



As village president, I feel responsible for development and a priority is the good health of the community. Family planning is not only a health issue. It is a social issue in the development of a village.

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VOICES from the VILLAGE:

Improving Lives through CARE's Sexual and Reproductive Health Programs

Going the Extra Mile to Provide and Sustain Family Planning Services in Remote Madagascar



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project



Introduction

Often called “the eighth continent” for its dazzling biodiversity and unique mix of people, language and traditions, Madagascar is struggling to balance economic growth with conservation of its priceless natural resources. Indeed, it was recognition of the spiraling tensions between environmental degradation, economic stagnation and overpopulation that led the government of Madagascar to reverse its once overtly pronatalist stance and make family planning and health one of eight pillars of its development action plan: “We will strive to assure that all our people are in good health and can contribute productively to national development and live long and prosperous lives. Malnutrition and malaria will be eliminated. HIV and AIDS will not advance; potable water will be available to all; *and through education and service provision*, the average size of the Malagasy family will be reduced.”ⁱ

In eastern Madagascar, CARE’s Extra Mile Initiative (EMI) has worked to ensure exactly that: education and services in family planning in six remote communesⁱⁱ that border important conservation zones, where ecological resources are under pressure from a growing population. When the EMI began, the contraceptive prevalence rate there was about 11 percent, traditional and modern methods combined — well below the national average of 27 percent.ⁱⁱⁱ A mere 12 months later, 24 percent of women of reproductive age in the project area were using some method to plan their families.

How was the EMI so successful in such a short time? Certainly, residents of the six communes exhibited tremendous unmet need for family planning, based on their stated wishes for the number and timing of future children. (In fact, unmet need among non-users remained high after one year of project activities despite the leap in contraceptive use; see the Next Steps and Future Opportunities section on page 8.) Add to that the remote communes’ embrace of CARE’s arrival as an opportunity – often among the very first – to participate in a development project. Yet CARE also strove to adapt the EMI’s approach to meet the needs of extremely isolated communities, and to leave behind a network of people and institutions empowered to sustain the gains that they have made.



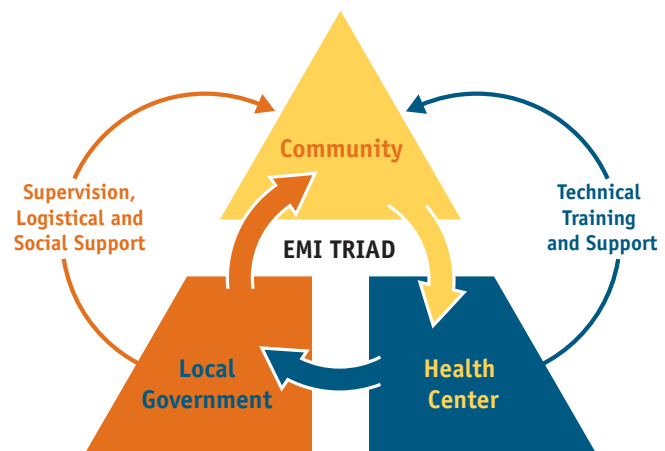
http://www.lib.utexas.edu/maps/africa/madagascar_npl_2003.jpg

CARE's Extra Mile Initiative

In 2005, USAID, through the ACQUIRE project,^{iv} invited CARE to implement the EMI. The project's very name indicated the additional effort CARE would need to invest just to reach the six communes — by motorcycle, canoe and, mostly, on foot.

At its core, the two-year EMI is a fairly standard, community-based family planning project. As is typical, CARE linked its work to the commune health centers (the lowest rung on the Ministry of Health's service system) and to the communities themselves, where the EMI trained an extensive system of citizen volunteers to provide their own villages with information and, in the case of Community Health Agents (CHAs), contraceptives.

But the twist — the operational extra mile, as it were — was to embed the EMI not only in the local health system and the communities it serves, but also in local government, forming a solid triad of implementation and oversight. In Madagascar, the national government mandates the structure of commune government; among the key administrative bodies is the Social Development Committee (SDC), charged with supporting basic services such as health and education. However, with virtually no training, guidance or funds, and with no clear authority to intervene in technical-service hierarchies managed by the state, many SDCs exist in name only. Such was the case in the six communes before CARE began the EMI.



CARE's Role: Guide, train, underwrite some costs.

To successfully embed responsibility for family planning in the SDCs, CARE had first to help each committee become functional.

What is the SDC?

The SDC is a microcosm of the commune. Its members are locally elected officials (such as the mayor), traditional leaders (village chiefs), religious and social leaders, local representatives of state services (doctors or nurses from the health centers) and, in EMI communes, selected CHAs.

What training did CARE offer each SDC?

General:

- Basic information on family planning and maternal/child health

Management and Oversight:

- Development of health strategy and action plans
- Participatory, transparent supervision, tracking, monitoring and reporting
- Meeting protocol; problem resolution
- Use of national equity fund for healthcare

Good Governance:

- Participation (more people have a voice in decision making)
- Transparent and accountable management of resources
- Gender, human rights and responsibilities

CARE's role in the EMI project was to train and coach to develop skills and build capacity to the three parts of the triad, and to create room for collaboration where none had occurred before. In addition to training SDC members, CARE and health center staff provided extensive training to the network of volunteers, who then offered information and services to community members. CARE also trained health staff how to use Cycle Beads (a tool to help those using the calendar or Standard Days method); they were already trained in the use of other modern contraceptives. With CARE's guidance, the six local triads shouldered responsibility for organizing and implementing family-planning education and service provision in the communes.

The Results

After only one year of EMI activities, the baseline contraceptive prevalence rate of 11 percent more than doubled, to 24 percent. The final evaluation will yield another measurement of the rate; in the meantime, monthly user data indicates a steady rise in the number of women choosing to use a contraceptive method.

People's knowledge of methods has also grown. The baseline survey showed that approximately 74 percent of women and 61 percent of men had heard of at least one way, modern or traditional, to prevent pregnancy. By mid-term, knowledge of at least one method had risen to 83 percent among women and 74 percent among men. This rise is due in large part to the extensive network of EMI-trained CHAs and other volunteers who are active in their communities. Jean Line, a CHA in Ambahoabe, says, "Before EMI, even I didn't know about family planning. Only the doctor did, and communities learned about it only by accident — for example, if a woman fell ill and the doctor prescribed a contraceptive so she wouldn't become pregnant while recovering."

The EMI has greatly increased the channels for spreading information on family planning. Fifi Aurélie is a member of Miaradia, one of dozens of civic groups that participate in the project. "Our messages and songs clearly

"I believe poverty will be overcome when we can plan our lives, when we don't have to just go along with what happens, but can really think about what we want our future to be. I don't want to see people suffer, to see children go without. That's why I was among the first to agree that all actors [must] be involved: the mayor, the health center and all the rest. It is the collaboration of all these that can make family planning – life planning – a success."

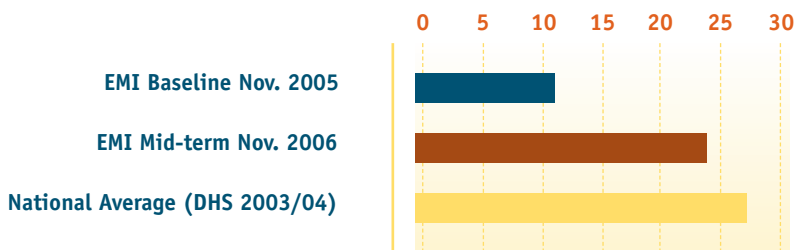
Remi Sonina
SDC Member, Fotsialanana

state the different methods and where to get them,” she says. “If a man or woman asks, we send them to the nearest CHA, or to the health center if they want injectables.”

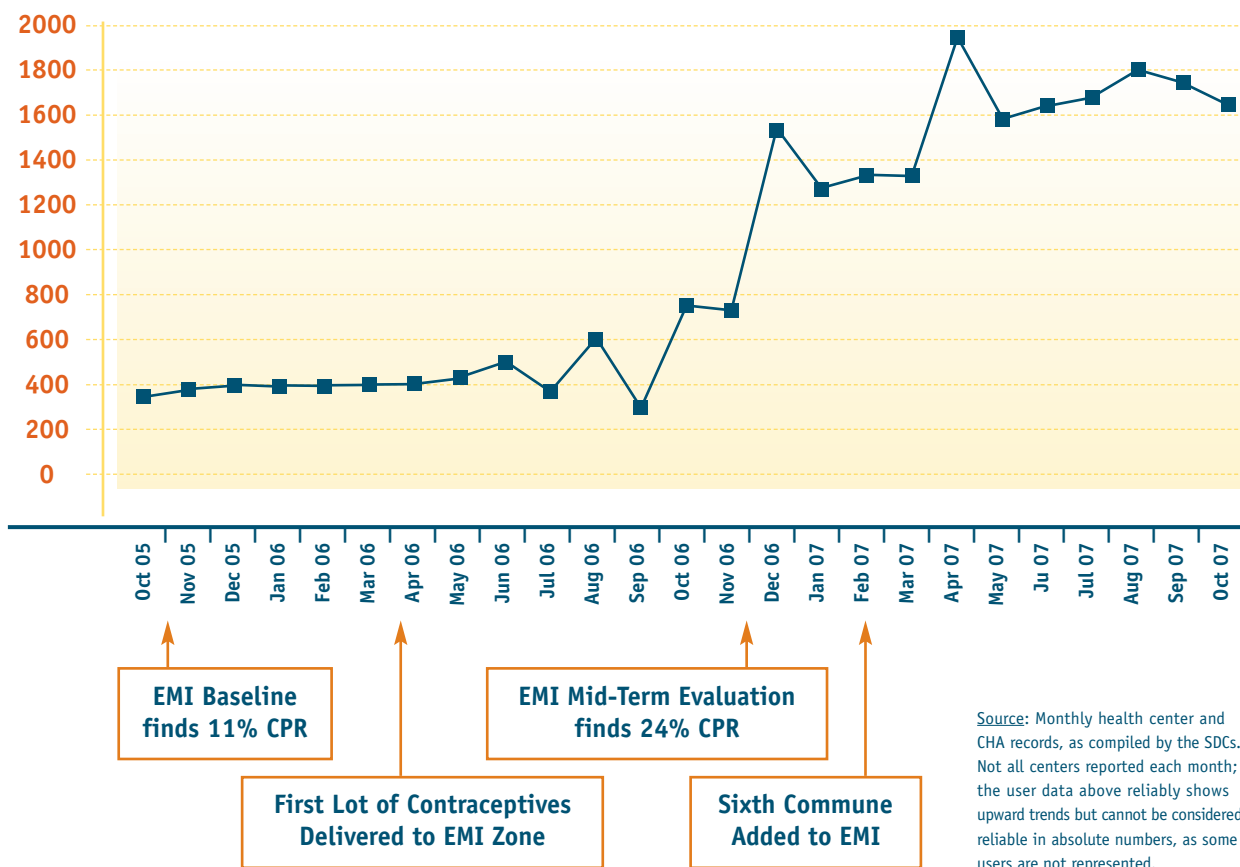
When the EMI began, the prevailing notion was that the topic of health (and thus family planning) “belonged” to the health center, and was only

nominally the business of local government. Over time, however, this view has shifted radically. In the words of Emmanuel Justin, mayor of Fotsialanana, “We can really define family planning as life planning. It is therefore the responsibility of all development actors, including us in the SDC and, in fact, right up to the nation.”

CONTRACEPTIVE PREVALENCE, WOMEN OF REPRODUCTIVE AGE (%)



REGULAR AND NEW USERS OF CONTRACEPTIVE METHODS



The Challenges

The remoteness of the six communes — the very reason for launching the EMI — was also the project’s greatest challenge.

Staffing and project logistics: CARE hired one field agent to work in each commune, where training and guiding all members of the project triad — community volunteers, health center staff and SDC members — required tremendous and consistent devotion of time, energy and planning skills. The field agents — five men and one woman — deeply respected Malagasy culture and traditions. They also felt a deep bond with rural people and adapted themselves to difficult working and living conditions. Fortunately, they also maintained a sense of humor: At monthly meetings, for instance, they enjoyed one-upping each other’s logistical woes.

Supplies and services: For health centers, ensuring a consistent supply of contraceptives also presented challenges. The doctor or nurse in charge of each center was required to travel regularly to district headquarters for meetings; for some, this meant up to a week’s absence. In its second year, the project trained select volunteers as senior CHAs to manage stock while health staff were away, and this resolved the problem of supply interruptions to clients.

Exclusion from sources of information and support: The EMI was among the first development projects to reach many of the participating communes. To succeed, it had to confront other challenges residents faced because of their isolation. For one, communities had far fewer sources of information about family planning than their more urban counterparts, and this meant that misinformation and rumors thrived. And without guidance, training or support, local

“... (A)t the fourth river we stopped in horror. A little kid pointed out the crossing but said that no one had dared try it since the rains began. In we went, but the current was too strong. We were up to our necks. What to do? If we went back, we’d have to cross those other three rivers again. But going forward was terrifying. In the end, Christophe decided to cross alone. “Mac,” he said, “if I get swept away, go back to the last village for help.”

*Mac Samuel
Field Agent in Antsiatsiaka Commune*

structures such as SDCs were largely non-functioning. Furthermore, while health staff reported up the Ministry of Health chain of command, they had little wherewithal to reach out to communities and local leaders.

Yet the project area's remoteness did serve the EMI well in one fundamental way: The communes were eager to participate in a development project, to learn new things and to take action to improve their well being. In roadless Ambahoabe commune, for example, the SDC organized residents of the commune seat to smooth out nearly five miles of trail so that field agent Sebastian Boutobé could reach them by motorcycle, rather than on foot. Today, Sebastian laughs as he recalls how his motorcycle was the first ever seen in town. "It made such an impression," he says, "that some people named their babies Sebastian in honor of the event."

What CARE Has Learned

The triad of project responsibility was crucial to success, perhaps especially so in remote areas:

Embedding the EMI in three entities — the health system, the community (via volunteers) and the SDC — provided a sturdy and integrated foundation. While the EMI guided activities and devoted substantial effort to building capacity within each part of the triad, CARE itself was not responsible for making decisions, hammering out negotiations or clarifying responsibilities. Those vital activities were carried out largely by members of the SDC. Now that the members of each commune's triad have a clear understanding of one another's roles and responsibilities, and two years' experience jointly planning and implementing all manner of activities related to family planning and health, they are poised to continue this work after the EMI formally ends. Remi Sonina, an SDC member in Fotsialanana, speaks of his committee's spirit of unity and purpose: "I really think we've found a way to make sure family planning continues, what with all the actors we have involved," he says, "from the village chiefs to all the [volunteers], the health staff, the commune leaders. We have the will and the skills to keep this thing going."

The principles of good governance^{vi} created space for dialogue and collaboration where none previously existed:

As trust and communication grew within each triad, they also grew in the communities they serve. Remi Sonina notes that in the beginning, "The people in the communities were afraid of the doctor. They thought he was of a better status and would not respect them."

"Now the problem is solved," he says. "People see the doctor as a civil servant who is interested in their well being."

In Ambahoabe, Dr. Florentine Baozoma speculates on what her health outreach work would be without the collaboration of the SDC. "In everything I do, every activity, I ask their advice and their support," she says.

“They do contribute materially ... but they also play a great role in awareness-raising. They can help change people’s attitudes; they hold the key to communities.” Deputy Mayor Robert Bezafy concurs. “Before the EMI, we did communicate, but now the collaboration is much better,” he says. “We can’t leave [the work] only to the doctor and the CHAs. We must support them. We meet before every set of activities to define roles and responsibilities, and this holds for all health matters, not only family planning.”

In the same commune, CHA Eliette Razafy reflects on the interdependency of the players. “We can’t do anything without the support of Dr. Florentine,” she says. “But without CHAs, there would have been no increase in the number of women who use family planning. The doctor simply does not have the time to travel around and do all the education that we do. She could only wait in the health center with her contraceptives.”

Senior CHAs headed a strong, diverse network of volunteers: At the beginning of the EMI’s second year, the senior CHA position was introduced to overcome gaps in contraceptive supply caused by health staff’s frequent absence. The most capable CHAs received training in supply logistics and in leadership skills. Now the senior CHAs can calculate need, order contraceptives, organize their distribution to other CHAs, and supply some types of contraceptives^{vii} directly to clients who typically seek re-supply at the health centers. Already trusted by women and men in the community, by health workers and by other volunteers, the senior CHAs are true leaders whose drive to make contraceptives available is apparent in deed and word.

“I have seven children,” says Augustine Rasoazamamy, senior CHA in Fotsialanana, “and it was so hard to raise that many. It was really a motivating factor for me.” In Ambahoabe, Eliette Razafy describes her passion for

“Behavior change in terms of family planning is really palpable here.

People really understand the need and advantages. As village president, I feel responsible for development here, and a priority for development is the good health of the community. Family planning isn’t only a health issue but a social issue in the development of a village.”

*Clovis Raphandra
Village President, Befotaka*

the work. “Women who practice family planning — you can see them change. They put flesh back on their bones, they can afford decent clothes. You see them grow younger right before your eyes.”

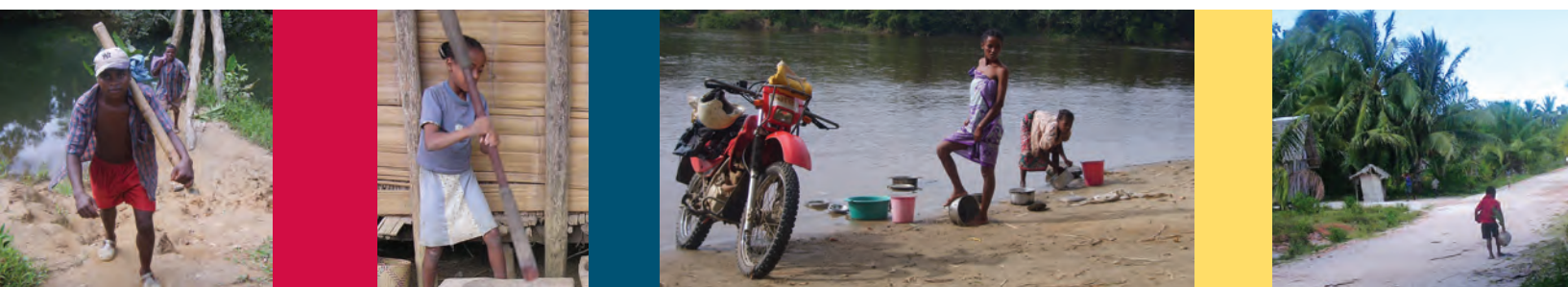
EMI has contributed to rising health factors (not only family planning knowledge and use):

The EMI concentrated on family planning but also invited each SDC to consider other health priorities when developing commune-level health strategies and action plans. In most cases, SDCs chose to prioritize and track the promotion of perinatal care, child vaccinations, Vitamin A provision and AIDS-prevention education, among others. In addition, the three parts of the triad have increasingly joined forces to plan and implement all manner of health outreach activities. And, even as knowledge and behavior is changing on a variety of health topics, CARE has seen the very meaning of health take on a new dimension in the communes. “Before, people assumed that good health was the result of economic development,” says field agent Sebastian Boutobé. “Now, it’s clear to them that good health can drive development.”

Next Steps and Future Opportunities

The leap in the contraceptive prevalence rate by the project’s midterm reflected the tremendous need for family planning in the project zone. And even as CARE anticipates measuring another important rise during the project’s final evaluation, it seems clear that unmet need remains a significant issue in the EMI zone. Among women not using contraception by the project’s midterm, a full 74 percent wanted to wait two or more years before becoming pregnant, and 12 percent had as many children as they wanted. What factors, other than lack of knowledge or services (assuming that the EMI has made these available to most men and women in the project zone), might be preventing women who want to use family planning from doing so? Jaime Stewart of CARE’s Sexual and Reproductive Health Team in Atlanta puts the question another way: “If the EMI project were to continue with the same activities, at what point would the contraceptive prevalence rate reach a plateau?” That is, when would the EMI cease to drive change in family-planning behavior in spite of unmet need, without addressing more complex issues around non-use of contraceptives? Below are three areas of opportunity for future family-planning work in remote Madagascar:

Challenging gender and power norms: CARE field agent Evance Raelinoro notes that the traditional Malagasy blessing for a newlywed couple is, “May you have seven sons and seven daughters.” And if a man



wants to have 10 children, the woman must agree. “Women don’t have rights in the decision,” Raelinoro explains. Meanwhile, at the health center in Ambahoabe, Dr. Florentine Baozoma observes, “We must involve men more, or we won’t meet our objectives. In fact, we must involve them in health generally, and not let them leave the matter in the hands of their wives. Their health, and that of their children and family, is also men’s responsibility.”

That said, she adds, “I do think that a fear of losing power, of changing the power balance between men and women, plays a role in men’s resistance to family planning.” Addressing gender norms and challenging the social status quo will be a fruitful angle for future family-planning work.

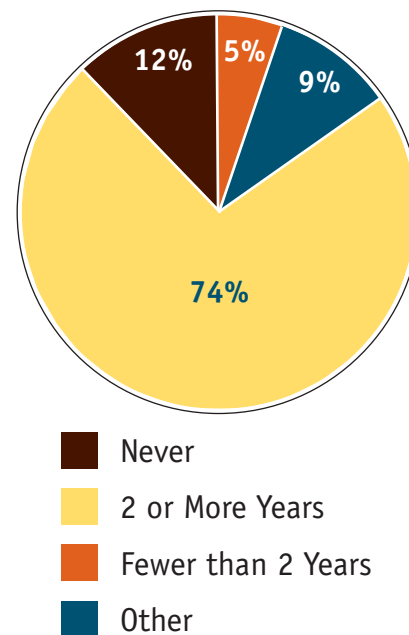
Reaching the younger sector of the population:

The final evaluation will provide numerical information on the age distribution of family planning users; in the meantime, observation indicates that older women – especially those who want no more children – may make up a disproportionately large group of users. Yet, as the mid-term study clearly showed, a substantial proportion of non-users wish to delay their next pregnancy. Additional and long-term investment is needed to help women and men of all ages, especially younger couples, to achieve their fertility intentions including the timing and spacing of births, as well as family size.

Meeting needs for long-acting methods: By the same token, women and couples who want no more pregnancies deserve access to long-term methods of contraception including the IUD, tubal ligation and vasectomy, but these are not at present available in the limited health centers of remote communes. The EMI project helped the SDC of Fotsialanana – the most accessible of the six participating communes – forge a partnership with Marie Stopes International, which has traveled once to the commune seat with its surgical equipment and generators to offer IUDs and surgical sterilization. Greater access to long-term methods is a third arena in which the future family-planning work of CARE and others can make a significant, lasting difference in the lives of rural women and men.

UNMET NEED FOR FAMILY PLANNING: DESIRE FOR NEXT PREGNANCY AMONG WOMEN NOT USING A CONTRACEPTIVE METHOD

Source: EMI Mid-Term Evaluation, n=277



ⁱ Plan d'Action Madagascar 2012 (2007), italics added; www.madagascar-presidency.gov.mg/index.php/item/445

ⁱⁱ A unit of government below region and district; Madagascar is home to some 1,500 communes.

ⁱⁱⁱ Among women currently in union; Madagascar: DHS 2003/2004

^{iv} See www.acquireproject.org for more information.

^v In both baseline and midterm evaluations, interviews were completed with 416 households. In 2005, 638 men and women of reproductive age were surveyed and in 2006 the total surveyed was 817.

^{vi} For CARE in Madagascar, these include participation, accountability, transparent communication and action; moreover, good governance requires that structures such as the SDC allow and even demand these principles while working from a common foundation of rights and responsibilities.

^{vii} At present, no CHA can administer injectables, although the district and commune health system is discussing the possibility of training some senior CHAs to do so.



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