



Women's Lives, Women's Voices: Empowering women to ensure family planning coverage, quality and equity

REPORT





Contents

Executive Summary	4
Introduction	6
CARE's Approach	7
Linking Gender Equality and Family Planning	9
Ensuring Quality, Equity and Accountability Through Participatory Governance	12
Ensuring Reproductive Health in Conflict and Emergencies	15
Innovative Partnerships: Working with the Private Sector	18
Conclusion	18
Key Recommendations	20
Endnotes	22

Executive Summary

CARE International joins the global call to re-energize and restore progress in family planning. Increased investment, targeted programming and supportive policies are all critical to meeting the reproductive health needs of millions of women and men. Consistent with the 1994 Cairo Programme of Action, which placed women's empowerment and reproductive rights at the center of development, CARE believes that access to sexual, reproductive and maternal health services is both a fundamental human right and a critical development issue.

In addition to a call to reprioritize family planning, however, the London Summit on Family Planning also offers the opportunity to consider the lessons from previous programmatic work – what strategies are needed to more quickly and efficiently fill the unmet family planning needs of over 200 million women? We know that progress has slowed over the last decade because of a lack of investment, inadequate access, and adverse policies, but we should not underestimate other critical, yet often overlooked, obstacles to progress: pervasive and deeply ingrained gender and social norms that continue to inhibit women and couples use of family planning services. CARE's experience in sexual, reproductive and maternal health and in development more generally suggest there are several significant factors for improving family planning use and reproductive health outcomes. In addition to addressing inequitable gender and social norms, we need to strengthen systems of governance and accountability, and ensure women's reproductive health needs are met in development and emergency contexts.

Inequitable gender and social norms that subjugate women's needs to others in the family, limit her ability to participate in decision-making, her mobility and her access to family resources, and give her little reason to expect quality and respectful healthcare services, present a powerful barrier to family planning. In our programming, we have observed firsthand the transformative power of directly addressing inequitable gender and social norms, helping people think differently about their roles and rights as women and men and make informed decisions about their reproductive choices. In a two-year controlled trial in India, CARE implemented a community-based intervention designed to encourage communities and couples to discuss, reflect on, and question harmful gender and social norms which led to substantial and statistically significant differences in women's mobility and access to resources. The proportion

of women who discussed contraception with their husbands doubled from 42 percent to 90 percent, and the proportion who delivered with a skilled birth attendant also increased significantly. Building on this experience, CARE developed the Social Analysis and Action approach, which has been used in multiple countries to surface and stimulate reflection on gender and social norms, often leading to transformation and greater equality in families and communities. While many believe that norms are resistant to change, our experience suggests that meaningful change can occur in a relatively short period of time and that transforming norms can unlock demand, enabling program success.

Empowering women overcomes barriers at family and community levels increasing women's ability to make decisions about their family size or spacing of pregnancies. For this opportunity to be realized, however, accessible and acceptable healthcare services must be available and providers must be held accountable for quality services. While trained healthcare workers and adequate supplies of contraceptive methods are critical, alone they are not enough to overcome systemic barriers in reproductive and maternal health. Disrespectful care – especially toward women who are poor, from a lower caste or an ethnic minority, or are unmarried – acts as a powerful disincentive to seeking family planning services. Further barriers are raised by differences in gender, social class, language and ethnicity. CARE's approach to overcoming these barriers has been to facilitate local governance structures and processes that bring together citizens, healthcare providers and local government officials to promote responsiveness to community needs, to improve quality and acceptability of care, and to ensure accountability and transparency.

Governance models differ depending on existing structures and local context. In Peru, CARE has trained indigenous women to be "social monitors" who observe health facilities and discuss with women their experiences receiving care. Findings are shared with an Ombudsman, civil society groups and healthcare providers, and action plans are developed to address concerns raised. Evaluations have shown increased knowledge of women's rights; greater satisfaction with services; increased acceptance of cultural traditions; and a one-third increase in the number of facility births after one year. This success contributed to citizen monitoring being institutionalized as national policy in Peru and has been shared with the UN Human Rights Council as an example of

a rights-based approach to maternal health. CARE has also used the Community Scorecard process – an approach where community members and healthcare providers independently define what they consider quality services; come together to develop a combined list; rate the current quality; and develop and monitor action plans to address deficiencies. Through these participatory governance approaches, we have witnessed the power of communities to sustainably improve the performance and responsiveness of their health systems, and to hold governments accountable to upholding policies and providing appropriate services.

In many countries, natural disasters and conflict threaten and reverse progress in family planning. The need for family planning and reproductive health services is particularly acute in disaster and conflict settings where health systems may have collapsed, supplies are scarce, and conditions are hostile to pregnancy and childbearing. Over the past five years, CARE has responded to 123 natural and conflict-related emergencies. CARE is a founding member of the Reproductive Health in Emergencies Consortium, and in 2012 adopted sexual and reproductive health as one of four focal areas for our humanitarian response, along with food, shelter and water. CARE is committed to providing the Minimal Initial Service Package for Reproductive Health as part of our emergency response work wherever appropriate and feasible. Working in challenging environments such as Eastern Democratic Republic of Congo, Chad and Pakistan, CARE has trained providers, built supply chains and addressed gender and governance issues, and in every setting has increased family planning use, particularly with long-acting methods.

At this pivotal moment, it is essential that greater commitment to family planning be linked with strategic approaches that lead to greater effectiveness. To increase the effectiveness and sustainability of investments and to reach the goals laid out at the London Summit on Family Planning, CARE International calls on governments, donors and civil society to:

- Put reproductive rights, women’s empowerment and gender equality at the center of programming and policy
- Strengthen local accountability mechanisms to promote quality, participation, transparency, equity and local ownership
- Ensure women and girls’ family planning and reproductive health needs are addressed in emergency and post-conflict response activities

In the document that follows, we share evidence and experience from our global programming to illustrate why we believe these areas are critical. We are committed to working in partnership with women, communities, civil society, governments, donors, and the private sector to implement these recommendations, to reduce the unmet need for family planning and to make reproductive rights a reality for all.

Introduction

As the world comes together to refocus commitment to family planning, CARE International joins the call to expand support and prioritize resources to address this global challenge. In spite of significant evidence and widespread recognition that family planning is an effective and cost-efficient strategy for improving health and development, millions of women, girls, and couples continue to have an unmet need for family planning. The question is, why have gains in family planning use stagnated? The answers are not just about money or supplies – real answers must also address gender inequality, pervasive social and cultural norms and poor governance that prevent women and girls from being able to access information and services that could save their lives.

Whereas increasing access to healthcare services will result in some gains, emerging data suggest that physical access to services is often not the major barrier to family planning. While it is essential to ensure an adequate and consistent supply of family planning commodities, this

alone will not overcome the barriers that prevent women from using them. And although we need policies that are supportive of family planning, if these policies are neither implemented nor enforced, or if they conflict with cultural norms, as they often do, family planning uptake is unlikely to increase, and the opportunity for the resulting health benefits will be missed. Programs and policies that remove barriers to access and eliminate interruptions to supply must be accompanied by programs that work with women and men to address social barriers to their utilization of family planning services, that empower people to take control of their reproductive lives, and that enable women and communities to hold health systems accountable for providing high-quality, responsive services. In addition, we must ensure that women's reproductive health needs are met during emergency contexts, where vulnerability and barriers to services are elevated. In this paper we highlight lessons learned from CARE's global work in sexual, reproductive and maternal health, focusing on those areas we believe are most critical to reaching our global family planning goals.



CARE's Approach

Since the late 1990's, CARE's programming has been moving steadily from a needs-based approach to a rights-based approach—one that seeks to reduce risk and vulnerability by addressing the underlying causes of poverty and social exclusion (see Box 1). A rights-based approach to health rejects the idea of health as a user-pays commodity and establishes healthcare as a right which every citizen is entitled to claim, and which the State is obligated to progressively realize. It is based on principles of respect, transparency, participation, inclusion and equity.

CARE believes that access to sexual, reproductive and maternal health services is both a fundamental human right and a critical development issue, in line with the 1994 Cairo Programme of Action, which placed women's empowerment and reproductive rights at the center of development.¹ In many countries, the low status of women and girls and persistent gender inequality are closely associated with women's inability to exercise their sexual and reproductive rights.² The realization of the "right to health" cannot be achieved through direct services alone; large-scale and sustainable change requires that we address underlying and systemic factors, including gender inequality, policy barriers, and power imbalances that have an impact on health.

As an organization that focuses on reducing global poverty and increasing social justice through the empowerment of women and girls, CARE has considerable experience in addressing underlying social factors to bring about more just and lasting change. CARE's over 65 years of experience and our work in more than 70 low to middle income countries, have shown that two of the critical factors for improving

the health and well-being of women and families are: 1) changing the relationships between people in families and communities by addressing social norms relating to gender roles; and 2) changing the relationships between people and communities, service providers, governments, and other power-holders by strengthening systems of equitable governance and mutual accountability.

In our work in sexual, reproductive and maternal health in particular (see Box 2), we have observed firsthand the transformative power of directly addressing inequitable gender and social norms. Helping people think differently about their roles and rights as women and men is a critical factor in empowering women and girls, in helping them make informed decisions about their reproductive choices, and ultimately in enabling behavior change and family planning uptake. In our work on participatory governance, we have witnessed the power of communities to sustainably improve the performance and responsiveness of their health systems, and to hold governments accountable to upholding policies and guaranteeing community entitlements, when they know their rights and are empowered to speak for their own needs.

While our programming in sexual, reproductive and maternal health prioritizes sustainable solutions in communities where we have a long-term presence, emergencies due to environmental instability, natural disaster, and conflict increasingly cause major disruptions to the provision of services. The successful integration of family planning into our emergency humanitarian responses has the power to ensure continuity of services for millions of the world's most vulnerable women.

Box 1. CARE's Rights-Based Approach

Ensuring the rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children can be applied at many levels: through treaties and international covenants, through national laws and policies, and through local customs and practices. As an organization dedicated to reducing poverty and achieving social justice, CARE works at all of these levels to secure the rights of the poorest, most vulnerable and marginalized among us. CARE right's-based approach seeks to:

- Increase opportunities for people to meet their basic needs and attain livelihood security;
- Promote individual and community efforts to overcome social inequity so that people can live a life of dignity and enjoy their rights without discrimination and exclusion; and
- Promote sound and equitable governance systems and policies to create a climate that promotes equity, justice and livelihood security for all, with governments and other actors meeting their human rights obligations.

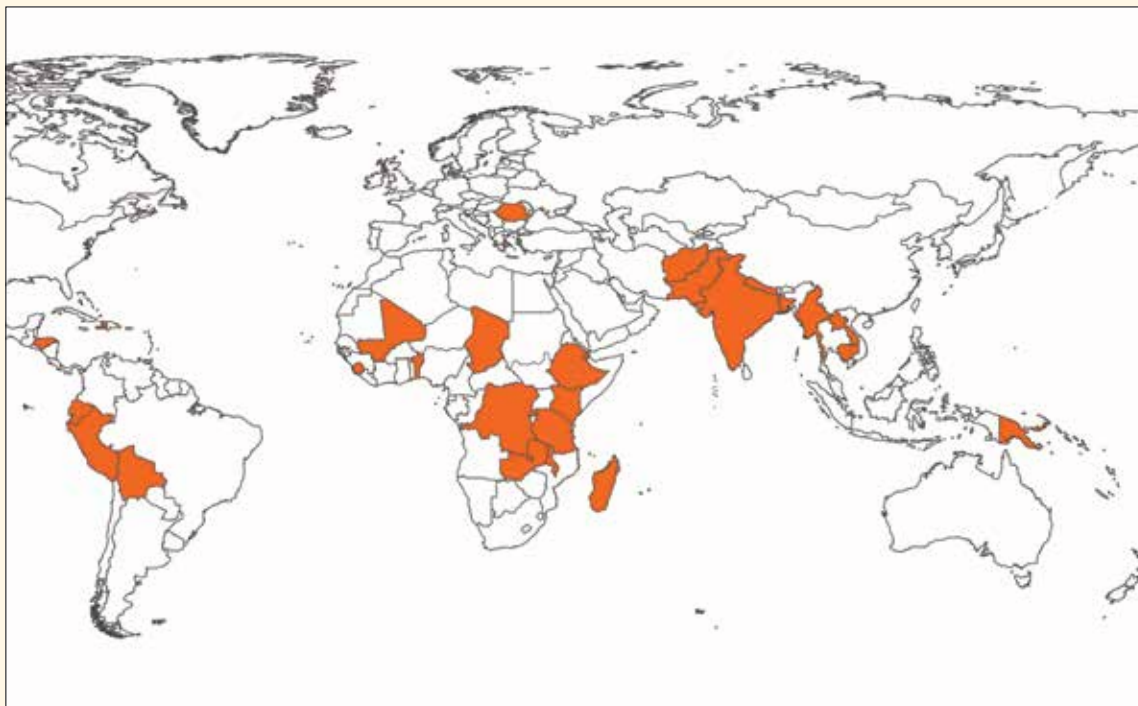
Box 2. CARE's Sexual, Reproductive and Maternal Health Programming

CARE has been working on sexual, reproductive and maternal health programming for over 50 years, and is currently working in over 30 countries on these issues. These countries have some of the highest unmet need for family planning services,³ and some of the lowest contraceptive prevalence rates⁴ in the world.

CARE's sexual, reproductive and maternal health program uses the following overarching strategies:

- Working with **communities** to empower women and promote gender equality and social equity to overcome barriers to the timely use of health services and improve healthy behaviors.
- Working with **health systems** to bring services to the community level, facilitate ongoing quality improvement, and enhance acceptability and responsiveness to community needs.
- Strengthening **participatory governance** structures and processes involving community, health system, and government representatives in shared oversight, responsibility, and accountability, and ensuring community voices are heard in local, national, and global policy circles.

In addition, sexual, reproductive and maternal health is also critical in times of natural and conflict-related emergencies, as women and young girls are often subjected to an increased risk of sexual violence, unwanted pregnancies and overall lack of control over their situation. CARE is working to ensure that the Minimal Initial Service Package for Reproductive Health,⁵ which addresses family planning, gender-based violence, maternal and newborn care, and sexually transmitted disease prevention and treatment, is implemented as part of our emergency response activities.



Africa

Benin
Chad
Djibouti
DR Congo
Ethiopia
Kenya
Madagascar
Malawi
Mali
Rwanda
Sierra Leone
Tanzania
Zambia

Asia

Afghanistan
Bangladesh
Cambodia
India
Laos
Myanmar
Nepal
Pakistan
Papua New Guinea

Latin America and Caribbean

Bolivia
Ecuador
Haiti
Honduras
Peru

Middle East and Eastern Europe

Romania

Linking Gender Equality and Family Planning

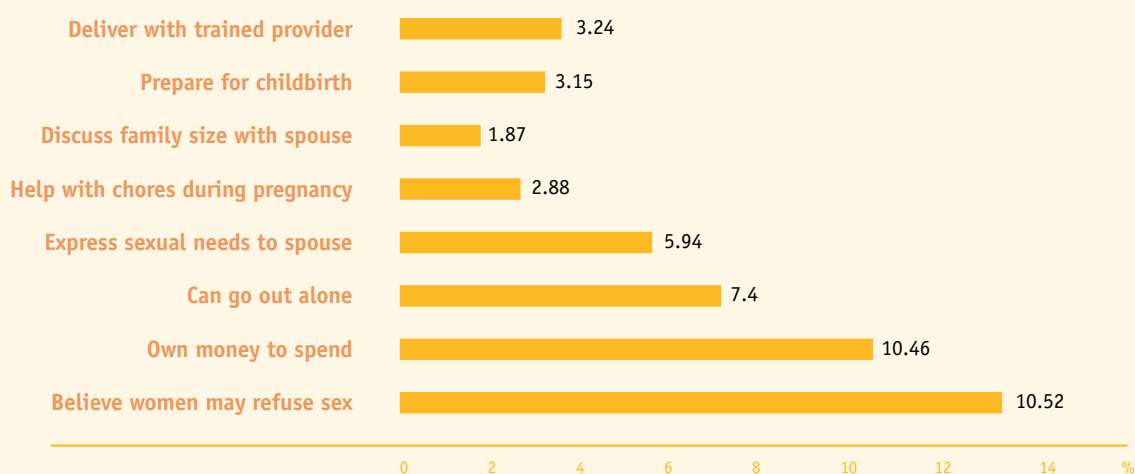
Every woman has a fundamental right to make her own decision about whether she wants to bear children, when, and how many. The duty to fulfill basic human rights should be sufficient to move the international community and national governments to action. But for a woman living in a rural Indian village, consideration of her individual and reproductive rights may be of little relevance when contrasted with the power of prevailing social norms. For example, in 2007 at the start of an initiative called Inner Spaces, Outer Faces (ISOFI),⁶ CARE surveyed women in rural Uttar Pradesh, India and found that the majority of the respondents believed their husbands had the right to beat them if they refused sex.⁷ It is not surprising that women themselves internalize such norms and feel unable to challenge them. After a two year community-based intervention designed to encourage communities and couples to discuss, reflect on, and question harmful gender and social norms, the proportion of women who held this belief had decreased by more than 80 percent, with no change in a nearby control district. Critically for family planning programming, we also saw that the proportion of women

in the intervention area who discussed contraception with their husband more than doubled, from 42 percent to 90 percent, that good maternal health behaviors significantly improved, and that other measures of women's empowerment such as increased mobility also were significantly greater (see Figure 1).

A growing body of evidence supports CARE's experience: women's empowerment and gender equality can have a positive impact on a range of health and development outcomes, even after controlling for education, economic status, religion, and other social factors. Social and gender norms present critical, yet often unacknowledged or unaddressed barriers to sexual, reproductive and maternal health. For example, the balance of power in relationships has been found to influence use of condoms,⁸ use of contraception,⁹ and use of health services.¹⁰ Fear of intimate partner violence and experience of gender-based violence are barriers to contraceptive use,^{11, 12} and a study from Bolivia found that experience of gender-based violence reduced demand for family planning and reproductive health services by 30 percent.¹³ Analyses of data from Demographic and

Figure 1: Results from CARE's Inner Spaces, Outer Faces Initiative 2010

Association between living in the intervention district at endline and selected factors (Adjusted Odds Ratios)*



*All odds ratios are significant at the 5 percent level. An odds ratio estimates how strongly a variable is associated with the outcome of interest

Health Surveys (DHS) in a number of African countries have shown that women’s empowerment, including equitable attitudes and beliefs about gender and participation in economic decision-making, is associated with smaller ideal number of children¹⁴ and contraceptive use.¹⁵

Still, while studies have consistently shown that communication, particularly communication between spouses, is positively associated with use of family planning,¹⁶ open discussions and public dialogue on issues related to gender and sexuality remain taboo in many settings. To help break this cycle, building on experiences like ISOFI, CARE has developed an approach called Social Analysis and Action (SAA) (see Box 3).¹⁷

The SAA approach has been used as part of integrated family planning and reproductive health programming in Ethiopia, Rwanda, Kenya, Mali, Madagascar, and Honduras, among other countries. As part of the Social Change for Family Planning Results Initiative, family planning programming was integrated into a food security program in Ethiopia, a women’s Village Savings and Loan groups in Rwanda (see Box 4); and a prevention of mother-to-child transmission

of HIV program in Kenya.¹⁸ The Results Initiative used the SAA approach to initiate reflection, critical dialogue and problem-solving about how social and gender norms affect sexual, reproductive and maternal health, including family planning. SAA was complemented by health systems strengthening interventions that improved the quality of and availability of family planning information, referral and method provision at both the community and clinic levels. A mid-term review of the Results Initiative in 2010 revealed a number of promising changes related to family planning. For example, community members in all three countries reported more communication in their household about sexuality and family planning, and more shared decision-making around household duties, finances, and family planning. In Kenya, the review suggested promising changes in health seeking behaviors, with more couples seeking family planning and voluntary counseling and testing services together—including women who had previously hidden use of family planning from their partners.¹⁹ Family planning utilization data at health posts and clinics showed an overall increase in use of family planning from 18 percent in 2008 to 56 percent in 2011.²⁰

Box 3. Social Analysis and Action: Addressing Social Factors that Influence Sexual and Reproductive Health

Social Analysis and Action is intended to catalyze a process of dialogue and reflection, leading to actions that support more equitable gender norms. CARE staff and communities discuss and explore power relations, and reflect upon and challenge existing social and gender norms that shape perceptions, expectations, decisions, and behaviors around sexual, reproductive and maternal health. Repeated dialogue sessions provide the space to explore, analyze and challenge these norms. They are also intended to increase people’s comfort with discussing sexual, reproductive and maternal health issues, and enhance understanding of how attitudes and norms may facilitate or inhibit healthy behaviors and outcomes.



A unique feature of SAA is that it starts with dialogue and reflection sessions with CARE staff, who examine their own beliefs and behaviors, and reflect on how these beliefs may influence how they approach their work. As a development approach, SAA assumes that honest and open exploration of sensitive social issues among community members is not possible if CARE field agents enter a community as “experts”—i.e., with a pre-defined problem to be addressed and with a set of prescribed messages and specific changes to press on the community.

Box 4: Village Savings and Loan Associations as a Platform for Integrated Women’s Empowerment and Family Planning Programming

Comprehensive financial services for the poor—particularly those focused on women—have far-reaching benefits for families and communities. Microfinance and access to financial opportunities are an increasingly effective strategy for economic empowerment for women, providing savings and financial services for those who are otherwise excluded from formal credit institutions. Savings-led approaches such as the Village Savings and Loan Associations (VSLA) methodology pioneered by CARE in the early '90s can create a platform to link women to economic opportunity, and expand their self-determination.

As part of the Results Initiative in Rwanda, CARE is testing a model for integrating family planning and women’s empowerment programming into VSLA. The activities of both initiatives work synergistically to contribute to a range of empowerment outcomes for women including social and economic empowerment as well as better sexual and reproductive health. As part of the pilot, peer educators trained in the Social Analysis and Action approach facilitate reflection and discussion in VSLA groups to identify and challenge restrictive gender roles and inequitable power dynamics in households. Addressing gender dynamics helps to ensure women’s meaningful participation in VSLA, as well as women’s ability to negotiate for and access family planning services. VSLA groups provide a critical platform for convening women and couples to have these discussions as well as to share family planning information and linkages to services. A final evaluation of this approach will be conducted in 2013.

While most people believe that inequitable gender and social norms are resistant to change and any progress will inevitably be slow, CARE’s experience in multiple countries is just the opposite: when families and communities surface

and question prevailing beliefs, they often find that new ways of interacting are good for their health, relationships, and well-being. Consider the story of Meeta and Ramkishore, a couple living in Madhopur, India (see Box 5).

Box 5. Meeta and Ramkishore²¹

In early 2010, with an infant in her arms, another on the way, and a heavy load of daily household chores, Meeta quickly grew weak and ill with exhaustion. Ramkishore did not help with chores. In Madhopur, household tasks are deemed “woman’s work.” Men seldom lend a hand around the house and often taunt other men who do. A social worker in the village noticed how weak and tired Meeta looked and invited her and Ramkishore to attend one of CARE’s maternal health meetings. The gatherings foster an atmosphere of openness, helping to improve the health and wellness of people in the village through communication, education, family planning, and the promotion of marital harmony.

Ramkishore’s eyes were opened during these maternal health meetings. He didn’t realize he was placing a burden on Meeta by not doing household chores or taking care of their daughter. Once he understood what Meeta was going through, he enthusiastically committed himself to helping her. Ramkishore was so moved by the profound and positive transformation in his home, that he began sharing his knowledge with other men in the village, organizing theater performances and film screenings to foster discussions of social issues. Understanding his wife’s needs turned him into an activist for the equality and well-being of all women.

Meeta gave birth to a healthy baby boy. She says she plans to use the family planning opportunities presented to her by CARE to ensure that any future pregnancy will occur at a time of her choosing. Ramkishore fully supports this choice and vows to continue speaking to men in the community about the importance of treating their wives with kindness, dignity and respect.



Because empowering women and girls and achieving gender equality play such a central role in CARE's work, we are developing a new tool to strengthen measurement of women's empowerment so that we can do a better job evaluating the impact of our programming on health and

development outcomes (see Box 6). These measures, once validated, will be widely shared for use and adaptation by CARE and other partners and organizations to contribute to our collective work in strengthening measurement of women's empowerment and gender equity.

Box 6. New Tool for Measuring Women's Empowerment

CARE is developing a multidimensional tool for measuring women's empowerment outcomes in sexual, reproductive, and maternal health and nutrition programs. Our goal is to design a practical tool, with a manageable number of questions, which CARE programs can use to measure women's empowerment outcomes across several key domains. This tool will help us more systematically measure the outcomes of our work, and better understand the relationship between women's empowerment and key health behaviors and outcomes.

The measures were built on and adapted from several validated measures, including the Gender Equitable Men (GEM) scale, the Sexual Relationship Power Scale (SRPS), the DHS Women's Empowerment Modules, and the World Bank Social Capital Assessment Tool (SCAT). Because so many of CARE's projects aim to achieve women's empowerment by enabling collectivization and catalyzing collective action, we prioritized inclusion of a set of items to measure changes in social capital, including social support and membership/participation in groups.

We also developed new measures where we found gaps, including a new set of self-efficacy measures that explore how women's confidence to enact health-promoting behaviors (e.g., use of family planning) is mediated by gendered power relations. We are in the process of field testing and validating the measures in two countries (one in Africa and one in Asia) and plan to publish our results and disseminate the measures for further refinement and validation.

Ensuring Quality, Equity and Accountability Through Participatory Governance

Empowering women and transforming inequitable gender and social norms will help overcome barriers to family planning access at the family and community levels, and increase women's ability to make decisions about their family size or spacing of pregnancies. Changes at this level, in conjunction with increased availability of trained health care workers and adequate supplies, will go a long way toward achieving reductions in unmet need. Still, these things are not enough. The quality of healthcare services is another critical variable in this equation: unless women are treated with dignity and respect, unless their privacy is guaranteed, unless they have all the information they need to make decisions, unless services are provided in a culturally appropriate manner and unless they are comfortable refusing services they do not want, many will choose not to seek family planning or other reproductive health services. While data are limited, several studies have shown that women are more likely to seek out and continue using family planning services they consider respectful and friendly;²² and for maternal care, a 2010 review concluded that, "Growing evidence suggests disrespect and abuse may sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles."²³

The same social and gender norms that influence individual and communities attitudes toward family planning may also be shared by program staff and healthcare providers.

As one CARE staffer from Rwanda noted: "In the past, other CARE staff called us "Agents of Satan" because we talked about sex and reproductive health. Now they come to us for information about family planning and sexuality."²⁴

These norms may limit the willingness of a healthcare worker to provide contraception to an unmarried adolescent girl or to a widow, for example, or they may lead to disrespectful treatment of a woman who is from a lower caste, is poor, or is from an ethnic minority. Exacerbating this situation is the substantial power differential between healthcare providers and clients. This inherent difference is magnified as providers generally have more education, come from higher socio-economic strata, and are often men. And in some settings these differences are further complicated by differences in language and ethnicity.

In one of CARE's maternal health programs in the highlands of Peru, Spanish-speaking healthcare providers did not communicate effectively nor provide services in ways that were culturally acceptable to Quechua women. Community

members identified this as an important barrier to their use of reproductive and maternal health services. CARE worked with community members and healthcare providers to identify solutions. As a result, signs were posted in the local language—Quechua—informing women of their rights, translators were made available, and culturally appropriate maternal health practices were adopted. These changes contributed to increased rates and timeliness of maternal health care-seeking, and within four years, maternal deaths had decreased by 49 percent from baseline.²⁵

The Peru experience shows the power of increasing the acceptability of care, and the need to engage communities and health providers as agents of change; however, further work is needed to promote systematic and sustained engagement between communities, healthcare providers and the government. For example, in a program called Participatory Voices in Peru, CARE collaborates with local partners in Huancavelica, Piura and Puno — regions with some of the highest maternal mortality rates — to strengthen the capacity of civil society networks and organizations to promote, advocate, monitor, and report on the quality of health policies and services. The work is spearheaded by indigenous women trained to be “social monitors”, who visit and observe health posts, hospitals, and pharmacies, and discuss with women their experiences in receiving care. The social monitors regularly produce reports and analyze them together with the Ombudsman Office, CARE, and the main health civil society network Forosalud. These findings are then shared and discussed with the health care facilities and providers, and an action plan is developed to address any concerns raised. This process creates space for sustained, systematic dialogue on what women expect from the healthcare system and the achievements and failures of health care delivery, thus promoting accountability to rural women’s expressed needs and increasing awareness of the rights and responsibilities between health service providers and users.

Evaluations of Participatory Voices show that it has increased knowledge of women’s rights among health providers and women are more satisfied with health services due to improved health worker attitudes, responsiveness, and acceptance of cultural traditions. A quantitative evaluation

showed a 33 percent increase in the number of births in health facilities in Puno within one year.²⁶

Through advocacy and technical assistance, this work has significantly impacted national and global action on participatory approaches to health. At the national level, the initiative, coupled with technical assistance from CARE, contributed to the institutionalization of citizen-monitoring activities as part of Peru’s national policy and the launch in 2011 of National Policy Guidelines for the Promotion of Citizen Health Monitoring.²⁷ A joint effort is underway between the Ministry of Health, the regional and local governments and civil society networks to support implementation of these mechanisms of citizen participation across the country. This will ensure that the right of citizens — rural, indigenous women in particular — to respectful and culturally appropriate sexual and reproductive health care is realized.

At the global level, CARE’s experience has informed the UN Human Rights Council’s development of guidelines on how to implement a rights-based approach to maternal health, in support of their 2009 resolution on maternal mortality.²⁸ CARE’s work, documented by the International Initiative of Maternal Mortality and Human Rights, shows how the principles of international human rights frameworks, such as participation, transparency, equity and accountability can be used at the local level in an effort to strengthen the quality of care provided in health care services.²⁹

The principles underlying the Participatory Voices program are found throughout CARE’s participatory governance work. Each approach brings together community representatives, health care providers, and other stakeholders from the local and district authorities, in a process of identifying needs, concerns, and barriers to effective service delivery and healthy outcomes. Working together, they identify problems and develop and implement solutions, generating buy-in and motivation, and leading to improved care and outcomes, accountability, and transparency. One approach CARE uses to facilitate the participatory governance process is the Community Scorecard, an internationally recognized model initially developed by CARE Malawi (see Box 7).

Since 2008, CARE has implemented the Community Scorecard process in 16 communities in the Mwanza Region of Tanzania. An assessment of the approach found increased utilization of family planning services, a stronger commitment by service providers to deliver quality services, greater citizen participation in planning, improved understanding of the constraints faced by providers, and more transparency and accountability.³⁰

As one health facility user explained, “We used to think that we were not supposed to sit near the doctor and ask questions of him directly, but this [Community Scorecard] process has made it easier for us to engage directly with the doctor and health service providers. Our situation has improved.”

In addition, the Community Scorecard process is currently being rigorously evaluated in Malawi through a cluster-randomized controlled trial to assess the impact of the process on increased coverage, quality and equity of sexual, reproductive and maternal health services. These results will be shared widely to inform ongoing use of the Community Scorecard process.

Another model of participatory governance involves strengthening existing structures for health system oversight, while supporting more robust community participation. As

many health systems decentralize, oversight committees are established at the local level with healthcare providers, local government, and community representatives; yet in many cases, these committees have limited functionality. As part of the Extra Mile Initiative in an extremely remote area of Eastern Madagascar, CARE implemented a community-based family planning program, including education and contraceptive distribution.³¹ In addition, we mobilized and strengthened the Social Development Commission, a legally-mandated body composed of elected officials, healthcare providers, and civil society. These groups were supported to plan, manage, and monitor services more effectively and transparently; maintain the “social equity fund” used to ensure free medicines (including contraceptives for the poor); and report on health and family planning statistics to ensure accountability to results. By the end of the project, the Social Development Commissions were functional, and included 31 percent women and representatives from 40 civil society groups.³² Provider absenteeism and stock-outs decreased, beneficiaries of the social equity fund significantly increased, and family planning knowledge among both women and men increased to more than 90 percent. Most importantly, family planning use by women of reproductive age more than doubled from 11 percent to 28 percent during the same period.

Ensuring Reproductive Health in Conflict and Emergencies

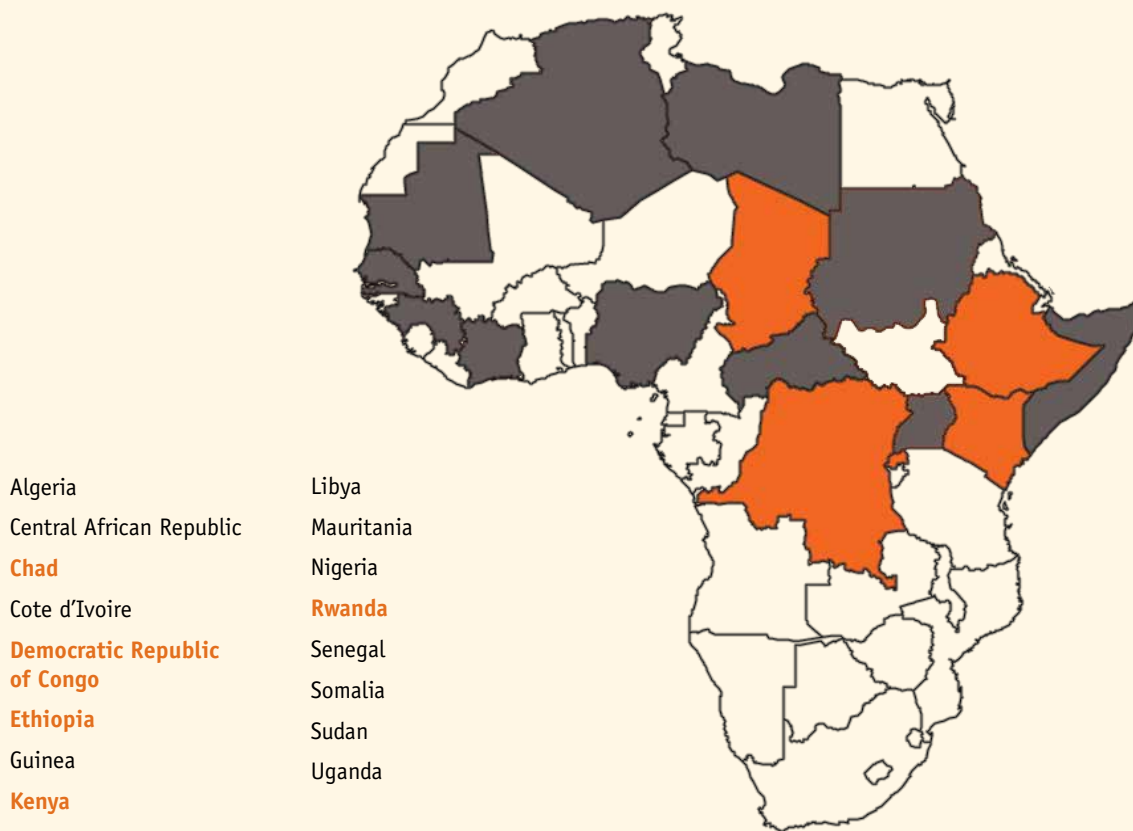
The last several years have seen an unprecedented number of disasters, from the massive earthquake in Haiti to the extreme flooding in Pakistan: there are currently an estimated 400 natural disasters per year, compared to 200 per year 20 years ago.³³ In 2010 alone, more than 42 million people were displaced by natural disasters.³⁴ Further, natural disasters can contribute to conflicts by increasing competition for scarce resources, shifting power relations, and exacerbating existing inequities. In 2010, there were 16 new or continuing armed conflicts in Africa (see Figure 3).³⁵ Ongoing conflict plagues some of the very nations most in need of family planning services and most at risk for disaster, including the Sudan, Ethiopia, Somalia, Senegal, Nigeria, the Democratic Republic of Congo (DRC), Uganda, and Kenya.

The negative effects of these shocks disproportionately affect the people least able to cope with them—especially women, who make up the majority of those who die in natural disasters. Moreover, the damage from disasters and

conflicts threatens development gains, and can undermine years of investments by governments and donors in improving the lives of families and communities.³⁶ These events also exacerbate existing gender inequalities and pre-existing vulnerabilities; for example, a woman’s risk is particularly acute during conflicts, where rape is used as a weapon of war, as has been the case in some 36 recent conflicts.³⁷

These trends have major implications for our work. How can we reduce vulnerability to these events and allow investments in education, economic development, and health to take hold? How will we meet the unmet need for family planning when disasters and chronic conflict threaten to wipe out any gains we make? One implication is clear: we cannot expect progress in meeting the unmet need for family planning to be perfectly linear; in many cases, progress will mean cycling between periods of building sustainable programs and periods of humanitarian assistance where we will directly deliver, or try to maintain, access to critical services and commodities.

Figure 3: Armed Conflict in Africa Since 2010



Countries CARE currently has SRMH programming in orange

This will take a significant shift in mindset both within the development and the humanitarian communities.

Although reproductive health services are among the most important life-saving interventions in times of crisis, these services were long overlooked in the traditional humanitarian response to complex emergencies. Response agencies argued that these services were not as critical as other life-saving interventions, and that they were more appropriate in long-term development contexts. And yet, the need for family planning and reproductive health services is particularly acute in disaster-affected and post-conflict settings; in these settings, health systems may have collapsed, families and communities may be dispersed, health workers and supplies may be scarce, and sexual violence is common. Cut off from their regular source of reproductive health services and contraceptive supplies, and thrust into conditions hostile to pregnancy and childbearing, women are more likely to turn to unsafe abortion when facing an unplanned pregnancy. As a result, UNFPA estimates

that 25-50 percent of maternal deaths in refugee settings are due to complications of unsafe abortion.³⁸

Over the past five years, CARE has responded to 123 natural and conflict-related emergencies, and has been working to reach women in disaster- and conflict-affected settings with needed family planning and reproductive health services for several decades. As a founding member of the Reproductive Health in Emergencies Consortium, CARE worked with partners to develop and launch the Minimum Initial Service Package for Reproductive Health to ensure adequate reproductive health services, including family planning, in acute emergencies. In recognition of the importance of reproductive health in both our development and humanitarian work, we have strengthened our commitment to sexual, reproductive and maternal health as one of our top priorities, and in 2012, CARE International adopted sexual and reproductive health as one of four focal areas for our humanitarian response, along with food, shelter, and water.

The challenges to providing reproductive health services in acute as well as protracted emergency settings are enormous, perhaps only matched by the need itself. When CARE implemented the *Uzazi Bora* project in Kasongo district in 2007, the area was still recovering from war—indeed, this part of DRC has been home to conflict for the last 15 years. The district was also characterized by severe geographic isolation there are no roads linking the district to the rest of Maniema province, or the country as a whole—and chronic neglect and underinvestment. The health system reflected this: most health centers in the district did not meet even minimal standards for care. Staff were underpaid and had little support or supervision. Turnover was high, especially in the most remote villages. Drugs, supplies and materials were grossly insufficient, and logistics systems were broken. Maternal and newborn health indicators in Kasongo were among the worst in DRC.

From mid-2007 to mid-2011, CARE and its partner, the local ministry of health (*Bureau Central de Zone*, or BCZ) and its 22 health facilities,³⁹ implemented a range of activities to strengthen the health infrastructure, to increase use of data at the facility to guide service delivery, and to engage the community through social and behavior change communication. All 22 health facilities were supplied with equipment and initial stocks of consumables. When *Uzazi Bora* began, only 40 percent of women in the project area reported that their most recent birth had been attended by a trained service provider.⁴⁰ Two and a half years later, the figure had nearly doubled, to 78 percent. The contraceptive prevalence rate for all modern methods rose from 2.8 percent at baseline to 5.9 percent just 20 months later. This was a significant gain in a relatively short time, given the chronic difficulty of ensuring supplies in Kasongo: stock outs of family planning supplies were so frequent that CARE chose to directly source supplies from United Nations Population Fund and a neighboring province, while joining others to advocate for improvements to the national system.

As Aruna Saleh, head nurse at Kilometer 18 Health Center, explains, “I’d had exposure to contraceptive before, and knew the technical aspects of most methods, but with the Uzazi Bora training, I am far more likely to promote family planning.”

We have recently intensified our efforts to provide family planning and post-abortion care in some of the most difficult settings in the world, recognizing that meeting the unmet need *now* may be the best we can do, while sustaining the gains will be the challenge for the future. In Chad, Pakistan, and DRC, we are working to increase the supply of qualified providers to provide family planning and post-abortion care, with a focus on increasing availability of long-acting methods, and on ensuring that all women seen for post-abortion care receive high-quality family planning counseling and a range of method options. The great need for the services is reflected in the extremely low percentage of women or their partners who are using modern methods of contraceptives – 1.6 percent, 21.7 percent and 6.7 percent, respectively.⁴¹

Chad, for example, has been involved in 12 wars (most recently in February 2008) since obtaining independence in 1960, contributing to the country’s poor health and social indicators. Additionally, Chad is host to approximately 300,000 refugees: 250,000 from Sudan, and 50,000 from the Central African Republic, a situation that has further stressed the country’s limited resources. Data from the 2004 DHS show a decline in some key reproductive health indicators since 1997.⁴² A government report cites abortion as the most common cause of obstetric complications (18.9 percent of cases).⁴³ There are many obstacles to family planning, including religious and cultural factors, and myths and misconceptions.⁴⁴

As a result of CARE’s programming, however, we have already seen a dramatic increase in use of family planning among women in the first year of the project: there were over eight times as many new users of family planning each month in the last quarter as compared to the first quarter of the project, with a cumulative total of 4,502 new users of family planning.⁴⁵ Further, 39 percent of new users selected a long acting method of contraception.

Innovative Partnerships: Working with the Private Sector

Meeting the global unmet need for family planning will require the combined efforts of numerous stakeholders, including the private sector. Partnership with the private sector has been recognized globally as critical to progress in global health and development, and there is a growing interest in exploring how the private sector, both health and non-health organizations, can work to improve health outcomes. The private sector can play an important role in filling gaps and undertaking innovative approaches that can support government investments. In addition, they can help in strengthening health systems, researching, developing and adapting existing products. At the same time, organizations like CARE can ensure that the private sector is designing and implementing projects that reflect and meet the needs of the local community, particularly the most marginalized among them, and that ensures transparency and accountability of all actors. Our partnership approach places a value on not only leveraging resources from the private sector, but also identifying areas where we can influence companies' policy and practice.

CARE is increasingly engaging in strategic partnerships with the private sector to increase coverage, equity, and quality of services for those in need of family planning services. For example, CARE is GlaxoSmithKline's Asia partner for their 20% Reinvestment Initiative focused on improving effectiveness of frontline health workers. GSK's commitment to reinvest 20 percent of its profits recognizes the need for long-term funding to address the shortage of frontline health workers in some of the world's poorest countries. Through this partnership, CARE is working in Afghanistan, Myanmar, Cambodia, Nepal, and Bangladesh to strengthen community health systems and to improve access to family planning and maternal, neonatal and child health services.

In Bihar, India, family planning is one component of a larger family health program. The focus of the family planning component is on post-partum family planning and birth spacing to reduce risks to women and their infants. To achieve this, CARE is partnering with Janani, a private sector network that provides quality care and long-acting family planning methods not offered at government facilities. The model of public-private partnership is for government frontline workers to integrate post-partum family planning counseling into all contacts with pregnant women and for Janani to expand their network to ensure services will be accessible. In addition, a "family planning corner" staffed by Janani will be established in Primary Health Centers so women who deliver at the facility can discuss post-partum family planning options and, if interested, either receive services from public providers or be referred to a Janani clinic. Communications during post-partum follow-up visits by government community-based workers also will emphasize the benefits of birth spacing and family planning options, and support decisions by women and their families to access services.

Conclusion

CARE International strongly supports the global movement to accelerate progress on family planning and is committed to catalyzing and supporting action at the local, national and global levels. Effective implementation of the commitments made at the London Summit on Family Planning will require the combined efforts of numerous stakeholders – including governments, bilateral and multilateral donors, the private

sector, and non-governmental organizations. CARE is committed to working in partnership with all stakeholders — most important among them the women and families we work with every day — to move us towards our goals of universal access to family planning and improved health and well-being for women, children and families.



Key Recommendations

At this pivotal moment, it is essential that greater commitment to family planning be linked with strategic approaches that lead to greater effectiveness. To increase the effectiveness and sustainability of investments and to reach the goals laid out at the London Summit on Family Planning, CARE International calls on governments, donors and civil society to:

Put reproductive rights, women's empowerment and gender equality at the center of programming and policy

- Ensure that national, district, and local level health plans and policies include reproductive rights, women's empowerment and gender equality as core principles. This means that health plans must recognize the linkages between social inequality, discrimination, harmful cultural practices and health, and must ensure that the social, political and cultural transformations necessary for change are outlined in design and implementation.
- Ensure that funding for family planning services and supplies is integrated and coordinated with funding that addresses women's empowerment, gender equality and social and cultural barriers to family planning access and utilization.
- Support development and use of indicators to assess achievement of women's empowerment and gender equity as part of reproductive health and family planning programming such as the Evidence for Gender Equality initiative (EDGE) led by the UN Statistics Division of UN Women that support the collection of gender-sensitive data.

Strengthen local accountability mechanisms to promote quality, participation, transparency, equity and local ownership

- Support participatory governance and social accountability mechanisms, such as the Community Scorecard, to help ensure universal access to quality family planning services and to ensure that women, girls' and families' rights to privacy, confidentiality, and respectful treatment are secured.
- Promote the meaningful participation of women and communities in the design, development, implementation and monitoring of programs and policies related to family planning at the local, district and national level.
- Adopt a human-rights approach to family planning programs and policies, which is informed by human rights principles such as equality, non-discrimination, participation and inclusion. A rights-based approach to family planning should also incorporate obligations outlined in specific human rights resolutions, such as the UN Human Rights Council's 2009, 2010 and 2011 Resolutions on Maternal Mortality, and be supported and facilitated by strong institutions and financing. The Human Rights Council will be releasing technical guidance later this year to guide these efforts.
- Establish accountability mechanisms to report on the progress made in implementing global commitments to family planning that align with the accountability framework for the UN Secretary General's Global Strategy for Women's and Children's Health and link to governance mechanisms being implemented at the local level.

Ensure women and girls' family planning and reproductive health needs are addressed in emergency and post-conflict response activities

- Support implementation of the Minimum Initial Service Package for Reproductive Health (MISP) as part of all initial life-saving emergency response activities. The MISP addresses family planning, sexual violence, maternal and newborn care, and sexually transmitted disease prevention and treatment.
- Support comprehensive sexual and reproductive health programming as part of the transition from early recovery to long-term development programming once the MISP is in place.
- Ensure that emergency responses are guided by human rights principles.

As we look beyond the London Summit on Family Planning, family planning and women's health and rights more generally, must be at the center of the post-2015 development framework, building on the tremendous progress made through the Millennium Development Goals.

Endnotes

- 1 In addition to the Cairo Programme of Action, other key UN consensus documents have recognized the need for increased efforts to promote the health and human rights of women and girls, including the Fourth World Conference on Women Platform for Action (1995) and the Millennium Development Goals (2000). A 2009 resolution by the UN Human Rights Council explicitly makes the link between preventable maternal mortality and human rights (A/HRC/11/L.16)
- 2 Population Action International. (2011). Why Population Matters. Available at: www.populationaction.org/oldmedia/Why_Population_Matters.pdf
- 3 The 10 countries with the highest unmet need for family planning (based on data available since 2000) include: Ethiopia, Ghana, Haiti, Liberia, Mauritania, Rwanda, Samoa, Sao Tome & Principe, Senegal and Uganda. CARE has SRMH programming in Ethiopia, Haiti and Rwanda. Source: WHO Global Health Observatory Repository, <http://apps.who.int/ghodata>
- 4 The 10 countries with the lowest contraceptive prevalence rates (based on available data) include: Angola, Benin, Chad, Eritrea, Equatorial Guinea, Guinea, Mali, Niger, Somalia, and Sudan. CARE has SRMH programming in Benin, Chad and Mali. Source: PRB 2001 World Population Data Sheet
- 5 The MISP for Reproductive Health is a priority set of life-saving activities which addresses family planning, sexual violence, maternal and newborn care, and sexually transmitted disease prevention and treatment. It should be implemented at the onset of every humanitarian crisis and be sustained and built upon with comprehensive services throughout protracted crises and recovery. More information on the MISP is available at: www.iawg.net/resources/MISP2011.pdf
- 6 For more information on ISOFI, see: CARE and the International Center for Research on Women. (2010). Challenge and Change: Integrating the challenge of gender norms and sexuality in a maternal health program. Available at www.care.org/careswork/whatwedo/health/srh/Challenge-and-Change-2010.pdf
- 7 CARE and the International Center for Research on Women. (2010). Meeting Challenges/Seeding Change: Integrating Gender and Sexuality into Maternal and Newborn Health Programming through Inner Spaces, Outer Faces (ISOFI) Initiative. Available at www.care.org/careswork/whatwedo/health/srh/meeting-challenges-seeding-change.pdf
- 8 Pulerwitz, J., Gortmaker, S. L., & DeJong, W. (2000). Measuring sexual relationship power in HIV/STD research. *Sex Roles* 42, nos. 7/8:637-660
- 9 Harvey, S. M. et al. (2003). Sexual decision-making and safer sex behavior among young female drug users and female partners of IDUs. *Journal of Sex Research*, 40(1):50-60
- 10 Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Studies in Family Planning*, 32(3): 189-213
- 11 Heise, L., Ellsberg, M., & Gottmoweller, M. (2002). A global overview of gender-based violence. *Int J Gynecol Obstet*. 78 (Suppl1)S5-S14
- 12 Pallito, C. C., & O'Campo, P. (2004). The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. *Int Fam Plann Perspect*. 30(4):165-173
- 13 Pinto Aguirre, Guido ; Kincaid, Mary ; Murillo Gutiérrez, Beatriz. (2010). The Relationship between Domestic Violence and Reproductive Health and Family Planning Services in Bolivia, 2003. *Población y Salud en Mesoamérica*. 7(2): 1-13
- 14 Upadhyay, Ushma D. & Karasek, Deborah. (2010). Women's Empowerment and Achievement of Desired Fertility in Sub-Saharan Africa. DHS Working Papers No. 80. ICF Macro
- 15 Do, M. & Kurimoto, N. (2010). Women's Empowerment and Choice of Family Planning Methods. Measure Evaluation Working Paper No. WP-10-115. Measure Evaluation PRH.
- 16 Bawah, A. A. Spousal communication and family planning behavior in Navrongo: a longitudinal assessment. (2002). *Studies in Family Planning*, 33 (2):185-194
- 17 For more information on the SAA approach, see: CARE. (2007). Addressing the Social Factors that Influence Sexual and Reproductive Health. Available at www.care.org/careswork/whatwedo/health/downloads/social_analysis_manual.pdf
- 18 For more information about the Results Initiative see: CARE. (2010). Social Change and Family Planning: Linking Social Norms to Family Planning Behaviors: Baseline Survey for the Results Initiative. Available at www.care.org/campaigns/mothersmatter/downloads/SCFP_Series_1.pdf
- 19 CARE. (2010). Midterm Review of Family Planning Results Initiative in Kenya.
- 20 Government of Kenya, Siaya District Development Plan Reports, 2008-2011 and 2011-2016
- 21 CARE. (2010). CARE USA Annual Report: Live, Learn, Earn, Lead. Available at www.care.org/newsroom/publications/annualreports/index.asp

- 22 Creel, L.C., Sass, J.V., & Yinger, N.V. (2002a). Client-centered quality: Clients' perspective and barriers to receiving care. *New Perspectives on Quality of Care No. 2*. Population Reference Bureau and Population Council.
- 23 Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth: a landscape analysis. Available at: www.whiteribbonalliance.org/WRA/assets/File/Respectful-Care-at-Birth_9-20-101_Final.pdf
- 24 CARE. (2010). Midterm Review of Family Planning Results Initiative in Rwanda.
- 25 Kayongo, M., Esquiche, E., & Luna, M. R. et al. (2006). Strengthening emergency obstetric care in Ayacucho, Peru. *Int J Gynecol Obstet*; 92:299-307.
- 26 Valdez, W. (2011). Evaluación Cuantitativa de la Vigilancia Ciudadana de la Calidad de los Servicios de Salud. CARE Peru.
- 27 Ministry of Health of Peru. (2011), Guidelines for Health Policy in Citizen Health Care Monitoring (R.M. 040-2011/MINSA. January 14, 2011).
- 28 United Nations Human Rights Council. (2009). Resolution on Preventable maternal mortality and morbidity and human rights (A/HRC/11/L. 16/Rev.1). The UN Human Rights Council has renewed its commitment through subsequent resolutions on maternal mortality in 2010 (A/HRC/15/L.27) and 2011 (A/HRC/18/L.8/)
- 29 International Initiative of Maternal Mortality and Human Rights. (2010). Human Rights Based Approaches to Maternal Mortality Efforts. Available at: <http://righttomaternalhealth.org/sites/iimmhr.civactions.net/files/IIMHR%20Field%20project%20booklet.pdf>
- 30 CARE Tanzania. (2011). The Community Score Card in Tanzania: Process, Success, Challenges, Lessons Learned
- 31 For more information on the Extra Mile Initiative, see: CARE. (2008). Going the Extra Mile to Provide and Sustain Family Planning Services in Remote Madagascar. *Voices from the Village No. 3*. Available at www.care.org/careswork/whatwedo/health/downloads/SRH_madagascar.pdf
- 32 Loucks, J., & Boredison, G. Empowering Malagasy Communities to Improve Family Planning Services. Presented at the Global Health Council Annual Conference, Washington, D.C., May 28, 2008
- 33 Farris, Elizabeth. (2010). Natural Disasters, Conflict, and Human Rights: Tracing the Connection. The Brookings Institution – University of Bern Project on Internal Displacement, 1-9
- 34 Norwegian Refugee Council (2010). Available at: www.nrc.no/arch/_img/9570202.pdf
- 35 Uppsala Conflict Data Program. UCDP Conflict Encyclopedia. Accessed on 6/4/2012 at [http://www.ucdp.uu.se/gpdatabase/search.php#__utma=1.167130345.1340050013.1340050013.1340050013.1&__utmb=1.11.10.1340050013&__utmc=1&__utmz=1.1340050013.1.1.utmcsr=\(direct\)|utmccn=\(direct\)|utmcmd=\(none\)&__utmv=-&__utmj=210230037](http://www.ucdp.uu.se/gpdatabase/search.php#__utma=1.167130345.1340050013.1340050013.1340050013.1&__utmb=1.11.10.1340050013&__utmc=1&__utmz=1.1340050013.1.1.utmcsr=(direct)|utmccn=(direct)|utmcmd=(none)&__utmv=-&__utmj=210230037)
- 36 United Nations Environment Programme. (2010). Disasters and Conflict. Available at www.unep.org/yearbook/2010/PDF/4_Distaster_n_conflicts_2010_low.pdf
- 37 Clifford, Cassandra. Rape as a Weapon of War and It's [sic] Long Term Effects on Victims and Society. Presented at the 7th Global Conference on Violence and the Contexts of Hostility, Budapest, Hungary, May 5-7, 2008. Available at: <http://ts-si.org/files/BMJCliffordPaper.pdf>
- 38 UNFPA. Working to Empower Women: Women and Armed Conflict. Accessed on 6/1/2012 at www.unfpa.org/modules/intercenter/beijing/armed.htm
- 39 All facilities in Kasongo were government-managed; no private providers were present during the project's lifetime.
- 40 CARE. (2011). Uzazi Bora: Meeting the Maternal Health Needs of Post-Conflict Kasongo District, Democratic Republic of Congo. *Voices from the Village No. 6*. Available at: www.care.org/careswork/whatwedo/health/srh/CARE-DRC-Maternal-Health-Study.pdf
- 41 DHS 2007 (DRC, Pakistan) and DHS 2004 (Chad)
- 42 Unmet need for family planning jumped from 9.7 to 20.7 percent and the percentage of married women using family planning dropped from 4.1 to 2.8 percent. Accessed on 6/4/2012 at www.measuredhs.com/countries/country_main.cfm?ctry_id=59&cnr_ytab=quickstats&cn=Chad
- 43 République du Tchad. (2008). Feuille de Route pour l'Accélération de la Réduction de la Mortalité Maternelle et Néonatale au Tchad 2008-2015
- 44 For example, people believe that women will become sterile and men impotent if they use family planning, and women must often obtain their husband's permission before using a method of family planning.
- 45 The initiative is working in two districts in Chad, serving a total population of over 520,000, with an estimated 130,000 women of reproductive age (15-44)



International Secretariat

Geneva

Chemin de Balexert 7-9
1219 Chatelaine, Geneva
Switzerland
T) +41 22 795 10 20
F) +41 22 795 10 29
www.care-international.org

Representation Office to the United Nations

New York

777 First Avenue
5th Floor
NY 10017 New York
U.S.A.
T) +1 212 687 3181

Representation Office to the European Institutions

Brussels

Rue du Trône 12
B-1000 Brussels
Belgium
T) +32 2 502 43 33

International Members

CARE Australia

www.care.org.au

CARE Canada

www.care.ca

CARE Danmark

www.care.dk

CARE Deutschland-Luxemburg

www.care.de

CARE France

www.carefrance.org

CARE International Japan

www.careintjp.org

CARE International UK

www.careinternational.org.uk

CARE Nederland

www.carenederland.org

CARE Norge

www.care.no

CARE Österreich

www.care.at

Raks Thai Foundation (Thailand)

www.raksthai.org

CARE USA

www.care.org

International Affiliate Member

CARE India

www.careindia.org

CARE Peru

www.care.org.pe

Founded in 1945, CARE is a leading humanitarian organization fighting global poverty and providing lifesaving assistance in emergencies. In 84 countries around the world, CARE places special focus on working alongside poor girls and women because, equipped with the proper resources, they have the power to help lift whole families and entire communities out of poverty. To learn more, visit www.care-international.org.