention to use contraceptives.

Holding other variables constant, women visited by CBDs were more likely to use modern contraceptives than other women, indicating that provision of information, contraceptive supplies and referrals in the community does increase contraceptive use. The addition of D&G interventions in RH intervention areas appears to increase contraceptive use. These findings suggest that **creating an enabling environment does promote contraceptive use above the level achieved by direct family planning interventions alone**.

Before basing programmatic decisions on these conclusions, this study should be replicated in other settings and in a more stable environment. The study found that there had been some contamination among the four study areas. Some of these effects may have been caused by displacement of families due to sectarian violence in 2001/2002.

Reference: Obeydiran, Kola and Charles Teller. 2003. *Linkages between Women's Participation in Democratic Activities and Reproductive Health: A Case Study of Plateau State, Nigeria*. Washington, DC: CEDPA.

Empowering Rural Women in Nepal

Under the ENABLE Project, the Nepal Red Cross Society (NRCS) brought RH services closer to women living in remote rural villages by training volunteer community-based distributors to educate women on family planning and safe motherhood. In addition, the NRCS organized discussion groups of 12-20 married women in three rural districts. These groups, known as Communication Action Groups (CAGs), meet regularly to discuss family planning, safe motherhood, HIV/AIDS and child immunization. By mid-2002, 495 CAGs with 9,900 members were active in 85 village development committees.

An evaluation study done in 2002 found that **participation in the CAGs had not only contributed to increased contraceptive use but also had led women to take more control over their lives and become more active in household decision making and in their communities.**

Women reported that they discussed contraception with their husbands more frequently after participating in the CAGs. Three in five CAG members had talked with their husband about condom use – an important topic in this area where many husbands migrate to India and other places for work, where they often contract sexually transmitted infections and HIV/AIDS.

More open discussion of family planning appears to be linked to increased contraceptive use. Between 1993 and 2001 contraceptive prevalence rates more than doubled in the three districts where CAGs were operating, while overall rates in rural Nepal increased by only 50 percent.

CAG members reported 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 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 savings credit program started by the CAGs 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 became more supportive of their wife's participation in the CAG. They also have taken an interest in what their wife is learning and have helped to put this new knowledge into practice.

The next generation may also benefit from the more open communication about reproductive health. CAG members and their husbands reported discussing sex,

HIV/AIDS, STIs, and menstruation with their adolescent children. With their new self-confidence and active participation in their communities, the CAG members will serve as role models for their children.

References: (1) Valley Research Group. 2002. Evaluation Study of the Effectiveness of Communication Action Groups to Enable Women to Communicate on Reproductive Health Issues. Kathmandu: CEDPA/Nepal. (2) Utilizing Women's Discussion Groups as a Force for Change. 2003. *ENABLE Highlights*. Washington, DC: CEDPA.

2. Influencing RH and Gender-related Policies

Promoting Social Mobilization and Advocacy

In 2000 CEDPA published the manual, *Social Mobilization for Reproductive Health: A Trainer's Manual*. CEDPA's definition of social mobilization encompasses four key areas: social marketing, policy advocacy, behavior change communication, and community mobilization. Based on ENABLE's work in India and Nepal, the manual was field tested in India and Nigeria.

The manual's 12 modules provide participants with a theoretical framework for social mobilization, a systematic approach to planning, implementing and monitoring a campaign, and opportunities to use key skills. It provides hands-on experience by having participants go through the actual process of choosing an issue and planning a campaign.

The *Social Mobilization* manual has been widely used in all ENABLE countries and in many other settings. For example, members of the Indian White Ribbon Alliance from six states of India used the manual for a one-week workshop. In Nigeria several RH and DG partners used the manual to conduct step-down mobilization training in their communities.

The *Social Mobilization* manual also served as the basis for a training manual on HIV/AIDS advocacy developed and pretested in Nepal. Entitled *Partners for Positive Action: Social Mobilization for HIV/AIDS Prevention, Care & Support*, the manual was developed in collaboration with Nepal's National Centre for AIDS and STD Control of the Ministry of Health, the Ministry of Women, Children and Social Welfare, and six local NGOs. The Government of Nepal is using this training manual in its HIV/AIDS program. Nepali and English versions are available.

References: (1) CEDPA. 2000. *Social Mobilization for Reproductive Health: A Trainer's Manual*. Washington, DC: CEDPA. (2) CEDPA. 2002. *Partners for Positive Action: Social Mobilization for HIV/AIDS Prevention, Care and Support*. Kathmandu, Nepal and Washington, DC: CEDPA.

Mobilizing Women's Groups

During ENABLE, CEDPA/Nigeria worked with 23 NGOs and community-based organizations (CBOs) in 18 states to strengthen their skills in advocacy and lobbying for increased women's participation and engagement in political processes. As a result of CEDPA/Nigeria's work, an estimated 689 coalitions of women's groups, known as 100 Women Groups, were formed at the community, local government, state and national levels. Each 100 Women Group brings together up to 100 women representing 10-15 CBOs to address issues of common concern. These coalitions have worked on a variety of women's issues, including reproductive health, women's rights, early marriage, girls' education, and women's participation in elections. Some 100 Women Group members have been elected to political office, while many women's organizations were involved in monitoring the polling stations during the 2003 elections.

Most 100 Women Groups were formed without outside assistance. Once women's groups observed that these coalitions had a strong influence with political leaders and provided a way to share information and concentrate collective resources, they picked up on the idea and formed their own groups.

To encourage individuals and groups to participate more actively in civil society, CEDPA/Nigeria also set up groups known as Vanguards of Democracy (VOD). Each VOD is comprised of two representatives each from 26 CBOs. The CBOs include casual laborers, road transport workers, farmers, and other community members. The VODs meet to discuss local problems and then select five representatives to take their requests to local councilors, who then forward them to the Local Government Council. One example of the effectiveness of VODs comes from Bauchi State, where the VOD persuaded local government authorities to purchase modern birthing beds for the local maternity center, replacing uncomfortable beds padded with cornstalk.

Under the Engendering Legislative Issues project, CEDPA/Nigeria has linked women's advocates with associations of women lawyers and women journalists. As a result of this combination of grassroots advocacy, legal expertise and media coverage, laws banning female genital cutting have been adopted in five states, while bills banning unjust widowhood practices are pending in several states.

References: (1) CEDPA 2002. "Bringing Women into the Political Process." *ENABLE Highlights*. Washington, DC: CEDPA. (2) Mangvwat, Joyce et al. 2002. *Giving Women a Voice: The 100 Women Groups*. Washington, DC: CEDPA. (3) CEDPA. 2002. "Vanguards Leading Change." *CEDPA/Nigeria News*. Lagos: CEDPA.

Raising Public Awareness about Condoms in Nepal

Condom Day in Nepal was originally organized by CEDPA with its partners in 1995. It has helped to raise public awareness of the dual role of condoms in protecting against unintended pregnancy and STIs and HIV/AIDS and has helped to reduce the stigma

associated with condom use. It has now become a national event celebrated throughout the country, with marches, rallies, contests, street dramas, and print and broadcast coverage.

CEDPA/Nepal took the lead in building a coalition of interested organizations. Today more than 30 organizations participate in this annual event. In 2002 CEDPA/Nepal passed on its coordinating role to the Nepal Red Cross Society, thus demonstrating that that this high-profile event has been successfully institutionalized in Nepal.

Condom Day has been a unifying force not just for the participating organizations and their constituencies but also for people throughout the country. The Maoists allow the Condom Day program to go forward in the Maoist-controlled areas because they see it as something that benefits the people.

Reference: Russell, Nancy and Marta Levitt-Dayal. 2003. *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood*. Washington, DC: ENABLE Project and Maternal and Neonatal Health Program.

Advocating for Greater Attention to Safe Motherhood

The ENABLE Project played a central role in founding and nurturing coalitions promoting safe motherhood in Nepal and India. In both countries, ENABLE provided office space to support the coalition's secretariat, technical assistance, and support funds. With the end of ENABLE, both coalitions' secretariats have been turned over to a local organization to manage.

In Nepal CEDPA's involvement in Condom Day led to the application of similar principles to form a coalition of organizations to hold National Clean Delivery Awareness Day in 1996. This event led to the formation of the Safe Motherhood Network (SMN) of Nepal, a coalition of multisectoral, local NGOs, government agencies, donors, and international organizations. Initially supported under CEDPA's ACCESS Project, the SMN has been supported under the ENABLE Project and the Maternal and Neonatal Health Program since 1998. Today the SMN has 99 organizational members. Its secretariat is housed at SAMANATA, a local NGO.

In India CEDPA built on its experience in Nepal to organize a coalition of organizations that led to the formation of the White Ribbon Alliance for Safe Motherhood of India (WRAI). Working closely with the Ministry of Health and Family Welfare, the WRAI organized the first National Safe Motherhood Day and built a diverse coalition of local organizations. By building on events such as public forums and fairs, the WRAI was able to expand its reach and enlist new partners.

The WRAI has played a major role in disseminating best practices in safe motherhood. It published the book entitled *Saving Mothers' Lives, What Works: A Field Guide for Implementing Best Practices in Safe Motherhood*. The initial printing of the book was

jointly funded by the ICICI Social Initiative Group, the ENABLE Project, and the MacArthur Foundation. The book was revised to incorporate input from SM experts and program staff in developing countries and is now available through JHPIEGO's Maternal and Neonatal Health Program (website: www.mnh.jhpiego.org).

In September 2002 the White Ribbon Alliance of India organized an International Conference on Safe Motherhood Best Practices. This conference, which was partially funded by ENABLE Core funds, hosted 475 participants from 35 countries. Substantive papers were presented and effective models of service delivery were shared. Considerable discussion centered on what constitutes a "skilled provider" and how to achieve skilled care in various local contexts.

References: (1) Safe Motherhood Network of Nepal. 2002. *The Safe Motherhood Network of Nepal*. Kathmandu: CEDPA; (2) White Ribbon Alliance for Safe Motherhood/India. 2002. *Saving Mothers' Lives, What Works: A Field Guide for Implementing Best Practices in Safe Motherhood*. New Delhi: WRAI; and (3) Russell, Nancy and Marta Levitt-Dayal. 2003. *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood.* Washington, DC: ENABLE Project and the Maternal and Neonatal Health Program.

Engaging Subproject Beneficiaries in Advocacy

Because advocacy was built into many ENABLE subprojects from the beginning, the project participants not only showed changes in their knowledge and behaviors, but also they passed on these new insights to others. Many participants took action at the community level, such as organizing well-digging, building special latrines for girls, and persuading school authorities to build an additional room to the local school so that girls could attend middle school.

One example of advocacy initiatives moving from the local to the national level is in Nepal. With support from Aama Milan Kendra (ANK), a women's organization, the adolescent girls who participated in the Adolescent Girls Initiative for their Reproductive Health Project organized a National Girls Congress to advocate for girls' needs and rights at the district, regional and national levels. At the Congress, a large meeting held in Kathmandu, the girls spoke up for positive changes to support girls' health and development. The girls also organized a follow-up meeting to advocate for their issues to be recognized by program planners and program implementing organizations. Leaders of the Girls Congress visited representatives from all the major political parties and presented a memorandum requesting that girls' issues be included in their election manifestos. The adolescent girls also organized a press briefing and asked the press to draw attention to girls' issues in the media.

References: (1) CEDPA/Nepal. 2002. *Adolescent Girls Literacy Initiative for Reproductive Health (A GIFT for RH).* Washington, DC: CEDPA; and (2) Centre for

Research on Environment Health and Population Activities. 2002. *A GIFT for RH Project: Endline Evaluation*. Washington, DC: CEDPA.

3. Providing Non-formal Education to Youth

CEDPA's Better Life Options and Opportunities (BLOOM) model is an integrated framework for young people's empowerment that combines nonformal education to increase self-confidence and gain knowledge and skills with the involvement of youth in social mobilization activities to advocate for community-level changes in health and education services. CEDPA's comprehensive family life education curriculum, C*hoose a Future! Issues and Options for Adolescents*, includes sessions on general health, sexual and reproductive health, STIs and HIV/AIDS, nutrition, hygiene, goals and future plans, gender relations, human rights, life skills (decision making, negotiating and resisting peer pressure), and civic responsibilities. The program also creates a safe, supportive environmental where young people can ask questions and learn to express their ideas.

The ENABLE Project supported evaluations of nonformal education programs for youth in India and Egypt. It also conducted additional life skills education programs for youth with NGOs in India and Nepal. As discussed below, the **life skills education programs have been effective in providing SRH information to low-income, marginalized youth but also in encouraging behaviors that will lead to important life changes, such as deciding to marry later, continuing their education, and learning a trade**.

Following are some of the accomplishments of life skills programs for youth implemented and/or evaluated under ENABLE.

India: Better Life Options Program Evaluation

The India Better Life Options Program (BLP) tries to break gender stereotypes by: (1) training girls and boys in life skills such as using the post office, bank, and transport system; (2) encouraging recreational and leisure activities; and (3) creating leadership skills. For girls aged 12-20, the Program challenges gender inequities, expands life options and uses the empowerment model through an integrated and holistic program. CEDPA works with NGOs to offer *Choose a Future!* courses in the community or linked with literacy and vocational classes.

The ENABLE-funded evaluation of the Girls BLP Program showed that **a significantly higher proportion of girls postponed marriage until age 18 and above** (52% among alumni compared with 35% among controls) **and had lower fertility**, with youth women who had completed the program having an average of 1.0 children ever born, compared with 1.5 children ever born in the control group.

Reference: CEDPA. 2001. *Adolescent Girls in India Choose a Better Future: An Impact Assessment*. Washington, DC: CEDPA.

India: Adolescent Reproductive Health Project

In India, ENABLE partnered with four NGOs — Prayatn and Young Women's Christian Association in Delhi slums, Bharitiya Grameen Mahila Sangh in Madhya Pradesh, and Society for the Promotion of Youth and Masses in Haryana — to provide a comprehensive package of reproductive health and nutrition information and services, skills development, and recreation.

CEDPA built the capacity of NGO partners to effectively implement its facilitator guide and to provide adolescent-friendly reproductive health services. The first technical guidelines for providing adolescent reproductive health services in India were developed through this process. The NGOs adopted a mix of strategies depending on the contextual circumstances in their implementing areas. The main strategies adopted were: (1) an integrated approach in which *Choose a Future!* was integrated into vocational training classes, remedial tutoring classes, and recreational clubs; (2) a short-term camp approach in which adolescents received intensive instruction; and a short-term school approach in which *Choose a Future!* was taught in the classroom.

A total of 7,782 adolescent girls and boys were provided family life education (FLE) and reproductive health (RH) information. Of these youth, 1,013 also received vocational skills training; 104 adolescent peer educators were trained and are actively participating in facilitating FLE and providing RH information to peers; 7,060 adolescents received health care and counseling services; and 77 adolescents formed theatre groups to address adolescent health and development issues.

The project took physicians to the project sites to provide medical check-ups to the girls. Often these check-ups identified health problems and provided an opportunity for counseling on health-related issues.

More than four in five adolescent girls were found to be anemic. After the girls received iron supplementation, their hemoglobin levels increased from a mean of 9.0 at first check-up to 11.1 among girls aged 10-14 and 10.7 among those aged 15-19 – a statistically significant increase.

Some lessons learned in implementing this program are:

- In developing an acceptable strategy and programs for adolescents, it is critical to elicit opinions from a wide range of community representatives, including parents, teachers, religious leaders, and other community leaders to avoid controversy.

- Providing adolescent reproductive health (ARH) as a separate service is not feasible in conservative societies. However, **when provided within the context of general health care services, ARH services are readily acceptable to adolescents and parents, even in conservative societies**.

- Linking life skills education with literacy courses and/or vocational training helps to ensure regular attendance and imparts valued skills to youth.

- Building the capacity of peer educators is a sustainable approach but requires continuous training, supervisory support and mentoring.

Reference: TNS MODE and CEDPA/India. 2003. *Improving Adolescent Reproductive Health Knowledge and Outcomes through NGO Youth-Friendly Services*. Washington, DC: CEDPA.

Egypt: Towards New Horizons Evaluation

During 1999-2002 CEDPA/Egypt implemented the Towards New Horizons program, which provided non-formal education to disadvantaged young women aged 9-20. Using an adaptation of the *Choose a Future!* curriculum, the program worked with 144 NGOs to provide education to 28,251 girls in 16 governorates.

In order to learn more about the program's effects on its beneficiaries, ENABLE supported an evaluation study. The study was originally planned as a survey of 1,604 program participants, non-participants, parents, and course facilitators. However, CEDPA was unable to obtain government permission to conduct the survey and had to reorient the evaluation to qualitative methods. Accordingly, the evaluators conducted 19 focus group discussions with unmarried and married beneficiaries and non-beneficiaries and 63 in-depth interviews with parents, male siblings, course facilitators and community leaders. The researchers reported that the beneficiaries valued education, were knowledgeable about self-care and medical care, were aware of gender-based inequities, knew about family planning methods, and expressed confidence in speaking in the presence of men or mixed groups. Clearly, the program had instilled new knowledge and had created interest in more equitable marital relationships.

Reference: North South Consultants Exchange. 2003. *Impact Study of the Towards New Horizons Program in Egypt*. Washington, DC: CEDPA.

Combining Literacy and Family Life Education in Nepal

Adding family life education to basic literacy classes has led to increased knowledge of reproductive health and increased use of health services among illiterate adolescent girls in Nepal, according to the findings of a 1999-2001 study. In the remote Baglung district, 891 illiterate girls aged 10-19 completed a nine-month non-formal education program implemented by the Aamaa Milan Kendra (AMK), a women's organization. Following the courses the girls continued to participate in small discussion groups. By the end of the program their knowledge of health issues as well as their actual use of health services increased greatly.

Awareness of adolescent reproductive health increased from less than 10 percent at baseline to 76 percent immediately after the classes to 99 percent by the end of the next year. The study found sharp increases in knowledge about how conception occurs and how to prevent pregnancy and awareness of family planning methods in all nine project sites. One year after the program was completed, almost all of these adolescent girls knew about HIV/AIDS, risk factors, and prevention methods.

The proportion of girls who felt that the best age for marriage and beginning childbearing is 20 years and above increased from nearly 50 percent at baseline to 99 percent at the end of the program. Recognition of the need for taking health precautions during pregnancy went from 13 percent to 94 percent between the first and third interview, while recognition of the need for nutritious foods rose from 1 percent to 94 percent. Of those girls who experienced health problems, 93 percent consulted a health care provider at the local health sub-post. Changes in the adolescent girl's health seeking behavior brought about changes in their entire family's health-seeking behavior.

The impact of the non-formal literacy classes was greatest on the 10-14 year-old girls, as almost all (93%) of them obtained their parents' permission to begin formal schooling. Only 26 percent the 15-19 year-olds went on to school. Presumably they had reached the acceptable age of marriage and in most cases became "too old" to return to school.

By the end of the project, the proportion of girls involved in discussions during family decision-making increased three fold from 17 to 49 percent; 97 percent of the girls reported that their parents seek their advice when making family decisions.

Some of the lessons learned from this project are:

- Involvement of community leaders, parents and adolescent girls in the program from the beginning helps develop ownership of programs.

- In terms of increasing health services utilization, observation visits to health institutions are an effective approach for motivating girls to use health facilities.

- Frequent monitoring, follow-up, and interaction with adolescent girls from central level staff helps to encourage the girls and the community to participate in the program actively.

Observers report that the transformation of the girls from shy, passive listeners to self-confident activists determined to improve their own health and that of their families and community was truly remarkable.

References: (1) CEDPA/Nepal. 2002. *Adolescent Girls Literacy Initiative for Reproductive Health (A GIFT for RH).* Washington, DC: CEDPA; and (2) Centre for

Research on Environment Health and Population Activities. 2002. *A GIFT for RH Project: Endline Evaluation*. Washington, DC: CEDPA.

Nepal Youth for Each Other

In order to test new ways of relating to young men living in rural areas, ENABLE supported a project implemented by the Nepal Red Cross Society. Known as the Youth for Each Other Project, the project formed 18 groups of young men aged 15-24 in two districts. The young men were given training in leadership, HIV/AIDS, basic counseling, and creating street drama. They then conducted a variety of activities, including promoting health check-ups, distributing condoms, providing informal counseling and making referrals.

At the end of the six-month project, the participating youth reported that they had adopted safer sexual behaviors. They also reported that they had greater confidence in making decisions and relating to outsiders. Although brief, this project generated a lot of interest among the participants and community residents. It proved to be a vehicle for inspiring young men to pay more attention to health issues, especially HIV/AIDS, and become more active in their communities.

Reference: Sharma, Mahesh. 2002. *Youth for Each Other Programme: Rapid Impact Assessment*. Washington, DC: CEDPA.

4. Testing a New Model for Peer Education

In Ghana, ENABLE tested two models of peer education to provide sexual and reproductive health (SRH) education to youth:

1. **The Structured Peer Network model**, in which a volunteer peer educator formed a group of 10-20 youth. These youth, known as peer promoters, formed their own youth groups with 5-10 members. These groups met weekly. Participants were recruited through community and religious leaders, friends, referrals, and personal contacts.
2. **The Unstructured Peer Network model**, in which volunteer peer educators discussed sexual and reproductive health issues with their friends informally. Participants met frequently, but most peer educators did not form groups. There was no formal recruitment system.

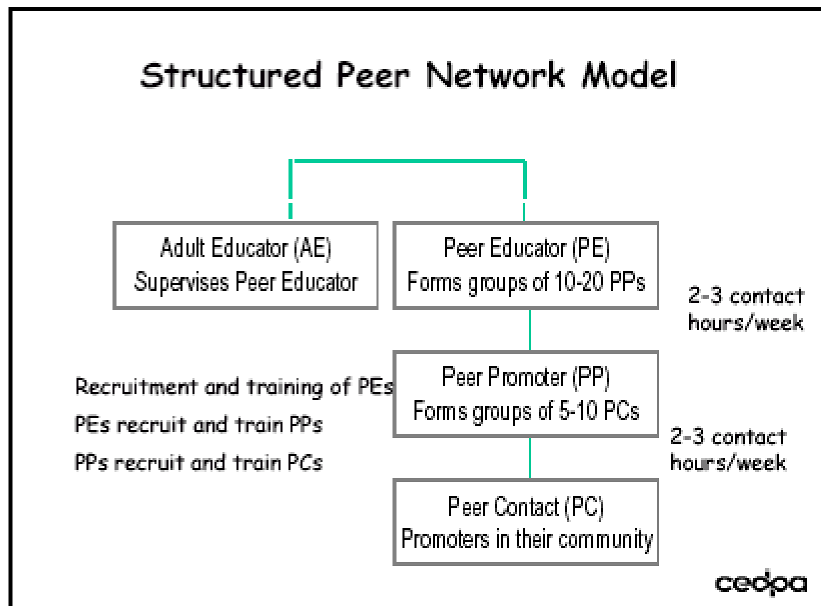
An evaluation study conducted in March 2000 consisted of a survey of 871 peer educators and promoters, focus group discussions, in-depth interviews, and observations with peer educators and community/opinion leaders. The study concluded that **the Structured Model was more successful at reaching youth and improving their knowledge of SRH than the Unstructured Model**. Because of the loosely defined nature of the Unstructured Model, it was more difficult to find youth who had benefited

from program activities. Both male and female participants in the unstructured model had limited knowledge of correct condom use.

Nevertheless, the Unstructured Model had some positive features, mainly due to its inherent flexibility. Educators and promoters were free to use their own recruitment and education strategies. The facilitators largely controlled meeting times and the duration of discussions. They could choose either to contact individuals or work in groups.

These two models need further testing to determine which approach works best in a given setting. Other recommendations that emerged from the study were:

- Since parents, teachers, and church leaders rarely teach SRH to youth, NGOs should increase advocacy efforts to promote themselves as credible alternatives and conduits to supplement SRH education in the schools.
- **NGOs should give some remuneration to peer educators and should provide in-service training**.
- Peer educators who had a senior secondary education were more effective than their less-educated counterparts, who often lacked the confidence to form their own groups. Peer educators without formal education or less than a secondary education should be given extra training in communication skills and self-confidence.
- Many youth who were sexually active were not using condoms or modern contraceptive methods to protect themselves from unplanned pregnancy or sexually transmitted infections. Educational campaigns need to stress the risks associated with unprotected sex.



References: (1) CEDPA. 2002. *Using Peer Educators to Improve Adolescent Reproductive Health in Ghana*. Washington, DC: CEDPA; (2) "Peer Educators Increase Knowledge of HIV/AIDS among Youth." *ENABLE Highlights*. Washington, DC: CEDPA, 2003; and (3) R. Cameron Wolf, Linda A. Tawfik, and Katherine C. Bond. 2000. Peer Promotion Programs and Social Networks in Ghana: Methods for Monitoring and Evaluating AIDS Prevention and Reproductive Health Programs among Adolescents and Young Adults." *Journal of Health Communication* 5 (Supplement): 61-80.

5. Bringing RH Services to Remote Communities

Reaching Remote Areas of Nepal

ENABLE's work in Nepal demonstrated that **contraceptive prevalence rates can be raised even in the poorest, most remote communities.**

The Reaching and Enabling Women to Act on Reproductive Health Decisions (REWARD) Project was carried out in conjunction with Nepal Red Cross Society (NRCS) from 1999 to 2002. The REWARD Project was implemented in 85 VDCs in Doti and Kailali districts in the far-western development region and in the Udayapur district in eastern-development region. The REWARD Project built upon the foundation for community-based distribution of FP and RH information and services successfully established by NRCS under the CEDPA-supported ACCESS Project.

Under ENABLE funding, CEDPA/Nepal and the Nepal Red Cross Society worked together to provide women with access to quality, gender sensitive family planning, maternal and child health information and services; teach women the skills to make and act upon reproductive health decisions appropriate to their needs; and help to create a supportive environment for improved reproductive health within families and communities. Women's discussion groups, known as Communication Action Groups, helped women to learn about RH methods and services. One youth-specific objective of this program was to provide reproductive health information and services to meet the needs of the adolescents and youth.

The contraceptive prevalence rate (CPR) in the baseline survey was 30.3 in Doti, 55.8 in Kailali and 40.4 in Udayapur district. These increased to 33 in Doti, 61 in Kailali and 45.5 in Udayapur by the endline survey. **The CPR figures for Kailali and Udayapur are higher than the national CPR**, which was 38.5 percent according to the 2001 *Demographic and Health Survey*. The CPR of Doti district is also a significant achievement, considering the terrain and socio-economic backwardness of the remote district. The project was able to provide 41,920 couple-years of- protection (CYP) through direct delivery and referral services. Of these, the contribution of pills, condoms and DMPA is 13,962 (33.3% of the total CYP and 86% of total current users).

Other health indicators also improved. The proportion of women receiving two tetanus toxoid injections increased from 33 percent to 58 percent, intake of iron folic acid tablets

rose from 6 percent to 25 percent, and the proportion of women receiving vitamin A supplements grew from 46 percent to 94 percent.

Some of the lessons learned from this project are:

- Community based distribution can work to deliver information and services related to FP, RH, CS, HIV/AIDS, STIs to remote communities.
- The Communication Action Group approach was effective in mobilizing women to discuss sensitive RH issues not only among themselves but also with husbands and other family members.
- The synergy between the various program components created a greater impact than more narrowly focused programs.

Reference: Centre for Research on Environment Health and Population Activities. 2002. *Enabling Women for Reproductive Health: The Reward Project of the Nepal Red Cross Society*. Washington, DC: CEDPA.

Reaching Rural India

Under the USAID-Government of India bilateral project, CEDPA/India scaled up its community-based distribution (CBD) project with dairy cooperatives. This project was introduced during the CEDPA's ACCESS Project. During the ENABLE Project from 1998-2002, CBD services through dairy cooperatives expanded to 15 million people in Uttar Pradesh, India's most populous state. About 5,000 female CBD volunteers and 250 female supervisors have been recruited and trained. More than 610,000 childspacing clients are currently being served.

In the areas covered by the dairy cooperatives, the contraceptive prevalence rate (CPR) increased by an average of three percentage points annually during 1995-2002, or more than four times the increase in the entire Uttar Pradesh project area, where CPR has increased 0.9 percentage points annually. The availability of spacing methods has encouraged more diversity in the contraceptive mix. Previously sterilization accounted for 70 percent of all contraceptive use; the current method mix is 58 percent condoms, 25 percent pills, 11 percent sterilization, and 6 percent IUDs.

The dairy cooperatives are introducing some sustainability measures. CBD volunteers sell contraceptives produced under the social marketing program and retain a portion of the profits. Three in five pill and condom users in the project areas purchase social-marketed brands from dairy cooperative CBD volunteers. Profits are also set aside to pay for district-level program activities.

Reference: CEDPA. 2002. Linking with Dairy Cooperatives for Large-Scale Community-based Service Delivery. *ENABLE Highlights*. Washington, DC: CEDPA.

Reaching Underserved Areas of Nigeria

In Nigeria, CEDPA is focused on helping NGOs implement family planning, reproductive health, child survival, and HIV/AIDS services. In addition, CEDPA promotes an enabling environment that strengthens women's RH decision making and encourages civil society to participate in the democratic process and respect civil rights. During ENABLE, CEDPA/Nigeria supported 12 partner organizations in Anambra, Ekiti, Kano, Lagos, Ondo, Osun, Oyo, and Plateau States to provide comprehensive RH services for women, men, and adolescents.

CEDPA partners implemented five models:

1. **Sale of subsidized contraceptives**. Two of the 12 partner agencies used a social marketing model for FP commodities distribution, which resulted in 65 percent of the couple years of protection (CYP) generated in Nigeria under the ENABLE Project during 1998-2002.
2. **Community-based distribution (CBD)**. Eight NGO partners supported community-based volunteers who distributed condoms, pills, and other health products and referred clients to clinical services in Ekiti, Kano, Lagos, Ondo, Oyo, and Plateau States. These volunteers also had an important role in generating demand for RH services by home visits and group discussions in the community. Some partners linked with traditional health providers. For example, the Christian Health Association of Nigeria trained traditional birth attendants to provide community-based RH services in Oyo State.
3. **Clinical service provision and referrals**. The Church of Christ in Nigeria (COCIN) has incorporated FP services and HIV/AIDS counseling and testing in its 150 clinics, linked to communities with trained volunteers. Five Community Partners for Health clinics also provide clinical RH services. All CBD programs refer clients to nearby clinical services.
4. **Market-based provision of contraceptives**. In Anambra and Osun States, the National Council of Women's Societies (NCWS) trained market traders to sell condoms, pills, and other contraceptives and to educate customers on RH issues. NCWS served over 140,000 FP clients; slightly more than half of these clients were male.
5. **Peer health educators**. Eight partner agencies supported trained peer health educators (PHEs) who provide counseling and non-clinical contraceptives to other youth. Roughly half of their clients are male, and thus the PHEs are helping to change the attitudes of young men to ensure more responsible sexual behavior.

During the ENABLE Project, CEDPA/Nigeria's partner agencies provided RH services to roughly 766,000 clients, generating a total 62,872 CYP.

Safe Motherhood Initiatives in Ghana and India

In Ghana and India ENABLE tested a new approach for involving communities in supporting safe motherhood activities. This approach entailed training and mobilizing two groups of community members:

- Safe Motherhood Volunteers (SMVs), who educated pregnant women and their families on danger signs of possible delivery complications, planning for home delivery, and preparedness for childbirth complications; and

- Safe Motherhood Advocates (SMAs), who worked to decrease barriers in the community to accessing appropriate care, such as lack of emergency transport.

Staff of partner agencies used participatory learning and action techniques to involve community members in identifying barriers to appropriate care-seeking behavior that led to life-threatening delays in recognizing danger signs, reaching care and receiving care. This formative research led to the design of an intervention to sensitize communities to the factors causing these delays and the consequences. During four to five-day workshops, the SMVs, who were volunteers working as community-based family planning educators and distributors of non-clinical contraceptives, were trained to take on the expanded role of safe motherhood counseling. The SMAs were community development workers, who focused on reducing barriers that prevent pregnant women from reaching appropriate care promptly. Their training lasted 3-5 days.

Through educational talks to groups, home visits and community meetings, the SMVs counseled women on prenatal care; diet, nutrition and workload reduction during pregnancy; planning for delivery and obstetrical emergencies; pregnancy complications; labor and delivery; and other health topics. The SMAs worked to identify community resources that could be used to improve the health of women and children, to establish funds to meet transport and medical expenses during emergencies, to establish emergency transport, and to identify possible blood donors.

In both countries, evaluation studies conducted after one year of intervention found improvements in numerous practices related to safe motherhood.

Ghana

In Ghana, the project was implemented in three rural communities. The proportion of pregnant women who attended an antenatal clinic increased from 5 percent at baseline to 86 percent after one year of intervention. Three in four recently delivered mothers said that they had eaten larger portions of food during their recent pregnancy, compared with previous pregnancies. Use of *kalugotin*, an indigenous root with oxytocic effects, was greatly reduced after community members recognized its harmful effects. The proportion of women who breastfed their babies immediately after delivery increased from 15 percent at baseline to 36 percent after one year of intervention.

India

In India, where the project was implemented in the slums of Delhi, the endline survey found significant improvements in knowledge and behaviors related to safe motherhood. The proportion of women who knew of at least three danger signs during pregnancy, delivery and the postpartum period increased from 27 percent at baseline to 59 percent after one year of intervention. Hospital deliveries have increased from 26 percent at baseline to 49 percent at endline, while home deliveries have decreased from 75 percent to 51 percent. In addition, the proportion of women who were visited by a health worker within one week of their delivery increased from 9 percent to 44 percent.

References: Ghana: Payne, Lola and Dela Afenyadu. *Safe Motherhood Initiative in Ghana: Endline Studies*. Washington, DC: CEDPA, 2003. India: Taylor Nelson Sofres Mode Pvt. Ltd. *Expanding the Role of CBD Workers and Advocates in Safe Motherhood in India: Final Report*. Washington, DC: CEDPA, 2003.

6. Working with Faith-based Organizations

The Church of Christ in Nigeria (COCIN) Project

COCIN, which was founded in Nigeria in 1904 and registered in 1975, has branches in 26 states and a membership of more than 2.5 million people. Its health system includes two major hospitals, a rehabilitation system, and 150 primary health care clinics throughout the country, mostly in rural areas.

CEDPA began working with the COCIN Women's Fellowship in 1998 on Democracy and Governance (D&G) activities, including civic education, capacity building and the formation of accountability and democracy watch groups. The program also educated the public on women's rights and promoted the participation of women in politics. COCIN mobilized women to register to vote and run in local elections. During the 1998 elections, voter turnout in targeted areas reached record levels.

After working with CEDPA on D&G activities, COCIN requested CEDPA's assistance in introducing family planning services and information into its existing social and health services structure. Prior to CEDPA's involvement, COCIN had been providing maternity care and limited FP services.

Under the ENABLE Project, COCIN mobilized community-based distributors, peer educators, traditional birth attendants, and health personnel to provide contraceptives and RH information and services to communities throughout Plateau State. Community-based volunteers provided contraceptives to 11,222 clients from 1999-2002; actual contraceptive use is probably higher, since many COCIN members visit government clinics and private providers. COCIN volunteers reached 578,287 people through group talks, home visits, one-on-one peer counseling, advocacy activities, and IEC materials.

The Integrated Reproductive Health Project initially focused on providing family planning information and services through community volunteers as well as in COCIN clinics and improving management of obstetric complications. **These activities led to a more open discussion of HIV/AIDS and to fundamental changes in the church's views on condom use, contraceptive use among unmarried youth, and care of people living with HIV/AIDS.**

A major turning point in COCIN's stance on HIV/AIDS came in 2000, when ENABLE organized a visit to Uganda by COCIN leaders. They met a Ugandan minister, Reverend Gideon Byamugisha, who is living with HIV/AIDS, and invited him and his wife to Nigeria. Their visit, which included meetings with 600 COCIN ministers and their wives, leaders from other Christian denominations, and the general public, had a powerful effect on participants' views regarding people living with HIV/AIDS. COCIN now encourages its ministers to talk about AIDS from the pulpit and to encourage condom use among married couples. It has added voluntary counseling and testing services and has increased the number of clinic patients being screened for HIV/AIDS. It has also established an HIV/AIDS unit to train church leaders, members and health workers about STIs and HIV/AIDS.

COCIN leaders have reached out to other churches to encourage them to offer RH services as well as HIV/AIDS prevention and support. It held a joint meeting with leaders of Nongo Kristu U Sudan Ken Tiv to encourage them to become more involved in RH education and services.

Reference: (1) CEDPA. Faith-based Initiative Proves to Be Successful. *ENABLE Highlights*. Washington, DC: CEDPA, 2003; (2) *The COCIN Integrated Reproductive Health Project/Nigeria: A Case Study Summary*. Washington, DC: CEDPA, 2003; and (3) Sulaiman, A.B. 2002. Case Study of Church of Christ in Nigeria (COCIN) ENABLE Integrated Reproductive Health in Plateau State of Nigeria. Lagos: CEDPA.

7. Integrating HIV/AIDS Prevention and Care into Reproductive Health Programs

Because ENABLE focuses on hard-to-reach groups, many partners find that family planning is often more acceptable if it is linked with other health concerns of community members, such as safe motherhood, HIV/AIDS, child survival, and STIs. Accordingly, many ENABLE-funded programs provide integrated reproductive health services. In the countries where ENABLE works, especially in sub-Saharan Africa, it is imperative to address the growing HIV/AIDS pandemic, which affects the reproductive health of women, men and youth.

To assist community organizations seeking to include HIV/AIDS prevention and care in reproductive health and family planning projects, ENABLE developed a four volume series of training manuals entitled, *Integrating Reproductive Health & HIV/AIDS for*

NGOs, FBOs and CBOs. These manuals address various facets of the pandemic and the issues of sexuality underlying both FP and HIV transmission. Priority areas include integrating HIV/AIDS education, prevention, and care and support activities into ongoing programming and building capacity in NGO partner programs, networks and communities affected by the destabilizing effects of the HIV epidemic.

The first volume, *Family Planning Plus: HIV/AIDS Basics for NGOs and FP Program Managers*, provides both NGO staff and the community at large with a deeper understanding of the dynamics and impact of the disease and sensitizes them to the current issues and challenges that people living with HIV/AIDS face. The curriculum covers the modes of transmission and prevention, including proper condom use, dual protection and universal precautions, cultural and social factors that contribute to the spread of the epidemic, the immune system and disease progression, and strategies for living healthy and coping with HIV/AIDS.

The second volume, *Faith Community Responses to HIV/AIDS*, provides an overview of the HIV pandemic to Christian clergy, religious leaders, laity and church groups. It also sensitizes them to the current issues and challenges that people living with HIV/AIDS face. The curriculum has an overview of the signs, symptoms, modes of transmission and prevention of HIV/AIDS and helps participants identify cultural and social factors that contribute to the spread of the pandemic. It orients participants to the various means by which faith communities can respond to HIV/AIDS, whether it is through care and counseling, education and outreach, or service delivery, and helps participants define what path to take to combat the pandemic. It also assists them in advocating and networking to reduce HIV/AIDS within their communities and churches. An additional benefit is the sensitization of clergy and their congregations to the broader issues of reproductive health/family planning. CEDPA's partners in Senegal have expressed interest in adapting this curriculum for use with Muslim groups.

The third volume, *Home Care for People Living with HIV/AIDS: The Power of Our Communities*, is designed to provide support to communities that have been hard hit by the HIV/AIDS crisis. Families and community groups that are caring for people living with HIV/AIDS and orphans and vulnerable children often need basic information on HIV/AIDS to keep themselves safe and to help those in their care stay healthy and emotionally positive for as long as possible. In addition to providing this basic information, the *Home Care* manual taps into the strength of the community and empowers participants to action. It offers people living with HIV/AIDS, orphans and vulnerable children, family and community members knowledge about living healthy with the virus, about care and support, and about death and dying. Community members are urged to visualize their regions protected against the ravages of HIV/AIDS and to work together to find solutions to the impact of HIV/AIDS on their areas.

The fourth volume, *Social Mobilization for HIV/AIDS: A Training Manual*, was adapted from CEDPA's Social Mobilization curriculum, *Social Mobilization for Reproductive Health: A Trainer's Manual*, for use in Nepal. The manual was developed and pretested by CEDPA/Nepal in collaboration with the Ministry of Health's National Centre for

AIDS and STD Control, the Ministry of Women, Children and Social Welfare and six Nepali NGOs.

A fifth curriculum on developing an HIV/AIDS capacity building program for community-based organizations and NGOs was drafted and field-tested under ENABLE. Further revisions are being made by CEDPA's Women's Leadership Program. The curriculum is designed to provide information and to enhance skills in four key areas: organizational and infrastructure development; intervention design, implementation, and evaluation; community mobilization; and community participation in HIV prevention.

India: Integrated Services in Jharkhand State

In India, ENABLE supported the first project in Jharkhand to integrate FP/RH and HIV/AIDS services into existing infectious disease services (malaria, leprosy, and TB). Kharkhand State, created in 2000, ranks below the national average on many socio-economic indicators. Only 8 percent of its people have access to modern health care. About 25 percent of reproductive-age women are using modern contraceptives, compared with the national average of 48 percent.

In this one-year project (Feb. 2002-Jan. 2003), CEDPA/India collaborated with Krishi Gramin Vikas Kendra (KGVK), an NGO involved in controlling infectious diseases. The project covered 43 villages of Ranchi District, Jharkhand. CEDPA introduced an integrated package of RH services that included family planning counseling and services, antenatal care, delivery by trained personnel, postnatal care, child immunization, treatment of diarrhea, general medicines, referral services, and laboratory services. To provide these services, KGVK strengthened six existing health centers and two community hospitals and established seven additional health centers. The seven new health centers were renovated by health workers with community involvement at no cost to the project.

CEDPA/India trained health workers in the integrated RH package and provided service providers with training in contraceptive technology, injectables, IUD insertion, infection prevention, and the Standard Days Method. KGVK staff were also trained in implementing the project's new management information system (MIS), cost recovery, and social marketing. Traditional Birth Attendants were trained in safe motherhood and child survival. CEDPA introduced a comprehensive computerized MIS for NGOs that integrates FP/RH and infectious disease service delivery.

For each health subcenter a Health Committee was set up to assist the health workers in creating a demand for services and in marketing health products. These products include condoms, oral contraceptive pills, disposable delivery kits, disposable syringes, oral rehydration solution packets (to treat diarrhea) and iron folic acid (IFA) tablets.

The endline survey found that nearly four in five (79%) women in the project area were aware of the project and its activities. Three in four of them had met the project health

worker in their community. For most types of health services, more women had utilized services provided during home visits or in the community than in the health subcenters. **Use of modern contraceptives increased from 35 percent of eligible couples surveyed in the March-April 2002 baseline study to 41 percent in February 2003**. Use of maternal and child health care services increased in the areas with the seven new health subcenters, while MCH utilization declined in the previously existing subcenters, perhaps due to the greater availability of services from community workers. Gains were greatest in provision of IFA tablets and child immunization. About 80 percent of the children aged 12-23 months received complete immunization.

In order to promote sustainability, KGVK conducted a study to determine household health expenditure, utilization of health services, and willingness to pay for specific services. Based on this study and a cost/pricing analysis of its existing services and product sales, KGVK revised its fee structure by charging fees for medical consultation, laboratory testing, X-rays, deliveries and surgery. Revenues included sales of health products as well as a family registration card to use the health facility. An analysis of KGVK's revenues found that the new system worked well: the two rural hospitals recovered 48 percent of their costs, while the 12 subcenters for which analysis was done recovered 31 percent of their costs.

CEDPA/India facilitated the formation of the Jharkhand AIDS Prevention Consortium (JAPC) in August 2002. This consortium of industries, NGOs and the government of Jharkhand was launched by the Minister of Health, Jharkhand. As part of its mandate to facilitate the state HIV/AIDS action plans, the JAPC has established four regional coordination centers and is working closely with the State AIDS Control Society.

Reference: *CEDPA/India and Krishni Gramin Vikas Kendra (KGVK). Enabling the Expansion & Sustainability of Integrated RCH/Infectious Diseases Outreach Services in Ranchi, Jharkhand: Final Evaluation*. New Delhi: CEDPA/India, 2003.

Assisting Orphans and Vulnerable Children in Nigeria

In Benue State, Nigeria, CEDPA piloted an innovative project to provide comprehensive support to orphans and vulnerable children and their caregivers by providing health care, education, and income-generating activities. CEDPA worked with two partners – the Catholic Women Organization and Opiatoha Kayin Idoma Multipurpose Cooperative Society – to implement this project in two Local Government Areas.

Up to the end of the ENABLE project, the Vulnerable Children Project provided direct support for health and education to about 1,050 orphans and vulnerable children. Of these beneficiaries, 416 children are in primary schools, 192 in secondary schools, and nine in vocational training centers. Forty caregivers and some older siblings of orphans have either completed or are in vocational training. Income-generating activities, benefiting more than 700 caregivers, include a gari plantation and mill and a rice mill. The project has leveraged both human and material resources from state and local governments, as

well as land, agricultural, and micro-level food processing materials and labor from the community.

In Rivers State, CEDPA supported AFRICARE's work to enhance the capacities of local community-based organizations to provide health care and education for orphans and vulnerable children as well as their caregivers.

8. Strengthening the Capacity of NGOs to Provide RH Services

The ENABLE Project has worked closely with more than 50 NGO partners in five countries to strengthen their management systems and service network in order to expand access to quality RH services. ENABLE built the capacity of NGOs in three ways: (1) through direct training of NGO staff; (2) providing continuing technical assistance and oversight; and (3) building the capacity of training centers and establishing partnerships with agencies that trained large numbers of NGO staff and volunteers.

In most countries ENABLE conducted Training of Trainers workshops for NGO managers and trainers, who then trained community workers, service providers, program managers, and others involved in RH and community development programs. The ENABLE Project tapped the resources of CEDPA's network of training alumni and worked jointly with NGO training centers and experienced NGOs with training divisions in order to strengthen their expertise and prepare training curricula.

The strategies that ENABLE used to build core capabilities with NGOs are modeling, facilitation, training, demonstration, shared experience and networking. For example, a common language and concepts were introduced to NGOs through training, but shifts in paradigm thinking required facilitating leadership to guide and support new activities, demonstrating practical applications of tools and methods in organizational settings, sharing implementation experiences through participatory learning and analysis to understand effects in communities, and networking to identify best practices and accelerate learning among organizations with common aims.

After assessing each partner's capabilities, the ENABLE Project designed a capacity building program. Some of the common elements of this program included:

- Program planning workshops;
- Subproject administration and budget monitoring;
- Strengthening technical skills in family planning, safe motherhood and other RH topics;
- Strengthening skills in counseling and interpersonal communication and speaking to groups;
- Social mobilization and advocacy skills;
- Monitoring and evaluation; and
- Sustainability measures.

With ENABLE support, staff from partner NGOs have attended CEDPA's Washington, D.C.-based training programs: Women in Management, Institution Building, and Youth Development and Reproductive Health. The curricula from these courses have been widely adapted for use by local NGOs. They have been widely used in training of trainers courses, which have in turn led to training for thousands of NGO staff and volunteers.

Helping partners develop mechanisms to sustain RH services was a major emphasis of the ENABLE Project. ENABLE staff developed a sustainability conceptual framework and set of tools to help organizations assess, plan, implement and monitor approaches to sustain their RH programs. The training manual, *Sustaining the Benefits: A Field Guide for Sustaining Reproductive and Child Health Services*, provides guidelines for a five-day workshop. The manual has been used in workshops for NGOs in Ghana, India and Nigeria.

Designed for 20-25 representatives of NGOs, including senior management, program and financial staff, the curriculum covers definitions of sustainability, the NGO sustainability model, assessment of each NGO, and development of an action plan. The curriculum is designed to help NGO staff think critically about what is meant by sustainability, what is to be sustained, and why sustainability is a critical aspect of any RH/FP program. Managers learn about the changing trends driving donors, organizations and clients toward a new way of thinking about the relationship to one another, a model of how the triple engines of institution, program and finance can support one another in an organization's drive toward commitment to sustainability, client-focused directions for achieving social impact, and what it means to exchange "value for value" -- an important dynamic for program quality and sustainability. The manual emphasizes that techniques that promote sustainability do not compromise the organization's mission but in fact enhance it.

The manual enables managers to assess where their organization is on the Sustainability Continuum, to learn about the array of sustainability mechanisms available to them, and how they have been successfully applied in RH/FP projects, and to plan strategically for increased institutional, programmatic and financial sustainability. Managers learn that sustainability is a process, is about relationships, is managing change and transition, and most importantly that sustainability is achievable.

The Reproductive Health Awareness Manual Series

ENABLE supported the development of a 14-module resource manual that provides a comprehensive overview of reproductive health. The manual is designed to help training providers develop reproductive health classes and training programs that will increase knowledge, foster supportive attitudes, and develop skills that are important for good reproductive health for people of all ages.

The manual focuses on reproductive health awareness (RHA), which includes an awareness of:

- The human body and the many opportunities for self-care;
- Gender issues that affect reproductive health and efforts to address gender inequities;
- A person's own sexuality, as well as the sexuality of others; and
- The power of interpersonal communication for improved reproductive health.

These points reflect the four key components of the RHA approach: body awareness and self-care; gender; sexuality; and interpersonal communication.

Following is a list of the 14 modules contained in the *RHA Manual*:

- Introduction
- Chapter One - Reproductive Health Awareness: An Overview
- Chapter Two - Gender: Implications for Health
- Chapter Three - Body Awareness and Self-Care: Focus on Fertility
- Chapter Four - Body Awareness and Self-Care Practices
- Chapter Five - Sexuality: Healthy Expression Throughout Life
- Chapter Six - Interpersonal Communication: Talking with My Partner
- Chapter Seven - Interpersonal Communication: Skills for Providers
- Chapter Eight - RHA through the Life Cycle: Birth through Adolescence
- Chapter Nine - RHA through the Life Cycle: Fertile and Aging Adults
- Chapter Ten - Family Planning and the RHA Approach
- Chapter Eleven - Creating Change: Achieving Healthy Behaviors
- Chapter Twelve - RHA and the Community: A Focus on Safe Motherhood
- Chapter Thirteen - Implementing the RHA Approach
- Chapter Fourteen - Evaluation: Trainer, Participants, Training, and Program.

The *Reproductive Health Awareness Manual* aims to provide a framework and a cohesive program that trainers can use to help providers of health services promote wellness of their clients at every stage of life. The RHA approach can be applied to many reproductive health topics, including family planning, safe motherhood, male reproductive health, and prevention of sexually transmitted infections. The goal of the RHA approach is to facilitate a process by which people of all ages are empowered to increase their understanding of and take action to better meet their own reproductive health care needs.

Reference: CEDPA. 2003. *Reproductive Health Awareness Manual*. 2 volumes with 14 modules. Washington, DC: CEDPA.

Increasing Community Contribution and Participation to MCH Services in India

Through a project with the Community Aid and Sponsorship Programme (CASP), the ENABLE Project had the opportunity to implement some of its strategies regarding sustainability. When its USAID-funded Child Survival Project in the urban slums of

Delhi ended, CASP wanted to give local communities responsibility for managing reproductive and child health activities. ENABLE supported a feasibility study that investigated sustainability options; the study directors recommended that the community come up with a structure for an organized body with democratically elected members. The CASP project staff shared the results of the feasibility study with the community and the community health guides who had worked in the previous project. These groups decided to form Community-Based Health Management Organizations (CBHMOs) comprised of 16-18 members from among the community health guides and members of existing community-based organizations.

CEDPA provided the members with an orientation to sustainability and trained them in various aspects of organizational management. CASP assisted the CBHMO to:

- Prepare by-laws;
- Open a bank account;
- Form sub-committees for various tasks (e.g. clinic management, operating the ambulance, and social marketing);
- Network with the private sector, private voluntary organizations (PVOs), and governmental organizations to generate revenue, provide services, and update skills;
- Shift costs from the project to the community by introducing fees for services, social marketing of health commodities, and implementing revenue generation activities; and
- Manage services, including ensuring continuous quality improvement of services at clinics, the collection and management of clinic and laboratory earnings, and procurement, storage, and sales of social marketing stocks

As a result of the community taking over management of the clinic and ambulance, the ambulance service, which was no longer functioning after the child survival project ended, was revived. Costs for maintenance and operations were reduced by 60 percent from Rs. 10,000 (US$220) to Rs. 4,000 (US$88) per month and ambulance cost recovery increased from 14 percent to 35 percent between April 2000 and January 2002. In addition, the CBHMO recovered 70 percent of the laboratory service fees in 2002, compared with 10 percent in 2000. With experience, time, and technical assistance, the CBHMOs are gradually on their way to taking complete responsibility of the management of the health services in their respective units.

Reference: Community Aid and Sponsorship Program. 2002. *Building Sustainable Reproductive and Child Health Services*. CASP and CEDPA, New Delhi.

9. Pioneering New Approaches to Eradication of Female Genital Cutting

ENABLE partners have been instrumental in advocating successfully for laws prohibiting FGC in five states of Nigeria. In addition, ENABLE supported community-level programs in Egypt and Ghana to raise awareness about the negative consequences of female genital cutting (FGC). The approach in Ghana, where the partners were a Muslim organization and a women's organization, was to encourage communities to develop their own strategies and messages to educate community members about FGC. Partners in Egypt adopted the positive deviance model, in which parents who have resisted FGC for their daughters serve as role models for others.

Nigeria

In Nigeria, ENABLE supported the work of the Rivers State Chapter of the International Federation of Women Lawyers, an association of professional women. FIDA-Rivers developed an FGC advocacy network to mobilize support for a bill banning FGC. Network members included the National Association of Women Journalists, Medial Women Association, National Council of Women Societies and the Adolescent Project. While FIDA-Rivers provided the legal expertise to draft the bill, the other groups provided media coverage, organized public hearings and debates, provided facts about the detrimental health effects of FGC, and rallied large numbers of advocates and supporters. Network members visited high-ranking state policy makers, including the Attorney General, the Minister of Justice, and members of the State House of Assembly. The wife of the state Governor also lent her support.

These alliances were so effective that the Ministry of Justice agreed to co-sponsor the draft bill, which gave it importance in the House of Assembly. The Female Circumcision (Abolition) Law 2000 passed and was signed into law by the state Governor of Rivers State in August 2001.

A similar strategy was followed in Edo State, led by the Edo State Chapter of FIDA. Activities included: local workshops for women and community leaders; advocacy visits to traditional, political and opinion leaders; legal clinics to assist women to seek legal redress, especially widows whose rights had been violated; radio and television discussion programs; and home visits by trained paralegals to inform mothers of newborn girls of the negative effects of FGC. Edo State passed a bill banning FGC in 1999, and a second bill banning harmful traditional practices was passed in 2001.

Cross Rivers State has also passed a law banning FGC, and individuals and coalitions are working towards passage of similar legislation in other states.

References: (1) CEDPA/Nigeria. 2002. *Mobilizing Networks for Legislation against Female Genital Cutting in Rivers State, south-south Nigeria*. Lagos: CEDPA; (2) CEDPA/Nigeria. 2002. *Softening the Ground for Compliance with Legislation Banning*

Harmful Traditional (Widowhood) Practices: the Experience of the Edo State Chapter of the International Federation of Women Lawyers (FIDA) in south-south Nigeria. Lagos: CEDPA.

Ghana

Although Ghana passed a law banning FGC in 1994, the practice continues, and few practitioners have been prosecuted. ENABLE worked with the Ghana Association for Women's Welfare (GAWW) and the Muslim Family and Counselling Services (MFCS) to develop community sensitization and mobilization activities. At a July 2002 workshop the two partners designed interventions to educate their constituents on FGC. To raise awareness about the harmful effects of FGC and motivate community members to educate others on FGC, GAWW and MFCS held sensitization workshops for nurses, midwives, local government authorities, Imams, schoolteachers, Koranic teachers, traditional birth attendants and women leaders. Since these workshops, Imams, elderly women and youth have joined the community education activities.

Some communities have adopted strategies towards the abandonment of FGC such as forming watchdog committees who visit the parents of infant girls and organizing an association of young girls to educate their peers on the hazards of FGC. In West Mamprusi District a district FGC team has been formed to coordinate FGC activities, nurses have incorporated FGC into their discussions during antenatal clinic visits and home visits, nurses are collecting hospital data on women who have undergone FGC, and students have formed anti-FGC clubs in their schools. In Jasikan District, teachers include FGC in the activities of the Civic Education Clubs. Prominent local leaders have committed themselves to working with GAWW and MFCS on anti-FGC activities.

An FGC training packet containing modules and handouts is available.

Reference: Owusu-Darku, Lucy. 2003. *Towards the Abandonment of FGC in Our Communities*. Washington, DC: CEDPA.

Egypt

Since 1998 CEDPA has been working to eradicate the practice of FGC in Egypt. CEDPA spearheaded the use of the Positive Deviance Approach, which identifies best practices already existing in a community and builds on them, suggesting immediate strategies for action using local resources. This approach takes a fresh look at the practice of FGC by asking the question, "What are the factors that enable some families not to circumcise their daughters?" CEDPA works with several partner NGOs in Egypt to identify Positive Deviants and work with them within their communities. By involving the communities directly, the Positive Deviance Approach reaffirms the development principles of sustainability and ownership. The Positive Deviance Approach also demonstrates that

positive role models already exist; these individuals can serve as advocates and strategists for the elimination of FGC.

Under ENABLE, CEDPA/Egypt expanded its FGC program from four local NGOs to eight NGOs. Community groups in three governorates (Giza, Beni Suef and El Minya) made 2,607 visits to the parents of 1,033 girls at risk of being cut. Nearly three in four families (73%) visited declared that they would not circumcise their daughters. Community groups are continuing to monitor the girls, since a girl cannot be definitely categorized as no longer at risk from FGC until she is married.

Reference: McCloud, Pamela A., Shahira Aly and Sarah Goltz. 2003. *Promoting FGC Abandonment in Egypt: Introduction of Positive Deviance*. Washington, DC: CEDPA.

Conclusions

The Enabling Change for Women's Reproductive Health (ENABLE) project formed an important bridge between its predecessor project, Access to Family Planning through Women Managers (ACCESS), and current recognition of the importance of building links between communities and health services and supporting women to make their own reproductive choices. The ENABLE project continued to work towards broadening access to family planning and other reproductive health services by strengthening provision of services by non-governmental organizations (NGOs) and involving community members in provision of RH information, services and referrals.

The ENABLE Project's focus was on helping low-income, marginalized women to overcome various barriers to contraceptive use. Many women in developing countries lead highly circumscribed lives, with their thoughts and physical mobility tightly controlled by social norms enforced by family and community members. By providing family planning information and services in the community by respected community members through home visits, discussion groups, literacy classes, income-generation activities, and other interventions, the ENABLE Project helped these women achieve a sense of self-confidence and self-efficacy that led them to adopt family planning. They also implemented many changes that will improve overall health and well-being in their communities such as building village wells and ensuring that more girls attend school.

The ENABLE Project succeeded in institutionalizing the concept of an enabling environment for reproductive health and other health and education goals. Both public and private agencies are giving more attention to the wide range of social and cultural mores, psychological and financial barriers, service delivery norms, and other factors that limit women's ability to make decisions regarding childbearing and implement those decisions. Programs are now taking a broader approach to behavior change, acknowledging that individuals, households, communities and social institutions all play a role in changing attitudes and behavior.

The ENABLE Project's study of the linkages between RH and participation in democratic activities in Plateau State, Nigeria, suggests that creating an enabling environment does promote contraceptive use above the level achieved by direct family planning interventions alone. Part of creating an enabling environment is empowering women to become more independent in their thinking and actions. Thus, this study confirmed the value of CEDPA's approach of providing integrated programs that expose women to new ideas and encourage them to adopt new behaviors.

By linking community mobilization and advocacy, ENABLE applied the concept of social mobilization to resource-poor settings. Grooming community members as advocates and social change agents and forming networks of NGOs and stakeholder groups, ENABLE found low-cost ways to raise the profile of RH issues, especially safe motherhood. By gradually expanding the supporters for RH, ENABLE was able to generate support at the community, state and national levels. The networks established by ENABLE continue to function independently and serve as models for similar coalitions in other countries.

CEDPA's long-time focus on supporting women leaders and strengthening grassroots NGOs showed results during ENABLE. Several women leaders who previously attended a CEDPA workshop were elected or appointed to high-level government positions. Other CEDPA alumni founded NGOs, influenced RH policies and programs, trained hundreds of others, and made other important contributions to the RH field. Some of the NGOs with long-term ties to CEDPA now offer training and technical assistance to other organizations independently.