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esd REACHING FURTHER extending service delivery

Since 2005, ESD has emphasized activities to change community norms in support of healthy adolescent behaviors.

The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Reaching Underserved Youth with Reproductive Health and Family Planning Services

The global youth community is vast and varied. Nearly half of the world's population, some three billion people, is under the age of 25, and in many developing countries youth aged 10 to 24 make up nearly one-third of the population. This "youth bulge" is far from homogenous: it is comprised of young men and women, in-school and out-of-school, working and unemployed, married and unmarried, sexually active or still abstinent, with children or still children themselves. In short, it is extremely important to recognize the diversity of need and experience of this age group when developing reproductive and sexual health programs and services.

There are several and persisting commonalities, however, among the adolescent community, especially in low to middle income countries:

- Their unmet need for family planning to delay or space pregnancies is high; [1]
- Their use of modern contraceptive methods remains low in many countries; and [2]
- Complications from pregnancy are the leading cause of death for young women. [3]

It is widely held truism that the youth of today are the leaders of tomorrow, and the investments made in youth will benefit them—and society—in the future. Yet today's investments in adolescent health are often limited. This is especially true with respect to reproductive health; programs seeking to increase the use of family planning and improve maternal health can lay a foundation for healthier attitudes and behaviors among this age group, which can, in turn, accelerate the use of family planning and improve the health of women and children.

Without a doubt, programs that seek to address the reproductive and sexual health of adolescents have faced many challenges and roadblocks. Despite the sheer number of adolescents and their evident need, reproductive health and family planning programs for young people have remained limited in scope and young people are among the least prioritized in health and development efforts. If we are to reverse these persistent trends of low rates of contraceptive use and high rates of pregnancy related morbidity and mortality among adolescents, and other health concerns such as HIV/AIDS, young people must be provided with the knowledge, skills and services to adopt healthy reproductive behaviors; health systems must be strengthened and made more responsive to the needs of youth; communities must be engaged in support of these changes, and; health programs must include healthy timing and spacing of pregnancy (HTSP) [4] for adolescent women and their children. These changes will inevitably lead more young people to use family planning, delay their first pregnancy to age 18 and better space subsequent pregnancies.

[1] John A. Ross and William L Winfrey, "Unmet Need for Contraception in the Development World and Former Soviet Union: An Updated Estimate," International Family Planning Perspectives 28, no.3, 2002.

[2] National Research Council and Institute of Medicine, Lloyd CB, ed. "Growing Up Global: the Changing Transitions to Adulthood in Developing Countries," Washington, DC, National Academies Press, 2005.

[3] UNFPA, *State of the World Population,* 2004; http://www.unfpa.org/swp/2004/english/ch9/pages5.htm; accessed 5/24/10

[4] World Health Organization, "Report of a WHO Technical Consultation on Birth Spacing," 2006; http://www.who.int/making_pregnancy_safer/publications/policy_brief_birthspacing.pdf, retrieved 5/24/10.

"We cannot always build the future for our youth, but we can build our youth for the future."

-Franklin D. Roosevelt

The Extending Service Delivery Project

As part of the Extending Service Delivery (ESD) Project's efforts to reach vulnerable, at-risk and underserved groups with reproductive health and family planning, youth are a key cross-cutting priority population. In addition to providing information on family planning and HTSP to young people and building the skills of health and social service providers, ESD has emphasized activities to change community norms in support of healthy adolescent behaviors.

ESD developed and implemented two models to address the health and well-being of youth in Nigeria and Yemen.

- ***In Nigeria,*** ESD worked with the Federation of Muslim Women Association of Nigeria (FOMWAN) in Kano State to help young married women delay first pregnancy and space subsequent pregnancies by at least two years.
- ***In Yemen,*** ESD worked in the governorate of Amran with the Yemeni Women Union (YWU) to encourage communities to delay marriage for girls until age 18 by promoting the education of young girls and teaching families about the harmful effects of child marriage.

YOUNG MARRIED WOMEN IN NIGERIA

One of the major factors contributing to poor reproductive health outcomes in Nigeria is the persistence of early marriage, which leads to early pregnancy. In the North West region of Nigeria, 73 percent of girls aged 15 to 19 are married. Young married women are often pressured by their mothers-in-law and families to become pregnant right away, despite evidence that early pregnancy may result in death or disability for the mother or the baby. Pregnancy is the leading cause of death for young women aged 15 to 19. Adolescents aged 15 to 19 are twice as likely to die during pregnancy and childbirth as those over 20, and girls under age 15 are five times as likely to die. [5] Adolescents are also more likely to suffer from pregnancy-related complications, such as pre-eclampsia and obstructed labor, which may result in fistula, and are more likely to deliver prematurely or to deliver low birth weight babies. Babies born to adolescents are more likely to die than children born to mothers in their 20s and 30s. [6]

In Northern Nigeria, modern contraceptive use is extremely low; only 3 percent of married women in the North East Region and 3.3 percent in North West Region report use of a modern contraceptive method. The acceptance and use of family planning are constrained by multiple cultural norms and traditions, especially the desire for many children. Some providers report that young married women are increasingly receptive to family planning for healthy child spacing, yet evidence suggests that access to family planning information and services still remains limited.

Healthcare providers are likely to come into regular contact with young married women during antenatal, postpartum and well-baby care services, and are well-positioned to help young women understand the health benefits of family planning and spacing, but many providers still have limited understanding of family planning and how it can contribute to the health of women and babies. They may also hold negative attitudes towards family planning, or have unfounded concerns about the appropriateness of certain methods for adolescents, which affects the information and education they provide to their clients. Even when a provider discusses child spacing and family planning with a young client, the client is not often free to make decisions about family planning, and must obtain the approval of her mother-in-law and husband. Husbands may even defer this decision about family planning and child spacing to their local imam.

To address those household and community norms that limit young women's access to information and services, and their ability to time and space their pregnancies for healthier outcomes, ESD partnered with the Federation of Muslim Women Association of Nigeria (FOMWAN), a Nigerian NGO that aims to empower women and improve the socio-economic

[5] UNFPA, *State of the World Population*, 2004; http://www.unfpa.org/swp/2004/english/ch9/page5.htm; accessed 3/4/08.
[6] Phipps MG et al, "Young maternal age associated with increased risk of neonatal death," Obstetrics and Gynecology, 2002: 100:481-486.

status of women, youth and children through training, education, health and humanitarian services, micro-enterprise and advocacy. FOMWAN educates women at the household and community level (especially in community schools, also known as Islamiyya schools) about health and was easily able to integrate information about healthy timing and spacing of pregnancy (HTSP) and family planning into the education of young married women, and importantly, their mothers-in-law. To date, FOMWAN has reached over 5,000 women across the five of the 44 local government areas (LGAs) of Kano State. [7]

Since husbands are also influential in a young wife's decision about family planning, FOMWAN worked with Islamic institutions in Kano, including the Council of Ulama [8] to educate local imams about the benefits of HTSP for women, children, families and communities. A workshop for 30 imams was held in February 2009 to highlight the high rates of maternal and child morbidity and mortality related to early and closely spaced pregnancies. The religious leaders favored HTSP's emphasis on healthy fertility as compared to limited fertility, which has been less well-received by some in this conservative region, and recognized that HTSP's recommendation to wait two years after giving birth before becoming pregnant again was congruent with the Qu'ran's encouragement of two years of breastfeeding.

Following the workshop, the imams began educating their followers from the mosque and in the community; based on the community's favorable reception and the obvious value in educating and improving the lives of their followers, other imams began to demand similar training. As of 2010, the 30 imams have gone on to train over 1,000 religious leaders with their own resources, and HTSP promotion efforts have spread from the original five LGAs to all 44 LGAs in Kano—and in some cases beyond Nigeria—as several imams support madrasas in Senegal and Niger. As a result of the training, imams report that they are educating and counseling their followers and disseminating information on reproductive health, family planning and HTSP in Friday prayers. Several imams also commented that their wives have begun speaking to women in the community about the health and social benefits of family planning and spacing. Dr. Dikko, the consultant gynecologist at Murtala Muhammad Hospital in Kano commented, "we (see) high incidence of sepsis…mostly due to prolonged, obstructed labor, so advice and messages on age at first pregnancy and timing and spacing for the next pregnancy (are) especially critical."

Women being educated about HTSP by members of FOMWAN.

"I am seeing girls, husbands, wives also. The HTSP messages are being received and accepted...they also want to hear about traditional methods (of spacing)."

- The Imam of Bichi, Kano State

HELPING COMMUNITIES TO CONSIDER ALTERNATIVES TO CHILD MARRIAGE IN YEMEN

In much of the Arab world, the practice of child marriage is on the decline, but in Yemen this practice is deeply rooted. Forty-eight percent of women between the ages of 20 and 24 are married before the age of 18, and 14 percent are married before the age of 15 [9] and in some rural communities, girls as young as eight are married. Yemen is one of 20 "hot spot" countries

[7] A community survey was implemented in select LGAs in April 2010 with young married women to assess the effect of FOMWAN's community education. These results will be reported in a more comprehensive paper on the work in Nigeria later in 2010.

[8] Council of Ulama is a Muslim clerical body.

[9] *Early Marriage in Yemen: A Baseline Study to Combat Early Marriage in Hadramout and Hudaiedah Governorates*. Gender Development Research and Studies Centre, Sanaa University, 2005.

A community educator at work in Yemen, disseminating information about the negative consequences of child marriage.
Photo Courtesy: Dalia Al-Eryani

14 percent of Yemeni girls are married before age 15.

where child marriage is common, and the government has little or no ability to prevent this practice; in fact, the current law states a girl can be married whenever her guardian agrees, although the government is now discussing establishing the minimum age of marriage at 17.

Child marriage is widespread among all social classes: 57 percent of poor girls are married before age 18 and over one-third of girls from the wealthiest families are also married before 18 years of age , [10] and once girls are married they are expected to become pregnant. Nearly half of young married women have had at least one child by the age of 19, and on average, 8 percent of Yemeni women aged 15 to 19 give birth each year. [11] The high rates of early marriage and subsequent early childbearing means that these young women and their children are exposed to greater health risks than women who marry and give birth at a later age. Further, family planning use is lowest among young women (9.7 percent for women aged 15 to 19 compared to 20.8 percent of women 20 to 24) and young mothers tend to have short birth intervals (45.7 percent of women 15 to 19 had a birth interval of less than 18 months compared to 31.5 percent of women aged 20 to 24), which increases health risks for both mother and baby.

The trend towards early marriage is slowly changing in urban areas, where early marriage is slightly less common than in rural areas, but beliefs about the benefits and acceptability of early marriage persist among families and communities, including the belief that Islam supports early marriage. At puberty, girls are considered to be adult, and ready for marriage and childbearing. In fact, it is not uncommon to see "trade marriages" take place; in this situation, men agree between themselves to trade sisters with each other for marriage, even if one of the sisters is very young. It is commonly believed that girls who are not married at an early age will be exposed to moral and sexual "depravity" or become a spinster, which will dishonor the family.

The effort to raise the age of marriage to 17 is part of a national campaign to reduce maternal and neonatal mortality in Yemen. The government has outlined a national plan to eliminate child marriage and promote girls' education, which is well-known to be a protective

[10] "Yemen: Early Marriage A Challenge to Development." Humanitarian News and Analysis (IRIN) March 26, 2006.
[11] This is one of the highest rates of early childbearing in the Western Asia region, where on average five percent of young women 15 – 19 give birth. [12] UNICEF 2007. Early Marriage: Child Spouses. Innocenti Digest No. 7, 11.

factor: research shows that on average, women with seven or more years of education marry four years later and have 2.2 fewer children than those with little or no education. [12] ESD, through the Basic Health Services (BHS) project, implemented a model program in two districts of Amran governorate in collaboration with the Yemeni Women Union (YWU) in support of the national strategy. The program was designed to engage the community to analyze the cultural rationale for early marriage and discuss the health and social implications for girls and their families, and to build community capacity to make changes.

The YWU has trained 40 community educators (20 men and 20 women) who strongly believe in the value of delaying marriage. Their personal commitment enables them to effectively educate and advocate with parents and community members about the benefits of delaying marriage and keeping girls in school. Community educators conducted four participatory education sessions per month through including story-telling, dramas, debates, and sermons. Ten Safe Age of Marriage open days or health fairs were organized at the village level, which included a movie followed by a discussion, a religious lecture, a knowledge competition and health services provided by a mobile clinic. The community educators sponsored plays and magazine competitions in the local schools. Print materials were developed for distribution, and messages about the benefits of girls' education were broadcast on the local radio. Finally, ten "model families" who decided not to marry their young daughters and allowed them to complete their education were recognized and celebrated in the community by the project. Preliminary findings from an endline survey completed in May 2010 found that 53 girl child and 29 boy-child marriages were averted and 101 girls and 56 boys were returned to school, based on project efforts. This program is described in more detail in ESD's companion legacy paper: *Safe Age of Marriage in Yemen: Fostering Changes in Social Norms*.

OTHER ESD YOUTH-FOCUSED ACTIVITIES

In the Nairobi and Central Provinces of Kenya ESD collaborated with Pathfinder International and the Ministry of Health to develop job aids as part of a Pathfinder-led initiative to implement models of youth friendly postabortion care. Job aids laid out recommendations for communication with and counseling of adolescent clients, options for pain management, and explicitly reminded providers to discuss family planning and HTSP with adolescent clients following an abortion or miscarriage. The job aids were piloted in three health centers and providers reported that they found them very useful for counseling youth and providing them with quality care.

In the refugee camp of Kakuma in the Turkana District of Kenya, ESD piloted the Healthy Images of Manhood (HIM) program for over 160 youth-serving organization staff and adolescent men living in the camp. The HIM program provided information about reproductive health, family planning and gender equitable behaviors as part of efforts to address high rates of gender-based violence (GBV) and to better involve men in promoting healthy behaviors in the camp. Participants used the training to facilitate community discussions around GBV and gender roles and to promote greater gender equity, healthy reproductive health behaviors and prevention of GBV. One participant observed that the HIM training "inject(ed) life" into the existing camp activities around GBV.

In Yemen, the BHS project is also working with the University of Sana'a to establish a Youth Center and peer education program at the university. The University of Sana'a has over 60,000 registered students, and 30 students have now been trained on life skills and 42 essential health messages were included in the national *Community Health Education Manual*. Students disseminate information to their colleagues and visitors to the Youth Center on important health issues to the students. The same youth center is also being planned for Amran University.

ESD Guinea works with 65 youth peer educators to promote family planning through the *Centres d'Écoute, conseil et orientation des jeunes* (or Counseling and Guidance Centers for young people) in the Kankan and Conakry regions. They also work with *Espace Vie Saine* (or Healthy Living Clubs) at universities to provide information on family planning and HIV/AIDS to students to over 500 students.

[12] UNICEF 2007. Early Marriage: Child Spouses. Innocenti Digest No. 7, 11.

LESSONS LEARNED

ESD's mandate has been to work with the most vulnerable and underserved populations, especially through community-based programming. Since the 1994 International Conference on Population and Development, adolescents have been identified as a priority population whose health behaviors and practices will influence the global community for many years to come. Yet the sexuality and reproductive health of adolescents has been politically and culturally sensitive in terms of what is taught to young people as well as the services that are provided. Innovative programs are piloted that often show short-term gains in knowledge and attitudes, but regrettably few have gone to scale: as a result, young people in many parts of the world remain underserved and vulnerable, with significant unmet need. In part, this may be due to limited community understanding and support for such programs, and little or no changes in social norms and values that support improved adolescent reproductive health and individual behavior change.

A 2004 study in Nepal found that involving communities (especially youth and adult gatekeepers, such as parents, family members and religious leaders) enhanced information and service delivery choices for young people and resulted in better health outcomes when compared to more traditional approaches that focused solely on behavior change communications and improvements in service delivery. [13] The most apparent changes were in community norms and values that influence adolescent choices, decisions and behaviors. ESD has applied these findings in its own programs in Yemen and Nigeria by giving equal weight to individual, structural and social change. Through these efforts that promote dialogue and critical analysis of common concerns, collective community action will amplify the efforts of organizations and projects such as ESD and its partners FOMWAN and YWU, leading to more effective and sustained change.

In conservative communities such as Northern Nigeria and Yemen, where traditions are deeply entrenched, efforts to promote change, such as the abandonment of early marriage or the use of family planning for HTSP can be viewed with suspicion and skepticism, especially when coming from US based organizations. ESD worked with local partners in both Nigeria and Yemen to ensure cultural relevance and sensitivity to local norms and practices, and importantly to build community and organizational capacity. Organizations such as FOMWAN and the YWU have many years of community mobilization and outreach experience, vibrant networks of contacts and high levels of recognition among major stakeholders/partners in both the government and in civil society, especially among religious leaders. ESD also found that it was important to not only obtain the tacit support of religious leader, but to actively build their capacity and skills to effect change in community norms and values, institutionalize change within these community structures, and ultimately ensure positive health outcomes in the community.

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[13] Mather S., Mehta M and Malhotra, A. "Youth Reproductive Health in Nepal: Is Participation the Answer?" New York: EngenderHealth and International Centre for Research on Women, 2004.

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