

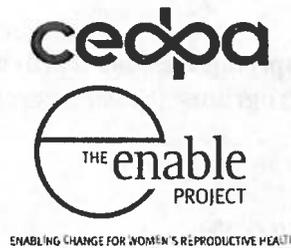


ENABLING CHANGE FOR WOMEN'S REPRODUCTIVE HEALTH™

PVO/NGO Contributions to Reproductive Health and Family Planning Programs

January 22 - 23, 2003
National Press Club
Washington, D.C.





**NGO NETWORKS, CARE-MORR AND ENABLE
PVO/NGO CONTRIBUTIONS TO RH/FP PROGRAMS:
END OF PROJECT CONFERENCE**

JANUARY 22-23, 2003

DAY ONE

0800 – 0830 **Meet and Greet Your Friends and Colleagues at the National Press Club**

0830 – 0900 **WELCOME: USAID Welcomes the Participants**
E. Anne Peterson, MD, MPH
Assistant Administrator, Bureau for Global Health (AA/GH)

0900 – 0915 **INTRODUCTIONS: Who's in the Audience?**

0915 – 0930 **OVERVIEW OF AGENDA AND ANNOUNCEMENTS**

0930 – 0945 **INTRODUCTION TO THE WORKSHOP: PVO/NGO Contributions to
Reproductive Health and Family Planning**
Anne Wilson, M.S.N.
Vice President, PATH

0945 – 1245 **SESSION ONE: Applying Lessons learned from Networking to Improve Impacts in RH/FP Programs** (Session coordinated by NGO Networks for Health)

Introduction

- *Our Networks – Slide Show*
- *Session Introduction*
Joe Valadez, Senior Monitoring and Evaluation Advisor

Did PVO Partners Change as Organizations due to the Project?

- *RH/FP Program Changes among PVO Networks Partners*
Gary Shaye, Vice President, International Programs, Save the Children

Can International Agencies Strengthen Sustainable National RH/FP Networks?

- *Learning to Foster Effective & Sustainable Networks for Social Development*
Dr. Darcy Ashman, Network Consultant
- *Q & A*

Have These Networks Had an Impact on Knowledge and Behavior?

- *Advances to LQAS as a Strategy for Change*
Joe Valadez, Senior Monitoring and Evaluation Advisor
Fernando Campos, Monitoring and Evaluation Officer, NicaSalud
Allan Hruska, Director, NicaSalud
- *NicaSalud: Recovery from Hurricane Mitch: Safe Motherhood and Infectious Diseases*
Joe Valadez, Senior Monitoring and Evaluation Advisor
- *Umoyo Network: HIV/AIDS Control and Enhancement of FP Method Provision and Use*
Joe Valadez, Senior Monitoring and Evaluation Advisor
Carrie Osborne, Program Manager, Umoyo Network
- *Q & A*

How Much Change is a Consequence of PVO/NGO Interventions? How Much Change is a Consequence of Network Interventions?

- *A Model for Programs and Network Evaluations*
Joe Valadez, Senior Monitoring and Evaluation Advisor
Professor Jerry Hage, Director, Center for Innovation, University of Maryland
- *Q & A*

Summary/Conclusion: Future Issues for PVO/NGO Networks

Trish Caffrey, Director, NGO Networks
Tom Leonhardt, Conference Facilitator

Break at approximately 10:30 – Materials Room opens

1245 – 1400 **LUNCH: Affinity Tables (discuss topics with interested colleagues) and Visit Materials Room**

1400 – 1700 **SESSION TWO: The Enabling Environment** (Session coordinated by the ENABLE Project)

Introduction

- *The Road to the Optimal Enabling Environment*
Dr. Victoria Wells, Director, ENABLE

Empowered Advocates Support an Enabling Environment for RH/FP Decision-Making

- *Giving a Voice to Women: The CEDPA Democracy and Governance Program in Nigeria*
Rose Khasiala Amolo, Program Associate, CEDPA/Washington DC
- *CARE Ghana's Approach to Community Participation in RH Programming*
Samuel Duh, Health Sector Coordinator, CARE Gulf of Guinea
- **Q & A**

PVO/NGOs Educate and Mobilize Communities for Improved RH/FP Outcomes

- *Transforming Women For RH: A Force For Change Through Communication Action Groups*
Deepak Bajracharya, Deputy Director CEDPA/Nepal
- *The Birth Preparedness Strategy in the Quang Xuong District in Vietnam: Progress and Challenges*
Nguyen Hoang Yen, Senior Project Officer, PATH Vietnam
- *Community Role: Reducing Barriers to Safe Motherhood, Amasachina: Tamale, Ghana and CASP: New Delhi, India*
Abimbola (Lola) Payne, Senior Advisor for Reproductive Health, CEDPA/Nigeria
- *Building Community Partnerships for Safer Motherhood through Home Based Life Saving Skills (HBLSS) in Liben Woreda, Oromiya Region of Ethiopia*
Nazo Kureshy, Behavior Change and Research Advisor, NGO Networks
- **Q & A**

Summary/Conclusion: Future Issues for PVOs/NGOs

Peg Marshall, Senior Advisor, Reproductive Health, ENABLE/CEDPA
Tom Leonhardt, Conference Facilitator

DAY TWO

0830 – 0900 **Meet and Greet at the National Press Club**

0900 – 0915 **Summary of Day One**

0915 – 1215 **SESSION THREE: Linking Among Communities, the Health and Other Sectors** (Session coordinated by CARE-MoRR)

Introduction

Susan Rae Ross, Director, CARE-MoRR

Linkages Between Civil Society and the Health System Improve Quality, Foster Accountability and Enhance Ownership of RH/FP Services

- *Learning from the Multi-Sectoral Population Project in Peru*
Dr. Carlos Cardenas, Country Director, CARE Peru
- *Sangini – Promoting Linkages for Reproductive Health in India*
Dr. Panwar Dharmender, Project Manager, CARE India
- *Linking Communities, Facilities and District Supervisory Structures in Integrated RH Service Delivery: The CREHP Project*
Susan Igras, Senior Technical Advisor, CARE-MoRR
- **Q & A**

Linkages Among Civil Society, the Health and Other Sectors are Key to FP/RH Service Delivery

- *NGO Networks, Youth Sexual and Reproductive Health in Asia*
Satish Pandey, ADRA Asia Regional Advisor
- *CEDPA, Increased Contraceptive Use Through Scaling Up Dairy Cooperative Services in Uttar Pradesh*
Dr. Marta Levitt-Dayal, Country Director, CEDPA/India
- *CEDPA, Working with Faith-Based Organizations: Church of Christ in Nigeria*
Dr. Paulina Makinwa-Adebusoye, Country Director, CEDPA/Nigeria
- **Q & A**

Summary/Conclusion: Future Issues for PVOs/NGOs

Susan Rae Ross, Director, CARE-MoRR
Tom Leonhardt, Conference Facilitator

1215 – 1330 **LUNCH: Affinity Tables and Visit Materials Room**

1330 – 1500 **SESSION FOUR: Future Directions for the PVO/NGO Community**

- *An Opportunity to Help Guide the Future Programming for PVO/NGO Contributions to RH and FP*

1500 – 1530 **Break – Last Chance to Visit the Materials Room**

1530 – 1630 **Summary and Final Remarks**

Tom Leonhardt, Conference Facilitator

Margaret Neuse, Director, Office of Population and Reproductive Health

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NGO Networks
for Health

Description

NGO Networks for Health (*Networks*) is an innovative five-year global health project created to meet the burgeoning need for family planning, reproductive health, child survival, and HIV/AIDS (FP/RH/CS/HIV) information and services in developing countries.

Title NGO Networks for Health

Period March 5, 1998 – August 4, 2003

Description of Partnership

Five PVO Partners -- ADRA, CARE, PATH, Plan International, and Save the Children -- are collaborating to implement the *Networks* project. *Networks'* main goal is to increase the ability of our Partners to integrate quality FP/RH/CS/HIV activities into their programming. *Networks* pursues its goal by creating innovative and enduring NGO partnerships and fostering and supporting networks that enhance the scale and quality of FP/RH/CS/HIV programs.

Main Goal Increase the ability of our Partners to integrate quality FP/RH/CS/HIV activities into their programming

Objectives

Networks is working to achieve four results: (1) sustained PVO/NGO capacity to provide quality services in family planning, reproductive health, child survival, and HIV/AIDS; (2) accurate knowledge and sustained behavior change at the community level; (3) expanded, sustained networks that deliver reproductive health services; and (4) expanded service coverage through public/private and private/private partnerships. Since *Networks* was established in June 1998, it has created an effective mechanism to improve FP/RH/CS/HIV information and services in targeted developing countries.

Countries where Networks has Worked

Armenia, Bolivia, Cambodia, Ethiopia, Ghana, Guinea, Malawi, Nepal, Nicaragua, Tajikistan, Uganda, Vietnam

Total Invested

USAID contribution	\$40,000,000.00
Match	\$10,000,000.00
Total	\$50,000,000.00



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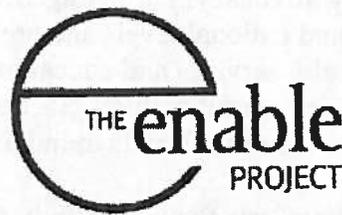
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ENABLING CHANGE FOR WOMEN'S REPRODUCTIVE HEALTH

Enabling Change for Women's Reproductive Health: Overview of the ENABLE Project

CEDPA's Enabling Change for Women's Reproductive Health (ENABLE) project works to improve women's reproductive health and to empower women to take action to better the health of their family and community. Initiated in 1998, ENABLE has two major objectives:

- To increase the capacity of non-governmental organizations (NGOs) networks to expand the quality, gender-sensitivity, and sustainable reproductive health and child health services.
- To promote an enabling environment that strengthens women's informed and autonomous reproductive health decisionmaking through NGO networks.

ENABLE is funded by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID) and by USAID Missions in five countries—Ghana, India, Nepal, Nigeria and Senegal.

ENABLE supports three major types of interventions:

- **RH services.** ENABLE makes RH services more widely available in under-served low-income areas by engaging trained community volunteers to educate their neighbors about RH, provide non-clinical contraceptive methods, and make referrals to clinic services. From 1998-2001, ENABLE partner agencies provided family planning services to more than 910,000 new clients and 690,000 continuing clients.
- **Community mobilization.** ENABLE works with NGOs, women's groups and community groups to educate communities about healthy behaviors and promote public discussion about RH. Broader discussion has led to problem-solving dialogues among community members and local leaders. Community members have also addressed social norms and cultural traditions that contribute to poor health.

- **Policy advocacy.** Partner agencies identify barriers to improved RH at the local, state and national levels and press for policy changes such as increased funding for health services and education, updating health service delivery guidelines, and banning harmful cultural practices. ENABLE has provided training for some 10,500 elected officials in India and Nigeria.

ENABLE subprojects focus on family planning, safe motherhood, HIV/AIDS prevention, gender equity, and youth education. Working mainly with NGOs, ENABLE has created linkages with non-health sectors such as literacy education and democracy and governance.

ENABLE has introduced family planning services into the work of diverse partners, including humanitarian, faith-based, women's and youth organizations as well as dairy cooperatives and a teachers' union. To ensure that program benefits continue after project funding has ended, ENABLE has emphasized building the capacity of partner agencies. ENABLE has trained more than 6,000 NGO staff in strategies to promote programmatic and financial sustainability. Based on its extensive training experience, ENABLE has developed training manuals for NGOs and community groups on RH awareness, program sustainability, and integrating HIV/AIDS into family planning programs.

Headquartered in Washington, DC, CEDPA is an international nonprofit organization that seeks to empower women at all levels of society to be full partners in development. Founded in 1975, CEDPA supports programs and training in leadership, capacity building, advocacy, governance and civil society, youth participation and reproductive health.

The ENABLE project was conducted with support from the Office of Population and Reproductive Health, Bureau for Global Health, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT and by USAID Missions in Ghana, India, Nepal, Nigeria and Senegal, under the terms of Cooperative Agreement No. HRN-A-00-98-00009-00.



CARE - Management of Reproductive Risk Project (CARE-MoRR)

The CARE-Management of Reproductive Risk (CARE-MoRR) project is a five-year project (1998-2003) which contributes to USAID's PVO Results Package. Through CARE-MoRR, CARE aims to contribute to household and health security by empowering people to achieve their reproductive intentions and to improve their reproductive health.

The CARE-MoRR Project has four specific goals.

1. Empower at least five million women and their families in ten countries with the information, skills and services to manage risks to reproductive and newborn health.
2. Empower targeted communities to be effective and informed consumers of and advocates for reproductive and newborn health services.
3. Increase the capacity of targeted, indigenous institutions (public, non-governmental, community-based and private, for-profit) and small to moderate international PVOs to deliver high quality, sustainable reproductive and newborn health services.
4. Significantly increase the technical and managerial sustainability of CARE's family planning and reproductive health program.

The CARE-MoRR project has been implemented in nine countries.

COUNTRY	PROJECT TITLE	COMPONENTS
Benin	Strengthening Health NGOs in Benin (SHNB)	FP/STI/HIV
Bolivia	Our Bodies, Our Health	FP/MH/STI
Ghana	Wassa West Reproductive Health Project (WWRH)	FP/STI/HIV
Ghana	Ashanti Region Community Health Project (ARCH)	FP/STI/HIV
Haiti	Reproductive Health 2001	FP/MH/STI/HIV
Haiti	Care & Support for People Living with HIV/AIDS	STI/HIV
India	Integrated Nutrition and Health Project II (INHP II)	FP/MH
India	CHAYAN	FP/STI/HIV
India	Improving Women's Reproductive Health and Family Spacing	FP/MH/STI/HIV
Nepal	Remote Areas: Family Planning and Health	FP/MH/STI/HIV
Peru	Multi-Sectoral Population Project	FP/MH/STI/HIV
Uganda	CREHP – Community Reproductive Health II	FP/MH/STI/HIV
West Bank/Gaza	Pilot Health Project	FP/MH

FP = Family Planning; STI = Sexually Transmitted Infection; HIV = Human Immunodeficiency Virus; MH = Maternal Health

CARE's Programming Approach

CARE is engaged in broad-based efforts to reduce poverty through programs in agriculture, natural resource management, micro and small enterprise development, basic education, food and nutrition, reproductive and child health and emergency relief. These diverse efforts are unified through the Household Livelihood Security (HCLS) Framework, which is the organizing construct for CARE's programming. Household livelihood security is defined as adequate and sustainable access to income and other resources required for households to meet their basic needs, including food, water, health, shelter, education and participation in civil society.

Health, including reproductive health, is both a cause and consequence of the social and economic circumstances of individuals and households. CARE's health programming is guided by the Health Security Framework, which reinforces the role of health, particularly reproductive health, within CARE's Household Livelihood Security strategy. Health security is defined as follows:

Health security is achieved when households identify, prevent and manage significant risks to the health of their members through healthy behaviors, empowered communities, capable institutions, optimal health technologies and appropriate public policies.

The project strategy is based on the delivery of quality information and services to under-served populations, through partnerships with public and private institutions, other private voluntary organizations (PVOs) and non-governmental organizations (NGOs). The project's primary areas of technical intervention are family planning (FP), maternal health (MH), newborn care, and sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS). Cross-cutting themes include behavior change, community empowerment, institutional capacity building, quality of care, and advocacy. In selected contexts, other reproductive health issues, such as cervical cancer and female genital cutting, are also addressed.

The reproductive health activities of CARE will continue through a diverse funding base once CARE-MoRR has ended. The portfolio currently includes 58 projects in 26 countries.

Contact

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CARE

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ross@care.org

Definitions of Terms Related to PVO/NGO Approaches and RH Programs

Access: Ability to obtain resources and services such as health care, credit, education, and other benefits.

Advocacy: The act or practice of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate a cause or issue because we want to build support for that cause or issue; influence others to support it; and try to influence or change legislation and social norms that affect it.

Awareness: Reaching an understanding that one can take action to achieve reproductive goals and protect one's health.

Communication: Being able to talk with one's spouse, peers, family members, community members, and people in power who make decisions. With specific reference to sexual health, communication also involves discussing sensitive topics without embarrassment.

Community-based distributors: People, either volunteer or paid, who provide reproductive health and other health-related information and distribute non-clinical contraceptives and other health products to members of their community.

Conscientization: The stage of women's empowerment when one becomes aware of women's reproductive rights and recognizes gender inequities.

Decision-making power: Women have the power to set their own agenda that responds to their specific needs related to reproductive health and other areas.

Empowerment: The sustained ability of individuals to knowledgeably and autonomously decide how best to serve their strategic self-interest and the interest of their societies to improve their quality of life.

Enabling environment: An environment in which the contextual determinants (social, cultural, educational, economic, and political environment) promote women's decision-making about reproductive health.

Gender: Denotes the power differentials between men and women which are a result of the economic, social, political and cultural attributes and opportunities, which in turn are associated with the socially constructed roles and responsibilities assigned to women and men in a given culture. All these attributes and (lack of) opportunities reinforce each other and thereby maintain and preserve power differentials.

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PVO/NGO Contributions to Reproductive Health and Family Planning

Anne Wilson, M.S.N.,
Vice President, PATH

Invest in Beginnings

- Compatible/complementary partners
- Committed leadership
- Effective partnership skills
- Cumulative good will
- Value strategic questions
- Facilitate local partnerships



Learn All You Can; Share What You Know

- Technical excellence and best practices
- Expand network of learning
- Access technical assistance
- Translate capacity into performance
- Measure performance



Vision and Discipline - like Mac and Cheese!

- Durability versus quick fix
- Unilateral versus multi-partner approaches
- Realistic expectations
- Effective partnership = commitment and effort



Fundamentals Apply as Time Goes By ...

- Grand vision and detailed blueprint
- Entire community contributes
- Build on earlier foundations
- Create new community wealth
- Pass along best practices



What's Ahead?

- New vaccines and technologies will emerge
- New health issues will emerge
- Environment of conflict may expand
- Community and NGO partnerships will be more vital than ever.



"As availability and mastery of information speeds up, we will need to rely on people less for facts and more for imagination"

Stanley Davis, Future Perfect





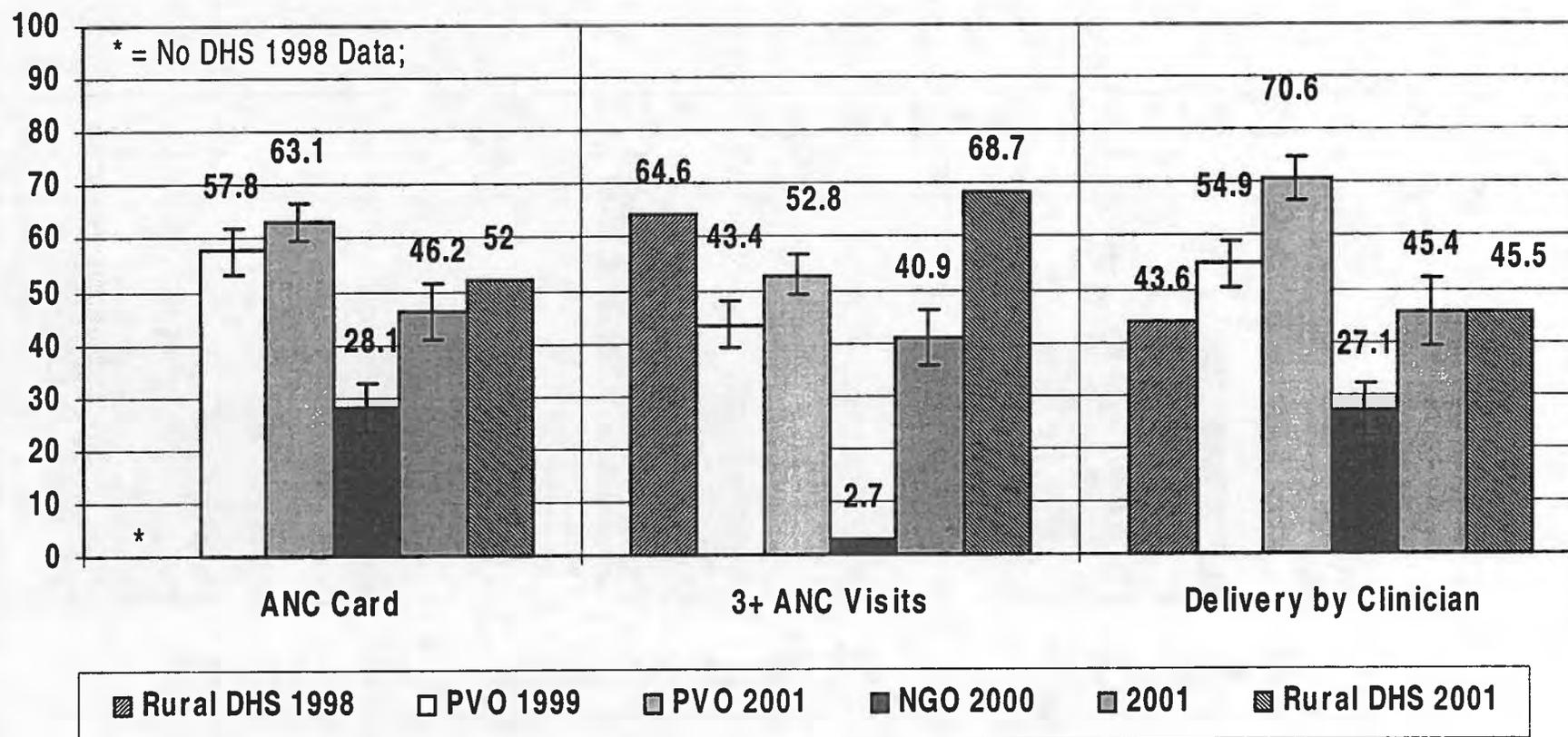
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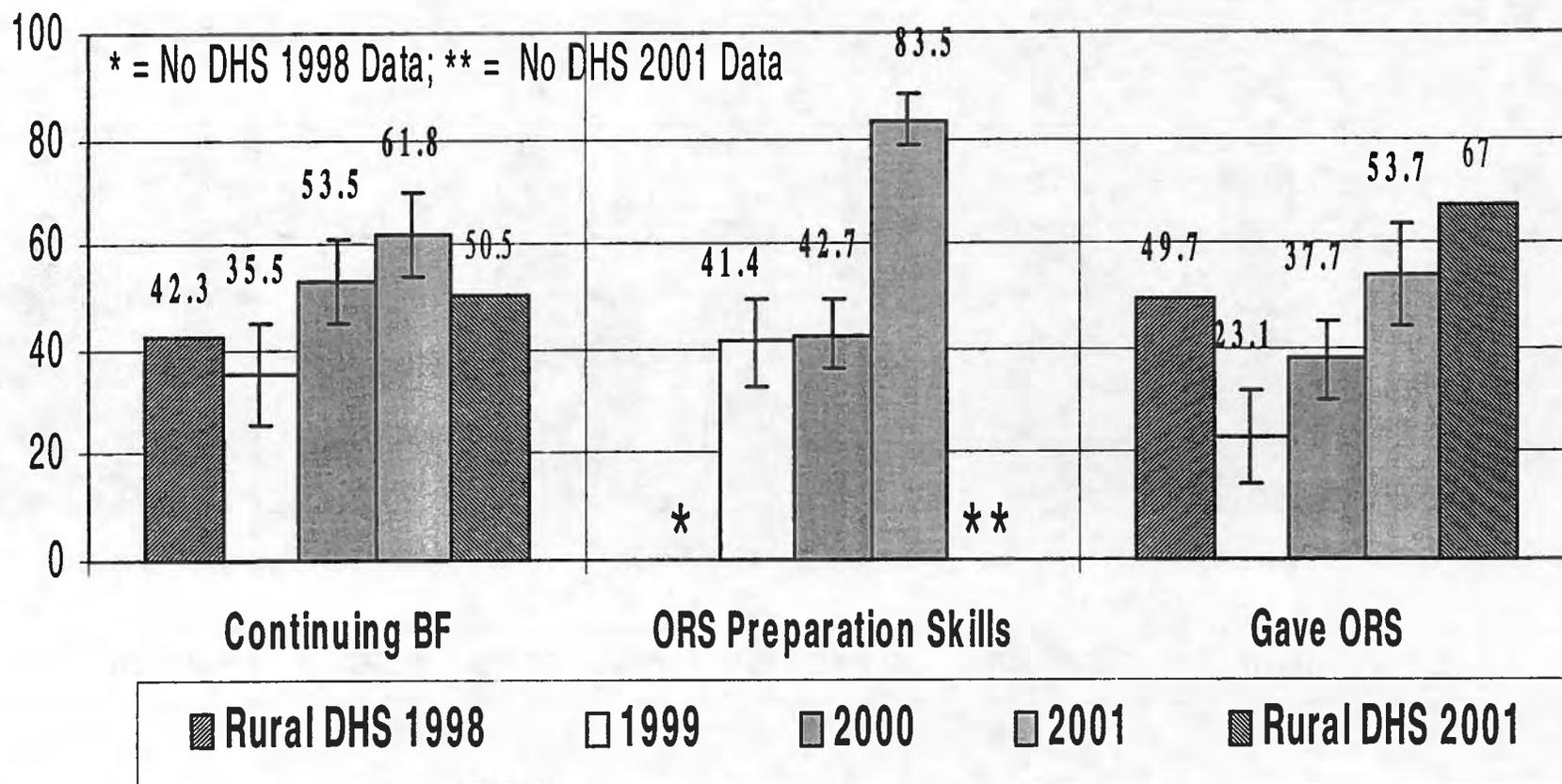
NGO Networks
for Health

Pre and Post Hurricane ANC and Delivery Behavior of Mothers with Children 0-11 Months Living in Nicaragua: National versus PVO Catchment Areas

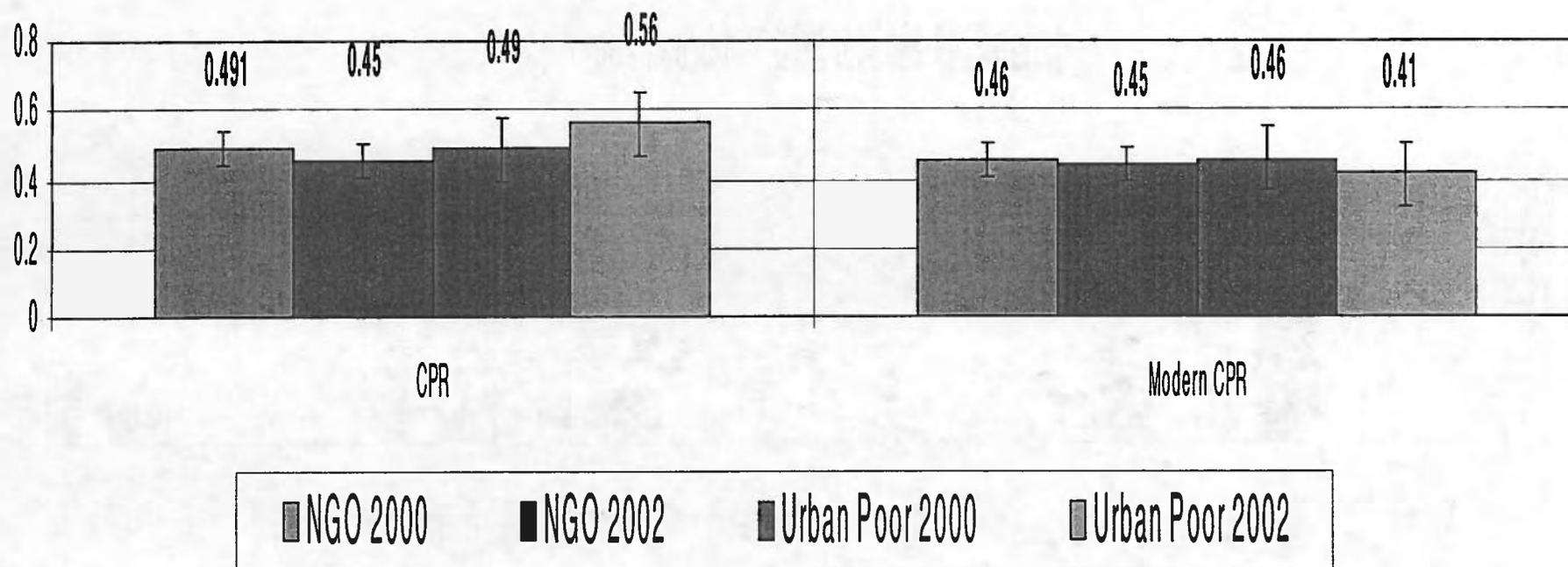




Pre and Post Hurricane Trends in Delivery and Diarrhea Treatment Related Behavior of Mothers with Children 0-23 Months in Jinotega Department, Nicaragua:
Comparisons of DHS 1998 & 2001, and Three Annual Measures by PVOs 1999-2001



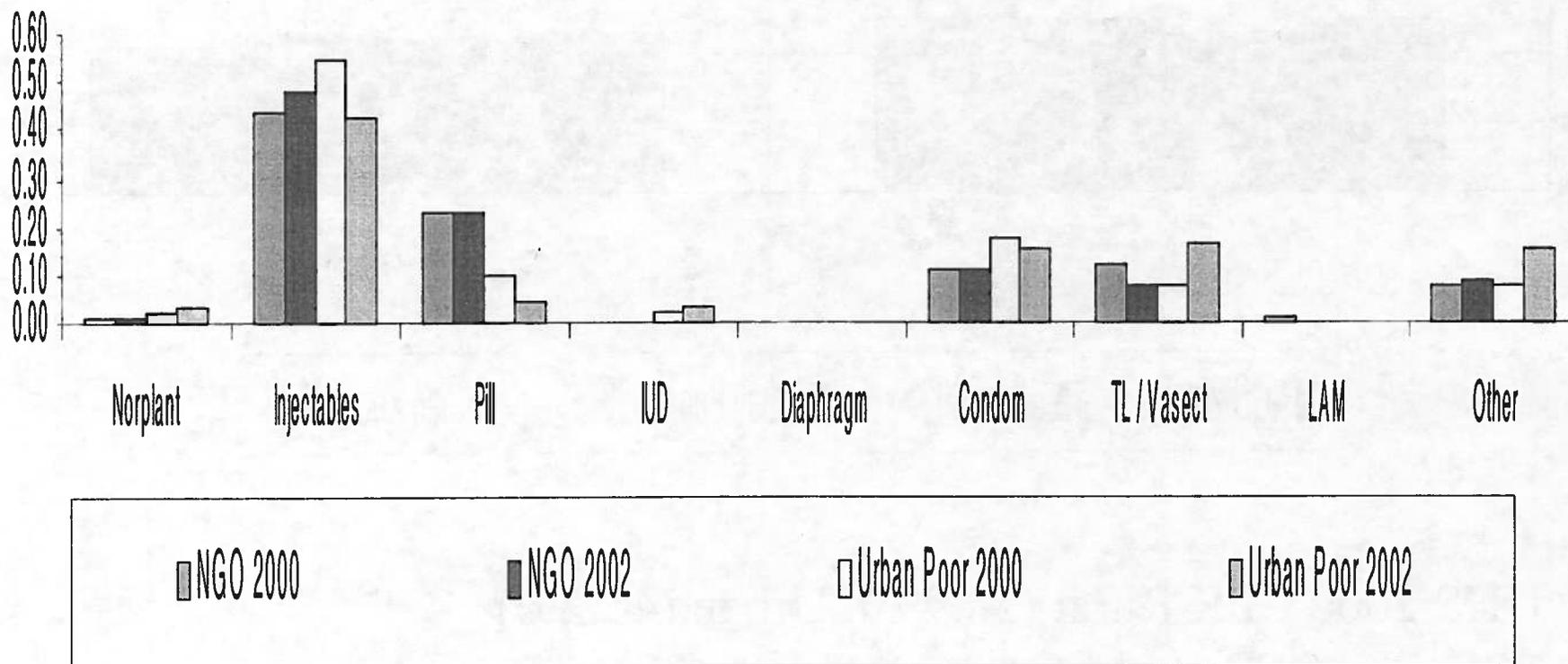
**Malawi Contraceptive Prevalence Rate: All Methods and Modern Methods
from 2000 to 2002 in NGO and Urban Poor Areas**



DHS 2000 CPR Rural (28.9%), Urban (41.2%)

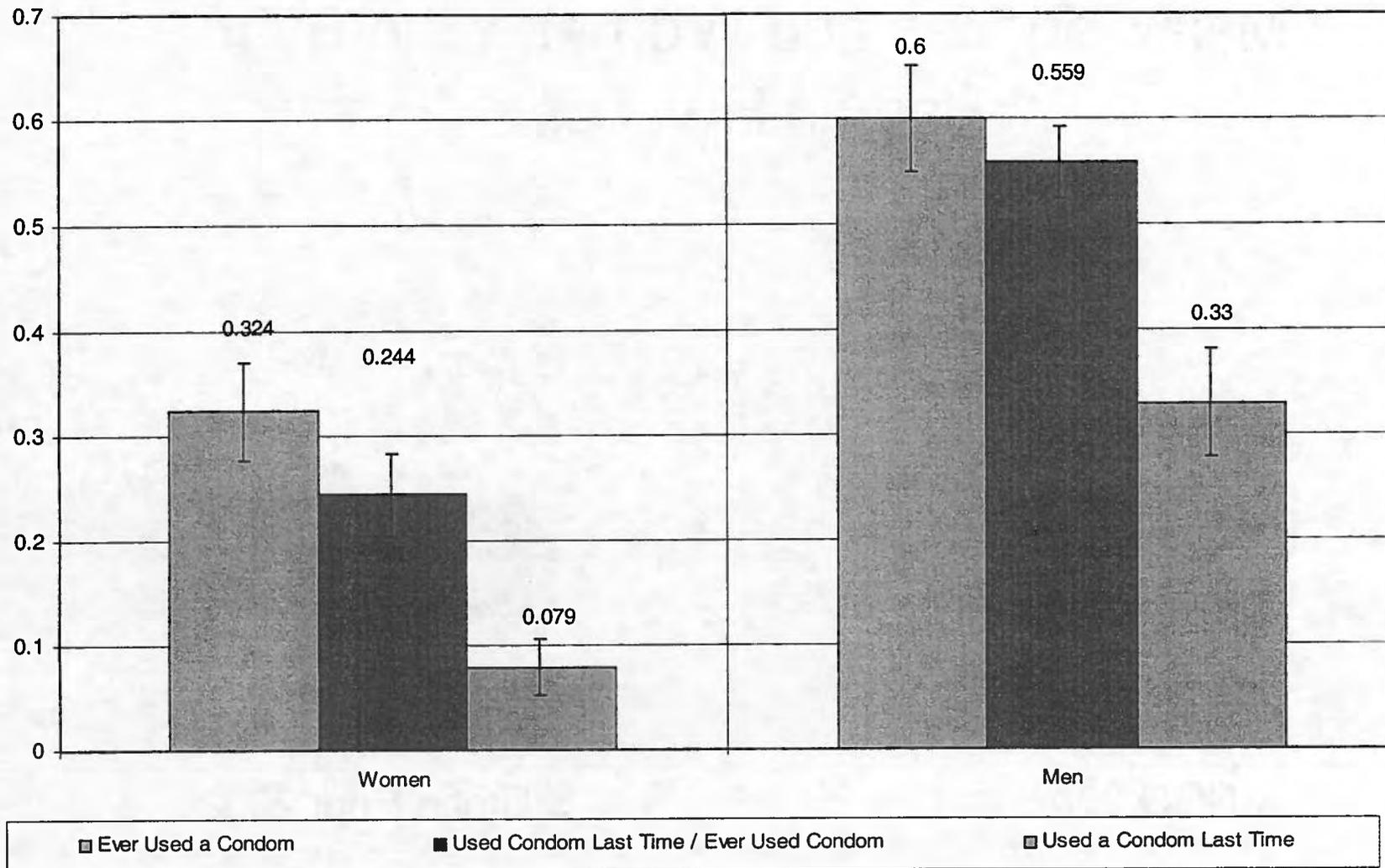
Modern CPR Rural (24.1%), Urban (38.2%)

Malawi Family Planning Method Mix during 2000-2002 for NGO and Urban Poor Areas



DHS 2000: Injectables (15%), TL (4%), pills (3%), condom (1%)
 Network 2002: Injectables (24%), pills (11%), condom (6%)

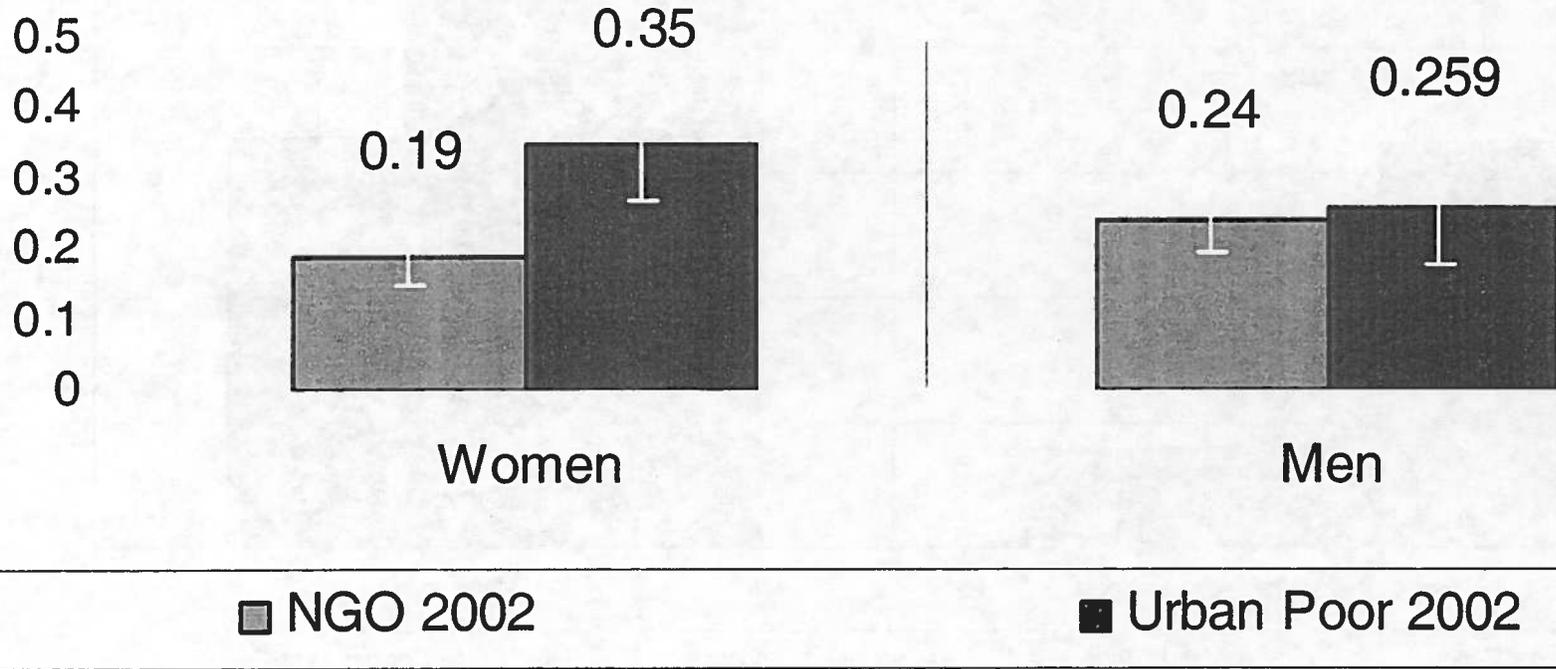
Malawi: Have Ever Used a Condom for 2000-2002 in NGO and Urban Poor Areas



DHS 2000 U/R Ever Use Condom: Women (8.4%), Men (35.4%)

Used Last Time: Rural Women (4.6%), Rural Men (13%)

Malawian Men and Women Who Ever Had an HIV Test



DHS 2000: Rural Women (7%), Men (14%)

Urban Women (17%), Men (22%)

LQAS Table: Decision Rules for Sample Sizes of 12-30 and Coverage Benchmarks or Average Coverage of 10% to 95%

Sample Sizes	Coverage Benchmarks or Average Coverage																	
	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%
12	N/A	N/A	1	1	2	2	3	4	5	5	6	7	7	8	8	9	10	11
13	N/A	N/A	1	1	2	3	3	4	5	6	6	7	8	8	9	10	11	11
14	N/A	N/A	1	1	2	3	4	4	5	6	7	8	8	9	10	11	11	12
15	N/A	N/A	1	2	2	3	4	5	6	6	7	8	9	10	10	11	12	13
16	N/A	N/A	1	2	2	3	4	5	6	7	8	9	9	10	11	12	13	14
17	N/A	N/A	1	2	2	3	4	5	6	7	8	9	10	11	12	13	14	15
18	N/A	N/A	1	2	2	3	5	6	7	8	9	10	11	11	12	13	14	16
19	N/A	N/A	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
20	N/A	N/A	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17
21	N/A	N/A	1	2	3	4	5	6	8	9	10	11	12	13	14	16	17	18
22	N/A	N/A	1	2	3	4	5	7	8	9	10	12	13	14	15	16	18	19
23	N/A	N/A	1	2	3	4	6	7	8	10	11	12	13	14	16	17	18	20
24	N/A	N/A	1	2	3	4	6	7	9	10	11	13	14	15	16	18	19	21
25	N/A	1	2	2	4	5	6	8	9	10	12	13	14	16	17	18	20	21
26	N/A	1	2	3	4	5	6	8	9	11	12	14	15	16	18	19	21	22
27	N/A	1	2	3	4	5	7	8	10	11	13	14	15	17	18	20	21	23
28	N/A	1	2	3	4	5	7	8	10	12	13	15	16	18	19	21	22	24
29	N/A	1	2	3	4	5	7	9	10	12	13	15	17	18	20	21	23	25
30	N/A	1	2	3	4	5	7	9	11	12	14	16	17	19	20	22	24	26

For all coverage benchmarks (except where noted) LQAS is at least 92% sensitive and specific

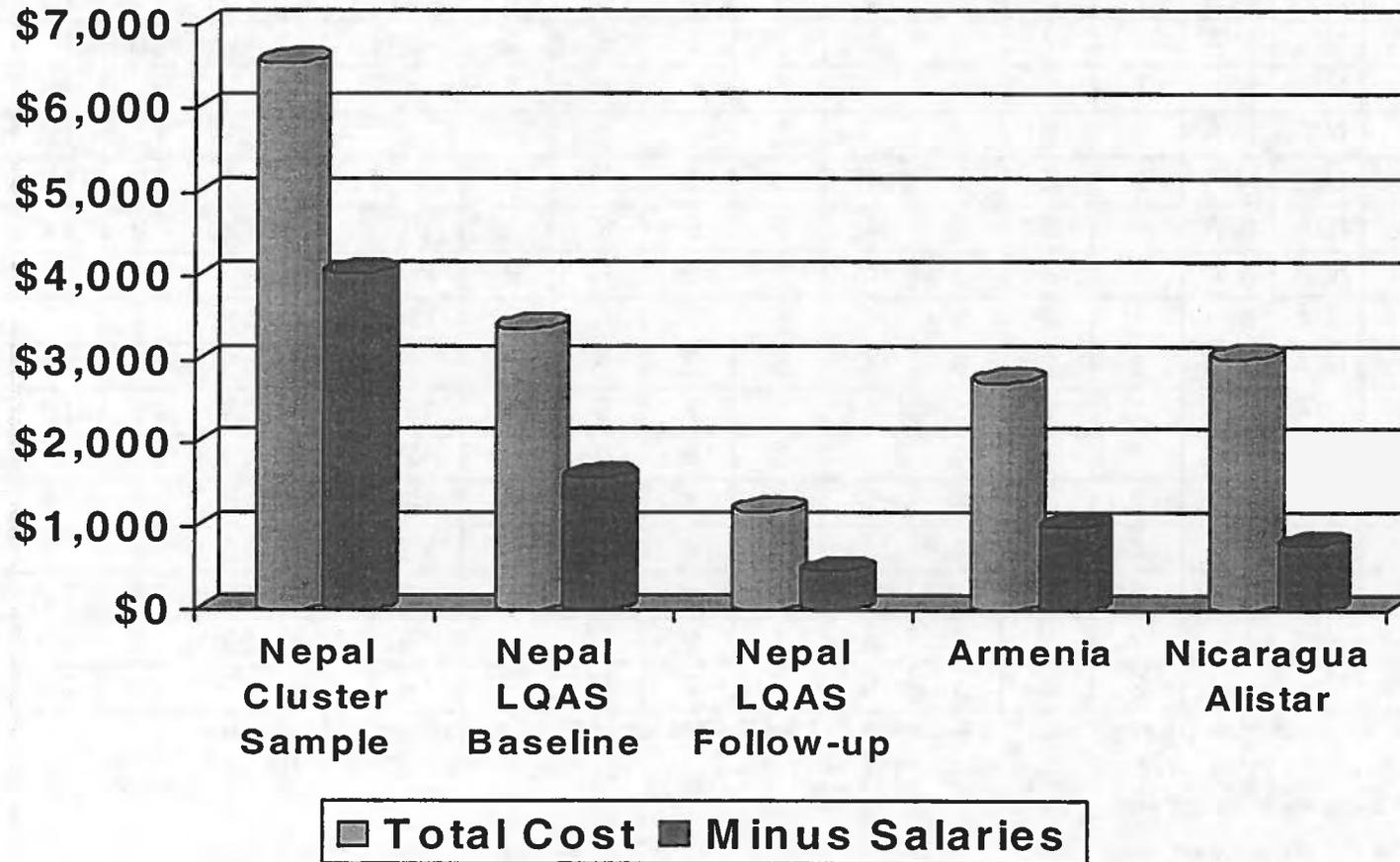
N/A = Not Applicable -- Indicates that LQAS should not be used since coverage is too low for LQAS to detect.

	Alpha and Beta Errors are > 10%
	Alpha and Beta Errors are > 15%



Comparative Costs of Evaluation

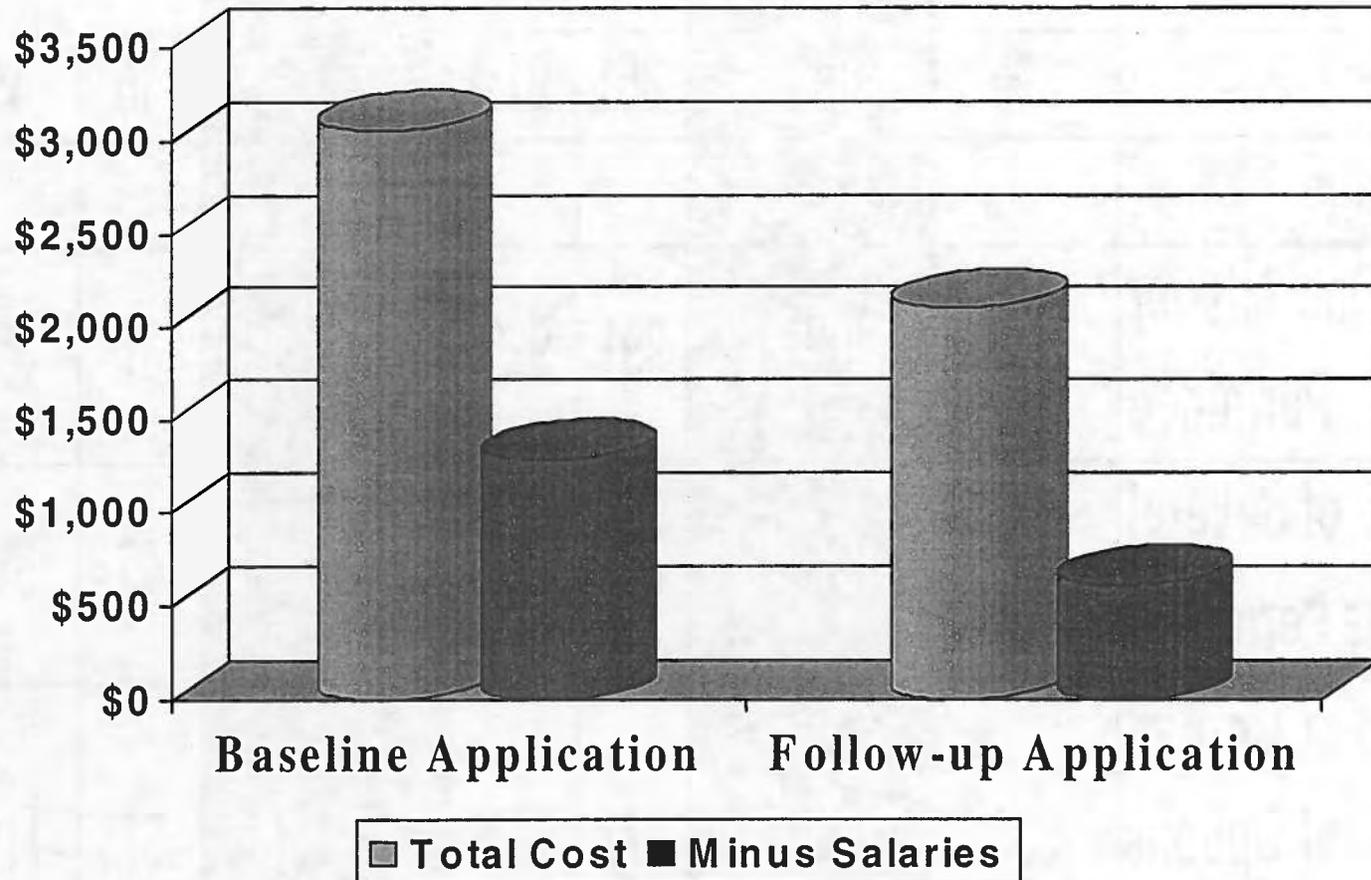
per NGO Project Area





Average Cost of LQAS

per NGO Project



Reliability of Malawian Health Staff Collecting Behavior and Knowledge Data to Assess Their Own Programs

	n	Exact Response		Same Result		Positive Bias		Negative Bias		OR
Behavior	396	348	88%	361	91%	20	5%	15	4%	0.65 - 2.82
Knowledge										
One Answer Permitted	1080	960	89%	991	92%	59	5%	31	3%	1.23 - 3.12
One of Several Options Permitted	889	646	73%	762	86%	82	9%	45	5%	1..29 - 2.82
Two or More of Several Options Required	533	273	51%	377	71%	97	18%	57	11%	1.29 - 2.68

Organization Interventions Affecting Behavior Change In NicaSalud: Maternal Health

Independent Variable *	3+ ANC		ANC Card		Clinical Delivery		Post Natal Visit	
	r	Exact p	r	Exact p	r	Exact p	r	Exact p
PHYSICAL CAPITAL								
Density of Community Health Huts Built (A)	0.397	0.159						
HUMAN CAPITAL								
Variety of Individuals/Groups that Received Charlas (B)								
Variety of Types of Paramedical Personnel Trained (C)	0.547	0.07	0.429	0.092				
Density of Paramedical Personnel (D)	0.546	0.085	0.79	0.019				
SOCIAL CAPITAL								
Density of Health Committees / Counsels (F)	0.650	0.044	0.581	0.041				
Density of Mothers / Women's Clubs (G)			0.408	0.105				

Organization Interventions & Organizational Learning: Maternal Health

Independent Variable *	3+ ANC		ANC Card		Clinical Delivery		Post Natal Visit	
	r	Exact p	r	Exact p	r	Exact p	r	Exact p
COMBINATIONS								
Physical Capital x Human Capital (A x D)	0.579	0.069	0.683	0.049				
Variety Human Capital x Density Human Capital (C x D)	0.612	0.057	0.809	0.018				
Human Capital x Social Capital (D x F)	0.655	0.037	0.804	0.023				
ORGANIZATIONAL LEARNING & VALUE ADDED								
Strategic Changes + Tactical Changes (ST)	0.639	0.042	0.76	0.03				

* Density is standardized by Population

Organization Interventions Affecting Behavior Change: Child Survival

Independent Variable *	Continuing Breastfeeding		ORS Given		Child with Diarrhea Taken to HC	
	r	Exact p	r	Exact p	r	Exact p
PHYSICAL CAPITAL						
Density of Community Health Huts Built (A)			0.427	0.094	0.59	0.045
HUMAN CAPITAL						
Variety of Individuals/Groups that Received Charlas (B)						
Variety of Types of Paramedical Personnel Trained (C)						
Density of Paramedical Personnel (D)						
SOCIAL CAPITAL						
Density of Health Committees / Counsels (F)			0.465	0.072		
Density of Mothers / Women's Clubs (G)			0.3	0.184	0.658	0.026

* Density is standardized by Population

Organization Interventions Affecting Change & Organizational Learning : Child Survival

Independent Variable *	Continuing Breastfeeding		ORS Given		Child with Diarrhea Taken to HC	
	r	Exact p	r	Exact p	r	Exact p
COMBINATIONS						
Physical Capital x Human Capital (A x B)			0.482	0.062	0.555	0.06
Human x Social Capital (B x G)			0.451	0.079	0.789	0.004
Variety and Density of Human Capital x Social Capital (B + C x F)			0.508	0.049		
ORGANIZATIONAL LEARNING & VALUE ADDED						
Strategic Changes + Tactical Changes (ST)			0.673	0.009		

* Density is standardized by Population



NGO Networks
for Health

Strategic Changes	Tactical Changes
17% N = 10	60% N = 35
Total Number of Intervention Arenas = 58	
Reasons for Strategic Changes	
NicaSalud	Other
100% N = 10	0% N = 0
Reasons for Tactical Changes	
NicaSalud	Other
88% N = 31	12% N = 4
Kinds of Strategic Changes Made	
Addition of Strategy	Social Capital
50% N = 5	60% N = 6
Kinds of Tactical Changes Made	
More Focus	Human Capital
31% N = 11	63% N = 22
Physical Capital	Social Capital
37% N = 13	20% N = 7
System Referrals	
20% N = 7	





***Applying Lessons Learned from
Networking to Improve Impacts of
RH/FP Programs***

January 22, 2003



Key Session Questions

This session will address four questions:

1. Did PVO partners change as organizations due to this project?
2. Can international agencies strengthen sustainable national RH/FP networks?
3. How can networks and NGOs/PVOs improve program impact?
4. What is the value added of networks/alliances?



Topics Presented

- RH/FP Program Changes among PVO Networks Partners
- Strategies for Strengthening Sustainable National Networks
- Network impacts on Knowledge and Behavior
- Behavior Change due to PVO/NGO interventions and Change due to Network interventions
- Future Issues for PVO/NGO Networks



FP/RH Program Changes among PVO Networks Partners

**Gary Shaye,
Vice President, International Programs
Save the Children**



Two Objectives of NGO Networks

- To build or strengthen PVO and NGO networks in the field
- To build the capacity of key PVOs to integrate quality family planning and reproductive health efforts into their field programs.



How We Started Out

- 2 partners with established capacity in FP/RH (PATH and CARE)
 - 3 partners with global reach interested in developing capacity and integrating FP/RH into their organization's field programs (ADRA, PLAN and SC)
- Process:**
- Capacity building/resource mobilization plans created and shared
 - Collaborative and organization-specific capacity building plans launched



Developing Commitment and Capacity

Built organizational commitment and field capacity through:

- Recruitment and placement of FP/RH Specialists in partner organizations
- Field trainings, technical assistance
- Partnering with CAs and PATH, CARE for expertise
- Board and constituent education
- Internal policy and strategy development

Results of Organizational Efforts to Expand FP/RH in Our Global Operations

Partner	New Funding Leveraged/ Programmed	New Country-level Activities	Populations covered with expanded/ strengthened efforts
ADRA	\$26 million	20	8.2 million
PLAN	\$16 million	46	10 million
SC	\$35 million*	25	12.3 million
TOTAL	\$77 million	91 country-level programs expanded	30 million

* Not including \$50 m. grant for newborn health



Examples of Growth in Capacity

ADRA - had no staff dedicated to FP/RH and now has three staff working on FP/RH integration in 23 countries

PLAN - added 4 RH advisors in the field and added RH as a core capacity of Health Advisors under recruitment in all PLAN country offices

SC - RH team has grown from 1 to 7 permanent positions supporting FP/ARSH/SM programs in 32 countries



Example: Nepal Program Results

• **ADRA/Nepal** – Couple Years of Protection (CYP) delivered '97 to '01 through ADRA FP/PHC Center: 71,247

• **PLAN/Nepal** – use of modern methods among women increased from 20% to 53% in 4 yr. effort; knowledge of pregnancy danger signs went from 31% to 98.6% (population =140,000)

• **SC/Nepal** - increased CPR from 27.6% to 42% in four years; temporary method use went from 4% to 14.7%; (pop = 582,000)



New Field Program Results

• **ADRA/Haiti** – in 18 mos. ADRA delivered 230,000 condoms to more than 3000 clients; 34% of women who desire to space births are using modern method (19% at baseline)

• **PLAN/Vietnam** – in 3 yrs, LBW decreased from 25% to 10% (pop=30,000)

• **PLAN/Bangladesh** – Incorporation of sexual and RH information for all 8 to 10th graders in schools (60,000 youth reached)

• **SC/Pakistan** – in 2 years, surgical contraception clients increased from 25 to 65 per month at Haripur District Hospital (pop = 500,000); injectables and IUD clients increased by 35 to 50% in key public facilities



Innovations Replicated

• **PLAN/Nicaragua** – ARSH activities started under Networks funding in one area have been taken up in 4 other PLAN program areas

• **ADRA/Asia** – Adolescent program materials developed in collaborative regional workshops now applied in 12 countries

• **SC/Nepal** –Community Defined Quality approach replicated in 6 new districts; CDQ now a strategy for increasing equity in NGO Services Delivery Project in Bangladesh



Development Education and Outreach

ADRA:

- Briefings for church leadership and donors around the US
- Adventist Review magazine articles (350,000 households)
- Global Village touring exhibit





Development Education and Outreach

Save the Children:

- Every Mother, Every Child Campaign PSAs
- Annual Mothers Day report
- *Behind Every Healthy Child*





Now, ADRA, PLAN & SC ...

- Integrate FP/RH into CS, Food Security HIV/AIDS, other program efforts;
- Channel private donations to FP/RH efforts;
- Measure the effectiveness of our FP/RH efforts;
- Raised an additional \$77 million from USAID, other bilaterals, and private donors for FP/RH/HIV programs globally
- Plan to CONTINUE growing our FP, ARSH, SM, and HIV activities in our global programs



Learning to Foster Effective & Sustainable Networks for Social Development

**Darcy Ashman, DBA
Network Consultant**



Why Foster NGO Networks?

- **Networks: increase reach, scale & quality of programs & their impacts.**
- **Effective networks achieve their goals & satisfy their members & major stakeholders.**
- **Challenges of sustainability: sound technical programs require strong institutional capacity.**



Presentation Objectives:

- **Share learning from current research with NGO Networks & similar consultancies.**
- **Focus on 2 key - *often overlooked*- characteristics of effective and sustainable networks.**
- **Recommendations for *planning & start-up phases of new projects* to foster networks.**



Key Characteristics:

Address social issues & opportunities perceived by national institutions working within the country context.

Take time for development & gain the commitment of members. Relationships grow out of experience, satisfaction, & learning.



Address Social Issues & Opportunities Perceived by National Institutions Working within the Country Context:

- Decentralize planning to the country level.
- Assess and build (on) existing linkages & networks.
- include national institutions in participatory planning & control arrangements.



Take time for development and gain the commitment of members. Relationships grow out of experience, satisfaction, and learning:

Where new relationships:

- Exchange ideas & experiences
- Share information & resources
- Coordinate organizational activities



and....

Recognize choices:

- 'Light' coordinating mechanisms can be efficient & enable individuals to develop skills & relationships.
- Donor relationships encourage autonomy & flexibility of network governance & management.



**Summary Recommendations:
Planning & Start-up of
New Projects**

1. Participatory planning & inclusive control with national institutions at the country level.
2. Management arrangements to foster development of successful collaborative relationships.



Q & A



NGO Networks
for Health

Network Impacts on Knowledge and Behavior

Dr. Joseph Valadez
NGO Networks for Health



NGO Networks
for Health

NicaSalud Network

- Aiding Nicaragua Recover from Hurricane Mitch
- Objective: Return Nicaragua's Health Indicators to Pre-Mitch Level?
- Mitch Money Earmarked for Maternal Health and Child Survival Only – Not Family Planning

Umoyo Network

- Aiding Malawi Improve Family Planning Services and HIV/AIDS Prevention, Care & Support



NGO Networks
for Health

M&E Methods Used

Advances to LQAS as a Strategy for Change

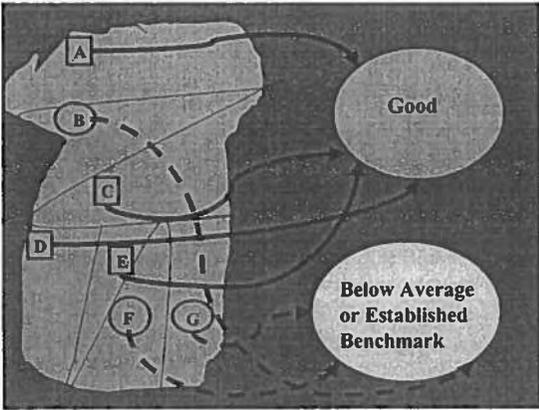
Lot Quality Assurance Sampling
or
Local Quality and Supervision

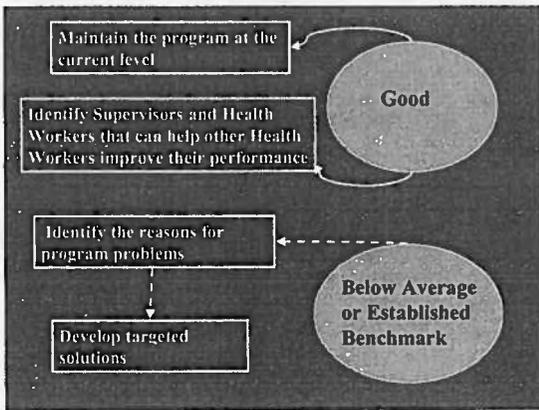


What is LQAS?

An analysis method that can:

- be used locally – in "supervision areas"
 - to identify priority areas: those not reaching established benchmark for an indicator
 - data for management decision making and for sharing information across supervision areas
- measure coverage at an aggregate level (e.g., program catchment area or district or nation)
 - suitable for Reporting Purposes
- LQAS uses small samples
 - Most frequently used size = 19 per SA
 - Larger sizes are seldom needed







More Information on LQAS Is in the Conference Binder

- Cost Analysis comparing multiple applications
- Reliability study
 - Behavioral Measures were 91% reliable in two separate data collections
 - With no detectable bias of behavioral measures.
- Networks Website for documents



Relevance of M&E to NicaSalud and Umoyo Network

For the network secretariat
For the member PVOs/NGOs

*Allan Hruska
Director NicaSalud*



For the Networks

M&E was a focal point for building the Networks:



Joint planning of uniform & standardized method, joint training and a comparison of zones that leads to shared learning



Results

Uniform presentation of results

A presentation card to MOH & donors





For the Individual PVOs & NGOs

- A commitment to the Networks
- Changed attitudes & practices vis-à-vis M&E
- Improved credibility





Demonstrated impact of projects

Use of data for decision making to improve programs





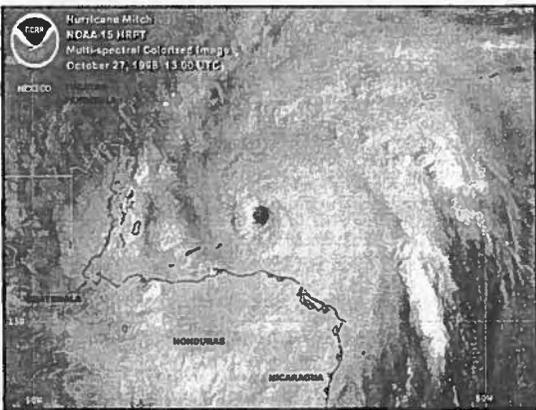
Increased technical capacity & application to other projects





NicaSalud

Aiding Nicaragua Recover From Hurricane Mitch





NicaSalud Members

1999	2000
• ADRA	• ADP
• CARE	• Alistar
• CRS	• CEPS
• HOPE	• Compañeros
• Partners of the Americas	• Fundemuni
• PCI	• Hablamos
• PLAN	• INPRHU
• SAVE	• Ixchen





Umoyo Network

Assisting Malawi to Improve RH Services, Increase Use of HIV/AIDS Prevention Practices and Improve Care and Support for PLWAs

*Carrie Osborne
Program Manager, Umoyo Network*



Umoyo Network Partners

7 NGOs, 2 Networks, 2 PVOs and 1 Private Sector

- Malawi Counseling and Resource Organization (MACRO)
- Word Alive Ministries International
- Ekwendeni Hospital Primary Health Care Program
- Adventist Health Services
- Malamulo Hospital
- Development Aid from People to People (DAPP)
- National Association of People Living with AIDS in Malawi (NAPHAM)
- Malawi Association of National AIDS Service Organizations (MANASO)
- Malawi Network of People Living with HIV/AIDS (MANET)
- The Salvation Army
- ADRA
- Bowler Beverages Co Ltd



Umoyo Network

- Malawi is very poor with limited health and education services
- High child and maternal mortality
- High STI and HIV prevalence
- Poor infrastructure and a dearth of trained human resources in the health sector.
- Much of the NGO sector is new since 1994 -- with limited capacity to deliver services of consistent quality



Umoyo Network Challenge & Direction

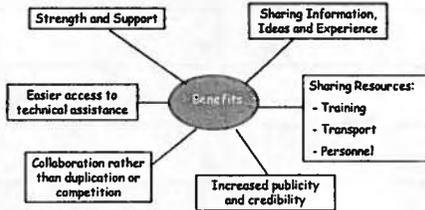
- CHALLENGE -- The fragile nature of most of the Sub-Grantee NGOs

Consequently, USAID Malawi through Umoyo Network:

- made a significant investment in NGO institutional development and capacity building to
- improve their ability to scale-up, expand and provide good quality services.



Sub-Grantees Views: the Benefits of Being Part of the Network



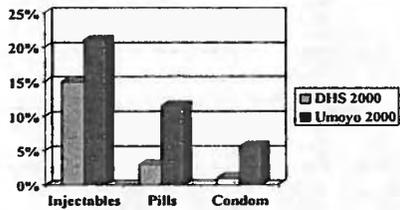


Umoyo Network of Malawi

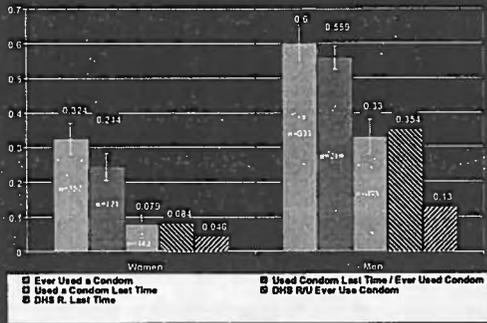
- 5 NGOs (2000 Baseline)
 - Adventist Health Services
 - Word Alive Ministries International
 - Ekwendeni Hospital
 - Malamulo Hospital
 - MACRO (No Community Outreach)



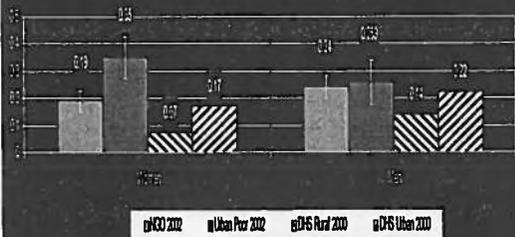
Comparison of DHS 2000 and Umoyo 2000 M&E Data

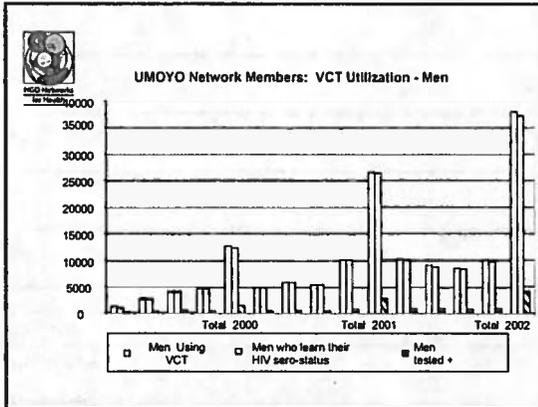


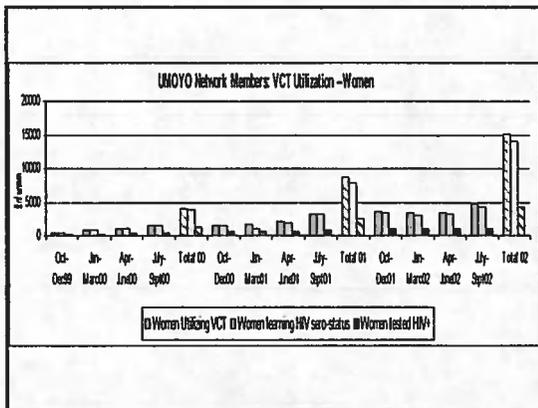
Malawi: Have Ever Used a Condom for 2002 in NGO and Urban Poor Areas



Malawian Men and Women Who Ever Had an HIV Test







Lessons Learned and Major Findings for Umoyo

- NGO rural areas have higher CPR than DHS 2000 possibly due to higher access to pills and condoms, and promotion of injectables
- Data indicate that people who used a condom at least once tend to use them in the last sexual contact
 - Need to understand this relationship
 - Target people who "Never Have Used"?
 - Continue to promote "Always Use a Condom"
- Continued increase use of VCT by men and women
 - Huge Gender Gap



Lessons Learned from Both NicaSalud & Umoyo

- M&E formed a rallying point for fostering collaboration and shared identity among PVOs/NGOs
 - Initially a required activity
 - Later the NGOs wanted it
- When program staff evaluated their own programs the reliability of behavior indicators was 91% and they gave an unbiased appraisal of their programs



Q & A





Behavior Change due to PVO/NGO Interventions and Change due to Network Interventions

**Assessing Strategies for Changing RH Behavior
and the Value Added of Networks
in Nicaragua**

**Prof. Jerry Hage
Center for Innovation, University of Maryland
Dr. Joseph Valadez
NGO Networks**

Organization Interventions Affecting Behavior Change In NicaSalud: Maternal Health

Independent Variable *	3+ ANC		ANC Card		Clinical Delivery		Post Natal Visit	
	r	p	r	p	r	p	r	p
PHYSICAL CAPITAL								
Density of Community Health Hubs Built (A)	0.307	0.159						
HUMAN CAPITAL								
Variety of Individuals/Groups that Received Charlas (B)								
Variety of Types of Paramedical Personnel Trained (C)	0.547	0.07	0.429	0.052				
Density of Paramedical Personnel (D)	0.545	0.065	0.77	0.018				
SOCIAL CAPITAL								
Density of Health Committees / Councils (E)	0.444	0.04	0.581	0.041				
Density of Mothers / Women's Clubs (G)			0.408	0.105				
*Density is standardized on Population								

Organization Interventions & Organizational Learning: Maternal Health

Independent Variable *	3+ ANC		ANC Card		Clinical Delivery		Post Natal Visit	
	r	p	r	p	r	p	r	p
COMBINATIONS								
Physical Capital x Human Capital (A x B)	0.579	0.059	0.683	0.049				
Variety Human Capital x Density Human Capital (C x D)	0.512	0.057	0.809	0.011				
Human Capital x Social Capital (D x F)	0.635	0.037	0.804	0.023				
ORGANIZATIONAL LEARNING & VALUE ADDED								
Strategic Changes x Technical Changes (S)	0.539	0.042	0.76	0.03				
*Density is standardized on Population								



Lessons Learned

- In Nicaragua in our study easier to measure change in Women's Behaviors than their Knowledge
 - Behavior is concrete and permits a programming focus
 - Knowledge has more measurement error
- Relative to Investments in human capital
 - density of paramedical personnel is better for maternal health
 - Charlas (talks) are better for child survival



Lessons Learned

- Relative to investments in Social Capital
 - Health committees is better for maternal health
 - Women's/mothers' clubs are better for child survival
- Relative to Investments in Physical Capital
 - Building health huts paid off especially with respect to Child Survival
 - Pay off for maternal health occurred when the density of paramedicals was high



Pending Issues

- We could not explain behavior change for the indicators "clinical delivery" and "post partum care"
 - Other MOH interventions may possibly account for the behavior change
- Post partum visits is highly correlated with clinical delivery which is correlated with 3+ ANC visits which is highly correlated with ANC card retention
 - Community health promotion gets women into the health system.
 - Then they stay in it !



NGO Networks
for Health

Q & A



NGO Networks
for Health

Future Issues for PVO/NGO Networks

Assessing Community Health Programs

Using LQAS for Baseline Surveys and Regular Monitoring

Joseph J. Valadez, PhD, MPH, ScD; William Weiss, MA
Corey Leburg, MHS; Robb Davis, PhD, MPH

International Public Health practitioners in the 21st Century will increasingly involve local health workers in the planning and monitoring of their own community health programs. **LQAS** is a tool that supports their active participation. It empowers local supervisors and managers to identify priority issues and to accurately focus programs. With information obtained by **LQAS**, community-oriented child survival, safe motherhood, HIV/AIDS, family planning, tuberculosis, nutrition, disaster relief, and other programs can be designed and refined by taking into account local conditions. **LQAS** helps health workers to steer and guide programs on a local level and to improve their impacts in a manner which centralized management systems are frequently unable to do.

The image shows the front cover of a book titled "Assessing Community Health Programs: A Trainer's Guide". The cover is dark blue with a collage of six photographs showing community health workers in various settings: a woman in a field, a woman pointing at a chart, a group of people in a meeting, a woman writing on a wall, a woman in a field, and a group of people standing together. The title "Assessing Community Health Programs" is at the top in white, and "A Trainer's Guide" is below it. The subtitle "Using LQAS for Baseline Surveys and Regular Monitoring" is also present. The authors' names are listed at the bottom right. On the left side of the cover, there is a white box containing text about LQAS and reports of users. At the bottom left, there are logos for WHO, UNICEF, and CORE.

Assessing Community Health Programs

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LQAS has been used successfully by supervisors of community health programs in Central and South America; in East, West and Southern Africa; in South and Southeast Asia; and in the Caucuses. These experiences have shown it to be a useful, practical and inexpensive tool for community health practitioners.

Reports of LQAS users:

...The first time we used LQAS to supervise our project, we learned that our initial strategy for teaching mothers how to prepare and use ORT was not effective. After re-planning the program together with our health workers, it became much more effective. LQAS was very important for us.
—Nicaragua

...We use LQAS every 6-months and have now integrated it into our regular supervision system. In our third application we learned that the government supply system had serious delays in shipping family planning methods. In response, we developed our own local delivery system. Many more women began using family planning methods as a result because the unmet need was addressed.
—Nepal

...LQAS helped us to scale up several child survival and maternal health programs in our district. Each municipality learned about their different problems and could address them. At the district level we were able to identify the municipalities on which to focus our support and how to make changes. Now we want to apply LQAS to improve our TB and HIV programs.
—South Africa

Assessing Community Health Programs • A Trainer's Guide

Assessing Community Health Programs

A Trainer's Guide

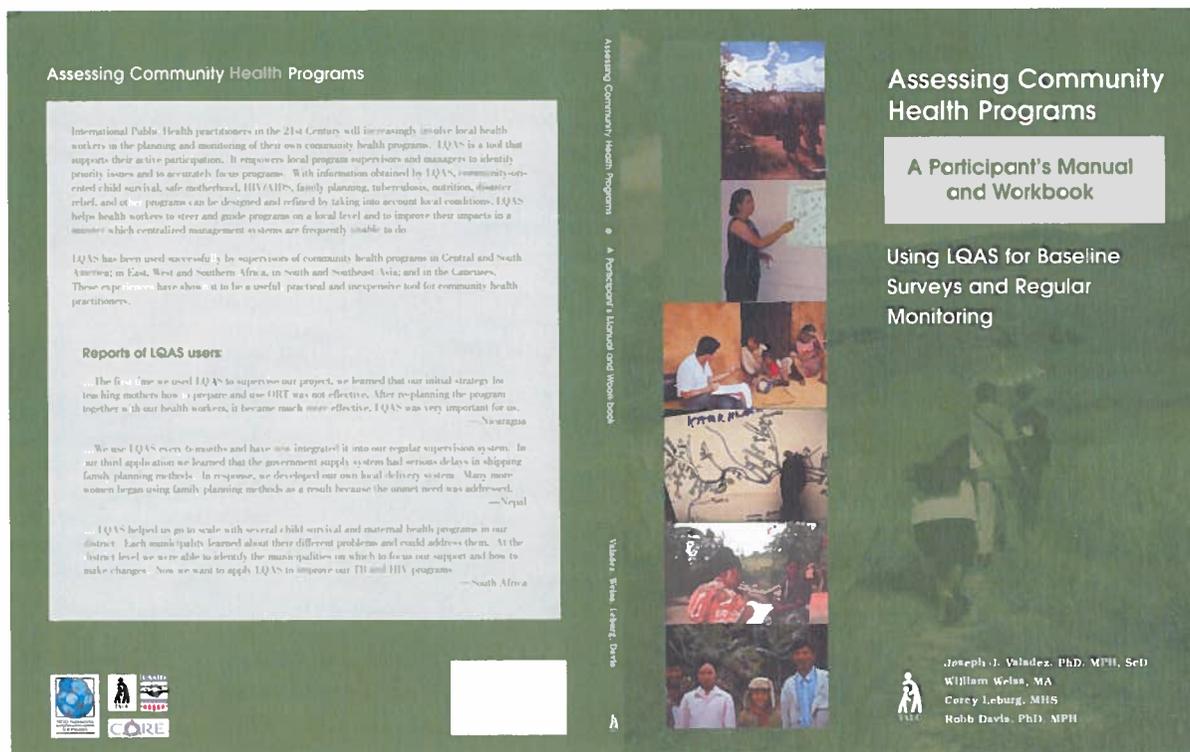
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Published by: Teaching-aids At Low Cost (TALC): London

Available January 2003

To order please follow instructions on TALC Website at <http://www.talcuk.org>

The Need...

MALAWI – Introductory Information



Umoyo Network

- Population of 11 million, 86% live in rural areas and are subsistence farmers
- Per capita income less than \$200 per year, most live on less than \$40 a year

Education

- Literacy rate: 34% women and 66% men
- Secondary schooling: 11% women and 20% men
- Higher education: less than 0.6% adult population

Health

- Ministry of Health budget is less than \$1.75 per person per year
- 49% of children are stunted, 25% are underweight
- Life expectancy at birth is 39 years
- Under-5 mortality rate is 247/1000
- Maternal mortality ratio has doubled from 1992-2000 from 620 to 1,120 /100,000
- According to the recent evaluation of the RH program by DFID "Lack of human resources appears to be the limiting constraint on increasing access to sexual and reproductive health services."
- Nascent NGOs requiring organizational development and capacity building

Reproductive Health

- Fertility rate is 6.3
- Modern contraceptive prevalence rate: 26%
- Over 70% of young women aged 15-19 become pregnant

HIV/AIDS

- HIV Prevalence rate of 15% in the 15-49 year age group, 38% of pregnant women in urban areas
- Currently estimated 840,000 PLWAs, high mortality and morbidity with loss of productivity and national income
- Inexorable increase in the number of AIDS orphans, estimated at 60,000 per year, currently estimated at over 390,000

The Benefit of Umoyo...



Umoyo Network

Quotations from the Evaluations of Umoyo Network and the NGOs:

Voices of Government - In what ways has Umoyo Network been useful? Sept 2002

"Umoyo has been the most concerted step to expand the national response on HIV/AIDS"

"Umoyo has been able to engage NGOs who would otherwise not be doing as much as they are"

"Umoyo fits the national strategy by identifying NGOs with missing resources and capacities. It also helps the National AIDS Commission understanding of ASOs at a local level...Umoyo support has brought a different perspective and brought a practical edge to the NAC" National AIDS Commission

"Umoyo has complemented government efforts to support NGOs by providing resources, giving them direction on activities. It has involved RHU in facilitating training courses, and actively attended national level meetings on policy development" Reproductive Health Unit, Ministry of Health and Population

"Umoyo has put OD onto the agenda and provided evidence that you can work with NGOs and CBOs. It has been a wonderful lesson how, taken through basic training, they can be transformed into viable organizations. Umoyo has demonstrated to donors that when you have the money and the technical know-how you can make it work" USAID Malawi

Voices of NGOs

"Other donors should fund assistance to NGOs to enable them to evaluate themselves, in the way that Umoyo is doing" DAPP

"Umoyo is a source of reliable support and valuable means of sharing information" Ekwendeni

"There are big benefits of the Network in so far as it promotes learning, avoids duplication of problems and (unlike many other organizations) provides consistent funding" Malamulo

"The Network increases the credibility of the NGOs" MANASO

**The Road to the
Optimal ENABLING Environment**

Victoria Wells, MD, DrPH
ENABLE Project Director
CEDPA

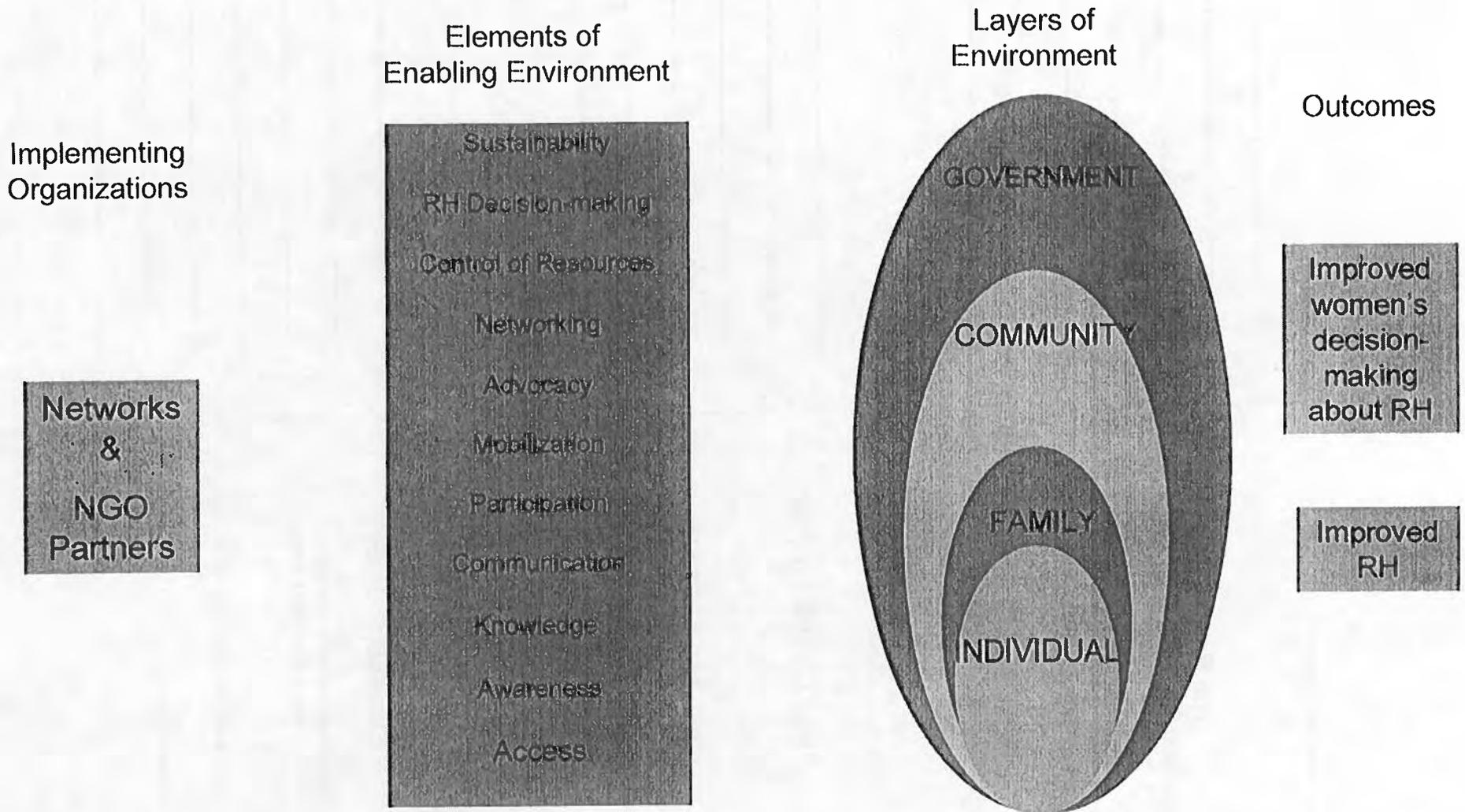
The ACCESS Project

Access to RH services is not
enough, you need to create an
ENABLING Environment

ENABLE'S Goals

- Strengthen women's capabilities for informed and autonomous decision-making
- Promote an ENABLING environment
- Increase capacity of NGO's

Program Framework



What Aspects of RH Are Important?

- Family Planning
- Emergency Contraception
- Safe Motherhood
- HIV/AIDS/STIs

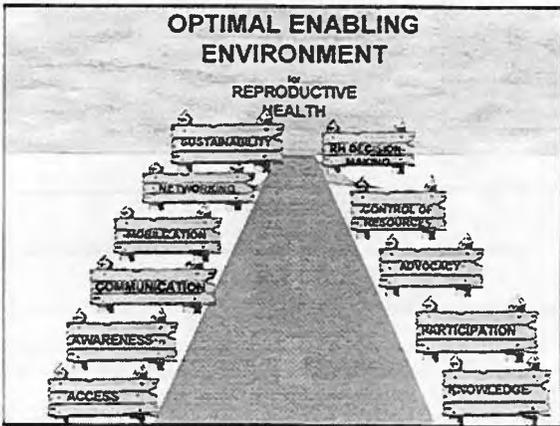
NGO Partners

- Parastatal
 - SIFPSA India
- Faith-Based Organizations
 - Muslim Family Counseling Services (MFCS) in Ghana
- NGOs
 - Nepal Red Cross Society in Nepal (NRCS)
- Trade Associations
 - Ghana National Association of Teachers (GNAT)

NETWORKS



- Faith-Based Organizations
 - Church of Christ in Nigeria (COCIN)
- International Affiliations
 - Society for Women and AIDS in Africa (SWAA)
 - White Ribbon Alliances
- Women's Groups
 - Country Women's Association in Nigeria (COWAN)
- Work Cooperatives/Private Sector
 - Bihar Dairy Cooperative in India



ACCESS



- Uttar Pradesh, India, Community-Based Distributors
- Provide FP
- Referrals to clinics
- 22 million reached

Photo by ReproCare

AWARENESS



- Nepal, Adolescent Girls Initiative for Their Reproductive Health (AGIT)
- Adolescent girls' awareness of marriage choices
- Increased from 33% to 67% in 2 years

AWARENESS



- Ghana, Female Genital Cutting (FGC)
 - Muslim Family Counseling Service
 - Ghana Association for Women's Welfare

AWARENESS



- Senegal, Women's Empowerment Project
- Elected officials made aware of health issues

KNOWLEDGE



- Nepal, AGIFT for RH
- Girls 10-14
- How a woman gets pregnant
- Increased from 25% to >90%

KNOWLEDGE



- Ghana, Safe Motherhood Initiative
- Oxytocic roots harmful practice
- Eradicated in 3 village pilot programs

COMMUNICATION



- Nepal, Communication Action Groups (CAGs)
- 60% women talked w/husbands about condom use
- 50% initiated discussion w/husband about condoms

COMMUNICATION



- Ghana, Peer Education
- 2 strategies tested
- Highly structured w/ close supervision: model far more effective

MOBILIZATION



- Plateau State, Nigeria, D&G
- 22 women trained:
 - Leadership
 - Campaign planning
 - Public speaking
 - Mobilizing resources
 - Negotiation
 - Advocacy
- All are still in contention

MOBILIZATION



- Nepal, Condom Day
 - Established by CEDPA partners
 - 7 years of celebration
 - 70 participating agencies

PARTICIPATION



- Nepal, AGIFT for RH
- Literacy classes
- >90% of girls 10-14 initiated formal schooling

ADVOCACY



- Rivers State, Nigeria, Engendering Legislative Issues
- Female Genital Cutting
- Successfully petitioned for legislation banning FGC

ADVOCACY



- India, CEDPA partners
- Improving method mix
 - Injections
 - Standard Day Method
 - Female condoms
 - Emergency contraception

NETWORKING



- India, Safe Motherhood Initiative
 - Thousands marched on the Taj Mahal

NETWORKING



- Nigeria, 100 Women Groups
 - 689 groups formed in 2 years
 - >66,000 members
 - 400 groups active & continue

NETWORKING



- Senegal, Coalition of Youth Groups

CONTROL of RESOURCES



- India, Better Life Options
- 42% adolescents could decide how to spend money vs. 12% outside project

CONTROL of RESOURCES



- Senegal, Women's Empowerment
- Income generating activities to support health needs
- Revolving credit system

RH DECISION-MAKING



- Nepal, CAGs
- Modern FP method use increased >200% in 8 years in 3 districts vs. 50% increased use of modern FP overall in rural Nepal

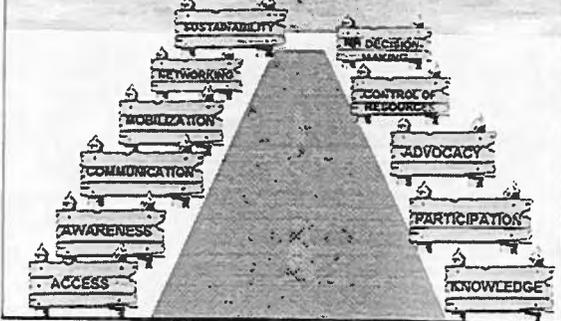
SUSTAINABILITY



- India, Community Aid Sponsorship Project (CASP)
- Clinic reduced service delivery costs by 72%
- More than doubled # of client visits

OPTIMAL ENABLING ENVIRONMENT

for
REPRODUCTIVE HEALTH





THANK YOU

ANY QUESTIONS?



DATE	DESCRIPTION



Giving A Voice TO Women

Democracy and Governance
Program in Nigeria
January 22, 2003

Rose Khasiala Amolo, MPH



Nigeria:1996

- **Military dictatorship**
- **Traditional patriarchal structure**

- **Women issues**
- **Gross human rights abuse**

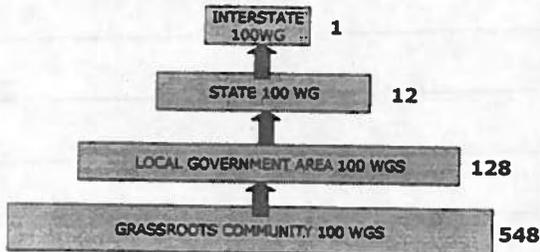
CEDPA's Intervention



What is the 100 Women Group?

- Brings together groups of women in a coalition to address issues of a common concern
- Formed at the community, local government, state regional and or national level.
- A bottom-up participatory approach

Networking for Participation and Action



Tools For Action

- Training/Capacity Building
 - General knowledge, literacy, proposal development etc.
- Lobbying
- Networking and coalition building skills
- management

Alliances at Various Levels

- Trade Unionists
- Women Activists
- Professionals
 - Lawyers
 - Journalists
 - Faith-based groups
 - Medical Doctors
 - Micro-credit groups



Impact on Women and Women's Groups

- ⤴ Increased participation in decision-making processes at all levels
- ⤴ Increased knowledge
 - ✓ Reproductive health and safe motherhood issues
 - ✓ Girls' education
 - ✓ Nutrition and sanitation
 - ✓ Income generation



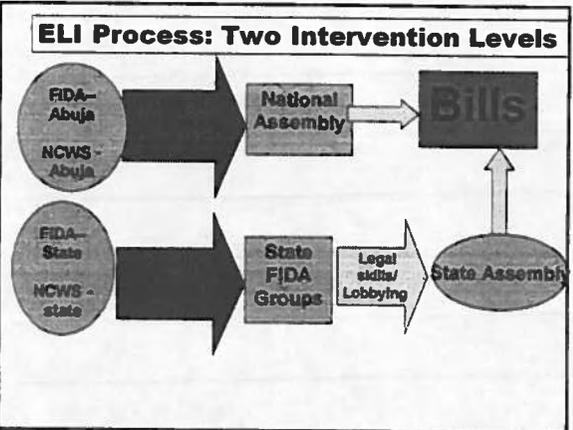
Good Governance in 1999 Elections

- ✓ Supported 145 female candidates for elective office- 43 were elected!
- ✓ Mobilized 753,396 people to register to vote nationwide



Engendering Legislative Issues (ELI)

- Linking grassroots constituencies to elected officials
- Promote transparency and accountability
- Training potential women candidates



Pro-Women legislation Achieved

- National Policy On women adopted
- Women's input incorporated in to draft Constitution
- Ban on harmful widowhood practices
- Ban on early marriage
- Anti-trafficking legislation
- Anti-FGC bills Passed
 - Edo State, October 1999
 - Rivers State, August 2001

Lessons Learned

- 100WG provide a critical interface between women leaders and rural poor women
- Involvement of women in Advocacy and lobbying at all levels

Challenges Ahead

- Enforcement of the laws passed
- Continue working at the National Level to ensure relevant Bills are passed

Transforming Women for RH



A Force for Change
Through
Communication
Action Groups

Deepak C. Bajracharya
CEDPA/Nepal
January 2003

INSERT VIDEO CLIP

Background to the Nepal Red Cross Society/ENABLE Project

•Built on the earlier ACCESS Project aimed at
non-clinical FP services

•ENABLE works in expanded areas to create
an enabling environment for women's decision
making abilities

•Offers mix of clinical and non-clinical RH/SM/CH
services provided by auxiliary nurse midwife

Overview of Communication Action Groups (CAGs)

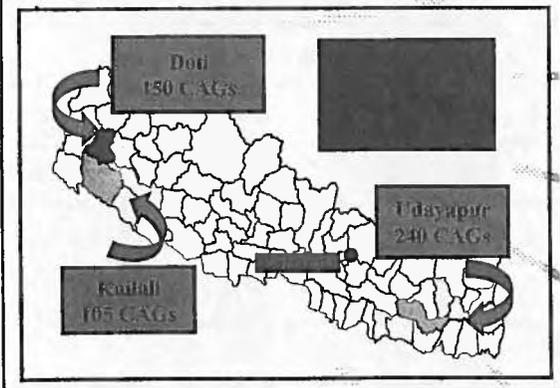
- 495 active groups with 9,900 members
- Leaders trained by NCRS staff
- Mobilize communities



A group of 20 rural women between 15-49 years of age who...

- Meet once a month to discuss RH and other issues
- Advocate practicing RH/other behaviors
- Practice the behaviors they learn about
- Operate savings and credit schemes

Number and Distribution of Groups



What kind of support does a CAG receive?

- † Training for group leaders and members
- † Participation/facilitation by depot holders and health workers in monthly meetings
- † Information and access to RH services through direct delivery and referrals
- † Basic/post-literacy classes
- † Support for exchange visits between CAGs

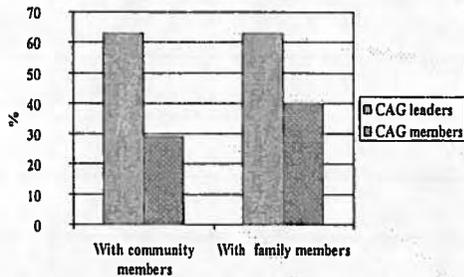


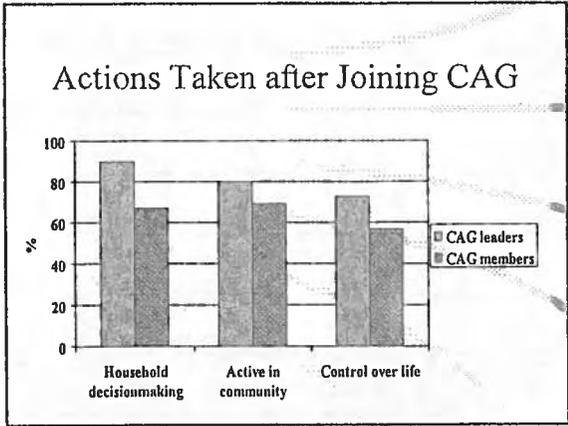
2002 Evaluation

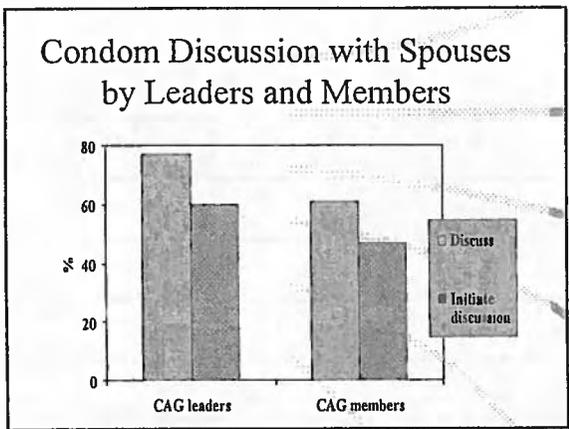
Quantitative: surveys with 949 CAG leaders, members, husbands and community influentials

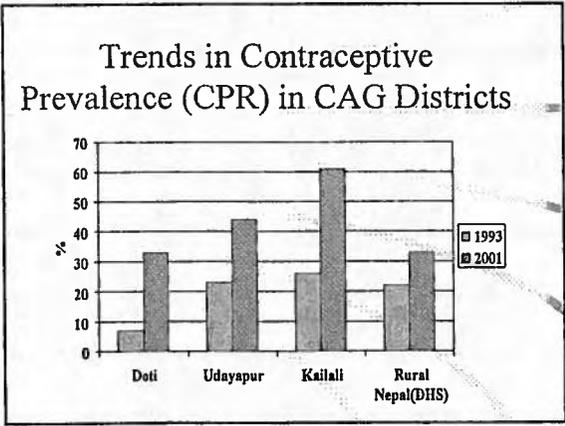
Qualitative: 25 focus groups with: CAG leaders and members; husbands; male educators, depot holders and fieldworkers

Ability to Communicate Information Frequently









Focus Group Quotes on Women's Empowerment



"Before we were like birds inside a cage, but now we have developed wings"

"The community now respects us after we have solved their problems. Therefore we have benefited personally."



Focus Group Quotes on Expanded Capacity to Solve Problems

"If someone has a problem admitting her child to school or paying the fees, we help her".

"Before, women had to give birth in the hay. These days they are allowed to give birth on a bed."

CAG Results

- Improved communication
- Empowered women
- Increased women's participation

Future Directions

- Overwhelming support for continuation and expansion by members, husbands, leaders
- Further training on other RH issues requested by members
- Savings Credit program should be expanded as it helps women gain approval



Safe Motherhood Advocate(SMA)

- Engages communities to promote Safe Motherhood
- Uses Participatory Learning Approach to identify problems and evolve solutions





Community Volunteers Trained

20 Safe Motherhood Advocates

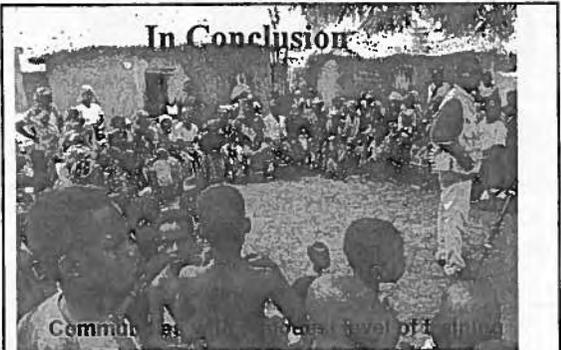


30 Safe Motherhood Volunteers

Early Successes in Ghana

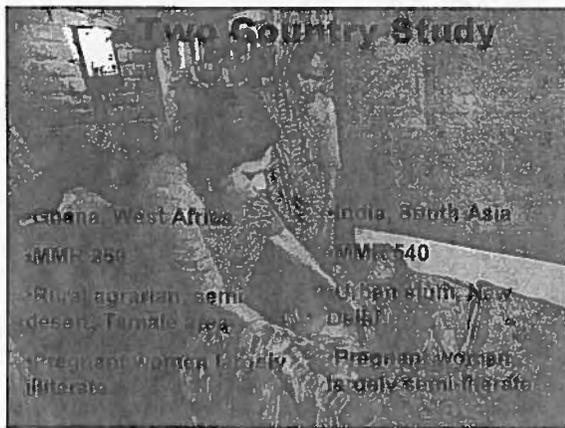
- No Deaths
- Elimination of a key harmful practice
- Emergency Systems in place

In Conclusion



Communities at a high level of health care are able to find local solutions to their problems by reducing barriers to care and thus increasing the safety of childbearing.





The Three Delays

- **First delay:** recognizing that there is a problem.
- **Second delay:** reaching the appropriate level of care once the problem is identified.
- **Third delay:** receiving appropriate care once reaching the referral institution.



Study Objective

To determine the effectiveness of community members in eliminating barriers to Safe Motherhood



Some Baseline Findings

- Delay in seeking antenatal care
- Use of Kalugotin (an oxytocic root)
- Heavy workload

Safe Motherhood Volunteer (SMV)

- Works with community through education of pregnant women and their families on:
 - early recognition and self referral for problems
 - Planning for clean home delivery
 - Planning for emergencies



Increased Contraceptive Use through Scaling-up Dairy Cooperative Services in Uttar Pradesh



Marta Levitt-Dayal, PhD, MPH
Country Director, CEDPA/India



The IFPS Project

- A 12-year \$325 million USAID-GOI bilateral to reduce fertility in Uttar Pradesh
- Aims to increase CPR from 20% to 32%
- Implemented by SIFPSA
- CEDPA provides TA to enable NGOs and networks to implement CBD service delivery

Linking with Dairy Cooperatives

- Largest community-based network in UP
- Existing infrastructure for training and field monitoring
- Strong management systems
- A business orientation that ensures quality and is committed to sustainability

Community Based Distribution through Dairy Cooperatives

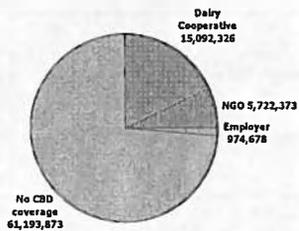


- Major private-sector strategy to increase access and use of services
- Local women hired as CBDs and given honorarium
- Go door to door serving all MWRA in project areas
- Provide counseling, pill and condom distribution, referrals and follow-up

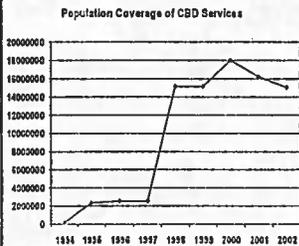
CBD Population Coverage, 2002

■ CBD Projects cover 26% of the total IFPS Project population.

■ Dairy Cooperative project areas comprise 70% of total CBD coverage



Scaling up of CBD Services through Dairy Cooperatives, 1995 - 2002

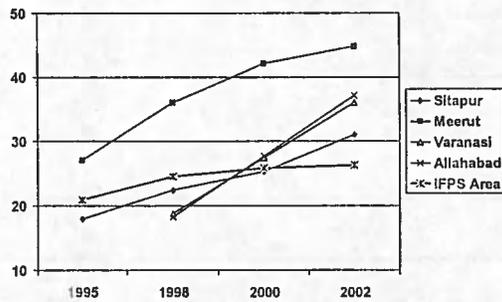


- 15 projects cover 5277 dairy societies and 15 million population
- 4979 female CBDs providing services
- 610,350 currently active clients being served
- 5 year sub-grants given

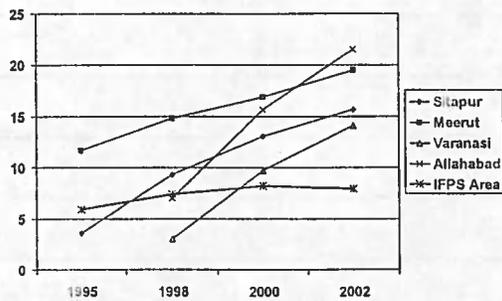
What Made Scaling up Possible

- Model tested and systems developed
- Strong management systems/MIS
- Standardized, quality training
- Village-based supervision
- Results-oriented implementation and monitoring

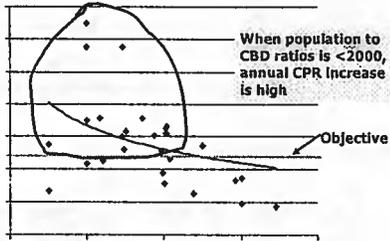
CPR Increases in DC Project Sites and Total IFPS Project Area



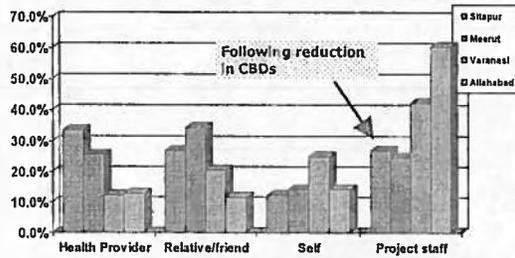
CPR Increases in Spacing Method Use, DC Sites and IFPS Project Area



Relationship of CBD-Population Ratio and CPR increase

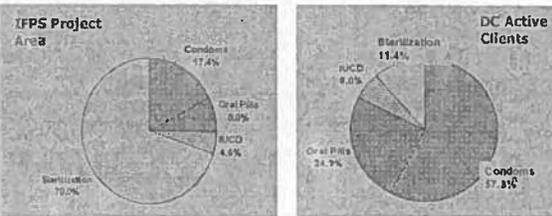


Who Motivated Clients for Current FP Method, 2002



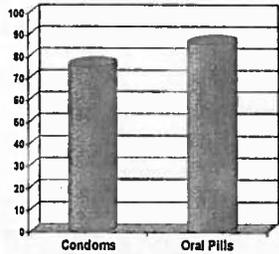
DC Project staff are an important source of FP motivation

Method Mix: Dairy Cooperative vs. IFPS Project Area, 2002



CBD Projects have enabled couples to access and use spacing methods

Percent of Pill and Condom Users Receiving Supplies from CBDs



- Dairy Cooperative CBD services are the major source of pills and condoms in project areas
- Over 90% of users stated they receive regular supplies

Social Marketing of Contraceptives is a Key Sustainability Measure



- 59% of pill and condom users now purchase commodities from CBDs
- Client willingness to pay is a move to sustaining benefits
- Clients who buy commodities inclined to continue method
- Statewide CSM efforts linked directly to DC ensures continuous supply

Scaling up While Maintaining Quality of CBD Services

“She is available all the time. She is from our village we go to her whenever we need re-supply. We have privacy; do not have to leave our homes.”

- Client

Unique Gender-sensitive Service Delivery

- Women empowered to provide services and work as supervisors
- Large mobilizing force of local women enabling RH behavior change
- Home-based counseling and follow-up enabled women's FP/RH decision-making



Results from Linking with Dairy Cooperatives for FP Service Delivery

- Large population coverage
- Rapid increase in CPR
- Significantly higher spacing method use
- Commitment to sustainability
- Acceptance of social marketing
- Systems strengthened for expansion, training and monitoring progress

Constraints

- Implementing agency cut costs by reducing number of CBDs, slowing down CPR increase
- In some areas, a competitive relationship emerged between CBDs and ANMs
- Difficult to fully integrate with male-operated Dairy Cooperatives
- Government operated dairy cooperative projects performed poorly and had to be closed down

What Did We Learn

- CBD model can be scaled up effectively and cover large populations
- Scaling up requires systems to be piloted and in place
- When CPRs are low, CBDs need to have a smaller working area to ensure intensity of service delivery
- Rural poor are willing to pay for good quality and reliable contraceptives

Thank You



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Working With Faith-Based Organizations



**Church of Christ in Nigeria
(COCIN)**

Prof. Paulina Makinwa Adebuseye

cedpa 



The Health Department

- **2 Hospitals +
1 Leprosarium**

- **150 health facilities**

- **43% of annual budget**

COCIN Women's Demand



- High Fertility
- High STI/HIV/AIDS
- CEDPA DG = Empowerment
- DEMAND RH/FP

CEDPA's RESPONSE

1. Capacity Building of Community Volunteers
 - Advocates (CBA)
 - Distributors (CBD)
 - Traditional Birth Attendants (TBA)
 - Peer Health Educators (PHE)
 - Health Extension Workers (CHEW)
 - Male Counselors
2. Integrated Reproductive Health (IRH)
3. Clinical Referrals
4. Assure Sustainable RH Services

BARRIERS to RH/FP

Church Doctrine

- HIV/AIDS + Sin
- Condom Taboo

South-South Cooperation



COCIN Visitors to Uganda



Hosts in Uganda

MEET REV. GIDEON & WIFE...



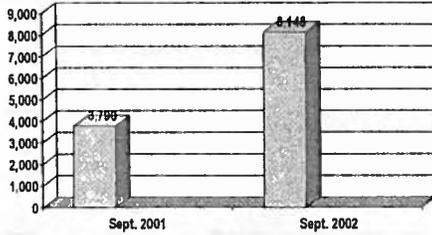
... both HIV positive

Rev. Gideon in Nigeria

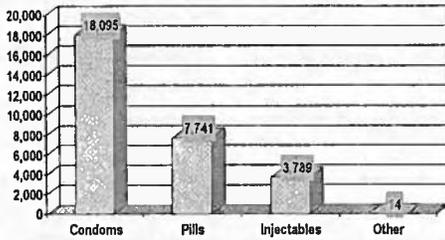
Resulting COCIN Policy Changes:

- Shift to Care & Love
- Church Support RH
- Approval: Condoms/ Couples
- Youth Counseling
- Pre-marital Counseling

Increase in FP Clients



Contraceptive Method Mix



SUSTAINABILITY



"CEDPA is helping the Church to do what God expects, so COCIN will sustain activities... ."

Rev. Alexander Lar, COCIN President, Nov. 2002

Challenges Ahead

- **Extending condom use beyond married couples**
- **Meeting the increasing needs of COCIN members for RH services**
