Improving Reproductive Health through Community-Based Services: 25 Years of Pathfinder International Experience
Pathfinder International believes that reproductive health is a basic human right. When parents can choose the timing of pregnancies and the size of their families, women’s lives are improved and children grow up healthier.

For over 50 years Pathfinder has provided women, men, and adolescents throughout the developing world with access to quality family planning and reproductive health information and services. Pathfinder works to prevent HIV/AIDS, provide care to women suffering from the complications of unsafe abortion, reach adolescents with services tailored to their needs, and advocate for sound reproductive health policies in the U.S. and abroad. Pathfinder collaborates with communities, partner organizations, and government at all levels to strengthen local skills and foster lasting change.

Community-Based Services
In the late 1970s Pathfinder was one of the first organizations to develop programs supporting the community-based distribution of family planning commodities. Since then, our community-based programs have reached dozens of countries throughout the developing world. Pathfinder works with communities at the grassroots level to expand access and knowledge, stimulate acceptance, and create awareness and ownership of family planning and reproductive health services.
Improving Reproductive Health through Community-Based Services:
25 Years of Pathfinder International Experience

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C ommunities in the developing world face a number of obstacles to receiving Reproductive Health and Family Planning (RH/FP) services and HIV/AIDS information and care. People living in remote areas may have to travel long distances to reach health facilities. Transportation can be difficult to find and prohibitively expensive. Many have heard little or nothing about family planning, and women do not know that there are safe, effective ways of preventing and spacing pregnancies. In many areas of the world a family’s prestige is tied to the number of children they produce. Traditional values hold large families in high esteem and are seen as a source of prestige. Consequently, women are expected to marry early and have many children. Traditional methods of child spacing are often ineffective and may be dangerous for both mothers and their children.

**Introduction**

**Ethiopia**

Women in Tuse town, in the Oromia Region of Ethiopia, traditionally had five to six children—and many had ten or more. Large families have always been valued and expected.

Five years ago, Aman Buli, farmer and father of three, was selected by his neighbors to become a community health worker. Even before his training, Aman knew it was important, because he recognized the relationship between large families and the poverty of his community. As a trusted member of the community, he could help people accept new ideas better than anyone else.

Aman joined health workers from other villages for intensive training in reproductive health and family planning, enriched with details on HIV/AIDS prevention, safe motherhood, nutrition, care of childhood illnesses, and arguments against harmful traditional practices.

In a few short years, Aman has helped transform his community. In a woreda with a total population of 19,000 he has counseled more than 4,000 women in contraception and he provides family planning to more than 400 regular clients. He meets with community and religious leaders, speaks out in mosques and churches, and distributes condoms and pills at weekly markets.

“When I started,” confides Aman, “many women came to me in secret to ask me for family planning. Couples argued and the husbands were against it. Now, everyone comes openly.”

“Before, women were considered only housewives. Now, they do many things on their own. Both boys and girls seek education, so fewer parents are forcing their daughters to marry early.”

Aman’s own family is a model. “Since my wife has stopped having children, she has gone to school. Many other women in the community have done the same thing, and many more girls are staying in school and getting educated.”

Characteristically, Aman took on the enormous challenge of trying to convince women to stop circumcising their daughters. Female genital cutting has been practiced in this region for hundreds of years, and girls are not considered marriageable without having been cut. After reviewing the Koran and Bible with religious leaders and informing them of the terrible harm caused by this practice, he was able to enlist their steadfast support.

“Before, women were considered only housewives,” says Aman. “Now, they do many things on their own. Both boys and girls seek education, so fewer parents are forcing their daughters to marry early.”

Aman Buli (front, left) with his wife (center), son (front), and other villagers.
Pathfinder International works with communities at the grassroots level to expand access and knowledge, stimulate acceptance, and create awareness and ownership of RH/FP services. Pathfinder has been implementing community-based programs since 1979, when it began the first community-based distribution of family planning information and commodities in Bangladesh and Kenya. In the 1980s and '90s, Pathfinder initiated the first community-based services in Azerbaijan, Côte d'Ivoire, Jordan, Kazakhstan, Senegal, Tanzania, and Uganda. We were among the first to implement wide-scale community-based services in Ethiopia and Nigeria. And in the 1980s Pathfinder supported wide-reaching programs in Brazil, Mexico and elsewhere in Latin America. Using a variety of approaches, including door-to-door delivery, depot holders (community members who sell family planning commodities out of their homes or small stores), mobile clinics, and clinic outreach, Pathfinder has proven that working with communities at the grassroots level is an effective way to improve access and challenge socio-cultural barriers to RH/FP services.

In several countries, Pathfinder has successfully enhanced access, knowledge, and cultural acceptance of reproductive health by training and supporting Community Health Workers (CHWs). CHWs (known by various other names throughout the world) are members of the community in which they work, and are selected by the community and community leaders, Pathfinder’s partner organizations, or Pathfinder itself to work as health volunteers. Their duties vary depending on the country, project, and local needs. But at a minimum, after a training of two to three weeks, CHWs have a basic understanding of male and female reproductive anatomy, how different contraceptive methods work, know when to refer clients for further care, and can provide clients with contraceptive commodities—including condoms and in some countries oral contraceptive pills—and information about their reproductive health. In addition, many CHWs are trained in maternal and child health, nutrition, and other health matters. They serve as an important link between the community and health facilities by providing referrals and helping clients follow through with their prescribed care.

Some programs train CHWs to provide care and support for people living with HIV/AIDS. Simple checklists and guidelines help CHWs identify sexually transmitted infections, malnutrition, complications during pregnancy, and early childhood illnesses, allowing them to counsel and refer the client to the proper facilities if necessary.

Pathfinder CHWs, with a few exceptions, work entirely as volunteers. The majority of them are women, selected because of their respect in the community and their leadership abilities. But for the most part they have the same financial concerns as their neighbors. Though many struggle to make ends meet, they take time away from caring for their own families, working their fields, and their business activities to serve their neighbors. Many become community leaders and are consulted on all aspects of village life. Some communities are so grateful to their CHW, they band together to work her fields or pay for her children’s education.

Because CHWs hold the esteem of their peers, they are effective in promoting change and challenging stigma surrounding HIV/AIDS, harmful traditional practices, and prejudices against family planning. They are motivated by a sense of duty to care for others around them and many were caring for others long before they received Pathfinder’s training. The training enables them to offer a wider range of services, gives them confidence that they are giving correct advice, and teaches them how to safely care for people living with HIV/AIDS.

Over the past 25 years, Pathfinder has learned many lessons about what makes community-based programs thrive. Outlined in this report are some of the lessons learned and examples of how these programmatic concepts are integrated into our work.
Lesson 1:
The support of local leaders and the community as a whole is important for ensuring access and sustainability, and stimulating substantial changes in community behavior. Building the capacity of communities and creating local partnerships is crucial to success.

Stimulating change in a community—from the simple adoption of bed nets to fight malaria to the eradication of female genital cutting—takes great sensitivity and patience, and must be supported by the community’s leadership. Furthermore, significant RH/FP improvements cannot be realized in many communities without substantial changes in cultural and social norms, including the status of girls and women. Even in the most open societies this type of change cannot be imposed from the outside, but must grow from within. The challenge is even greater in traditional, conservative societies, which are home to many Pathfinder projects. To reach these communities, Pathfinder works with grassroots organizations with local links and established reputations. These organizations help us forge links with local governments and traditional leaders.

Ethiopia
In Ethiopia, nearly 85 percent of women suffer some form of female genital cutting. The median age of first marriage for women currently aged 25-49 was 16 years, and only 13.9 percent of currently-married women use a modern method of contraception. Clearly, these are not simple problems to solve. They require a major shift in thinking about women’s rights and roles in society. Before women can make the choice to use contraception or resist early marriage and female genital cutting for themselves or their daughters, the community must acknowledge their right to make these decisions. To address these problems and related ones, Pathfinder has organized Woreda (district) Advisory Committees (WACs). These committees include members from the national ministries of health, women’s affairs, capacity building, agriculture, education, and youth and sports, as well as local community and religious leaders, and members of the local women’s and farmers associations. Over 200 WACs have been created in four regions.

Pathfinder and its partner organizations train and work with the WACs to help them become agents for social change, emphasizing the dangers of female genital cutting and early marriage and the importance and benefits of safer sexual behaviors, maternal and child health care, and family planning. Highly respected by their communities, WAC members are in a unique position to gain community trust and pave the way for CHWs to introduce their lessons and family planning methods.

The WACs have embraced their role and have had great success in influencing change at the district level. To ensure their impact at the village level, many communities have formed village advisory committees as well. The village committees work more closely with individual CHWs and recommend individuals to be trained as CHWs by the WACs.

Over the past four years, more than 14,000 early marriages have been prevented or annulled, and the incidence of female genital cutting has declined in some areas where priests and Imams who are either associated with or inspired by the WACs have spoken out against it.

India
Bihar is one of the poorest and least developed states in India. In 2001, at the commencement of the Promoting Change in the Reproductive Behavior of Youth (PRACHAR) project, the median age at first marriage for women currently aged 20-49 was 16.9 in urban areas and 14.3 in rural areas. Only 13 percent of married adolescents had ever used contraception.

References:
3. Wilder, Jenny, Promoting Change in the Reproductive Behavior of Youth: Pathfinder International’s PRACHAR Project, Bihar, India, Pathfinder International, iii.
PRACHAR’s goal is to improve the health of mothers and their children by changing the customs of early marriage and childbearing and spacing subsequent births. To reach this objective, Pathfinder works with every section of society that influences the decisions of young people. Pathfinder has trained staff of 30 local partner organizations, who in turn have trained 342 community members to work as change agents, the key village-level representatives of the PRACHAR project.

The project was launched in each village with a community meeting. The presence and support of respected local leaders at these events is crucial to the project’s success.

Through social occasions, public events, and meetings with individuals and couples, change agents trained by Pathfinder teach young people about the health benefits of delaying first childbirth and spacing subsequent births. Group meetings with newlyweds help them learn to work together, make joint decisions, negotiate with parents-in-law, and understand the economics of raising children. Parents are urged not to demand early childbearing and encouraged to support delaying the first birth. Older villagers are trained to promote delaying marriage and childbirth in their extended families and communities.

This multifaceted approach to engendering community support has led to outstanding results over the course of the project. The percentage of the population that believes that contraception is both necessary and safe more than doubled. The percentage of newlyweds who use contraceptives to delay the birth of their first child has tripled. And the number of parents who use contraception to space their second child has more than doubled.4

Egypt

The TAHSEEN project in Egypt took advantage of local leaders’ great influence and power for positive change by training them to be positive influences for change in RH/FP practices. With Pathfinder training, clergy, community outreach workers, traditional birth attendants, teachers, local civic leaders, and members of the media helped spread knowledge and understanding about healthy timing and spacing of pregnancies; postpartum, antenatal, and postabortion care; advantages of delayed marriage and childbearing; continued schooling for girls; and communication between couples and between parents and children about RH/FP. The leaders were also trained on the importance of not just educating people about these services, but endorsing them and encouraging their use. During the training individuals decided on how they would relay this information to their constituents. Methods included home visits, sermons, public events, and media outreach.

TAHSEEN-trained leaders served on clinic boards and raised awareness of the services to be offered in the newly-renovated Ministry of Health and Population clinics by publicly acknowledging their good work.

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4 Wilder, Jenny, iv.
Participating on clinic boards also provides an efficient avenue for the leaders to present the communities’ unmet needs to other local leaders and clinic staff.

More than 350 television and radio segments, and print media articles have appeared on RH/FP topics—many coordinated with the opening of TAHSEEN-renovated Ministry of Health and Population clinics. Caseloads have tripled at TAHSEEN-supported clinics, indicating a successful increase in the appropriate use of clinic services.6

**Brazil**

In some deeply-spiritual communities, the religious hierarchy holds the society’s respect and is able to guide change. *Candomblé* evolved from West African religions brought to Brazil by slaves between the sixteenth and nineteenth centuries and incorporates some aspects of Catholicism as well. The candomblé community has a high level of unemployment and illiteracy, low access to health and social services, and is generally wary of outside influence. To reach them, Pathfinder and its local collaborating partner, the *Centro Baiano Anti-Aids* (Anti-Aids Bahia Center), first explained to the temples’ leaders how HIV was affecting their community and what they could do to protect their followers. Motivated by this knowledge, the leaders joined Pathfinder staff in presenting safer-sex workshops in the temples and spreading HIV prevention messages at the community level.

Traditionally, groups of new initiates to the religion’s priesthood have their heads shaved with one common blade during the initiation ceremony—potentially exposing them to HIV. Convincing leaders to use new, clean razors on each initiate was of utmost importance, but also a complex process; the replacement of traditional tools with safer ones represents a major change in candomblé norms and beliefs. Though older candomblé priests still dislike the departure from the traditional use of the single ritual blade, the use of a new, disposable razor on each initiate has become standard practice in the 217 temples reached by the project.

Monthly meetings for candomblé leaders promoted discussion of, among other things, HIV prevention and promotion of condom use among the faithful community. Though funding for these meetings ended in 2004, a group of about 60 religious leaders still gathers once a month. At each meeting 60,000 condoms provided by the *Centro Baiano Anti-AIDS* and the Municipal Health Secretariat of Salvador are provided to the leaders for distribution in their temples. Some of these leaders have taken the initiative to spread HIV-prevention messages not only within their own temples, but to other religious centers in their communities.

The Brazilian Ministry of Health and the National HIV/AIDS Program have become increasingly interested in providing more focused interventions and services for the black community. The Pathfinder candomblé project can be seen as one of the first interventions in Brazil specifically addressing the needs of this under-served group.

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Lesson 2: Integrating HIV information and other health services into community-based distribution programs does not distract from the family planning and reproductive health aspects of the program and can be a cost-effective way to reach a large population with services.

Kenya Pathfinder’s efficient and effective response to the HIV/AIDS epidemic in Kenya can be attributed to its ready cadre of trained and effective CHWs. In the early-1990s Kenyan CHWs reported that their communities were asking about HIV—they had heard about it and knew people were dying from it, but they had little information about what it was, how it could be transmitted, and how to care for people suffering from it. The CHWs knew little more than their neighbors. Their requests for further training were answered in 1995 when Pathfinder began training its CHWs, who had previously focused solely on RH/FP, to deliver HIV/AIDS prevention messages and care for people living with HIV/AIDS.

In 1999 Pathfinder launched the Community-Based HIV/AIDS Prevention, Care, and Support Program (COPHIA). CHWs were initially trained to perform basic home-based care duties, train primary caregivers, and provide HIV/AIDS prevention information in the community. But again, CHWs requested further training to meet community needs, prompting additional workshops in nutritional counseling, prevention of mother-to-child transmission, and prevention of opportunistic infections. Eventually, CHWs came to support the large population of orphans and vulnerable children, and they refer clients for family planning, legal services, food security, voluntary counseling and testing, and support groups. And they take on the responsibility of ensuring their clients’ adherence to difficult treatment regimens. In addition to these services, the COPHIA CHWs continue to provide RH/FP information. Since the program’s inception, COPHIA has trained 230 home-based care supervisors and 740 CHWs. They have provided care for 13,717 people living with HIV/AIDS and have trained 30,970 primary caregivers during nearly 88,000 home visits.

Pathfinder’s HIV/AIDS response in Kenya has been so successful that our community home-based care training curriculum has been adopted by the government to train all CHWs in the country since 2001. Pathfinder’s university-based peer education project has been running continuously in Kenya since 1988 and has successfully integrated HIV/AIDS prevention information into its educational program.

Pathfinder CHWs have continued to provide RH/FP information and services for their clients since the introduction of HIV/AIDS home-based care, but between 2000 and 2003 donor support focused solely on HIV/AIDS. In 2003 Pathfinder found private support to rejuvenate its community-based family-planning efforts. Their latest project, launched in the summer of 2006, focuses on improving clinic-based care, but will also include community outreach activities to ensure that the facility-based services are available to all who need them. Community home-based care activities for people living with HIV/AIDS will continue to receive support.
Nigeria  In the traditional region of Northern Nigeria, Pathfinder has struggled to promote the use of modern contraceptive methods to delay and space pregnancies. Traditional communities in this area generally see children as a gift from God and, assured that He will provide for their families, resist limiting their family size or spacing women's pregnancies. Sexuality is not openly discussed, so reaching families with RH/FP information and services has been difficult. It has been observed however, that because HIV/AIDS is recognized as a deadly disease, communities are more open to discussing RH/FP in its context.

Pathfinder is therefore increasing the attention given to HIV/AIDS in its Northern Nigeria programs, not just to improve the communities' understanding of the disease, but also to stimulate dialogue about more traditional RH/FP issues. Plans are underway to integrate HIV/AIDS messages into discussions with Imams and other religious leaders, reach men with HIV/AIDS and RH/FP information at sports matches, and reach women through traditional beauticians and hair stylists.

Mozambique  In Mozambique, Pathfinder is going beyond traditional maternal and child health to ensure the survival of children into adulthood. In addition to their traditional role distributing family planning information and products, CHWs have begun distributing water-purification solution and insecticide-treated bed nets for malaria prevention to pregnant women and mothers of children under five. They are promoting exclusive breast-feeding to the age of six-months, iron and folate supplements for pregnant women, growth monitoring, deworming, and proper nutrition. CHWs also identify children that have not been immunized and encourage immunization at vaccination posts or during campaigns. In the last six months, 4,700 bed nets and 1,650 bottles water purification liquid were distributed through the CHW network.
Lesson 3: Systematic, effective referral networks, including referrals for long-term family planning, food security, and medical backup, are essential components of community-based services. Community health workers are an essential link between clinics and hard-to-reach areas.

In rural areas, access to RH/FP services can be extremely limited because of the distance to facilities and the associated costs of services and travel. CHWs can help bridge that divide by providing information and short-term family planning methods, or home-based care for people living with HIV/AIDS. But clients who require the care of a trained provider for treatment of an illness, or to those seeking a long-term family planning method, still must travel to the clinic.

For a rural woman who has never been to a clinic and finds such a visit threatening, a CHW might accompany her on her first visit, making sure she follows through on the referral. Such support gradually improves the facility’s reputation and reinforces its acceptance in the community.

Ethiopia When organizing a training session on Norplant or IUD insertion for a group of providers, it can be difficult to gather enough women who want to receive the contraceptive method at one time for the practitioners to receive adequate training. Though service providers are first trained on pelvic models and training arms, without supervised practice on clients their training cannot be complete. Pathfinder developed a referral system for long-term family planning methods that not only addresses the needs of the clients, but the training needs of the service providers as well.

When, through counseling on all types of contraceptive methods, a CHW identifies a woman who wants to use a long-term method, she is given pills or condoms as a short-term method, along with a referral card for the long-term method. When Pathfinder later organizes a Norplant and IUD training in the area, they alert the local CHWs, who in turn review their records and inform women who had asked for one of these family planning methods. Pathfinder arranges travel for clients from very remote areas who are still interested in receiving a long-term method and, over the course of one or two days, hundreds of women receive Norplant or IUDs at each clinic. Service providers visit multiple clinics during each training. Between January 2005 and May 2006 Pathfinder trained 156 service providers and provided long-term family planning methods for over 10,000 women.

Tanzania In Tanzania, CHWs focus on providing home-based health care to people living with HIV/AIDS. CHWs provide palliative care, treat some opportunistic infections, provide emotional support, help link clients to other services such as food security, and train families and neighbors to care for their friends and loved-ones living with AIDS. The care and information CHWs provide for families is instrumental in helping their clients live longer, healthier lives, and preventing their reinfection or the infection of caregivers. As their clients are living...
longer the CHW role has expanded to include teaching their clients how to avoid illnesses such as malaria and water-borne diseases and how to adhere to treatment regimens.

Pathfinder has developed a two-way referral system for infections and serious complications. CHWs send clients to nearby health facilities with a referral note, which helps ensure that people living with HIV/AIDS are seen promptly and free-of-charge. In some cases, if the client is too weak to travel alone and has no family to accompany him, or is afraid of the stigma associated with being HIV-positive, the CHW escorts the client to the health facility. The service provider returns the referral note with information about diagnosis, treatment, and follow-up appointments, which CHWs use to help clients manage their care at home. CHW's estimate that they receive the return referral note for about 75 percent of cases they refer.

**Rift Valley, Tanzania**  
Maria Laurent and her newborn son were sleeping on the dirt floor of her rented mud-brick home before they met Margaret Uisso, a Pathfinder-trained CHW. Maria had been sick throughout her pregnancy and spent the last three months of it in the hospital. Two months after giving birth she fell ill again. Not knowing where to find help, she was worried for her child’s future. Then Maria met Margaret, who convinced her to be tested for HIV. When the test came back positive Margaret and her supervisor, Sarah Lomayani, immediately enrolled Maria in Pathfinder International/Tanzania’s community home-based care program. Meeting the community health workers has helped turn Maria’s life around.

Margaret helped find a bed and mattress for the mother and baby to sleep on. Margaret and Sarah, whom Maria affectionately refers to as Mama Lomayani, taught Maria how to exclusively breastfeed her son so that the risk to the baby was greatly reduced and helped her obtain food support from local organizations. She is now on antiretroviral therapy and continues to grow stronger and healthier. Her son, now over one year-old, is walking and has never been ill. He will be tested for the virus when he reaches 18 months, the earliest a child can be tested in Tanzania.

"I was able to achieve this success and many others because of the training I got from Pathfinder. I am very grateful to them. I have five clients, who are HIV-positive, but I know how to care for them adequately and I enjoy working with them."

Before meeting Margaret and Mama Lomayani, Maria would go to church and cry all day. But now, "They have given me hope," she says. Maria braids hair and washes her neighbor’s clothes to earn money, but it is difficult to make ends meet. Mama Lomayani is helping Maria obtain a small loan to buy shampoo and oils to sell and to expand her hair-brading business. She also hopes to sell jewelry and other small items to her clients. This money will go straight into a bank account to pay for her son’s future school fees. Margaret volunteers as a community health worker because she doesn’t want to see others suffer when she is healthy and eating and sleeping well. She used to care for her neighbors before she received the Pathfinder training, but feels more confident doing so now. "I was able to achieve this success and many others because of the training I got from Pathfinder. I am very grateful to them," she says. "I have five clients, who are HIV-positive, but I know how to care for them adequately and I enjoy working with them."
Lesson 4: Appropriate compensation for community health workers leads to increased productivity.

Most Pathfinder CHWs work as volunteers and are given only a small stipend meant to cover their travel costs. But there are arguments to be made for performance-based compensation. Not only do CHWs deserve to be compensated for time spent away from their families, fields, and other work, but like most other laborers, CHWs are more productive when they are paid or otherwise compensated for their services. Funding limitations and concerns about sustainability prevent many programs from providing a salary or monetary rewards for CHWs, but some schemes have proven both sustainable and effective.

**Bangladesh** The Pathfinder-managed NSDP program in Bangladesh manages 317 Smiling Sun clinics and nearly 8,000 part-time satellite clinics throughout the country. The rural service sites receive referrals from over 6,000 depot holders. When depot holders encounter a client with an illness they are unable to treat, or a desire to use a long-term or permanent family planning method, the depot holder refers them to a Smiling Sun clinic if possible, or chooses from a list of NSDP-recommended clinics. At the end of the month each depot holder receives a percentage of the fees paid at Smiling Sun clinics by the clients they referred. To ensure that depot holders don’t discriminate against the poorest of the poor by not serving them or not referring them, a system is in place for depot holders to also receive a percentage of the money earned from contraceptive sales in addition to clinic referrals. Such a referral system motivates depot holders to recruit more clients in their communities. The number of referrals has increased each month since the program began in July 2002. The compensation scheme is sustainable because it comes from a fee-for-service, which is standard in Bangladesh for clients who are able to pay. Clinics do not mind paying, because the depot holders are stimulating more business for them.

**Azerbaijan** From 1995 to 2003 Pathfinder trained and supported 90 CHWs in 29 areas of Azerbaijan settled by internally displaced people. The project allowed for generous compensation of the CHWs—they received salaries large enough to support a reasonable quality of life. Because of both the nature of the population addressed, and because of the salary offered, Pathfinder was able to recruit CHWs who were significantly more educated than in most programs. The project’s 90 CHWs included physicians, nurses, and teachers among others.
The program reached over 88,000 people, meaning that each CHW carried a caseload of almost 1,000 clients. Surveys performed in 2000 and 2003 showed astounding improvements in knowledge and health-seeking behavior. These results can be attributed to the ability and dedication of the CHWs. Because they were highly educated, often as medical professionals, they were better able to explain the details of contraception and reproductive health to their clients. And because they were paid a reasonable salary they were able to dedicate their time and energy to their duties as CHWs.

Other programs have found that allowing health workers who sell contraceptives to keep a small commission has motivated the CHWs. In Ghana, the African Youth Alliance’s peer educators and nontraditional condom distributors kept a portion of the money earned from the sale of condoms and were further motivated by prizes for the top performers. Contents such as this can be sustainable if the private sector is motivated to donate small prizes.

### Table 1.
Results of a Knowledge, Attitudes, Practices and Behavior Studies Performed in Pathfinder Project Areas of Azerbaijan

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>2001 Baseline Survey</th>
<th>2003 Survey</th>
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<tbody>
<tr>
<td>Women who have never visited a gynecologist</td>
<td>67%</td>
<td>12%</td>
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<tr>
<td>Women who gave birth in a health care facility</td>
<td>53%</td>
<td>96%</td>
</tr>
<tr>
<td>Men who had visited a doctor or urologist</td>
<td>25%</td>
<td>52%</td>
</tr>
<tr>
<td>Women who had never heard of a sexually transmitted infection</td>
<td>28%</td>
<td>1%</td>
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<tr>
<td>Women who had knowledge of contraceptive methods:</td>
<td></td>
<td></td>
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<tr>
<td>Pills</td>
<td>23%</td>
<td>70%</td>
</tr>
<tr>
<td>IUD</td>
<td>27%</td>
<td>80%</td>
</tr>
<tr>
<td>Injectable</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>Condoms</td>
<td>74%</td>
<td>95%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>3%</td>
<td>15%</td>
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<tr>
<td>Adolescent females who understood how women get pregnant</td>
<td>68%</td>
<td>84%</td>
</tr>
<tr>
<td>Adolescent females who know methods of contraception</td>
<td>28%</td>
<td>75%</td>
</tr>
<tr>
<td>Adolescent females who had knowledge of sexually transmitted infections and HIV</td>
<td>29%</td>
<td>71%</td>
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Lesson 5:
Programs must use multiple approaches to bring about behavior change in youth.

When trying to affect behavior change in youth, Pathfinder has found that a single-tiered approach isn’t enough. Youth may learn about HIV/AIDS at a youth group or in school, but without access to condoms and the negotiation skills and self esteem needed to abstain from sex or to insist on condom use regularly, they are still vulnerable to the disease. A peer educator may be able to convince someone to be tested for HIV, but if the clinic is not open to receiving youth, or counseling and testing services aren’t available, it may be impossible to follow through with their decision. While these problems occur to some extent in other sectors of society, without the maturity or the full skill sets that their elders have to negotiate these obstacles, youth are left particularly vulnerable.

To reach youth in developing countries, programs must use different approaches to reach both in-school and out-of-school adolescents. Furthermore, hearing the same message from different sources, peers, teachers, parents, and coaches helps reinforce it.

Mozambique Pathfinder’s Geração Biz program in Mozambique is implemented by the ministries of health, education, and culture, and youth and sports. The three ministries work together to address youth’s health concerns in clinics, schools, and in the community. The Ministry of Health’s main objective in this project is to create health facilities, or areas within health facilities, that meet youths’ unique health-care needs, including privacy, confidentiality, and respectful staff. The Ministry of Education has incorporated HIV/AIDS and adolescent sexual and reproductive health information into its curriculum for classes 1-7 and also trains school-based peer educators to provide information, life skills, and referrals for services to young people. The Ministry of Youth and Sports is charged with reaching out-of-school youth by training peer educators who participate in community events, perform plays and dance, show educational videos, visit churches and nightclubs, counsel peers individually and in groups, distribute educational materials and condoms, and refer clients to youth-friendly clinics.

The three ministries’ programs work together through mutual referrals. The YFS clinics receive clients because the in- and out-of-school peer educators create the demand. Peer educators counsel youth in clinic waiting rooms and support peers who may be nervous about receiving services.

The Geração Biz program has been extremely successful in both providing quality adolescent sexual and reproductive health services and in changing attitudes and behaviors surrounding it. In 2005 alone the project reached 1,012,649 youth and distributed 1,595,662 condoms.

To measure the Geração Biz program’s impact on youths’ knowledge, attitudes, and behaviors surrounding their reproductive health, Pathfinder conducted surveys in 2003 and again in 2005, using a random sampling of 10-24 year old students. Between the 2003 study and the 2005 study:

- Respondents who used contraception during their first sexual experience increased from 35.7 percent to 60.2 percent;
- Respondents that believe HIV can be transmitted through kissing decreased from 16.5 percent to 6.2 percent;
- Respondents that know about condoms as a contraceptive method increased from 80.1 percent to 87.4 percent;
- Respondents that didn’t use a condom because their partner refused decreased from 9.4 percent to 4.4 percent; and
- Consistent condom use, even when “in love,” increased from 70 percent to 83 percent.
Lesson 6: Alternative service delivery options help reach vulnerable and hard-to-reach populations, such as adolescents, rural and urban poor, and men.

The populations most vulnerable to reproductive health problems and in need of family planning services are often the hardest to reach. Adolescents are one of the populations most affected by HIV/AIDS. An estimated 10 million people between the ages of 15-24 are living with HIV/AIDS, and half of the 6,000 new infections that occur every day are in young people. In sub-Saharan Africa, 18 percent of girls give birth before age 18. But because in many cultures, it is taboo for unmarried teens to have sexual relationships or to even talk about sex, they are often overlooked in traditional reproductive health and family planning projects. Adolescents may be too embarrassed to talk to their parents or teachers about reproductive health issues, and thus are left susceptible to sexually transmitted infections, HIV, and unplanned pregnancy.

Ghana
Under Pathfinder’s leadership, the African Youth Alliance project addressed adolescent sexual and reproductive health concerns in Ghana, Uganda, Tanzania, and Botswana. In each country Pathfinder trained youth as peer educators who provided RH/FP information and distributed condoms. The Ghana program integrated nontraditional condom distributors, an innovative technique to provide condoms in businesses throughout the community. They were trained as peer educators, but also had to be employed in a trade—such as sewing or hair dressing—or be involved in selling goods or services in a location that attracts young people. The condom distributors provided RH/FP information and condoms to their clients.

Though the project supported more peer educators (297) than nontraditional distributors (200), at the end of the five-year project, 58 percent of the more than 1,300,000 condoms distributed were through non traditional condom distributors. In interviews, clients of nontraditional distributors reported more comfort accessing condoms from their barbers, seamstresses, or the local kiosk, because the reason for their visit was not obvious to outsiders. Condom distributors welcomed increased business, as clients too shy to come only for a condom would get their hair cut or bring something to a seamstress to be repaired as a cover for their real motivation.

Nigeria
The nontraditional distributor as a source of RH/FP information is being replicated in Northern Nigeria, a region that has proven particularly reluctant to use modern contraceptive methods. Local women can be hard to reach because of the tradition of Purdah, which keeps them in the home unless escorted by a male relative. But traditional beauticians (Mai Lalle) and hair stylists (Mai Kitso) have access to both young married and unmarried women. Pathfinder plans to train these women to counsel their clients on RH/FP issues, including healthy timing and spacing of pregnancies. They will distribute contraception and will refer their clients to health facilities when necessary. Mai Lalle traditionally provide advice on sexuality, marital responsibilities, and traditional contraceptive methods, and both Mai Lalle and Mai Kitso provide traditional aphrodisiacs to married women. Their new role providing modern RH/FP counseling will be a natural evolution.

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In Ethiopia, a similar practice has been implemented in markets with market-place agents. Pathfinder and its partner NGOs have trained 270 market vendors in 120 different markets to provide RH/FP information, condoms, and oral contraceptive pills. They receive two weeks of training and are provided with educational materials, including tape-recorded educational messages and music to use in their market stall to attract customers. This approach has provided access to people in extremely remote areas and among semi-nomadic groups, who travel regularly to the market, thus removing transportation barriers. Men and youth have also been served in great numbers since accessing services and supplies is less conspicuous than going to the clinic, a concern for both these groups.

Both the nontraditional condom distribution and market-place strategies provide the seeds of sustainability by introducing contraceptive supplies into the market paradigm. Clients become accustomed to meeting their contraceptive needs at the market and vendors make more money, both by the small commission they receive on contraceptive sales, and by driving more customers to their stalls with these additional services.

Peru

The Huanta province in Peru was torn apart by guerrilla warfare between 1981 and 1993. Sitting 8,500 feet above sea level, one-third of the province is covered by thick jungle. Sixty percent of the population lives in rural areas. Over half of the population is 19 years old or younger.

To reach this vulnerable, remote population of youth with sexual and reproductive health information and services, the ALCANCE project (1997-2002) used three methods: mobile clinics, education of school directors and teachers on adolescent sexual and reproductive health, and community informational-entertainment programs.

Mobile health teams, consisting of a nurse-midwife, psychologist, and a clinical nurse, traveled monthly to 12 secondary schools and 15 places where youth congregated, offering RH/FP services and information. The team also attended social and sports events and festivals, where they used videos, theater, and games to attract young people, including out-of-school youth. A bimonthly half-hour radio program on sexual and reproductive health reached an even larger audience, and leaders of mother’s clubs were trained to carry the information back to their members.

To expand training into the school curriculum, the Pathfinder team helped school directors and teachers develop appropriate teaching materials on adolescent sexual and reproductive health. Peer educators were trained to reach youth no longer in school with the same messages.

As a result of this intervention, more than 160,000 clients received services and over 92,000 contraceptive methods were distributed.
Lesson 7:
Community-based service projects must evolve into more cost-effective permanent operations. Use of depot holders, social marketing techniques, and linking with other organizations or programs improves coverage and acceptance.

Bangladesh
In 1979, to overcome the cultural restrictions, traditional values, and travel difficulties that stood between women and family planning in rural Bangladesh, Pathfinder initiated a community-based distribution program that brought family planning information and commodities door-to-door. The first CHWs in Bangladesh were salaried and worked full-time. They visited each household in their project area and used a check-list to identify potential oral contraceptive users. As family planning was a controversial idea at the time, Pathfinder held workshops for local leaders to educate them on the benefits of family planning and it was discussed at Islamic community meetings. The inclusion of maternal and child health information and services helped CHWs gain respect in society.

As the program and concept of family planning grew more accepted, demand grew for other types of contraception, resulting in a pioneering project that used CHWs to deliver Depo Provera injections to their clients in their homes. The community-based distribution program proved so successful, it expanded from its initial three sites to 72 by the mid-1990s.

Door-to-door delivery, however, is a costly and time-consuming approach to delivering family planning services. In 1991 Pathfinder’s projects in Bangladesh began to move toward a more sustainable village-based depot approach. By 1997, 27 percent of pill and condoms users were getting their supplies from a village depot holder or satellite clinic. As family planning has become the norm rather than an exception in Bangladesh, many people now seek services in clinics and buy name-brand contraceptives marketed throughout the country.

As a result of this self-reliance, the resources that were once funneled towards community-based distribution can now be used for a wider variety of health services. In the late 1990s Pathfinder supported depot holders, as well as static and satellite clinics in rural areas. In 2002 Pathfinder began supporting urban facilities as well. The clinics integrate family planning services with other essential health care needs, such as treatment and prevention of childhood diseases, antenatal and postnatal care, immunization, and basic first aid. Over the last nine years the clinics have moved from relying heavily on donor support to becoming increasingly self-sufficient.

Kenya
Pathfinder/Kenya’s history in community-based services has been similar to that in Bangladesh, but the program arc has been altered by the HIV/AIDS epidemic. Kenya’s community-based family planning services began in 1979 with a one-year pilot project providing condoms and pills through CHWs and creating awareness for family planning services through community gatherings. Later that same year, Pathfinder began scaling up its community-based distribution projects by partnering with the Maendeleo Ya Wanawake Organization, a network of grassroots women’s clubs. This new network grew to cover ten districts in four provinces with a catchment population of 13 million. Between 1993 and 2000 it was the largest community-based distribution network in the country.

Like Pathfinder/Bangladesh, Pathfinder/Kenya’s services began to evolve from door-to-door delivery to a static depot holder approach in the early 1990s, proving the program’s growing security and a wider client base. Kenya, however, was deeply affected by the HIV/AIDS epidemic and in the mid-1990s Pathfinder began integrating HIV/AIDS prevention and care into its RH/FP programs.

In 1986 Pathfinder helped develop a community-based distribution program for the National Council for Population and Development. Kenya later adopted Pathfinder’s community-based care training curriculum. As family planning has become the norm rather than an exception in Bangladesh, many people now seek services in clinics and buy name-brand contraceptives marketed throughout the country. As a result of this self-reliance, the resources that were once funneled towards community-based distribution can now be used for a wider variety of health services.
Lesson 8:
The financial and professional support of the private sector can be engaged to strengthen community programs and provide sustainability.

As a way to diversify their funding sources, some Pathfinder projects pursue partnerships with local and international businesses. Links with corporate social responsibility programs can be a sustainable way to provide services in specific communities because both parties benefit. Pathfinder receives funds for program activities and the partnership creates good will for the business in the community.

**Egypt**
Pathfinder has developed an ongoing partnership with Barclays bank through the Egyptian Finance Executive Foundation, a network of chief financial officers. In April 2006 Barclays donated $60,000 to the TAKAMOL project to renovate the Kafret Nasser clinic in Giza Governorate. The renovation was completed in July 2006, but the partnership has not ended. Barclays adopted the clinic and will continue to be involved in its upkeep and care. The bank has assigned an employee to be part of the clinic board and the clinic will send the bank’s managing director quarterly reports on their achievements to ensure sustainability of the partnership. The executive director of the Egyptian Finance Executive Foundation has invited the clinic board to a monthly meeting to present their activities and to discuss areas of possible future linkages.

Barclays interest in the TAKAMOL project’s social responsibility initiative inspired other foundation members to donate to the clinics as well. Mentor Graphics donated furniture and office equipment to the Nazlet El Ashgar clinic.

**Bangladesh**
The NSDP program in Bangladesh is also partnering with international businesses to improve clinics and increase access to services for the poorest of the poor. British American Tobacco, Bangladesh has formed an interesting alliance with NSDP to provide health care for farmers and their families. British American Tobacco bought 2,500 health cards, which act like insurance policies, providing all members of the family low-cost health care for one year. They have also donated funds to cover the cost of medicines and laboratory tests and support satellite clinics on their farms.

**Peru**
In 2002, under the CATALYST program, Pathfinder facilitated a partnership between two pharmaceutical firms, Schering Peruana and Pharmacia Upjohn, the social marketing organization, APROPO, and the Peruvian International Planned Parenthood Affiliate, INPPARES, to create a network of professional midwives in Lima called RedPlan Salud. Each pharmaceutical company provided $10,000 and a supply of contraceptives to launch the network.

By joining RedPlan Salud, midwives procure discounted reproductive health products and benefit from INPPARES’s promotion of the franchise. Men, women, and adolescents in the communities served by RedPlad Salud receive affordable, high-quality services close to their homes.

Since its inception, RedPlan Salud has grown from a network of 50 to more than 500 midwives. Schering continues to provide contraceptives at a reduced cost. RedPlan Salud is meeting its health objectives—it has distributed over 135,000 contraceptive products—and as a result of its operational efficiencies and strategic partnerships, has achieved financial sustainability.
Lesson 9:
Income-generating activities can significantly improve the lives of participants and advance program goals.

Tanzania
In June 2006 Pathfinder was awarded a two-year grant to establish a network of self-governing saving and investment groups in the Arusha and Armeru regions of Tanzania. The program will create 72 groups, drawing its membership largely from Pathfinder’s established network of CHWs, their clients, and members of local organizations such as women’s groups.

The project is based on the Village Community Banking (VICOBAs) model, which works like a revolving investment club, and has been used successfully in many other countries, and elsewhere in Tanzania. Members make weekly savings contributions, and once an initial training period has passed, they can borrow loans from the group’s savings up to three-times their personal savings amount. The interest rate and fees on the loan are decided by the group members and are paid into the group savings account. Money borrowed from the group can be used to fund business activities or for immediate needs such as school fees or housing.

VICOBAs is unique in both its investment model—interest on loans is paid directly to the investment group, not a higher authority—and in its ultimate goal. The VICOBAs program aims to empower communities to serve their vulnerable groups and build capacity and willingness to finance community services. It does this through education of its members—making it clear during the sensitization and training period that the program’s goal is to help them so that they can help others—and through a community endowment grant given to each investment group at the end of the 12-week training period that matches the amount of money saved by the group. All of the money earned from the interest this grant generates is to be used for community needs such as food or housing for widows, or school fees for orphans.

Both selection of group members and training is intense and thorough. Because members will be borrowing and repaying one another, mutual trust is essential. The 12-week training course is not just an introduction about how to run the investment group, but also covers the basics of village economics, and how money moves within the village, business planning, and how to manage the money that they earn.

Kenya
The COPHIA project in Kenya has linked with the Kenya Rural Enterprise Program (K-REP) to provide microenterprise loans to CHWs, their clients, and people caring for orphans. Like the Tanzanian program, groups are formed to begin a savings account. Each member is required to put a minimum of 50 Kenyan Shillings (less than $1) per week into the group savings account. Once a minimum amount of savings has been reached, K-REP issues the group a loan, most often used for a group business venture. The savings is used as collateral and
cannot be withdrawn by the group members. K-Rep charges 15 percent interest, which is used to manage the funds and increase the amount of money available for loans.

Within three years the program has provided 7,843 loans to 3,600 individuals with a 95 percent repayment rate (98 percent for women, 90 percent for men). Successful businesses have included selling vegetables, firewood, fruit juice, or other items, animal husbandry, bottling honey, a hair salon, bicycle repairs, tailoring, metal working, and boda boda bicycle taxis.

COPHIA has also provided seed money or materials for some organizations to establish income generating activities to fund their activities. Pathfinder provided the Community Implementing Initiative in Nairobi’s Mukuru, South B slum with an oven, baking table, trays, charcoal, and a trainer to teach their CHWs to bake bread. The money earned from selling the bread goes to feed and care for the CHW’s clients, care for orphans and vulnerable children, provide for CHWs immediate needs such as school fees for their children, and also helps fund a jewelry and hand-bag making project that brings in additional funds. After only one month, the bread-making initiative was creating an income of over 1,000 Kenyan Shillings per day (about $14).

**Ethiopia**

In Ethiopia, income-generating activities have been used to support women’s rights initiatives. A high prevalence of harmful traditional practices such as female genital mutilation, early marriage, and marriage by abduction is both a cause and an effect of women’s subservient role in Ethiopian society. In general, women in Ethiopia have little decision-making power within their families, including decisions about their own and their daughters’ reproductive health. The Empowerment of Ethiopian Women project advocates for women’s rights through community educational activities on the effects of harmful traditional practices, the organization of girls’ clubs, media outreach, and providing legal defense for women exposed to discrimination, harassment, and abuse. The project saw notable success and was boosted by the criminalization of female genital mutilation, early marriage, marriage by abduction, and other forms of gender-based violence.

As part of the project, Pathfinder trained 188 women in small-scale business management and provided them with seed money to establish businesses such as animal husbandry, dairy processing, beekeeping, pottery, tailoring, and baking. The income earned from these ventures did more than help provide their families’ financial security; it gave them negotiating power with their husbands. This ability to negotiate for their needs and for the rights of their daughters has been invaluable in these women’s fight for equality. Most of them are now using family planning, a testament to their empowerment.
Conclusion

The greatest lesson learned in Pathfinder’s 25 years of experience in community-based services, is that working at the community level is essential to improving the health and welfare of people in underserved communities. Donor interest in community-based projects ebbs and flows, but the need to engage communities in the development of their health services always remains.

Without strong community support and demand for RH/FP services, clinics cannot exist. Likewise, community-based services are not the end-point in the chain of health services communities require. The ideal health care situation requires an informed community that uses and supports their health care facilities, which provide compassionate, high-quality care by well-trained professionals.

As the lessons learned in this document outline, community health programs cannot be static. They must continue to grow and adapt to the needs of their environment. To meet this challenge, Pathfinder’s programs continue to find new ways to engage communities, such as including income generating activities, new, innovative forms of alternative service delivery; and developing the support local and government leaders.
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Without strong community support and demand for reproductive health and family planning services, clinics cannot exist. Likewise, community-based services are not the end-point in the chain of health services communities require. The ideal health care situation requires an informed community that uses and supports their health care facilities, which provide compassionate, high-quality care by well-trained professionals.