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VOICES from the VILLAGE:

**Health Improvement and
Women-Owned Transformation (HIWOT)**

**A CARE Family Planning Project
in Ethiopia (Phase III)**



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Introduction

With more than 3,000 years of history, Ethiopia is uniquely situated at the crossroads between the Middle East and Africa. Having maintained independence, even during the colonial period, Ethiopia is culturally, linguistically, and environmentally rich and unique. However, after decades of ongoing political upheaval and social unrest, Ethiopia today is mostly dry and barren, lacking sufficient sources of water and unable to produce enough food for its nearly 80 million inhabitants, most of whom live in extreme poverty.

In this environment of scarce resources, family planning is a critical need. The rate of contraceptive prevalence in Ethiopia was 14 percent in 2005 — a significant increase from only 6 percent in 2000, but still one of the lowest rates in Africa.¹ This is one of the main reasons why the country's fertility rate is estimated at 5.4 children per family.²

Reaching people with family planning messages and services is an extremely challenging endeavor in Ethiopia. Eighty-five percent of the population lives in rural areas, and more than half is illiterate.³ The family planning services that are available are often limited by frequent stock-outs of contraceptive commodities, poorly functioning logistic management systems and insufficient numbers of skilled service providers. Moreover, women and girls in Ethiopia are usually limited in their mobility, ownership of resources and access to education — all of which factor into their health. Despite these challenges, the country's economic hardships are helping to make Ethiopians much more agreeable to messages promoting family planning, particularly messages that extol the financial benefits of having smaller families.

For more than 10 years, CARE has been partnering with the government of Ethiopia to improve awareness of and access to quality reproductive health services in rural communities through the Family Planning and HIV/AIDS Prevention Program, funded by the Royal Netherlands Embassy. The first phase of the program began in four zones of the country's Oromiya Region in 1996. In this phase, program staff worked to raise demand for modern family planning methods by building the capacity of volunteers to promote, provide and advocate for short-term contraceptive



methods, and to address HIV prevention. The second phase shifted toward an increased emphasis on community participation, social mapping, male involvement and improved health service quality. Building on successes and lessons learned from these first two phases, the program's third phase (February 2006–June 2009) expanded to the neighboring Afar and Dire Dawa regions, increasing the original target population by a factor of 10. This final phase focused on promoting long-term contraceptive methods and increasing the ability of government staff to provide these clinical services. Also in this last phase, the program addressed underlying causes of poverty (e.g., large family size, scarcity of land and resources) through a women's empowerment framework by implementing livelihood-focused initiatives, such as savings groups and adult literacy classes for women, within the projects family planning and HIV/AIDS prevention objectives.

Project Description

The third phase of the Family Planning and HIV/AIDS Prevention Program was known as Health Improvement and Women-Owned Transformation (HIWOT), which translates as “life” in English. The project was implemented in five zones, which include 19 *woredas* and 291 *kebeles*.⁴ Overall, the HIWOT project aimed to create a better life for communities through the empowerment of women. To do this, the project promoted women's rights and participation within its family planning, HIV/AIDS prevention, and credit and saving interventions.



The program complemented the government of Ethiopia's Health Extension Package, which trains and deploys young women and men as *kebele*-level health extension workers (HEWs). CARE supported facilitators to work with HEWs and community volunteers. The facilitators provided them with guidance and on-the-job training around youth interventions, reproductive health promotion, community participation in improving health-service quality, actively involving men in reproductive health, and outreach for persons living with HIV/AIDS and other marginalized groups. These activities also built on “community conversations,” an interactive platform developed by the United Nations Development Programme and initiated in Ethiopia in 2002. Community conversations were designed to help communities explore the underlying factors fueling the HIV/AIDS epidemic in their environment. These activities were complemented by the introduction of long-term contraceptive methods and by strengthening links between community volunteers and health service providers.

To reach the most remote program areas and earn community members' trust around sensitive reproductive health issues, CARE developed a phased approach for community mobilization. CARE facilitators (men and women) who

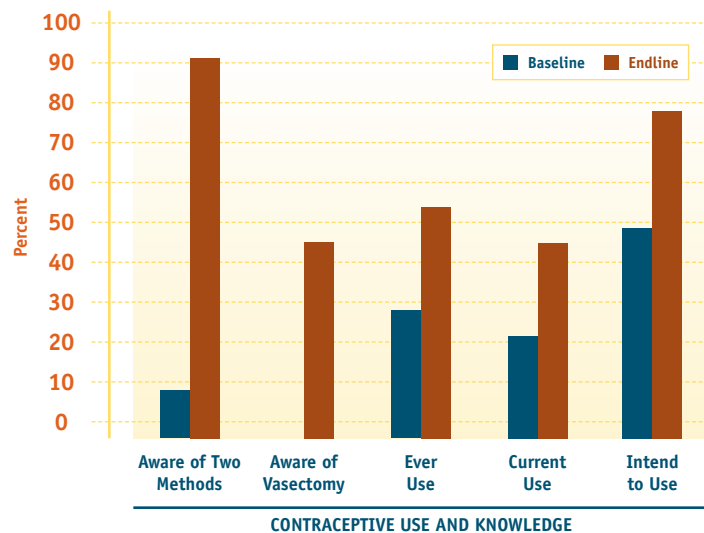
spoke the local language moved into communities for six months, often living in a tent. Together with community stakeholders, the facilitators worked to raise awareness about sexual and reproductive health and help community groups play an active role in managing their own health-related issues. The facilitators not only built relationships with community members, they also developed strong linkages and trust between HEWs, community-based reproductive health volunteers (usually two in each community), formal and informal community leaders, other volunteers and youth peer educators.

Key Results

Increased family planning awareness and use

The HIWOT project documented a significant increase in awareness of and increased access to reproductive health services through community-based distribution and health-center strengthening. In addition, targeted community outreach through identification of couples eligible for family planning and marginalized groups also led to significant increases in contraceptive use. The graph to the right illustrates changes in family planning behaviors from project baseline to endline. The baseline survey was conducted in May 2007 and involved 1,427 households.

CHANGES IN FAMILY PLANNING BEHAVIORS AND CONTRACEPTIVE USE FROM BASELINE TO ENDLINE IN ETHIOPIA



The endline survey was conducted in October 2009 and involved 1,320 households.⁵ Given the short time between surveys, the data suggest a remarkable increase in both contraceptive awareness and use.

Family planning no longer taboo

“With some of us having nine and 10 children, obviously we did not talk openly. We had no information, how could we talk? The topic was not there to talk about.”

LOCAL WOMAN WHO RECENTLY HAD TUBAL LIGATION



As a result of HIWOT interventions, family planning became less of a taboo topic of conversation at home and in public. The data indicate there was a considerable increase in the number of women openly accessing reproductive health services as well as an increase in household communication about these services.⁵⁵ Family planning has become part of the public discussion and elders, recognizing the economic pressures facing their children, actively encourage its use. Community members, particularly women, are now exercising power over their reproductive lives.

The social changes documented in project areas are a result of HIWOT's commitment to working with communities in a meaningful way over a long period of time. According to Dr. Theo Pas of the Royal Netherlands Embassy, "Working with local communities is often more effective than just working at the policy level. In order to reach millions of people, you have to start with one. By investing in social change, a critical mass develops that eventually creates a wave that will wash over the country."

Lessons Learned

Comprehensive approach to reproductive health

During the 10-year program, CARE learned to make its family planning interventions more effective by refining community mobilization strategies, linking more effectively with health services, strengthening and expanding essential reproductive health services, and increasingly involving elders, community leaders and other men in reproductive health initiatives. These efforts allowed the project to significantly scale up community interventions.

As time went on, program staff also recognized the importance of a more comprehensive approach – creating social change in order to support sustainable change in reproductive health choices and behaviors. The HIWOT midterm evaluation found that the project had been effective in building on community conversations as a platform for reflection and review of personal attitudes and practices around reproductive health. As individual attitudes and societal norms around family planning use began to shift, both men and women felt more able to seek family planning services. By articulating women's empowerment as a project objective, by promoting women's rights to services and not just providing information, and by offering opportunities to participate in savings and credit programs as part of the intervention, HIWOT expanded opportunities for women and other marginalized people to have a greater voice in their community.

“Having empowerment as an objective, we can look at health in a social environment, recognizing the multiple sectors that affect health outcomes. In addition, having space with the donor makes it possible to be flexible, which is a good development.”

DR. BARBARA POSE, CARE SRH PROGRAM COORDINATOR

Community participation in reproductive health

The strategies for community participation described in this section were key to project success. The project was able to implement them at scale through the mobilization of local volunteers and health service partners, who eventually took the lead in their respective communities.

COMMUNITY CONVERSATIONS

“People are critical of us because women are in our community conversation group, but I tell them women are a part of our flesh.”

COMMUNITY MEMBER, CHULUL KEBELE



HIWOT adopted the community conversations approach in 2006. As mentioned earlier, this is an interactive process designed to help communities to explore underlying factors fueling the HIV/AIDS epidemic in their environment. This process is based on the idea that people have the capacity, knowledge and resources to transform individually and collectively once they articulate, confront and “own” a particular social issue affecting their lives. Community conversation groups — participants include community leaders, men, women and members of other marginalized groups — discuss a variety of topics, ranging from family planning and HIV/AIDS to harmful cultural practices, such as female genital cutting (FGC) or early marriage. Facilitated by a local representative, the conversations follow a cycle that includes identifying key issues, implementing actions and monitoring change. Community conversations have also led to the formation of credit and savings groups, which reinforce participation by women and have become a venue for family planning discussions.

The HIWOT midterm evaluation indicated that in general, women felt more comfortable participating in public meetings. Another important aspect of public discussions is that they led to increased community knowledge about women’s human rights.

“Previously, I was poor and reluctant to participate in any groups. I felt like I was not human – voiceless. Now, I am able to communicate and I can teach my children about family planning and HIV/AIDS.”

WIDOW WITH SIX CHILDREN AND A MEMBER OF COMMUNITY CONVERSATION GROUP

COMMUNITY LEADERS AND INDIVIDUAL CHAMPIONS

CARE’s approach recognizes individuals and community groups as agents of change, not just targets of change. CARE also recognizes that social change is cultivated through holistic, multi-sectoral and locally significant strategies. To promote acceptance of family planning, the HIWOT project mobilized a variety of formal and informal community groups and leaders to discuss reproductive health issues and social issues more broadly.



For example, even in areas where FGC is practiced and girls often have to drop out of school early, young people can become spokespersons for change. In one village, for example, two young men refused to marry their future wives unless the women’s parents promised not to subject them to FGC. A local community volunteer met with the family and assured them that their decision to reject the practice would be beneficial to the young women and would be supported by the community.

The couples are married now. The women use long-acting family planning methods and continue to attend school. The couples speak to groups in neighboring villages and act as role models to their peers. They discourage harmful traditional practices (FGC, early marriage and even early pregnancy) and encourage the use of family planning, even if only to delay a first child, allowing couples – especially the wives – to achieve their educational goals and maintain good health.



Who Feeds the Birds?

Ato Mohammed has been a prisoner twice under different political regimes in Ethiopia. He lost his daughter to AIDS and now raises his orphaned grandchildren. Despite these hardships, he decided to take on the responsibility of being a community-based reproductive health volunteer.



“I got interested in family planning because of the day-to-day problems and the suffering of women and children in my area,” Mr. Mohammed says. Prior to the HIWOT project, it was common for people in his community to respond to questions related to family size with, “Who feeds the birds?” It is a rhetorical question meaning that God takes care of the birds, no matter how many there are. People relied on this philosophy instead of using family planning methods.

When Mr. Mohammed was chosen to be a volunteer at the start of the project, only 15 people in his village used family planning methods. Now he has more than 100 clients for pills and condoms, and 40 of his clients are using long-term methods (both Norplant and Depo-provera). He takes advantage of government-sponsored health campaigns to mobilize the community to discuss family planning. He travels door-to-door meeting with husbands and wives to discuss family planning, HIV/AIDS and other reproductive health issues. He says the HIWOT project introduced him to the concept of coordination and collaboration.

“When I was young,” Mr. Mohammed says, “if you raised the issue of family planning publicly, you would be killed.” Now there are open discussions between men and women during community conversations, where Mr. Mohammed answers questions about reproductive health and, when necessary, refers questions to experts. He now works as part of a team with other local community volunteers, a program facilitator and two health extension workers (HEWs).

“I do this work because of my humanity,” Mr. Mohammed says. “Whether I am paid or not, it does not matter. I should help because I am part of our society.”

Partnership with health providers

The HIWOT project provided training in supportive supervision for HEWs and built their capacity to serve the community, using tools such as EngenderHealth’s Client Oriented Provider Efficient Performance (COPE®) to improve the quality of service delivery in clinical settings. CARE has also supported the training of local health service providers in long-term contraceptive methods, helping to ensure that communities have a wider range of choices for family planning.



By building alliances and partnerships with government workers, skills are transferred and effective programming approaches can be scaled up. To ensure high-quality service delivery, institutional linkages are strengthened through collaboration and networking among formal and informal institutions and groups.

Taking a model to scale

Several factors helped the program increase its reach from an original target population of 264,000 to 2,073,815 by the third phase:

- The phased approach allowed for intensive facilitator input in order to develop trust among community members, mobilize their participation and encourage among them a sense of up-front ownership. This approach led to less need for continued maintenance and support. As a result, facilitators were able to move on to new communities more easily.
- A balanced package of interventions, which addressed community access, linking with health services and addressing social and cultural factors around fertility, led to a change in “family planning culture.” As this shift gained momentum, it became easier to achieve change on a large scale, and that change is more likely to be sustainable as long as the necessary services are in place.
- The program effectively engaged partners, including government, CARE projects in other sectors, community-based organizations and other like-minded organizations (e.g., EngenderHealth, Family Guidance Association of Ethiopia). This led to a broader reach for both community and technical interventions.
- The HIWOT project was uniquely poised to support the government of Ethiopia as it implemented its community health strategy. CARE worked with the government on a large scale to increase community access to reproductive health dialogue, information and services by supporting construction of health posts where HEWs were assigned, and by training and linking newly deployed HEWs with community-based reproductive health volunteers who the project had previously trained.

Again, according to Dr. Theo Pas, “The program’s success is due to working closely with a government that knows what it wants and is going for it.”

Challenges

Relying on volunteers

Although it is generally recognized that working at the community level is a sustainable approach, relying on community volunteers was a challenge. Specifically, it was difficult to ensure volunteers' long-term commitment, because they frequently expressed the need for financial support and continued training. The lack of an operational framework to link government HEWs with community-based services and volunteers remains an issue. Further exploration and support is needed to effectively utilize the potential within the community, where the ultimate accountability for community members' own health lies.

Opportunities

Despite the end of funding from the Royal Netherlands Embassy, this program has several opportunities for enhanced implementation.

- As part of CARE's organizational focus on integrated programming, family planning and reproductive health interventions are currently being implemented through two community-level projects that address food security.
- Reproductive health efforts continue to build on collaboration with the government, and to influence government approaches to addressing social factors impacting fertility and reproductive health. This includes continued support for HEWs as the essential link between community activities and health services, and expanded development of the community conversation approach to issues other than HIV/AIDS.
- CARE's Ethiopia country office is continuing to refine strategies and indicators for achieving and measuring social change as it relates to reproductive health.
- CARE's experience in community-based approaches in different contexts (e.g., pastoralist, agro-pastoralist, agrarian/sedentary) has enriched the organization's knowledge base in terms of how communities understand SRH issues. Drawing on this learning, CARE continues to adjust its community approaches by taking different contexts into account, yet always working closely with community members as an intervention's primary owners and source of support.

¹ Ethiopia Demographic and Health Survey 2005, MEASURE Macro.

² *Ibid.*

³ *Ibid.*

⁴ In Ethiopia, a zone is the largest division within a region. A *woreda* is equivalent to a district. A *kebele* is the country's smallest administrative unit, typically including approximately 5,000 people living in 1,000 households.

⁵ CARE Ethiopia HIWOT endline evaluation, October, 2009.

⁶ CARE Ethiopia HIWOT Mid-Term Evaluation, January, 2008.

Written by: Nancy Russell and Marcie Rubardt

Edited by: Anthony Jaffe

Design by: Jason Abbott

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For more information:

Luis Ortiz Echevarria

Communications & Knowledge Manager

Sexual and Reproductive Health

Tel. 404-979-9259

Fax 404-589-2624

lortiz@care.org

CARE

151 Ellis Street

Atlanta, GA 30303

1-800-681-2552

reprohealth@care.org

www.care.org/reprohealth

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