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Village Health Committees Drive Family Planning Uptake

Communities Play Lead Role in Increased Acceptability, Availability

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Women and men in rural Guinea typically have large families by preference, but also because family planning is neither widely available nor widely accepted. As a complement to its child survival programs, Save the Children received funding from the U.S. Agency for International Development (USAID) to increase contraceptive acceptance and use in Mandiana and Kouroussa districts of Kankan region, upper Guinea. There, they intended to increase contraceptive acceptance. A vital element of Save the Children's success was the Village Health Committee (VHC).

The VHCs were leaders in changing people's attitudes and access to family planning. Membership of these committees included respected villagers and staff from the health system. Through the committees, Save the Children and its partner nongovernmental organizations (NGOs) tackled contraceptive availability with such activities as training community-based distributors in each participating village and adding family planning promotion to the job description of every committee member. The committees also addressed family planning acceptability. For example, male and female distributors—via in-home visits and outreach clinics—made birth spacing a topic not only for women and health workers, but for couples and communities.

With plenty of training and support from Save the Children and its local partners, the VHCs were essential players in bridging the physical and attitudinal gap between families and health services. This held true for contraceptive uptake, due largely to bringing information and services out of the health facility and into the community. Met need for family planning rose from 24 to 61 percent after just 4 years and uptake continued high through mid-2008, 2 years later.

Number of units dispensed	2006-07	2007-08	Change
Injectables	347	4,632	+ 1,235%
Oral contraceptives	6,540	35,027	+ 436%
IUD	90	228	+ 153%
Condoms	38,107	70,348	+ 85%
Lactational amenorrhea method	0	101	

Source: Save the Children monitoring data

A nurse provides family planning counseling in her consultation room.

INTRODUCTION

In Guinea, the gap between knowledge and practice of family planning is enormous. Ninety-two percent of women and men knew of at least one modern method of contraception in 2005,[i] yet only 9 percent of women in union used any method (and only 6 percent used a modern method) to prevent or plan pregnancies. In the rural areas where most Guineans live, large families remain the norm and indeed the preference. The national total fertility rate in 2005 was 5.7—virtually unchanged from health surveys dating back to 1983—and the rural total fertility rate was 6.3. Regardless, women did express a desire to space and limit the number of their pregnancies. Of all married women surveyed, 22 percent desired no more children. Of those who did want more children, 45 percent wished to wait 2 years or longer before becoming pregnant again.

In Kankan Region of Upper Guinea, women bear an average of 7.4 children during their lifetimes. Forty-one percent of 15- to 19-year-old women were mothers or were pregnant at the time of the 2005 survey. In Kankan (as in Guinea as a whole) child health was showing signs of improving.

From 1997 through 2006, Save the Children's child survival projects[ii] in Kankan Region's Mandiana and Kouroussa districts were designed to reduce the principal causes of child and infant mortality by offering an intervention mix that

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A new IUD client exits the health center during a campaign promoting IUD use. Besides receiving a dependable family planning method, she also received a T-shirt which promoted the project.

included maternal and newborn care, nutrition and micronutrients, HIV/AIDS, and immunization.

With the addition of funding from USAID's Office of Population and Reproductive Health during and beyond this same period,[iii] Save the Children integrated community-based family planning into its activities. Save the Children's aim was to improve the use of modern family planning services with special attention to women with children under 2 years. To ensure integration, Save the Children relied not only on the village health committees but also on the work of its own staff of district health teams, health center managers, health care providers, administrative and political authorities, locally elected representatives, religious leaders, traditional communicators, women's associations, and representatives of civil society (including international, national, and local NGOs).

This document highlights the Village Health Committee, a vital player in the child survival project and the integration of family planning work. The document briefly describes the committee's purpose, membership, and tasks. It focuses on a handful of the people and activities that exemplified the VHCs' unique role in ensuring that family planning was not only accessible but acceptable to the villagers they served. The document concludes with some outcomes of Save the Children's family planning component in Mandiana and Kouroussa. In effect, the VHCs' stellar success in building demand for contraception (when coupled with modest investments in existing health workers' ability to supply modern methods) resulted in a sustained increase in the use of contraception in the project zone.

PROJECT APPROACHES

The Village Health Committee: An Introduction

The VHC's primary purpose was threefold: (1) to forge a link of ownership and responsibility between the community and the health system, (2) to increase the community's demand for and use of quality health services including family planning, and (3) to increase the health system's ability to provide such services in a way acceptable and accessible to the local population. The VHC's secondary purpose was to help its community manage basic health problems. An evaluation in 2004 described the VHC as follows:

> *The VHCs are clearly the backbone of the program. They are the behavior change agents in the communities and are composed of leaders, traditional birth attendants, traditional healers, family planning promoters, a village nutritionist, and HIV/AIDS peer educators. Save the Children and its local partners train the VHC, but it is the VHC that passes the messages and encourages or enables the woman or guardian to take action. The VHC also maintains the community-based health information system and shares the data that is collected at the district level. The committee conducts health promotion activities and organizes health system outreach visits. Because the VHC is composed of respected members of the community, its guidance is taken very seriously.*[iv]

In an earlier era, the Government of Guinea declared that communities were the "owners" of their health facilities and mandated that village-based management committees called Comités de Gestion (COGES) be created to formalize the links between consumers and providers. COGES never fully succeeded and were essentially defunct by the time Save the Children began its child survival work. Still, the idea inherent in COGES was a good one. Building on lessons learned from COGES in Guinea and from its work in neighboring Mali, Save the Children and stakeholders in the child survival projects formulated the VHC.

Members of a Village Health Committee (VHC).

Before Save the Children launched its first child survival project in Mandiana, it undertook a slate of research into health knowledge, attitudes, and practices. A study of community organization and perceptions of health highlighted a real need for the community to participate in managing its own health problems. However, no structure existed through which it could adequately do this. Save the Children in collaboration with district health authorities decided to create the VHC in all project villages. The objective was not to recreate COGES, but to link communities and facilities in order to increase the use of health centers.

Creating the VHC was a long process that included working with communities to select members, training members, and supporting and following their work within communities and with health facilities. Briefly, Save the Children and stakeholders ensured that communities owned the process by holding village assemblies to discuss health and baseline research that was conducted. These assemblies were also intended to gather input on the purpose and activities of a VHC and to discuss criteria for membership. Once formed, a VHC elected officers from within its ranks. All members were thoroughly trained in health topics in general and their individual roles and responsibilities in particular.

In its first child survival project, Save the Children established 133 VHCs in the same number of small and large villages in Mandiana District. The Mandiana VHCs enjoyed growing recognition for success and were often referred to in Guinea as "the Mandiana Model." The second project saw an expansion of the VHC in Mandiana and Kouroussa districts to the east. A total of 225 VHCs now exist in the two districts.

VHC Membership

The VHCs were composed of seven to nine members, each a permanent resident of his or her village and respected by the community as a whole. All "community agents" already belonging to any Ministry of Health program and present in the community were automatically VHC members (e.g., local liaisons to the national onchocerciasis eradication program also served on the committee). Typically, the VHC included selected local leaders (e.g., district chiefs, imams, and village elders) and representatives of traditional health workers (e.g., healers and birth attendants). A traditional communicator (the oral historian known as a griot) served on each VHC. At least two members of each committee were able to read and write in French.

As the family planning component was added, all VHC members learned about the topic and how to promote family planning in their work. Two current types of VHC members had a particular bearing on making family planning accessible and acceptable: community-based distributors (CBDs) and religious leaders.

CBDs—One man and one woman from each VHC were trained as CBDs, supervised by the VHC and the local health center. Save the Children offered the CBD a 5-day training in the basics of family planning; pertinent government policy; family planning promotion, sales, and referrals; prevention of and referral for sexually transmitted infections and HIV/AIDS; and working with health facilities. CBD duties included health education sessions with groups and individuals to recruit new clients and monthly follow-up visits with existing clients. They also engaged in advocacy sessions with religious leaders; participated in monthly health center meetings to review education activities, sales, referrals, and resupply commodities; and attended in-service trainings as needed.

When Save the Children began its child survival work, fewer than 40 CBDs—all male—were present in Mandiana, trained by an earlier USAID-financed program. Today, 450 CBDs (half are women, half are men) serve 225 communities in Mandiana and Kouroussa. The choice to train one woman and one man per village was a crucial factor in increasing the acceptability and use of contraceptive methods. Male CBDs were able to engage men and persuade them that family planning is indeed a man's concern, and social custom allowed female CBDs access to women (and couples) that no man could have had.

A group of Community-Based Distribution Agents receive their bags after completing CBD training.

Religious leaders—Each VHC also has a religious leader—typically a village imam—as a member. This was an essential element in an area where some religious leaders renounced birth spacing and family planning as opposed practices to Koranic teachings. Save the Children and its partners offered a 3-day training to these men to learn basic family planning information; Guinean policies related to family planning; the relationship between Islam, family planning, and reproductive health (especially as referred to in the Koran); and their role and responsibilities in family planning promotion. Attendees created an action plan, including ways to introduce family planning information during sermons, discuss the topic during community consultations and meetings with mosque councils in each village, and orient their peers to the topic and to Koranic verses that pertain to women's health including supportive use of birth spacing and men's responsibility vis-à-vis their families.

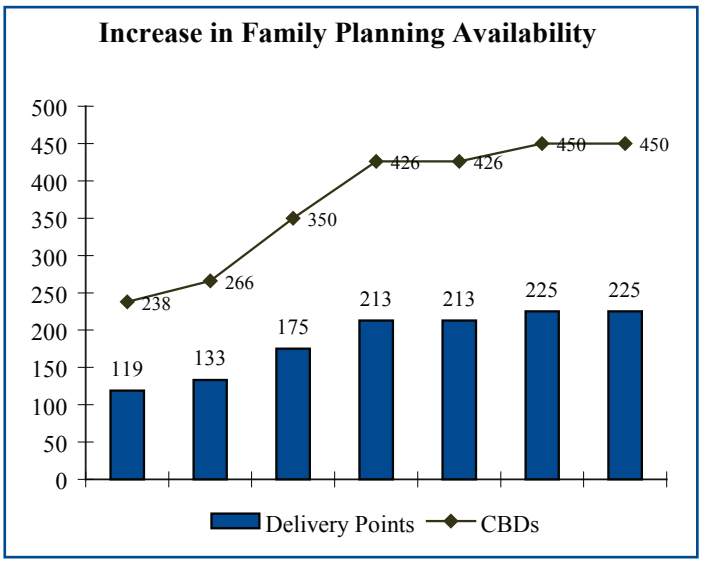
As described above, community-based distribution and integration of family planning messages into local religious life were two vital factors in bringing information and services out of the health facility into the community and successfully raising contraceptive prevalence rates in Mandiana and Kouroussa.

VHC Links Community-based Family Planning to the District Health System

This section highlights a few more important ways that the VHC helped the health system make family planning accessible and acceptable to women and men in the project zone.

Save the Children and its partners guided each VHC to develop and follow a work plan of promotional activities, such as awareness-raising sessions, group discussions, nutritional demonstrations, and baby weighing. To supplement this work, regular outreach clinics brought health workers to villages to offer child immunizations, antenatal care, and family planning information and methods. The VHC acted as the health services' local liaison, informing villagers of the clinic date, organizing the service site, seeking out those lost to follow-up, and encouraging women and men to attend.

The VHC maintained records of these outreach clinics as part of their general health information systems, which also included data on promotion and sales of contraceptives, home visits, referral to health facilities, vital events, cases of disease, and the progress of pregnant women. They also included observations on topics such as village sanitation and residents' compliance with public hygiene rules that the VHC itself set. The VHC periodically reported to the community and to the health



system on health-related data. Monthly assemblies allowed the VHC to discuss changes in health information with villagers and allowed villagers to debate and discuss the adoption of new behaviors and use of new services. In the other direction, Save the Children's partner NGOs collected village data every month and moved it up the chain, where quarterly aggregation made changes in indicators readily apparent.

Integrating the VHC

The VHC quickly became important partners in the district health and administrative structures. Local governments used the VHC registers because of the accuracy of dates and details of births and deaths. Health workers invited VHC members to participate in awareness-raising activities at facilities and to help organize and implement outreach strategies. Trained traditional birth attendants were integrated into health facilities as auxiliary staff. VHC, health services, and transport unions agreed in writing to rush women to a health facility in case of complications during pregnancy or labor. The VHC also allowed women to borrow money from the emergency funds for emergency obstetric care (EmOC), called Murigas, for purchasing family planning methods. The rationale is that these funds are suppose to ensure that women survive complications of childbirth by facilitating access to EmOC. In the same way, the use of family planning promotes maternal survival by preventing unwanted and unintended pregnancies.

KEY FINDINGS

The contraceptive prevalence rate increased substantially among women with children under 2 years in Kouroussa and Mandiana, from 16 percent in 2002 to 49 percent in 2006 when the child survival grant ended. According to Save the Children's final project evaluation in 2006,[v] the use of modern family planning methods by mothers not wanting another child in the next 2 years rose from 23 to 53 percent (against an objective of 50 percent).

In addition—

- Almost three-quarters (73%) of women in Mandiana and Kouroussa spaced their last two pregnancies by at least 24 months.
- A similar proportion (76%) of women of reproductive age lived within 5 kilometers of a service delivery point for family planning.

VHC HELP REINTRODUCE THE IUD IN MANDIANA

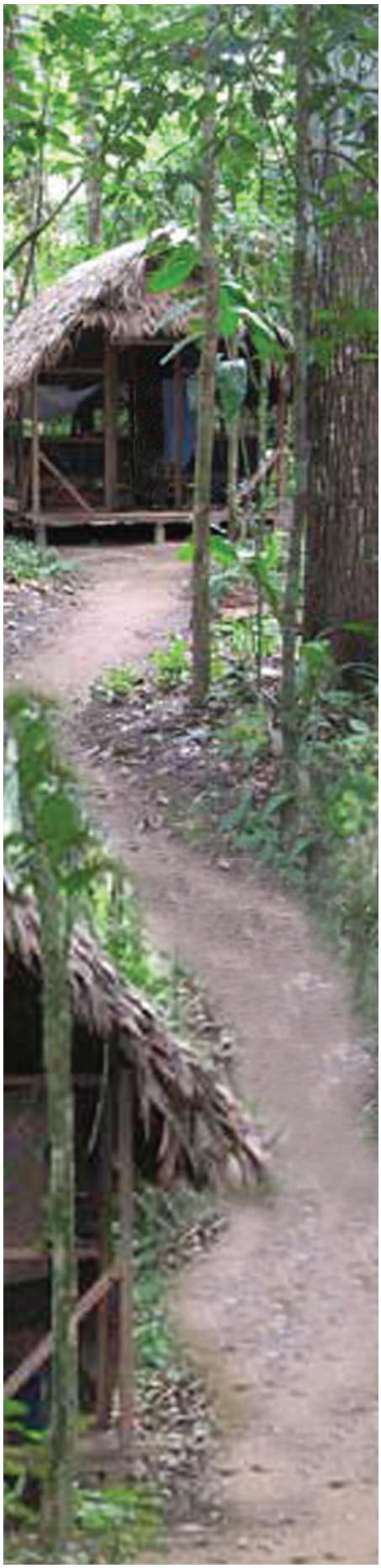
The VHC in Mandiana district (and later in Kouroussa) were active allies when Save the Children and district health officials piloted a reintroduction of the intrauterine device (IUD) as a safe, long-acting method for couples wishing to halt or significantly delay childbearing.

In late 2004 only two higher-level facilities offered the method. Save the Children and its partners refreshed providers' skills and knowledge in these centers, trained providers in two rural facilities, and added counseling and referral services to nine others.

However, as work on the ground had already proved, the existence of a service within a health facility was not enough. Again it was the VHC—community and religious leaders, CBDs, and others—who informed and fostered acceptance of the IUD in villages where the method was virtually unknown. Save the Children and its partners supported the VHC in a series of public awareness campaigns to bring information about the IUD (among other family planning methods) to the people. VHC members included messages in theater and folklore events; local radio stations broadcast discussions on the merits of the IUD and broadcast testimonials from satisfied users; and CBD held weekly meetings to discuss the IUD with community members and referred interested couples to the nearest participating facility.

In the first half of 2005, 73 women chose to use the IUD, compared to 13 in the 6 months before, an increase of 460 percent. Women in 113 villages were able to access IUD services. Health care providers continued to uphold accepted international standards for IUD insertion and removal and continued to maintain the medical supplies necessary to offer the method.

Adapted from Research Utilization Case Study: *Reintroducing the Intrauterine Device in the Mandiana District of Guinea*, Save the Children, Family Health International and USAID, 2008.



- In all villages, imams—many of whom were once opponents of family planning—talked about birth spacing via breastfeeding and oral/injectable contraceptives in their mosques. In some cases, the children or siblings of imams became CBDs.
- CBDs—225 women and 225 men—were trained in family planning policies and promotions, sales, referrals, sexually transmitted infections and HIV/AIDS, and improving relations with health facility workers.
- Villages without health facilities benefited from the family planning component as much as those with health facilities because of the presence of VHCs and their CBDs. Villages with access to family planning services almost doubled over 5 years.

Contraceptive use and uptake continued to rise in ensuing years, as seen in project data (from clinics and CBDs) gathered while USAID supported activities in the two districts.

CONCLUSIONS

The VHC proved an essential player in increasing their villages' sense of having a stake in health services and the health services' sense of duty to those they serve. The VHC as a group (and its members in their individual tasks) ensured that family planning information and selected services moved beyond the domain of the health facility and into communities and homes. In its final child survival project evaluation,[vi] Save the Children strongly recommended that the VHC be replicated elsewhere, stating that the project "demonstrates a potentially viable model of an effective community health program in Upper Guinea". This model created a functional bond between the professionals and managers of health and the community forces. All [stakeholders including the district health services] recognize the importance of these new partners for the achievement of project success.

In fact, the VHC model is already spreading in Guinea. With help from Save the Children, the Adventist Development and Relief Agency replicated the VHC model in its child survival project in Siguiri District. USAID's PRISM Phase II project tested the model in nearby Kankan District.[vii] Finally, Plan International has begun to replicate the VHC in five districts (Kissidougou, Gueckedou, Macenta, N'zérékoré, and Lola) of Guinea's far eastern forest zone.

Mothers who wish to space births shall breastfeed their babies for two full years. Women who wish to wait before having another child or do not want to have any more children may use means that are not prohibited by Islam. Our religion considers the use of condoms as infanticide. As any other medicine that is taken for the treatment of illnesses (such as malaria, diarrhea, or coughing), medicines for birth spacing are not prohibited by our religion because they promote the health of our wives and children of which we are fully accountable according to the Koran.

Imam's interpretation, delivered during a religious event

Provide Ample Guidance and Support to the VHC

From its experience in Kouroussa and Mandiana, Save the Children admits that in order to succeed and survive, the VHC required guidance and mentoring—from formal trainings to casual conversations—for a long period and from an array of stakeholders including Save the Children and partner NGO staff, and health workers and administrators. This recommendation may appear obvious, but Save the Children stresses that its own staff, its partner NGO staff, and members of the formal health structure needed to conscientiously mentor and support the VHC for longer than originally planned lest the nascent structures dissolve under the weight of their members' other pressing duties.

I am 28 years old and have three living children. When my first child was 4 months old my husband used to disturb me a lot at night. I went to a friend of mine who advised me to practice family planning. When I talked to my husband about it, he reacted angrily and threatened to divorce. Four months later, I got pregnant when the child I was nursing was only 8 months. I got sick and was referred to the hospital. I was saved, but my 8-month-old died. Since I delivered, my husband himself has been giving me money to buy contraceptives. He makes sure I do not run out of them.

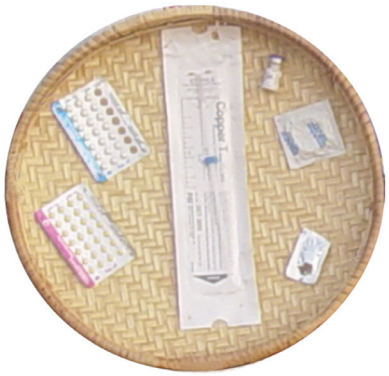
Project participant

Form Alliances with Religious Structures

In addition, the full participation of religious leaders in the VHC was essential to making family planning acceptable to women and men in Mandiana and Kouroussa. Imams were invited to study and debate Koranic verses related to women's and infants' health and the role of the husband in promoting his family's health.

Encourage Couple Communication on Family Planning

Finally, Save the Children noted that at the beginning of its community-based family planning work, men were strongly averse to discussing the topic and felt it was "women's business." Home visits to discuss family planning helped men feel more comfortable talking about the topic with their wives, and many men accepted the idea of having a married woman—the CBD—enter their home to discuss family planning with couples.



Community-based Distribution agent and a traditional communicator (Griot) inform the community about IUDs.

Community-based Distribution agents and traditional communicators (Griot) participate in a campaign to increase knowledge about the IUD method.

Radio discussion with a nurse, two community-based distribution agents, a community leader, and a current IUD user.

Members of a Village Health Committee after an orientation session on family planning.

[ii] Direction Nationale de la Statistique (DNS) and Macro International Inc. 2005. *Demographic and Health Survey: Key Findings*. Calverton, MD: DNS and Macro.

[iii] Child Survival 14 (1997-2002) took place in Mandiana only. Child Survival 18 (2002-2006) reached Mandiana and Kouroussa districts. Both projects were funded by USAID/Washington (Office of Global Health; Child Survival and Health Grants Program).

[iv] Save the Children implemented complementary activities with funding from USAID's Office of Population and Reproductive Health's Flexible Fund Program from 2003-2008. The most recent grant was active from July 2007 through June 2008.

[v] Save the Children. 2004. *Child Survival 18: Community health initiative for the districts of Kouroussa and Mandiana mid-term evaluation report: Guinea.* Save the Children, p. 24.

[vi] Save the Children. 2006. *Child Survival 18: Community health initiative for the districts of Kouroussa and Mandiana final evaluation report: Guinea.* Save the Children, p. 20.

[vii] Save the Children. 2008. *Child Survival 18: Community health initiative for the districts of Kouroussa and Mandiana final evaluation report: Guinea.* Save the Children, p. 8.

[viii] Though not described in this document, Save the Children initiated 24 such associations in Mandiana and Kouroussa to increase the reach, power, and voice of the VHC to the subdistrict level.

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