

Social mobilization project

Developing a dialogue on sexuality, bringing services to a very poor, traditional and highly conservative region, and engaging the community in ways once considered unimaginable are all positive outcomes of the **Social mobilization and expansion of sexual and reproductive health (SRH) services in Middle Guinea** project. By helping people to articulate their needs, the project also creates a demand for and an environment favourable to the provision of services.

Initiated by the Association Guinéenne pour le Bien-être Familial (AGBEF), the project's main objective is to promote access to sexual and reproductive health services in Middle Guinea (Fouta Djallon). The project has increased accessibility to services by introducing family planning and screening and treatment for sexually transmitted infections (STIs) into 17 rural governmental primary health care centres.

In addition, the project has set up community-based services in 90 villages – an approach greatly appreciated by the population and recognized by other health organizations in the region as best practice.

Project strategies include awareness-raising and community mobilization as well as service provision. In particular, advocacy aimed at religious and community leaders gains their commitment and active involvement; targeted activities are improving knowledge among women, men and young people; a model clinic in the regional capital Labé has been upgraded, and is diversifying its services and improving its effectiveness; and service providers in government health centres receive tailor-made training in sexual and reproductive health care.

These services are a life-saver for many people living in villages in this very remote, rural and inaccessible mountainous region, who would otherwise have to travel for many days to get to Labé. The innovative, dynamic and experimental nature of the project has also encouraged other initiatives, partners and donors to work within the structures created by AGBEF.

The project corresponds to the five priorities in IPPF's Strategic Framework: to meet the needs of young people, to increase access to services, to address issues related to abortion and HIV/AIDS, and to strengthen advocacy for SRH.

PROJECT TITLE

Social mobilization and expansion of sexual and reproductive health services in Middle Guinea

IMPLEMENTED BY

Association Guinéenne pour le Bien-être Familial (AGBEF). AGBEF was set up in 1984. A pioneering organization in the introduction of family planning, AGBEF is a close partner of the government in promoting sexual and reproductive health services.

PROJECT AIM

To promote access to sexual and reproductive health services in Middle Guinea (Fouta Djallon).

FUNDING

IPPF Vision 2000 Fund

BUDGET

US\$600,220

DURATION

July 1997 to December 2003





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Demographic data paint a challenging picture. Fertility is high, yet use of modern contraceptive methods is low; young people make up a third of the population and form the group most vulnerable to unwanted pregnancies and STIs/HIV/AIDS.

DEMOGRAPHIC DATA PAINT A CHALLENGING PICTURE

Guinea has four distinct natural regions, both geographically and culturally: Lower Guinea, Middle Guinea, Upper Guinea and Forest Guinea.

In 1988, the government set up primary health centres throughout the country. Four years later Guinea adopted a national population programme which aimed to increase contraceptive use, integrate SRH services into the national programme of vaccination and primary health care, improve the status of women and intensify the fight against HIV/AIDS. At the same time, a family planning programme was introduced in more than 100 health centres in Forest Guinea, and extended to Upper Guinea in 1993.

The status of women is low, with 70% married before the age of 20; induced abortions account for 3–5% of hospital admissions; and female genital mutilation is almost universal at 99%.

Despite its considerable unmet SRH needs, Middle Guinea did not benefit from this programme. Although 49% of women and 64% of men knew about contraception, the contraceptive prevalence rate was only 0.3% in 1999. The high rate of male emigration to countries with a high level of HIV/AIDS prevalence, as well as the marriage traditions of 'levirate' (where a widow marries the brother of her deceased husband) and 'sororat' (where a widower marries the sister of his deceased wife) are important risk factors for HIV infection.

Middle Guinea includes 10 of the country's 40 prefectures and communes. The population is mainly Muslim, and the region is populated by the Peuls.

Demographic data paint a challenging picture. Fertility is high, yet use of modern contraceptive methods is low; young people make up a third of the population and form the group most vulnerable to unwanted pregnancies and STIs/HIV/AIDS; the status of women is low, with 70% married before the

age of 20; induced abortions account for 3–5% of hospital admissions; and female genital mutilation is almost universal at 99%, one of the highest rates in Africa.

MODEL CLINIC ... CONTRIBUTING TO AN INCREASE IN CONTRACEPTIVE PREVALENCE

The Labé clinic sees, on average, 400 female clients per month. Most clients visit for family planning services – 15,807 between 1997 and 2003. The pill is the most popular method, followed by condoms and injectables. The total number of clients increased by 56% between 1997 and 2003.

AGBEF's clinic in Labé has been completely renovated: it acts as a model clinic for the project.

The clinic offers a wide range of services including contraception, diagnosis and treatment of sexually transmitted infections, gynaecological care and infertility treatment. General health services are also offered, especially for malaria and parasitosis. New services have been added in response to the unmet needs of the population: these include voluntary counselling and testing for HIV, emergency contraception and laboratory services.

Women make up 90% of the clinic's clientele: most are aged 20–30. Feedback shows that clients are very happy with the welcome and quality of staff: their approach is committed and warm, and staff are seen to have empathy with the community which makes the services attractive. A number of clients are under 20 and unmarried, proof of the non-discriminatory attitude of clinic providers towards young people.

The clinic's location in the town centre is both a plus and a minus. It is near the regional public hospital and four other public and private clinics that also offer SRH services and family planning. Its location partly explains the relatively low clinic attendance, and AGBEF will need to work hard to make the clinic more cost-effective and to further increase client flow by expanding the range of services (such as voluntary surgical contraception, male-oriented sessions, and services related to menopause, reproductive cancers and abortion-related care).

EXTENDING, EXPANDING AND UPGRADING HEALTH CENTRE SERVICES

The most popular method of contraception in the health centres is the condom, followed by the pill, injectables and spermicides.

The project works with 17 health centres established and managed by the government as rural primary health care centres. A key project achievement is that family planning and STI treatment have been integrated into these health centres. Service quality is assured through 14 AGBEF trainers who have trained 230 providers in contraceptive

technology, emergency contraception and the prevention and treatment of STIs/HIV/AIDS.

The centres are run by management committees made up of local community leaders who play an essential role in raising community awareness and gaining the support of local political and administrative authorities.

Paid community organizers were recruited by the project to work in the centres from 1999 to 2001: they played a key role in community mobilization and awareness-raising. Another project milestone is that 16 of the 17 community organizers passed the civil service recruitment tests – the equivalent of public health examinations – and their salaries are now paid by the government. Although some have remained in post, most have been transferred elsewhere, the downside of being a government employee.

COMMUNITY-BASED WORKERS ... A MUCH-VALUED PUBLIC HEALTH SERVICE

The most popular method of contraception distributed is the condom, followed by the pill. Some community-based service workers now also distribute the emergency contraceptive pill, a service added in 2004.

Community-based service workers sell contraceptive pills, condoms, spermicides and oral rehydration salts. Purchase and selling prices are set by the project, with the workers allowed to keep the profits, apart from emergency contraception pills which are presently sold at cost.

The project has 90 community-based service workers (47 male and 43 female) attached to the 17 health centres – five per centre. These workers are posted in 90 villages (one per village) with each worker also covering an additional three or four smaller villages, depending on their location.

The workers are chosen by the community according to certain criteria, such as their ability to read, write and count, as well as the level of trust they enjoy within the community. Their knowledge is clearly up-to-date and their reputation is growing: for instance, they have been asked by Médecins Sans Frontières to participate in a prevention programme against tuberculosis.

It is clear that community-based services have been, and remain, one of the most successful project components. Beneficiaries appreciate the ease of access and confidentiality of the services and have complete confidence in the workers. Community-based service workers are also an important source for distributing condoms to young people. Their non-judgmental approach in supplying young people with contraception is one of the most positive aspects of the project and workers view the supply of condoms to young people as a public service to prevent unwanted pregnancies, STIs and HIV/AIDS.

VIOLATIONS OF RIGHTS ... OPPORTUNITIES TO BREAK WITH TRADITIONAL PRACTICES

Members of a women's group in Labé summed it up: "If we don't know what our rights are, how can we claim them?"

An incredible amount of groundbreaking work has been done to initiate a dialogue about sexuality and SRH, and some attitude and behaviour change is evident, even in issues which are deeply rooted in the social culture (such as men's role as family decision-maker). Such advances – the result of pushing back the barriers to promote sexual and reproductive rights – are here to stay.

The development of a gender strategy that responds to the challenges of sexual and reproductive rights violations is a potential area for expansion. AGBEF could lead the fight against practices such as female genital mutilation, and forced and early marriages; other campaigning issues include increasing male acceptance of contraceptive use, and reducing unsafe abortions and the number of pregnant young women who drop out of school.

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Such advocacy work could include awareness-raising activities among men, partnerships with women's groups, forums for facilitating the dialogue between men and women, and the provision of legal and psychological counselling for women who are left on their own because of high rates of male emigration, polygamy and divorce.

UNCONDITIONAL SUPPORT FROM COMMUNITY AND RELIGIOUS LEADERS

The project mobilized 3,583 community leaders to encourage use of the services.

Community participation, using innovative communication techniques, has been a key strategy, and the success of the project's advocacy and awareness-raising activities is a direct result of the enthusiastic involvement of community groups and leaders. Community leaders include elders, members of the councils of mosques and women's associations, political and administrative leaders, and youth leaders.

Community-based services have been, and remain, one of the most successful components of the project. The impact and scope of the service is described by a community-based service worker in Kouramangui, in Labé prefecture.

"You cannot imagine the number of human lives we save through our work. The taboos which surround the issue of sexuality have been broken. Couples are able to control their reproduction and talk to each other at home. Sexuality is less and less a taboo: women are able to express their concerns in front of men. Young people buy contraceptives without shame or fear, something unthinkable a short time ago."

(Source: community-based service worker interviewed during the Final Evaluation, March 2004)

Developing a dialogue on sexuality, bringing services to a very poor, traditional and highly conservative region, and engaging the community in ways once considered unimaginable are all positive project outcomes.



profile

Guinea

The project enjoys unconditional support from community and religious leaders who act as essential links in raising awareness among communities on issues related to sexual and reproductive health. As a result, the project is making a significant impact on people's knowledge, attitudes and behaviour.

The involvement of imams has been an innovative and successful strategy and SRH messages are placed within a religious context and communicated during Friday prayers. An imam in Labé prefecture confirmed this: "Before [the project], talking about STIs or family planning was taboo in religious circles. Now, we talk about it by referring to verses of the Koran which focus on the health of the mother and the child."

GOOD INDICATORS FOR INCOME GENERATION AND SUSTAINABILITY

The fact that the health centres are government-run and now have fully integrated family planning and STI services is one of the key strategies for sustainability.

Widespread community support, the demand for services that has been created within the population and the development of skills among AGBEF personnel are also good indicators for sustainability.

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A strategy for increasing the income-generating capacity and cost-effectiveness of the model clinic could be achieved by expanding the range of services; reviewing the price of contraceptives, medicines, services and laboratory tests; vigorous promotion of services; and exploring the establishment of a mobile clinic with financial support from the community, for example through a system of mutual health insurance.

Two additional initiatives have complemented the project. In 2002, AGBEF received funding from the IPPF Netherlands Trust Fund to set up a youth centre in Labé and, in 2003, it obtained funding from the Compton Foundation to implement a project promoting emergency contraception.

DYNAMIC, INNOVATIVE AND EXPERIMENTAL APPROACH

The project has had many qualitative and innovative impacts, and a number of lessons have been learnt.

- The consistent involvement of community, political and religious leaders plays a vital role in establishing a dialogue about sexuality and SRH needs in an area which, while conservative, has a strong tradition of social mobilization and mutual support.
- The integration of family planning and STI services into the government's health centres is a major achievement which enables access to services in remote rural areas.
- The frequent transfer of staff by the regional government causes serious logistical difficulties.
- In the context of increased competition, and with new service outlets opening in urban areas, it is essential to regularly evaluate the cost-effectiveness of clinics in comparison to other models of provision which would enable a wider coverage in rural areas.
- The attendance rates at the model clinic could be increased through more aggressive promotion and marketing.
- The results of the project underline the advantage of AGBEF's decentralized structures and management.

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The project is located in 17 sub-prefectures, containing 90 villages spread over six of the 10 prefectures in Middle Guinea (Fouta Djallon), with a catchment population of 360,000 inhabitants.

- **Population is 9.2 million, with 34% aged 10–24.**
- **Human Development Index ranking: 157 out of 175 countries.** (Source: UNDP 2003)
- **Average life expectancy at birth is 49 years.**
- **The infant mortality rate is 97.8 per thousand live births.**
- **The maternal mortality rate is 1,200 per hundred thousand live births.**
- **The total fertility rate is estimated at 6.0 with only 6% of married women aged 15–49 practising family planning (4% for modern methods).**
- **Only 35% of all births are assisted by trained personnel.**
- **Population living with HIV/AIDS (15–49) is 3.2%.**
- **The literacy rate among adults is 27% for women and 55% for men.**

(Source: PRB 2004)

contact

Vision 2000 Funds, International Planned Parenthood Federation
Regent's College, Inner Circle, Regent's Park, London NW1 4NS, UK
Tel: +44 20 7487 7900 **Fax:** +44 20 7487 7950 **E-mail:** info@ippf.org

www.ippf.org

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