Culture Matters

Working with Communities and Faith-based Organizations:
Case Studies from Country Programmes

UNFPA

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FOREWORD

It gives me great pleasure to issue this new report on working within cultures to foster stronger progress towards achieving international development goals and advancing human rights. The experience gained in implementing the Programme of Action, adopted in Cairo at the 1994 International Conference on Population and Development, provides a wealth of knowledge to integrate cultural analysis in development programmes, especially in the critical areas of reproductive health and rights, and gender equity and equality.

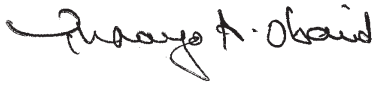
The ICPD Programme of Action was reached by consensus with respect for all cultures and religions and in line with internationally recognized human rights. However, social and cultural realities create both challenges and opportunities for further implementation. Changing attitudes, behaviours and laws—especially those dealing with gender relations and reproductive health—has proved to be a complex and often painstaking task, demanding a great deal of sensitivity to social and cultural dynamics, and real dialogue.

Experience shows that cultural sensitivity demonstrated by programme staff, in designing programmes and advocacy campaigns using local knowledge, leads to higher levels of programme acceptance and ownership by the community, and programme sustainability. In fact, using culturally sensitive approaches can reduce resistance to implementing the ICPD Programme of Action and create windows of opportunity for further progress.

This report is the culmination of two years' work with UNFPA field offices, headquarters staff and technical advisers examining culturally sensitive programming approaches during the past decade. It contains case studies from nine countries—Brazil, Cambodia, Ghana, Guatemala, India, Islamic Republic of Iran, Malawi, Uganda and Yemen.

Through this effort, UNFPA is striving to enhance local and national ownership of the ICPD Programme of Action. We believe this can be accomplished by making culture a cross-cutting issue in UNFPA's work, by mainstreaming cultural analysis in programmes, and by strengthening key alliances and partnerships—with activists, cultural and religious leaders, artists and others—to mobilize communities.

As development agents, our common objective, as stated in the Millennium Declaration, is to foster freedom from want and freedom from fear—so that people can enjoy their rights. This requires putting people, especially women, first and working with them to increase their participation, decision-making, opportunities and choices. It is my sincere hope that the analysis and lessons learned in this report will enable UNFPA staff and those in other development and humanitarian agencies to perform their work more effectively and with greater success.



Thoraya Ahmed Obaid
Executive Director
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EXECUTIVE SUMMARY

1. Eradicating poverty, achieving universal primary education, empowering women, reducing maternal and child mortality, combating HIV/AIDS, ensuring environmental sustainability and establishing a strong partnership for development are goals shared by the Millennium Development Declaration adopted by the Millennium Summit in 2000 and by the Programme of Action of the International Conference on Population and Development (ICPD) in 1994. Making these goals a reality, however, depends largely on their ownership by local communities and on serious efforts to sustain a "*development enabling environment*", where local resources are tapped and mobilized to achieve these goals.

2. To address these challenges, the United Nations Population Fund (UNFPA) has been examining its programming approaches since ICPD with a view to refining its knowledge and tools to develop more inclusive programming approaches that encompass culture and religion and the roles played by local power structures and institutions in mobilizing communities to become active partners in development.

3. This review is part of a UNFPA effort to strengthen its capacity to explore windows of opportunities for the implementation of ICPD and to address resistance that is rooted in traditions, customs and social practices in countries where UNFPA supports programmes. It attempts to explore the contribution of culturally sensitive approaches and partnerships with local power structures and institutions to the effective implementation of rights-based population and development programmes. The review demonstrates *that development entry points and constraints that derive from social and cultural systems and structures cannot be overlooked or underestimated.* Programmes that gave serious consideration to cultural factors facilitated a supportive environment for advocacy and service delivery and managed to achieve better positioning of the ICPD Programme of Action at the country and community levels.

4. The review highlights another important lesson. *Collaboration and partnerships between UNFPA and local power structures and institutions, including traditional leaders and faith-based and religious organizations often perceived as the community's custodians of culture, have proved instrumental in neutralizing resistance and creating local ownership of the ICPD Programme of Action.* These organizations have large numbers of constituents in public posts, including political leaders, policy makers, civil servants, academicians and media specialists who are involved daily in determining social and economic priorities, allocating resources and influencing public opinion. In addition, religious organizations have large networks of schools, health clinics and income-generating activities that reach villages and towns. In countries where partnerships with these structures and institutions were formed, UNFPA was able to mainstream reproductive health concerns and services into many of these networks.

Objectives

5. The objectives of this review are:

- To review UNFPA culturally sensitive programming approaches implemented in selected country programmes;
- To achieve a deeper understanding of the role played by local power structures in promoting the ICPD Programme of Action and universal human rights principles;
- To use these lessons to strengthen and refine UNFPA programming tools; and
- To contribute to the knowledge base on culture and development.

Assumptions

6. The basic assumptions underlying this review are:

- Cultures are realities of history and geography;
- Cultures are the context in which all development work takes place;
- Cultures are the context in which international human rights agreements are implemented;

ADDING THE "CULTURE LENS" TO UNFPA PROGRAMMING TOOLS

The culture lens is an analytical tool that enables development practitioners to:

- Understand the realities of societies in which development and humanitarian programmes are delivered;
- Identify influential local power structures and pressure groups (religious, cultural, political, legal and professional, etc.) that can be potential allies or adversaries to development programming;
- Identify internal cultural tensions and aspirations of the various sub-cultures;
- Develop skills for dealing with individuals, communities and interest groups living in a specific cultural context;
- Develop culturally acceptable language and "negotiation and communication tools" in contexts where they work;
- Achieve the goals of development programming more effectively and efficiently, with stronger community acceptance and ownership; and
- Facilitate the creation of an environment in which bridges can be established between local cultural values and universally recognized human rights and gender equity and equality.

- Cultures are dynamic, interactive and subject to change. No culture is immune to external stimuli;
- People are products of their cultures, but they are also active participants in shaping these cultures;
- Development paradigms have paid limited attention to cultural variables and approaches to create an enabling environment for the promotion of international human rights and gender equity and equality;
- There is need to reformulate the premises of development paradigms to include factors that contribute to ownership of development programmes;
- Adopting culturally sensitive development policies and practices does not entail making positive or negative value judgements on any culture, ethnicity or religion;
- In essence, using the "culture lens" in development programming enables policy makers and practitioners to understand the context in which programmes are implemented;
- Culturally sensitive approaches can be applied to understand social practices that are harmful to people and hinder their enjoyment of human rights;
- The culture lens is an analytical tool that helps policy makers and practitioners to contextualize development approaches to fit the diversified national and local contexts in which programmes are being implemented, without losing sight of the human rights that they are promoting. Thus, these approaches should facilitate an enabling environment for promoting human rights as an integral part of the development framework; and
- *Evidence of what works and what does not work at the country level is the most crucial input for developing more effective and holistic development approaches.*

Sources and Methodology

7. This review is the product of teamwork between UNFPA Country Offices and Headquarters. Five national consultants and an international consultant developed the country cases, under the supervision of the Culture Adviser in UNFPA's Technical Support Division.

8. Nine country programmes were selected by UNFPA geographical divisions to provide examples of:

- Programming approaches that were highly sensitive to the cultural contexts in which they were implemented (Guatemala, the Islamic Republic of Iran, Uganda and Yemen);
- Projects that operationalized human rights (see table on following page);
- Partnership approaches with cultural, religious and faith-based organizations that facilitated implementation of the ICPD Programme of Action (Brazil, Ghana, the Islamic Republic of Iran, Uganda and Yemen); and
- Country programmes in which there is strong potential for partnerships for HIV/AIDS prevention with faith-based and religious organizations (Cambodia and Malawi).

9. Field research in Ghana, India, the Islamic Republic of Iran, Malawi and Uganda was based on:

- Questionnaires;
- Project visits;
- Interviews with beneficiaries, partners, project staff and UNFPA staff in country offices; and
- Reviews of project documents and reports on project implementation.

10. For Brazil, Cambodia, Guatemala and Yemen, desk research was carried out in close collaboration with UNFPA geographic divisions and country offices. It included:

- Analysis of project documents;
- Questionnaires to programme staff; and
- Written and verbal discussions through communication with country offices.

11. Throughout, country offices and geographic divisions provided assistance with technical inputs and reviewed the case studies.

12. A mix of external and internal data was used to produce the case studies. Sources for external data are indicated in the review. Internal data was obtained from country offices and geographic divisions.

13. The detailed case studies were summarized for the purpose of this review.

14. All the case studies point to a common denominator. Each project is designed to promote one or a mix of human rights provisions under covenants that have implications for sexual and reproductive rights. The matrix on the following page identifies the forms of rights-based actions launched by the selected projects in this review.

Major Findings and Lessons Learned

Programming Approaches

15. The countries in this review are different in their political systems as well as their economic, social and cultural profiles. UNFPA programmes also differ in size and in the type of interventions designed for each country. Nevertheless, except for Cambodia and Malawi, where future HIV-prevention possibilities are explored, the review points to common denominators in seven countries.

16. Demonstrating cultural sensitivity was appreciated by beneficiaries, government officials, non-governmental organizations (NGOs), and religious and traditional leaders. Culturally sensitive approaches were instrumental in creating and establishing "trust assets" invaluable for the smooth implementation of projects considered culturally sensitive.

17. Case studies highlighted *competencies that facilitated the creation of entry points for the implementation of the ICPD Programme of Action*. These competencies include:

- The capacity to demonstrate patience, transparency and perseverance, which are invaluable programming skills when the long-term objective of a programme is to bring about behaviour/position change on gender relations, women's empowerment and the right to choose;
- The capacity to understand the complexity of the cultural contexts in which programmes are implemented;
- The capacity to sustain a positive negotiation environment with partners;
- The capacity to engage in inclusive information-sharing;

Rights-based Actions Operationalized by the Case Studies

Human Rights	Rights-based Actions	Case Studies
Right to life and survival ▪ Universal Declaration of Human Rights (UDHR), 1948, Art. 3 ▪ International Covenant on Civil and Political Rights (ICCPR), 1966, Art. 6 ▪ Convention on the Rights of the Child (CRC), 1989, Art. 6	▪ Prevent avoidable maternal deaths ▪ End female foeticide and infanticide ▪ Screen for cancers that can be detected early and treated ▪ Ensure access to dual-protection contraceptive methods	▸ Brazil, Guatemala, the Islamic Republic of Iran, Uganda ▸ India ▸ The Islamic Republic of Iran, Uganda ▸ Guatemala, the Islamic Republic of Iran, Uganda
Right to liberty and security of the person ▪ UDHR, Art. 25 ▪ International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, Art. 12 ▪ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, Art. 11(1)(f), 12, 14(2)(b)	▪ Eliminate female genital cutting ▪ Encourage clients to make independent reproductive health decisions	▸ Ghana, Uganda, Yemen ▸ Brazil, Ghana, Guatemala, the Islamic Republic of Iran, Uganda, Yemen
Right to marry and establish a family ▪ UDHR, Art. 16 ▪ ICCPR, Art. 23 ▪ ICESCR, Art. 10 ▪ CEDAW, Art. 16 ▪ CRC, Art. 8,9	▪ Prevent early or coerced marriages	▸ Guatemala, the Islamic Republic of Iran, Uganda, Yemen
Right to decide the number and spacing of one's children ▪ UDHR, Art. 12 ▪ ICCPR, Art. 17 ▪ ICESCR, Art. 10 ▪ CEDAW, Art. 16 ▪ CRC, Art. 16	▪ Provide access to a range of modern contraceptive methods ▪ Help people choose and use a family planning method	▸ Brazil, Guatemala, the Islamic Republic of Iran ▸ Brazil, Guatemala, the Islamic Republic of Iran, Uganda, Yemen
Right to the highest attainable standard of health ▪ ICESCR, Art. 12 ▪ CEDAW, Art. 12, 14 ▪ CRC, Art. 24	▪ Provide access to affordable, acceptable, and comprehensive reproductive health services	▸ Brazil, Guatemala, the Islamic Republic of Iran, Uganda
Right to the benefits of scientific progress ▪ UDHR, Art. 27(2) ▪ ICESCR, Art. 15(1)(b) and (3)	▪ Fund research on women's as well as men's health needs ▪ Provide access to obstetric care that can prevent maternal deaths	▸ Brazil, Guatemala, the Islamic Republic of Iran, Uganda ▸ The Islamic Republic of Iran, Uganda
Right to receive and impart information ▪ UDHR, Art. 19 ▪ ICCPR, Art. 19 ▪ CEDAW, Art. 10(e), 14(b), 16(e) ▪ CRC, Art. 12, 13, 17	▪ Make family planning information freely available ▪ Offer sufficient information for people to make informed reproductive health decisions	▸ Guatemala, the Islamic Republic of Iran, Uganda, Yemen ▸ Guatemala, the Islamic Republic of Iran, Uganda, Yemen

Source: Adapted from "A Rights-Based Approach to Reproductive Health," Outlook, *vol. 20, no. 4, December 2003, p. 3.*

"Before ICPD, we had family planning programmes, but ICPD broadened our perceptions and introduced us to the more holistic reproductive health approach. When we needed to know more about this approach, UNFPA facilitated a process whereby the Government became motivated to define its objectives for an ambitious reproductive health programme. Following ICPD, UNFPA facilitated the establishment of a network of reproductive health programmes all over the country."

—A leading staff member of the Ministry of Health in the Islamic Republic of Iran

- The capacity to demonstrate culturally sensitive communication skills and language; and
- Honouring agreements reached with others.

18. The review indicated that UNFPA Country Offices played an effective role as "facilitators" of change in contexts where "position change" on sensitive issues was a challenge. Case studies from Brazil, Ghana, Guatemala, the Islamic Republic of Iran, Uganda and Yemen provided good examples of this role. In all these countries, UNFPA, through its understanding of the local context, managed to identify "local change actors" who had the capacity and the leadership to tap local resources and launch effective action to promote the ICPD Programme of Action. Once these actors of change were engaged, they took the leadership as the main actors, while UNFPA continued to facilitate the process as requested and to provide technical assistance as needed.

19. UNFPA's role as a facilitator was complex. It required UNFPA Country Offices to build strong in-house capacity to "manage diversity" by bringing together political leaders, civil society organizations, local power structures, religious and faith-based institutions, and the private sector (in the case of Guatemala) around reproductive health and rights issues. As a facilitator, UNFPA had to ensure a confluence, though incomplete, of the various interests of diverse groups by building upon commonalities in their agendas that would promote the ICPD Programme of Action. The case studies in Guatemala, India and the Islamic Republic of Iran, for example, demonstrate that UNFPA offices in these countries have assimilated and, more importantly, have applied a key lesson from ICPD: *that consensus on culturally sensitive issues can be created through interventions based on ICPD respect for cultural diversity, in conformity with universally recognized human rights.*

20. All the case studies demonstrate that an instrumental approach *to minimizing cultural tensions and creating interest in the ICPD Programme of Action was the provision of reliable, evidence-based information produced through quantitative and qualitative research on national or regional reproductive health indicators,* such as maternal and child mortality rates, HIV/AIDS prevalence, teenage pregnancies, and violence against women. Such information creates awareness and elicits concern at the ethical level, whether among government officials, NGOs or religious organizations. This often leads to the formation of a coalition for action to address specific reproductive health issues and opens windows of opportunity for strengthening the reproductive health and rights agenda.

21. *The review demonstrates that participatory approaches should be adapted to the cultural context. Some cases indicate that before involving grass-roots communities in project design and implementation, it was necessary to engage the leaders of local power structures and/or religious and faith-based institutions and facilitate their participation in the initial stages of the programme*. In Guatemala, the Islamic Republic of Iran, Uganda and Yemen, it was deemed necessary first to engage cultural and religious institutions before engaging grass-roots communities. Once the leaders of these organizations realized that partnering with UNFPA was viable and could lead to improvements in communities' well being, they themselves began to call for grass-roots participation.

22. The case studies indicate that developing a *"culturally sensitive language" is an invaluable negotiating and programming tool*. If the language used is loaded with negative judgements on the community or its values, it creates unnecessary tensions and constructs a wall between the community and the programme. For example, when a community has practised female genital cutting for centuries, it might perceive that the use of the phrase "female

genital mutilation" is value-loaded language. This perception may lead to the community's resistance, at least in the project launching phase, to any advocacy campaigns to terminate the practice. On the other hand, the phrase "female genital cutting" describes the practice in neutral language that allows discussions of the practice and its negative impact on the health and rights of women.

23. *Language sensitivity also applies to the choice of project titles and the messages they convey to the community, especially in areas where reproductive health and rights projects have not previously existed*. Interviews in some countries indicate that when reproductive health projects were established for the first time, it was better to give titles that frame reproductive health in the broader context of health, and then to move gradually to the reproductive health and rights context. This is not a matter of semantics but an approach that raises the bar of inclusivity. At the initial phases of projects it offers wide latitude that allows diverse partners to engage, participate and provide support.

24. Interviews for the case studies indicate that in discussions of harmful practices, *it was important to make clear the distinction between "cultures as broad ethical and value systems" and certain "traditional practices" that are harmful to the individual and the community*. In sensitization processes during the pre-project implementation phase, it was important to clarify that UNFPA does not make value judgements on cultures; rather, it has a strong position on specific traditional practices, such as early marriage, lack of wife inheritance, and female genital cutting, which are considered harmful to women's health and violate their human rights.

25. Cases indicate that flexibility and using a win–win strategy with partners could open windows of opportunity to expand activities and encourage partners to become better acquainted with the ICPD Programme of Action. A clear example of this is the project with the Church of Uganda on natural birth spacing. UNFPA took the decision to engage the Church and keep an ongoing dialogue, knowing the Church's position on family planning. Dialogue and joint work allowed UNFPA to advocate among the clergy and the Church's constituents for the promotion of issues such as the health threats caused by early marriage, the right of women to safe delivery, the need for adolescent sexual education and HIV prevention. In the case of Brazil, a win-win situation took the form of selective collaboration based on agreements that partners would work jointly within the mutually agreed upon spaces allowed by their mandates.

26. Case studies also indicate that projects that are likely to lead to cultural or religious controversy must be preceded by strong advocacy campaigns. To be effective, advocacy should be designed after researching the cultural context and the nature of cultural challenges to the ICPD Programme of Action. *First, in most countries, the opposition is not a monolithic group with a common position and message; therefore, it is necessary to analyse the rationale of the different forms of opposition before launching the campaign.* Second, it is important that advocacy campaigns include approaches that target potential allies as well as the different opposition groups. Third, it is important that advocacy campaigns are "contextualized" by drawing on the different forms of cultural expressions in a specific context. In Brazil, the use of the well-known approach "to see, judge, act, evaluate and celebrate", drawn from Catholic teachings, had a strong impact in campaigns for awareness-raising on reproductive health and rights issues. In Uganda, the use of African music, poetry and drama as channels for the dissemination of reproductive health and HIV-prevention messages reached wide segments of the population because they related easily to these messages.

27. In Muslim contexts, using Islamic sources in advocacy campaigns has proved to be an effective strategy to facilitate project ownership. To design interventions in a religiously complex context, it is important to understand the role religion plays in the community. This contributes to designing rights-based advocacy messages that are neither in conflict with religious precepts nor carry negative value judgements. In the Islamic Republic of Iran's literacy project, Uganda's reproductive health project for the Muslim community, and Yemen's advocacy project, Islamic texts were researched and consulted at different phases of the project cycle. In Uganda's case, for example, a team of scholars was called upon to study various reproductive health messages and related them to texts in the Koran. The involvement of scholars was essential in gaining access to the Muslim community in Uganda and in promoting reproductive rights and service delivery among its members.

Engaging Local Power Structures and Religious and Faith-based Institutions

28. The review demonstrates that when engaged and

"People are changing their thinking on the size of the family and women's health, and rethinking old practices like early marriage and female genital cutting, and they often come to us with their questions. These changes came with a UNFPA-assisted project in our Diocese. I believe that when the project is finished, these changes will remain with the clergy and the community and will trigger further positive changes both at the family and the community levels."

—A priest from the Church of Uganda

provided with evidence-based information, religious organizations and various power structures were willing to partner with UNFPA in a number of areas. *In most countries, partnerships were strengthened when it became clear to both sides that working together addressed the needs and the rights of communities they both served.*

29. The engagement of religious organizations with UNFPA in implementing the ICPD Programme of Action has done more than bring about a change in the thinking and behaviour of the clergy who partnered with country offices. This engagement *has placed reproductive health and rights on the agenda of religious organizations, thus moving these issues from the private space to the public space where they must be discussed and addressed.* Issues considered taboo by these organizations before ICPD, such as family size, early marriage, violence against women, wife inheritance, female genital cutting, reproductive rights and reproductive health services are now being discussed publicly, from the pulpits of a village church, mosque or temple.

30. *Furthermore, the clergy are increasingly finding themselves in positions where they have to provide answers to their congregations on reproductive health and rights issues.* This has created a necessary debate within religious establishments in developing countries. Such change is largely due to ICPD and its Programme of Action. Unfortunately, it is rare that evaluation reports on country and regional programmes capture these important but often hidden achievements.

31. Partnerships with religious and faith-based organizations allowed UNFPA-supported programmes to reach some of the most vulnerable and marginalized communities by using their countrywide networks, such as churches, mosques, schools, health units, income-generating projects and youth organizations. This made projects "familiar" to the community and minimized suspicions and/or perceptions that projects were being imposed by external actors to threaten the community's lifestyle and values.

32. Most partnerships with religious and faith-based organizations adopted a win–win strategy and targeted collaboration. *Selective collaboration assumes that each partner is aware of the position of the other and is willing to perform joint work in areas where the two partners have common objectives and beneficiaries.*

33. *Another approach that strengthened these partnerships was that each partner respected the difference in position the other partner may have.* For example, the mandate of religious leaders in HIV/AIDS prevention was found stronger in the area of promoting family values, abstinence and faithfulness in marriage than in promoting condom use. The religious leaders were encouraged to follow their mandate. At the same time, it was agreed that they would not undermine those whose mandate it was to promote condom use.

34. The case studies demonstrate that traditional and religious leaders are open to discussions on the ICPD Programme of Action if approached with care and sensitivity. In fact, many changed their positions towards UNFPA once they realized the value of its services to their constituencies. *One of the most effective approaches used tapped their ethical and moral positions by providing them with evidence-based information on issues such as child and maternal mortality rates, incidents of violence against women and HIV/AIDS prevalence rates.*

35. The case studies indicate that joint programming with religious and faith-based organizations should be an ongoing process that extends beyond a single programme cycle.

36. The Cambodia and Malawi cases strongly indicate that fighting HIV/AIDS requires more than the appropriation of funds. A great deal of capacity-building must be accomplished, especially within religious institutions that have the legitimacy and the networks that make them strategic partners in the area.

Conclusions and the Way Forward

37. The findings of this review indicate:

- Lessons from country programmes in which UNFPA implemented culturally sensitive programming approaches are knowledge sources that could be used to provide guidance for programming and for strengthening alliances with local partners to promote reproductive health, reproductive rights and gender equity and equality;

- Before individuals and communities can own and promote the ICPD Programme of Action and universally recognized human rights, they need to understand these standards, relate to them and see the value they add to their welfare. *Building bridges between universal rights and local cultural and ethical values is a key strategy to provide the motivation to individuals and communities to understand universal rights standards and appreciate the need to practise, advocate and promote these rights;* and

- Culturally sensitive approaches can provide an effective mix of tools for building such bridges. The culture lens facilitates positive negotiation environments in which the ICPD agenda and universal rights can be explored and understood by local communities and their traditional and religious leaders, who are often perceived by communities as the custodians of their culture.

38. The major policy and programming response to further advance UNFPA's initiative to mainstream the use of culturally sensitive programming approaches are:

- To develop a clear policy on linkages between cultural sensitivity and the promotion of the ICPD Programme of Action and universally recognized human rights;

- To establish a knowledge base on culture and development programming, based on actual cases from work in the field; and

- To develop a set of programming tools that will ensure the mainstreaming of the culture lens into UNFPA country and regional programmes.

1 PURSUING ADVOCACY AND CONSENSUS-BUILDING IN GUATEMALA, LEADING TO A NEW LAW ON REPRODUCTIVE HEALTH

In 2001, the Social Development Law was enacted in Guatemala, promoting, for the first time, specific policies on population, reproductive health, family planning and education. Ten years earlier, a similar law had been passed by Congress and vetoed by the President as a result of intense lobbying from opposition groups.

The success of the recent law was a product of a year and a half of negotiations and consensus-building, facilitated by UNFPA through advocacy approaches that were sensitive to the local environment and ensured ownership by the national stakeholders. Including opposition groups in these negotiations and using the reduction in maternal and infant mortality as the centrepiece of the law were two keys to success.

GUATEMALA: COUNTRY CONTEXT

Well over half the population of Guatemala—57 per cent—live in poverty. An estimated 27 per cent live in extreme poverty, and a large percentage face high rates of social exclusion, according to a 2000 Living Standards Measurement Survey. It therefore comes as no surprise that Guatemala has one of the highest maternal mortality ratios in Latin America: 270 per 100,000 live births. These high rates are influenced by an above-average total fertility rate of 4.4 children per woman, low levels of education, limited access to information on reproductive health issues, the small percentage of married women between the ages of 15 and 49 that use some method of family planning (38 per cent), and an unmet demand for family planning (23 per cent of married women). Limited access to health services, which are often rudimentary, in addition to scarce coverage, also contribute to a high rate of infant mortality (41 per 1,000 live births).

Until recently, the establishment of comprehensive reproductive health programmes in Guatemala lacked political support. Historically, religious groups with the capacity and power to influence government decision-making played a key role in impeding the development and implementation of such programmes.

Population and Reproductive Health

Although reproductive health and family planning programmes were introduced in Guatemala in the 1960s, it was not until 1970 that services were widely offered to the country's population. The services were provided through APROFAM, a local family planning NGO, with support from the United States Agency for International Development. Initially they covered urban centres but were eventually expanded to rural areas.

It was during this period that, for the first time in its history, the Ministry of Health began to include family planning as part of its maternal and child health services. Although the services reached only a small percentage of the population, their existence within the ministry created an opportunity for implementing broader and more comprehensive programmes for women's health and rights.

During the 1980s, development plans and programmes established by the Presidential Secretariat for Planning included population issues in the analysis of sectoral problems. These and other advances helped lay the groundwork, in the early 1990s, of a population and development forum that incorporated reproductive health and population issues. The forum, called the Inter-Sectoral Commission on Education and Population, was established in 1992 by civil society groups, including the Catholic and Evangelical churches. The Commission successfully initiated conversations on population issues and reproductive health education within the Guatemalan education system.

One year earlier, in 1991, Congress had passed a pioneering reproductive health and rights and population

SELECTED INDICATORS: GUATEMALA

Total population, 2003	12.3 million
Average population growth rate, 2000-2005	2.6%
Life expectancy for females	68.9 years
Life expectancy for males	63.0 years
Total fertility rate, 2000-2005	4.4
Births with skilled attendants	41%
Contraceptive prevalence for women aged 15–49, modern methods	31%
Contraceptive prevalence for women aged 15–49, any method	38%
Infant mortality per 1,000 live births	41
Maternal mortality ratio per 100,000 live births	270
Illiteracy rate for females over 15 years	39%
Illiteracy rate for males over 15 years	24%
HIV/AIDS prevalence rate for females 15–24 years	0.83%
HIV/AIDS prevalence rate for males 15–24 years	0.90%
Gross national income per capita (PPP$), 2001	$3,850
Access to safe water	92%

Source: UNFPA, State of World Population 2003.

initiative. However, due to strong opposition by the Catholic and Evangelical churches, lay religious groups and related sectors of civil society, the President vetoed the initiative. The success of these forces in convincing the President to veto the act had a significant impact on the decision-making capacity of successive Governments regarding population issues, especially reproductive health. One of the most serious effects was the subsequent lack of support from the Government of Guatemala for the Programme of Action adopted at the International Conference on Population and Development in Cairo in 1994.

Indeed, many of the gains of the 1980s were lost in the following decade. Population and reproductive health issues were virtually eliminated from public health planning, and population data were used only for statistical reference. Moreover, family planning activities within the Ministry of Health were significantly curtailed, and reproductive health services focused only on prenatal and delivery care.

The 1996 Peace Accords and Population Issues

The 1996 Peace Accords, which focused heavily on development issues, reopened the door for inclusion of population and reproductive health and rights issues within the government agenda. The reduction of maternal mortality was a specific goal of the accords, along with the provision of broad and comprehensive health services for women and improvements in women's education. The Peace Accords also included specific recommendations to reduce gender inequalities in the economic, social and legal spheres.

As a result, population issues were gradually mainstreamed at the legislative and institutional levels and in sectoral work plans. The public health system included comprehensive services to improve women's health, while reproductive health services, including family planning, were reintroduced into public health facilities.

There were also important legal steps to improve the gender agenda nationwide. The civil code was amended to prohibit a number of discriminatory policies against women. In addition, a law was passed reaffirming and establishing specific actions to end gender discrimination, and a national plan for equal opportunities was approved. In the education sector, the Inter-Sectoral Commission on Education and Population was legalized through government negotiations, and population issues were included in curricula of public primary schools.

Changes in the Political Context since 2000

The Government elected in 2000 took decisive steps to support women's reproductive rights. One of the first initiatives of the Minister of Health was the promotion and dissemination of information and education materials on

reproductive health and family planning. Furthermore, reducing maternal mortality and introducing a nationwide reproductive health programme became part of the Government's agenda.

This positive environment provided the opportunity for parliamentarians to demonstrate their political support for initiatives on population and reproductive health and the drafting of a new law around those issues. Meanwhile, the broad national consensus built around the Peace Accords allowed the Government and other stakeholders to examine more closely the socio-economic conditions of the Guatemalan people, which led them to take reproductive health and population activities more seriously.

UNFPA PROGRAMME

Strategic Decision-making

In furthering the development of a new law, the UNFPA country office worked with national stakeholders to analyse the obstacles encountered in previous attempts to promote sexual and reproductive health. In doing so, they identified a number of key factors that helped to develop a strategy based on facilitation and negotiation between the Government and civil society:

- ***Previous population and reproductive health initiatives had been created with the exclusive participation of traditional allies. These initiatives were not successful because long-standing opposition groups used their influence to reject any proposal and lobbied Congress to prevent passage of the legislation.*** Based on previous negotiations within the context of the Inter-Sectoral Commission on Population and Education, which had led to the inclusion of population issues in educational curricula, UNFPA initiated consultations with the Catholic Church on issues of mutual interest and to begin a critical phase for political sensitization;

- ***In the past, attempts to reach consensus with dogmatic groups were not fruitful because these groups were unwilling to show flexibility on their position or to negotiate entry points from within that position.*** The absence of these groups, which are often vocal but represent only a small percentage of the population, created a more neutral environment for negotiations and consensus-building;

- ***The misconception about organizations working on population issues often created a climate of mistrust that affected the level of social participation and institutional support.*** To counter this perception, UNFPA promoted an environment based on confidence and trust by facilitating a transparent negotiation process among national stakeholders. Furthermore, a concerted effort was made to respect deadlines and commitments, and agreements were reached only through full consensus;

- ***The reduction of maternal and infant mortality, as a response to meet immediate and urgent needs, became the focal point of the law,*** thus generating broad consensus among all stakeholders; and

- ***The role that international entities played in the past, in what was considered to be internal politics, led to adamant attitudes on the part of national institutions and civil society that believed that international involvement and foreign proposals were in the interest of international agendas, not national interests.*** In response, UNFPA fostered the negotiation process as a facilitator while leadership and visibility was assumed by national stakeholders. Government institutions and civil society organizations were public actors in the process; all agreements were the result of national negotiations and debates, with full participation by national stakeholders, who, in turn, were accountable for advocating for and implementing decisions.

A Carefully Prepared Negotiation Process

To ensure the success of the negotiation, efforts were focused on two main objectives:

- To facilitate the formulation of the law through consensus and negotiation by civil society leaders, including representatives from the Catholic Church, thereby significantly reducing resistance to the passage of the law by Congress and ensuring ratification by the President; and

- To identify points of common interest with the Catholic Church, thereby placing emphasis on priority issues within this common ground, which would help overcome traditional areas of disagreement.

As a first step, political analysis was conducted to identify the various groups that have different positions on the law; the result of this analysis became the basis for the strategy for the negotiation process.

A detailed list of principles and issues valued by each group was made. In addition, the shared values, interests and points of divergence among the various groups were documented. Arguments to be brought to the negotiation table to demonstrate the advantages of participating in the process were formulated, and individuals from all groups who would be receptive to these ideas were identified.

Advocacy among Opposition Groups

Key individuals, such as the opposition group leaders who demonstrated some support for population and reproductive health issues, were identified. They were then approached and sensitized on the following issues:

- The importance of reproductive health as a means of reducing mother and child mortality;
- The relationship between birth spacing and reducing infant mortality;
- The relationship between infant mortality and the reduction of births at an early age and pregnancies at a later age; and
- The different methods of modern contraception.

After this targeted advocacy/sensitization campaign, UNFPA identified lessons learned. This made possible further improvements on the strategy and strengthened its arguments. Similar presentations were made to the boards of directors of private-sector institutions, which helped to increase the level of awareness within these organizations.

This was followed by negotiations with the boards of directors to promote their participation in the elaboration of the draft law, with the aim of achieving consensus support before the draft law's submission to Congress.

All efforts were focused on ensuring that the draft law was submitted as a joint initiative of civil society and the Government.

The Catholic Church

The presidents of the Episcopal Conference[1] and the Committee of Pastors for Health and Family[2] were approached to achieve consensus with the Episcopal Conference of Guatemala on the need to ensure the involvement of like-minded groups in the process.

Presentations on Guatemalan reproductive health indicators were shown to all bishops and members of the Committee of Pastors for Health and Family. These meetings were held to encourage members of the Church to discuss evidence-based population and reproductive health issues and to share the thinking of the Church on these issues, as well as to hear recommendations regarding the proposal.

The Episcopal Conference agreed to participate, with the understanding that some specific issues that could break the consensus would not be included in the proposal. On the other hand, the Episcopal Conference did agree to the dissemination of information on family planning (including modern methods of family planning), to strengthen emergency obstetric procedures and sexual education and to include the analysis of population in development programmes.

Evangelical Churches

In the past, Evangelical churches rejected similar proposals on reproductive health on the basis that every individual should make decisions according to his or her conscience, and that to make these decisions, the person should have access to non-biased information, which is in agreement with the ICPD principle of "informed choice" and "informed decisions". The strategy thus took into account the churches' beliefs and stressed the importance of improving the quality and dissemination of reproductive health and population information, so that individuals can make voluntary and informed decisions accordingly. To obtain support from this sector, numerous presentations and visits were made to participating members of Evangelical churches.

Business Leaders

Gaining the support of the Coordinating Committee of Agricultural, Commercial, Industrial and Financial Associations (known as CACIF from its Spanish acronym), a consortium of the most powerful economic organizations in Guatemala, was crucial for promoting the ICPD Programme of Action in Guatemala. It was necessary to increase the level of participation and representation of CACIF members. The information they received allowed

1. Episcopal Conference: permanent committee of bishops at the national level in charge of defining the Catholic Church's position vis-à-vis national policies.

2. Committee of Pastors: permanent sectoral sub-committees in charge of defining, advocating for and monitoring the implementation of the Catholic Church's position at the country level.

them to use their ties to religious groups to create a supportive environment for population and development and the adoption of the Social Development Law. CACIF members played a positive role in promoting the consensus-building process as well as in mobilizing support for population issues and eventually for the law itself.

Indigenous Groups

The Peace Accords explicitly state that cultural aspects of indigenous groups should be taken into account in the development process. This is especially important because these groups have often viewed family planning efforts with scepticism and distrust. The indigenous population in Guatemala is made up of numerous and varied groups that are not united into a single representative body. Therefore, it was difficult to identify interested indigenous leaders who were supported by a significant number of indigenous organizations. As an effort to include the indigenous sector in the political process, visits were made to the National Coordinator of Widows of Guatemala and the National Organization for Rural Workers, organizations known to include various indigenous groups. Representatives from these organizations were receptive to the proposal and agreed to participate in discussions and support the initiative. Unfortunately, no representatives from either organization attended the meetings and fora to which they had been invited.

Advocacy among Supportive Groups

The following national actors formed the "supportive sector":

- The State, which included the following key stakeholders:
  - A significant majority of members of parliament in the Congress, who created an enabling environment for the elaboration of this initiative, especially with the support of the Second Vice-president of Congress;
  - The Social Cabinet, which endorsed the implementation of the programme for cooperation between the Government and UNFPA;
  - The Minister of Public Health, who declared reproductive health to be a priority of the health sector;
  - The Secretary of the Presidential Secretariat for Planning and Programming (known as SEGEPLAN);
  - The Secretary of the Presidential Secretariat for Women (known as SEPREM); and
  - The Minister of Education, who incorporated population topics in educational reforms.
- Important civil society groups, including universities and research institutes, women's organizations, trade unions and other workers' organizations, the media, political parties, and the Association of Gynaecology and Obstetrics, in addition to other health-related institutions.

A political analysis of supportive groups was made to establish strategic partnerships that could help reduce opposition. The institutional capacity of supportive groups was assessed in terms of their ability to create discussion fora on the draft law; representatives of the media were sensitized and new alliances were sought that would reinforce and strengthen support for the law.

Approximately 15 civil society groups participated in the process of formulating and supporting the law.

Activities among Supportive Groups

The main goal was to achieve consensus within supportive groups on the purpose and content of the draft law so that they would internalize the proposal, act as advocates, and promote the law within their groups and among their supporters. To achieve this goal, the following steps were undertaken:

Capacity-building among Key Institutions

Sensitization and training workshops were held in the following areas:

- Reproductive health issues;
- Coverage and application of reproductive health services; and
- Advocacy and communication skills to build capacity in presenting the key argument of the law to the media.

The UNFPA Country Technical Services Team in Mexico assisted in the design and execution of these workshops. The workshops were attended by Government officials from the Ministry of Health, including the Minister and Vice-Minister, members of parliament and staff, representatives from the Presidential Secretariat for Women and the Presidential Secretariat for Planning and Programming, members of women's organizations, and NGOs that work on reproductive health issues.

Research and Circulation of Supportive Scientific Documentation

Studies were carried out by credible and technically specialized organizations on topics related to family planning and reproductive health. For example, experts from the Association of Gynaecology and Obstetrics prepared a report on the functioning of modern contraceptive methods, concluding that they were not abortive in nature; reports on reproductive health topics were formulated and circulated by the National Congress of Gynaecology and Obstetrics, and the Presidential Secretariat for Planning and Programming published a study entitled "Guatemala: Population, Development, a Socio-demographic Diagnostic", produced jointly with the Economic Commission for Latin America and the Caribbean.

Promoting Support in Influential Areas

The following activities sought to create an enabling environment for presentation of the law in a public forum.

Within the Government, the Presidential Secretariat for Planning and Programming became the most important advocate of the law in the Social Cabinet and among various institutions and stakeholders, principally through contact with ministers, vice-ministers, counsellors, advisers and staff of the President.

Women's networks convened meetings with their respective organizations and with civil society groups to focus on the importance of reproductive health.

The Ministry of Health's media department provided information on the importance of health for the population and government-sponsored reproductive health activities. At the same time, media and communication representatives promoted population issues in newspapers and magazines. Fora on reproductive health and population issues were also aired on television and radio.

The Consensus-building and Approval Process

- Members of parliament from the majority party publicly stated their support for a law focusing on population and reproductive health, and took the initiative to write a first draft of the law. This process was facilitated by UNFPA's Country Technical Services Team in Mexico and the Mexican National Advisory Council on Population.

- The first draft was sent to supportive members of parliament in all parties, which allowed for further revisions, discussions and suggestions.

- With the initial consent of the supportive members of parliament, the draft was circulated among institutions that had shown interest in participating in the process. Meetings were conducted with institutions to refine the proposal through the clarification of doubts, the prioritization of criteria and the collection of suggestions and modifications.

- The draft was then revised and forwarded to participating institutions for final comments and suggestions.

- Fora were organized for all participating institutions to review and revise jointly the draft law, article by article. Representatives of civil society then presented the approved document to Congress.

- A declaration signed by all participating institutions was issued simultaneously with the law, stating their involvement in the process and their agreement with the content of the law. These declarations were presented to the Congress along with the law.

- An important factor in the organization of the fora was the selection of a moderator to foster an environment of trust and participation. This person—a well-respected university president—was selected on the basis of his credibility among all participating institutions. His contribution gave a strong push to the law's success.

- Likewise, MINUGUA (the United Nations Mission for the Verification of the Peace Accords in Guatemala) was invited to participate in the forum to ensure and observe that the final product was indeed an agreement based on consensus.

Preparing for the Enactment of the Law

It was essential to maintain regular communications with all participating institutions and individuals during this phase and to provide the necessary technical assistance. In this context, the following activities were carried out:

- Meetings with members of parliament from minority parties were held to promote their ownership of the law, in order to get the support of all political parties. During these meetings, presentations were made on the importance of reproductive health for the reduction of maternal and child mortality; the relevance of sexual education for youth and adolescents; and the need for improved quality and quantity of public information on these subjects;

- Meetings were conducted with the Congress Commission for Legislative Affairs and with the Commission for the Family, Women, Children and Adolescents, in order to inform them about the law, seek their views, clarify questions and offer required assistance during the process of revision and passage of the law. At the same time, meetings were organized with congressional advisers to coordinate their support for the approval process and to provide adequate arguments in order to counteract any attempts by opposition groups to influence the process;

- Meetings with participating organizations aimed: first, at anticipating and solving problems before they arose, ensuring at the same time that the terms agreed upon in the proposal were fully respected; and, second, at reiterating their commitment to the law before the Congress and the President required them to do so;

- Ad-hoc meetings were held with supportive institutions when opposing groups attempted to impede the passage of the law, for example, when the President was requested to veto the law after Congress had approved it;

- Supportive institutions developed a strong media campaign to stimulate the publication of articles about the law to weaken the position of opposition groups that could have jeopardized its passage; and

- Representatives of donor countries and other bilateral and multilateral cooperation agencies were informed and sensitized to gain their support, which was a key factor in raising awareness and interest in the law.

"Patience, perseverance, and the willingness to start a dialogue are 'tools' for behaviour change in conservative environments. It took nearly 15 months of hard work and negotiation to dispel suspicions, build consensus, create the necessary capacity and establish a constructive environment to prepare the ground for the enactment of the law. This in turn demonstrated the UNFPA role in the service of the country."

—UNFPA Representative in Guatemala

ACHIEVEMENTS

It took a year and a half for participating groups to reach a consensus that met the expectations of all parties involved. The following are the most important results:

- ***The passage of the Social Development Law in September 2001.*** The Government and civil society jointly formulated a law that, for the first time, promotes the formulation and implementation of specific development policies in the areas of population, reproductive health and rights, family planning, and sexual education;

- ***The intrinsic value of the entire political and consensus-building process,*** which was characterized by a high level of participation from all stakeholders, including the Government and the Congress, as well as civil society groups, including those who had traditionally been opposed to these issues. A great deal of effort was invested to achieve this level of organization, social mobilization and marketing of the law. In essence, it helped to create an enabling environment that led to the adoption of the law. The political and consensus-building process was vital to the approval of a law that enjoys the support of all participating sectors;

- ***UNFPA had a key facilitating role in the negotiation process*** and in supporting it through the provision of evidence-based information and the building of national capacities and skills for advocacy and social marketing. UNFPA earned respect and trust for its role in the country as a transparent facilitator and mobilizer for social development. This was acknowledged by the Government, civil society organizations and international groups in the country; and

- One of the most important spin-offs of the project was the strengthened partnerships that UNFPA was able to form with civil society organizations and women's groups, an asset for further action for the promotion of the ICPD Programme of Action and its mainstreaming into national policies and programmes.

LESSONS LEARNED

- ***Understanding the nature of opposing views and the rationale on which they are based.*** In most countries, the opposition is not a monolithic group; therefore, from the outset, it is important to conduct an in-depth analysis of the views of the various groups and to identify areas of common interest that could lead to joint action.

- ***Developing different advocacy strategies that address the various groups.*** It was essential to identify the various

groups that have the potential to participate in consensus on population and reproductive health issues and to support their understanding of the issues at hand through advocacy and data and information-sharing. Identifying and expanding such alliances among groups that may have not worked together before created a more neutral environment for negotiations and consensus-building.

- ***Ensuring transparency to create mutual trust and respect.*** The perception that groups working on population issues cannot be trusted was dispelled through the promotion of transparent processes of consultation and negotiation in which all stakeholders had full access to information.

- ***Promoting confidence by following through on commitments.*** Agreements were respected, deadlines met and promises realized. This helped to create an environment of trust and respect and inspired confidence in the capacity to facilitate consensus-building to move the social agenda forward.

- ***Facilitating negotiation among the various stakeholders on issues relating to the ICPD Programme of Action.*** The UNFPA Country Office provided technical assistance as required through conducting research to identify points of common interest and divergence among stakeholders along with the principles and values of each group. This was followed up by the formulation of arguments that could be brought to the negotiation table to demonstrate the advantages of participating in the process. Individuals from each group that would be receptive to these ideas were identified beforehand.

- ***Designing advocacy campaigns that create consensus.*** It was found essential to use an advocacy strategy grounded in evidence-based data on issues that tend to bring stakeholders together as an entry point. Such issues include: the importance of reproductive health as a means of reducing mother and child mortality; the relationship between infant mortality and the reduction of births at a young age and pregnancy at a later age; the relationship between birth spacing and reducing infant mortality; HIV/AIDS prevalence nationally and poverty reduction.

- ***Involving as many stakeholders as possible to ensure inclusiveness and to create societal ownership.*** This is important in creating an environment that allows each stakeholder to identify the "value added" of the proposed interventions. An inclusive strategy that brought together religious institutions, the Government, civil society organizations and the private sector was implemented, and this created national ownership of the new law by the widest possible coalition of national stakeholders.

- ***Strengthening the capacity of national stakeholders by providing them with technical backstopping and information.*** In the period between the proposal of the law and its enactment, UNFPA was involved in a wide range of capacity-building activities involving partners and potential allies.

2 MOVING THE ICPD PROGRAMME OF ACTION FORWARD IN THE ISLAMIC REPUBLIC OF IRAN THROUGH PATIENCE AND AN ENABLING ENVIRONMENT

In the Islamic Republic of Iran, recognition on the part of the Government of the negative impact of rapid population growth, along with concerted advocacy efforts and one of the best primary health systems in the region, has reduced fertility rates by more than half in the last decade. Moreover, the country has exceeded the targets laid out at the 1994 International Conference on Population and Development (ICPD).

This chapter reviews four projects from the UNFPA Country Programme that have played an important part in advancing reproductive health and rights in the Islamic Republic of Iran. The most important lesson learned by UNFPA in that country is not to underestimate the importance of culturally sensitive issues, and to patiently seek resolution of such issues at the outset.

THE ISLAMIC REPUBLIC OF IRAN: COUNTRY CONTEXT

Cultural Roots

With more than 6,000 years of recorded history, the Islamic Republic of Iran is a land of rich cultural diversity. The result has been the development of a social structure consisting of three interrelated systems that have co-existed for centuries: the nomadic or tribal system, the rural system and the urban system. The nomadic way of life is the context in which a patriarchal culture has emerged. Social solidarity was essential for the survival of the nomads. Thus, unconditional acceptance of the value system and norms of the society was required from each member.

There is no separation between politics and religion in the country. Islam operates as a regulatory mechanism in Iranian society and its importance is reflected in almost every aspect of daily life.

For several years after the Islamic Revolution of 1979, having large families was publicly encouraged. This led to a high rate of population growth (3.9 per cent). The Government soon realized, however, that such a high growth rate meant increasing poverty, acute housing shortages, rapid expansion of informal settlements, higher rates of unemployment, and other ill effects. In time, political and religious leaders were publicly endorsing the need for family planning. Thus, new edicts (*fatwas*) allowing reproductive health services and family planning were announced.

Demographic Trends

The Islamic Republic of Iran's population was estimated at nearly 69 million in 2003. During the last decade, the total fertility rate declined from 5.6 to 2.3 children per woman. Many have singled out economic hardship as the main reason for this decline. This can be a contributing factor, but cannot, on its own, lead to such a dramatic reduction in the birth rate. Changes in public awareness coupled with accessible and affordable reproductive health services, including family planning, are also required. This has been accomplished through successful family planning and health programmes, some of which are reviewed in this report. The country has exceeded the targets laid out at the 1994 International Conference on Population and Development in terms of demographic and socio-economic indicators. A structured programme for family planning began in 1989. Twelve years later, the second demographic transition towards low mortality and low fertility was achieved. The official maternal mortality ratio in the Islamic Republic of Iran is 37 per 100,000 live births.[1]

1 Although some sources cite a lower figure, UNFPA's *State of World Population 2003* report shows the Islamic Republic of Iran's maternal mortality ratio as 76 per 100,000 women.

UNFPA PROGRAMME

UNFPA is now implementing the Third Country Programme in the Islamic Republic of Iran, covering the five years from 2000 to 2004. The country programme coincides with the Third Five-Year Development Plan, which aims at sustained economic growth; the eradication of poverty and illiteracy; the empowerment of women and youth, including their involvement in development; the reduction of maternal and child morbidity and mortality; and the reduction of fertility and population growth rates.

The country has made significant achievements in reproductive health, having one of the best primary health systems in the region and comprehensive reproductive health services. Many methods of contraception, including tubal ligation, condoms, vasectomy, the pill and injectables, are provided at no cost. In addition, there is a compulsory system of pre-marriage counselling, without which a couple's marriage cannot be registered.

The UNFPA Country Programme focuses on specific areas where it can have the greatest impact. Its main goal is to improve reproductive health in hard-to-reach and deprived areas. The programme is being carried out at the national level and in four provinces—Bushehr, Golestan, Kurdestan, and Sistan and Baluchestan—and one semi-urban area in metropolitan Tehran called Islam-Shahr. In these areas, general health indicators and, in particular, those related to reproductive health are lower than the national average.

In addition to representing some of the country's most disadvantaged areas, the selected sites include two important ethnic communities, the Baluchis and Kurds, for whom issues related to reproductive health are extremely sensitive. The selected sites include other ethnic groups such as Turks and Lores, and all sites contain Afghan refugees. The selected sites also contain both Sunnites and Shiites. The project sites in the four provinces are relatively homogeneous, whereas Islam-Shahr is a heterogeneous community.

The Third Country Programme comprises seven projects that fall under the general thematic areas of reproductive health, advocacy, and population and development strategies. Four of these projects are discussed in this chapter:

- Two projects that are part of the reproductive health subprogramme: Strengthening Delivery of Reproductive Health Services in Five Areas of the Country and Management Development Support to the Ministry of Health and Medical Education;
- Reproductive Health/Family Life Education Advocacy through the Literacy Movement Organization, known as the "Literacy Movement Organization Project"; and
- Advocacy for Women's Rights to Reproductive Health and Mainstreaming Gender in Development Planning project, known as the "Women's Project".

Projects 1 and 2: The Reproductive Health Subprogramme

The reproductive health subprogramme is composed of the two projects described above. The projects are the centerpiece of the UNFPA-supported programme and reflect the numerous changes in approach to reproductive health that have taken place since the ICPD in 1994.

One of the major achievements of the ICPD is that it established that it is no longer adequate to programme for reproductive health exclusively from a biomedical perspective. For many years, that perspective dominated efforts to improve health, especially in developing countries where traditions have a strong influence on values and beliefs. The biomedical perspective, as far as reproductive health is concerned, emphasizes the availability of various health-care services, including family planning. The importance of these health services and their components is undeniable. However, sociocultural factors, normative systems, and the communities' perspectives, attitudes and perceptions towards health in general, and women's health and reproductive health and rights in particular, have often received insufficient attention. In rural and tribal areas of the Islamic Republic of Iran, these factors are critical to the success of a reproductive health programme.

Objectives and Coverage

The purpose of the subprogramme is to contribute to increased utilization of quality reproductive health and family planning information and services by men, women and adolescents as an integrated part of the primary health-care network. To achieve this goal, four outputs have been identified:

- Strengthened capacity of the Ministry of Health and Medical Education to formulate a reproductive health strategy and to coordinate and implement reproductive health and family planning programmes in partnership with civil society and concerned sectoral ministries;
- Increased availability of quality information on reproductive health and family planning and services that are sensitive to the needs of women, men, adolescents and vulnerable groups in the five selected areas;
- Strengthened national capacity to provide population education that incorporates reproductive health and

SELECTED INDICATORS: ISLAMIC REPUBLIC OF IRAN

Total population, 2003	68.9 million
Average population growth rate, 2000-2005	1.2%
Life expectancy for females	71.9 years
Life expectancy for males	68.9 years
Total fertility rate, 2000-2005	2.3
Births with skilled attendants	86%
Contraceptive prevalence for women aged 15–49, modern methods	56%
Contraceptive prevalence for women aged 15–49, any method	73%
Infant mortality per 1,000 live births	33
Maternal mortality ratio per 100,000 live births	76
Illiteracy rate for females over 15 years	31%
Illiteracy rate for males over 15 years	17%
HIV/AIDS prevalence rate for females 15–24 years	0.01%
HIV/AIDS prevalence rate for males 15–24 years	0.05%
Gross national income per capita (PPP$), 2001	$6,230
Access to safe water	93%

Source: UNFPA, State of World Population 2003.

gender issues as part of the recommendations of the ICPD Programme of Action in both formal and non-formal education systems in selected areas; and

- Increased awareness of reproductive health issues, including reproductive rights, among target populations—women, men, youth, key influential leaders, health personnel and teachers.

With the exception of the capacity-building project involving the Ministry of Health, which is being carried out at the national level, the geographic coverage of the component projects is limited largely to the sites of the overall UNFPA Country Programme, that is, the four provinces and one urban district south of metropolitan Tehran. The target groups are the marginalized poor and communities with a high rate of illiteracy.

Achievements

UNFPA supported the Ministry of Health in undertaking research, organizing seminars and workshops, and initiating other health-related activities at both the national and the provincial level. Some of the project activities undertaken or in progress are listed below.

- ***Research*:** a secondary analysis of the Demographic and Health Survey, with 10 papers prepared by national experts and a seminar to disseminate the findings; a list of indicators at district, provincial and central levels that were disseminated widely; a collection of edicts concerning reproductive health and family planning; the second stage of a survey on the situation of deliveries in suburban areas of Zahedan; a survey on the incidence of sexually transmitted infections in Zahedan; and a situation analysis of the reproductive health and safe motherhood situation in Nikshahr.

- ***Managerial and operational functions*:** guidelines on administration, finance and family health programmes; operation of two safe delivery centres in peri-urban areas of Zahedan; expansion of reproductive health programmes to Nikshahr; procurement of midwifery kits and uniforms for trained midwives; and procurement of contraceptives, as appropriate.

- ***Capacity-building through training*:** conducting short training course for high- and mid-level directors; training of national medical specialists (obstetricians and gynaecologists) on various technical issues and on supervising the training of physician/midwives and other health workers; conducting meetings with a scientific committee to develop standard protocols on safe motherhood and hosting training workshops on how to use the protocols; developing a training video

on counselling and holding training workshops to train trainers; conducting baseline and post-intervention surveys in five provinces; organizing a meeting to develop a reproductive health and family planning package for soldiers, including a training module for soldiers and a guide for trainers; holding training workshops for health staff; identifying and training individuals at risk; conducting training classes along with recreational activities for adolescents.

- ***Publications:*** training materials on strategic planning, management and surveillance of maternal mortality; books and pamphlets on issues related to reproductive health, family planning and HIV/AIDS; guidelines on emergency contraception; behaviour change communication materials related to safe motherhood and other issues.

A Culturally Sensitive Approach

The following are some of the strategies used to maximize the chances for success in a complex cultural context:

- ***Involve influential local partners by providing them with information about the project and about the added value it can bring to the local community.*** This type of interaction can help to garner support or neutralize possible opposition. In the case of the reproductive health subprogramme, project staff invested considerable effort in sensitizing religious leaders prior to project implementation.

- ***Especially at first, use capacity-building to address any doubts or resistance on the part of partner organizations.*** Initially, capacity-building activities focused on staff of partner organizations and were carried out through workshops, seminars and meetings to ensure that unexpected roadblocks did not occur during project implementation.

- ***Take on the role of facilitator and technical resource, which sends a clear message of non-partisanship in an environment characterized by ethnic and religious sensitivities.*** During the implementation phase, UNFPA acted as a neutral facilitator. In doing so, it avoided religious, political, sociocultural and ethnic sensitivities. The approach proved to be effective. UNFPA became associated more with the technical aspects of reproductive health, a role welcomed by the partner organization. Consequently, the partner organization was able to address culturally sensitive issues under the umbrella of UNFPA, which was regarded as a neutral organization.

PATIENCE, PERSISTENCE AND PRAGMATISM

Dr. Feridoon Falahi, who is responsible for the Family Health Office in Marivan City, Kurdestan and a partner in the reproductive health subprogramme comments on why, in his view, the programme has been a success:

"Our successes have not been achieved overnight. Implementing the programme has been very gradual. All the actors involved—that is, UNFPA, the Ministry of Health and Medical Education, provincial offices, Behvarzes *(peers) at the village level, doctors in health centres, health houses and the beneficiaries, all agreed that reproductive health and related issues are important and should be addressed sooner or later. Also, all actors knew that they were dealing with sensitive issues. Thus, all were extremely cautious. At first, we addressed the least sensitive issues, emphasizing women's health in general. By doing so, and after some success in reducing infant mortality, people trusted us and realized that our services were important.*

"The next step was bringing religious and community leaders together in a number of meetings and seminars where the reproductive health and family planning experts discussed the programme and asked for the community and religious leaders' help. This type of activity proved important and effective.

"The collection of newly issued edicts (fatwas) *issued by important religious figures was very helpful. People realized that reproductive health and family planning are not against their religion. Then it became possible to address culturally sensitive issues. A few external factors should also be mentioned: increase in the rate of literacy; economic hardships of families, which led to the acceptance of the importance of family planning; a well-prepared programme by UNFPA-Iran; and close collaboration between UNFPA and the Ministry of Health and Medical Education. The* Behvarz *project should not be forgotten.* Behvarzes *are trusted by the people. They are from the same villages where they work and have relatively the same socio-economic status. They use the face-to-face method to educate people, which has proved to be the most effective method."*

- ***Carry out sensitization and advocacy campaigns that highlight the economic and social welfare of small families and the negative economic consequences of having large families.*** The implementing organizations, especially staff of the Ministry of Health and Medical Education, emphasized the negative economic consequences of having many children on the welfare and well-being of families. They did this by comparing the situations of families with similar backgrounds, social class and income, that differ only in the number of children they have. This was helpful in this particular context to illustrate the importance of family planning in a way that was easily understood.

- ***Provide field-based evidence to religious leaders, policy makers and the public.*** Research implemented within the context of the country programme on the importance of reproductive health for Iranian society was influential in dialogues with religious leaders and policy makers and proved an effective advocacy tool for the programme.

"Due to the dedication of Literacy Movement Organization staff and the people's trust, we are now able to speak about gender issues, even about AIDS. Literacy Movement Organization networks are active all over the country. Instructors are natives of each region, and therefore people trust them. They consider the Literacy Movement Organization as an organization that can deliver."

—UNFPA Assistant Representative in the Islamic Republic of Iran

Project 3: The Literacy Movement Organization Project

The Reproductive Health/Family Life Education Advocacy Project (known as the Literacy Movement Organization Project) integrates population and reproductive health messages into literacy classes at all levels in the four provinces selected for interventions in the UNFPA Country Programme.

The messages that are disseminated touch on topics ranging from women's empowerment and reproductive rights to male involvement, gender equity, and adolescence and puberty.

The Literacy Movement Organization, which implements the project, is affiliated with the Ministry of Education and headed by the Deputy Minister of Education. It has a staff of more than 7,000 and approximately 50,000 instructors. Working throughout the country, in both urban and rural areas, the organization carries out a basic literacy programme as well as complementary and continuing education for various target groups, including civil servants, factory workers and school dropouts. For this project, the target group is between 15 and 35 years of age.

Previous UNFPA Involvement in Literacy Programmes

UNFPA has provided support for the integration of population education into the Government's literacy programme since 1992. These efforts succeeded in providing orientation and training to more than 17,000 instructors and in developing curricular and reading materials on population and family planning issues. More than 30 booklets were produced on population issues, including health, pregnancy, childcare, and son preference. These materials were used extensively by other agencies and distributed to other Islamic countries in the region.

In the Second Country Programme, the Literacy Movement Organization addressed HIV/AIDS education on a pilot basis in 575 classes in six provinces (Ardabil, Gilan, Golestan, Kermanshah, Khorasan and Tehran). Materials were produced by a project with the Ministry of Education. Preliminary results of this pilot effort indicate that learners appreciated receiving information about HIV/AIDS and that there was no problem in integrating HIV/AIDS education into the literacy classes. This was largely due to the ability of the Literacy Movement Organization to present messages in a discreet manner, taking into consideration social, cultural and religious issues and sensitivities.

Project Objectives

The project has undertaken two distinct sets of strategies and activities:

- The first deals with advocacy on issues such as health, family life, gender equity, women's empowerment and male participation; and

- The second focuses primarily on mainstreaming selected reproductive health issues, including gender and women's empowerment, into the literacy programme through the orientation of teachers, the production of reading materials and the teaching of these issues in literacy classes. By the end of the project, it was expected that these topics would be fully integrated into the national literacy programme. That goal was achieved even before the end of the project.

CULTURALLY SENSITIVE TOPICS, ACCORDING TO INTERVIEWEES

(N=69)

	Culturally sensitive issues	Frequency
1	Sexual relationships	69
2	Religion, especially those issues forbidden by religion	69
3	Political issues, especially those considered as insults	45
4	Childbirth	41
5	Pregnancy	32
6	Gynaecology and obstetrics	31
7	Gender and related concepts	28
8	Ethnicity implying criticism	18
9	Teachings that could lead to wives' dissatisfaction about the family and their marital situation	17
10	Males' sexual abilities and topics like reproductive health and family planning that are perceived as being irrelevant to males	12
11	Centuries-old prejudices about gender, reproductive health and women's rights	11
12	Absence of a friendly atmosphere within families so that important issues are not discussed and gradually become taboo	4

Achievements

To accomplish the project objectives, the Literacy Movement Organization, as one of the implementing agencies for the country programme, undertook the following:

- ***Teaching and training:*** teaching reproductive health issues in literacy classes to more than 72,000 females (since the initial project) and more than 16,000 males (in 2002); training 3,360 literacy instructors;

- ***Advocacy activities*:** Advocacy seminars were implemented on reproductive health issues to sensitize local policy makers, religious leaders, government officials and journalists. About 4,500 persons participated, including governors, urban and rural council members, officials from the Ministry of Health and Medical Education and other relevant sectoral ministries and organizations, national and local journalists, and Literacy Movement Organization staff and instructors. One result was the publication of more than 31 newspaper and magazine articles on issues related to reproductive health; and

- ***Publications*:** 50,000 copies of a reproductive health booklet for male learners and 10,000 copies for instructors; a quarterly newsletter covering reproductive health news for distribution among literacy learners in selected areas. A teaching guide on the subject was prepared, and 7,000 copies were printed for nationwide distribution. Booklets entitled "A Season to Blossom", "Dealing with Children", "Dealing with Adolescents", and "Health of Infant Girls and Women" were published and used in literacy classes, which included more than 55,000 females. In 2002, there were also classes for more than 16,000 males, with a booklet specially prepared for male learners.

Improving the Socio-economic Conditions of Women

The other initiative introduced to enhance the status of women was to combine skills-development training with literacy and reproductive health education in three urban areas and six villages in Kurdestan Province. Under this initiative, 114 impoverished women and girls completed courses and received seed money to begin economic activities relevant to their training. The initiative also proved to be an incentive to attract women to literacy classes. Within the framework of this initiative, a baseline study was conducted to assess the current socio-economic and demographic situation of the target group. An impact evaluation of the intervention is planned for 2004.

A Culturally Sensitive Approach

- ***Identify issues that are considered culturally sensitive in terms of reproductive health, gender issues and sexual education in the specific context and environment where programmes are to be implemented.*** Interviews with the local directors of the Literacy Movement Organization revealed a similarity in their definitions of culturally sensitive issues, defining them as issues that people are reluctant to discuss in public, issues that cause people a sense of shame, and issues that wives prefer to talk about only with their mothers and sisters, not with their husbands. The table on the previous page shows the degree of sensitivity of various issues as measured by interviewees.

- ***Identify and select a partner that has sound knowledge of local sensitivities and can address them appropriately.*** The Literacy Movement Organization is widely regarded as an organization with a traditional mindset, and a considerable segment of its staff is religious. For these reasons, few people thought that the Organization would be an appropriate partner for an initiative of this nature. Experience proved the contrary. Arriving at an initial agreement with the Literacy Movement Organization took time and much discussion. Yet, eventually, mutual trust was established and the Organization became a dedicated partner.

- ***Seek partners that have large networks in grass-roots communities and are respected by these communities.*** The countrywide infrastructure of the Literacy Movement Organization, which reaches most of the country's marginalized groups, was the reason why the project was able to achieve such wide coverage in terms of its advocacy messages, reproductive health education and dissemination of publications.

- ***Let your partners do the job themselves, but provide continual support through technical backstopping, capacity-building and information.*** This approach led to the creation of trust and to ownership of the project by the Literacy Movement Organization and the communities in which the project was implemented.

- ***Select a partner that has proved it can contribute to the quality of people's lives.*** People from all walks of life, especially in smaller towns, villages and remote areas, trust the Literacy Movement Organization and regard it as an organization that has no hidden agenda and can deliver on its promises.

- ***Select a partner capable of developing creative solutions to reach people.*** The Islamic Republic of Iran's educational infrastructure covers rural areas. However, in areas where there is no school, most classes for adult learning take place in people's homes.

Project 4: The Women's Project

The Advocacy for Women's Rights to Reproductive Health and Mainstreaming Gender in Development Planning project aims at creating an enabling environment by mobilizing support from religious leaders and decision makers for quality reproductive health and family planning services and the promotion of women's rights. It also aims at strengthening the institutional capacity of government organizations for mainstreaming gender concerns into development planning.

The specific outputs are the following:

- Increased support of parliamentarians, national and provincial policy makers, religious and community leaders and the mass media for a broader reproductive health programme for men, women and adolescents, and advocacy for women's rights, including their reproductive rights;

- Strengthened capacity of relevant NGOs, autonomous bodies and ministries dealing with the social sectors to

"By attending Literacy Movement Organization classes, I have learned a lot. I learned how to convince my husband that it will better for our lives if I take contraceptive pills. I can explain the negative consequences of a high rate of population growth not only for our own well-being but also for our country. Now I know the negative impact of too many pregnancies and the problems of marrying a very close relative. What I have learned has changed my attitude towards life. I have changed my husband's attitude as well. He regrets not allowing me to attend those classes sooner. We have far fewer problems, fewer quarrels. In short, I am another individual. A new one."

—A 32-year-old woman from Kohak village

CAREFUL PLANNING

Mr. Nasser Tavakoli, Director of the Literacy Movement Organization in Ahar City, responds to a question concerning the Literacy Movement Organization's approach to culturally sensitive issues and the reasons behind the success of the project:

"From the beginning, we knew that reproductive health, family planning, rights to reproductive health, women's rights and the like were very sensitive and required careful planning in advance. The first step was to assign the instructors who were from the same region, from the same social class, with familiarity about the communities in which they will work. Second, we did not raise culturally sensitive issues from the first day of the project. We announced the establishment of a class entitled 'life skills', in which the instructors taught adult learners skills such as tailoring, embroidery and similar skills.

"During those classes, the learners gradually became friendly, and trusted their instructors and one another. Then the instructors began talking about family planning, using the format of storytellers. In the course of teaching family planning, methods of birth control were discussed. At this point, reference to important edicts (fatwas) *was made. These edicts helped considerably, for the learners became convinced that nothing was taking place against their beliefs.*

"Simultaneously, meetings with religious and community leaders were held, and their approaches changed in favour of discussing culturally sensitive issues. They were aware of the recent edicts. When the atmosphere became appropriate, the most sensitive issues such as reproductive health, rights in reproductive health, gender equity and the like were addressed. Now it is normal to have these issues as a part of our curriculum."

promote the reproductive health rights of women, provide information on reproductive health issues, and advocate on gender issues and male involvement in reproductive health;

- Increased support for improving women's socio-economic conditions, especially in marginalized areas; and

- Increased South-South cooperation on issues including gender, population, reproductive health and family planning.

The UNFPA partner organization in the project is the Centre for Women's Participation, which resides in the Office of the President. One result of recent reformist gains in presidential elections and in city and village councils has been the upgrading of organizations dealing with women's affairs. The Director of the Centre became an Adviser to the President on Women's Affairs and is expected to participate in Cabinet meetings.

The Centre for Women's Participation is implementing its activities in nine districts, two in each of the four provinces and one in Islam-Shahr.[2] The project is based on four interrelated strategies: research, support for an enabling environment, institutional and organizational capacity-building and women's empowerment. These strategies and related activities are reviewed below.

Achievements

Of all the projects in the UNFPA Country Programme, the Women's Project is the most sensitive. After several years of effort with little progress, there is a new environment in which protective legislation and other measures are discussed and promoted.

Research strategy and accomplishments

The research strategy aims at collecting vital information concerning the most critical issues requiring interventions. Selected research includes:

- Situation analyses of women's conditions in selected districts through attitudinal surveys on gender, reproductive health and women's rights in reproductive health. The target groups of those surveys are members of parliament, religious figures and leaders;

- Sociocultural studies on women's behaviour in regard to reproductive health and health in general; and

2 Bushehr City and Kangan in Bushehr Province; Zahedan and Sabol in Sistan and Baluchestan; Marivan and Divan dareh in Kurdestan; and Gorgan and Minoodasht in Golestan.

- Research relating to violence against women in selected districts.

Supportive strategy and accomplishments

The supportive strategy has the following objectives:

- Creating an environment conducive to policies that support reproductive health; and

- Creating an enabling environment through public awareness campaigns on gender issues, reproductive health and violence against women.

A number of sensitization activities were conducted targeting members of parliament, policy makers, religious and community leaders, the media, NGOs, individuals working in health-related fields and volunteers. A one-day seminar entitled "Women's Empowerment with a Focus on Reproductive Health and Reproductive Health Rights" was held and was attended by the wives of senior government officials and ministers, parliamentarians, religious figures, governors, provincial officials, media representatives, NGOs and representatives of United Nations agencies. Ten papers were presented and lively discussions took place on sensitive issues. The event was a breakthrough in that the presence of high-ranking officials and their wives, and especially the presence of religious figures in a meeting in which gender equity, women's rights, violence against women and similar issues were discussed, was unthinkable even a few years ago. To many, the mere presence of these people was taken as an affirmation of their support. Another breakthrough was the positive reaction of newspapers and government-controlled radio and TV to the seminar on topics that have always been sensitive in terms of coverage.

As a result of strong and persuasive advocacy efforts, parliamentarians, policy makers and key religious and community figures have issued more than 35 statements in favour of reproductive health issues, including women's empowerment, women's rights and gender equity.

In selected provinces, a number of one-day seminars were organized on topics ranging from advocacy for reproductive health to reducing gender inequity and violence against women. The fact that religious and community leaders as well as government officials attended these seminars reinforced the role of UNFPA as a neutral facilitator that supports national leadership and national ownership of the country programme.

Institutional and organizational capacity-building strategy and accomplishments

The strategy aims at building capacity to address gender issues among institutions and organizations working in the social sector. Its objectives include establishing a gender network within governmental organizations and developing appropriate mechanisms for coordinating activities at national, provincial and local levels. After lengthy discussions and deliberations to demystify gender-related issues, the opposition to this initiative was contained and the gender network was officially established.

Women's empowerment strategy

The strategy aims at empowering women through a rights-based approach. It also aims at raising awareness of women on legal issues and on the resources that could be made available to them. To improve conditions in selected areas, an income-generation scheme was introduced in five pilot villages.

A Culturally Sensitive Approach

- ***Do not underestimate the importance of cultural sensitivities. Reaching consensus on delicate issues requires patience and care, but is worth it in the end.*** At the beginning of the First Country Programme, for example, there were misunderstandings about the meaning of reproductive health and women's right to reproductive

"The advocacy programme [for women's rights to reproductive health] is well prepared. Any step towards the programme's goals has proved to be very time-consuming and, at times, tiresome. . . . But my experience has shown that when you deal with culturally sensitive issues, you have no choice but to be as careful and as patient as possible. Every concern should be addressed properly. Otherwise, greater problems emerge at later times, when nothing can be done."

—National Project Director

health that had to be patiently discussed. Not only were these issues accepted, but eventually they were promoted throughout the country.

- ***Address sensitive issues in the context of health.*** Approaching culturally sensitive issues initially in a technical or scientific context can make discussion and acceptance of such issues easier. In the case of the Women's Project, UNFPA approached women's issues from a health-related viewpoint, which enabled it to fulfil its role as facilitator.

- ***Recognize the value of brainstorming and concept clarification.*** It is worth the time at the beginning of a project to clarify issues and thoroughly address doubts that participants may raise. If doubts and questions remain, they will surface later and affect project implementation. Thus, several brainstorming sessions took place early on to clarify concepts. Members of committees that designed the project strategy and coordinated the selection of sites were present at those sessions.

- ***Undertake extensive and continual research.*** UNFPA is taking an integrated approach in its programming in the Islamic Republic of Iran, which requires comprehensive knowledge and deep familiarity with the issues at hand. This not only helps in planning and implementing a project but in anticipating possible obstacles and sensitivities. Constant involvement in research, especially targeted research, has been a factor in the success of the Women's Project and the overall programme in the country.

- ***Maintain a dialogue.*** UNFPA staff demonstrated their faith in the value of dialogue with partner organizations, even under difficult circumstances. For this reason, preparatory phases of a few projects were excessively time-consuming. Nevertheless, the dialogues continued until the environment for socio-economic and political changes became favourable. This approach, which sometimes meant "one step forward, two steps back", requires patience and adaptation to a changing environment. For example, one of the major problems faced by the Centre for Women's Participation was frequent change in the directorship of the implementing team, requiring a re-review of principles and goals previously agreed upon.

- ***Limit the scope of the project so that outcomes are realistic.*** The selection of a few sites proved manageable, contributing to the successes of the projects. Visible and measurable achievements encouraged government agencies to expand their cooperation with UNFPA.

- ***Monitoring is essential in building mutual trust.*** Ongoing technical assistance, systematic monitoring and constant dialogue at all levels and during all phases of project implementation were cited as reasons for the fruitful cooperation and the creation of trust between UNFPA and the Centre for Women's Participation.

- ***Depend on the judgements of local personnel.*** It is important to listen carefully to local project staff who are familiar with the overall environment in which they work, conscious of cultural sensitivities, and respect the concerns of their partner organizations.

- ***Create opportunities for women to demonstrate their potential.*** In this way, culture-based and false beliefs concerning women are diminished.

SUMMARY OF LESSONS LEARNED

All four projects reviewed are dealing with similar issues—reproductive health and rights and gender related issues—and have confronted similar sensitivities.

- ***Recognize the need for multifaceted interventions that take into account cultural and religious sensitivities locally.*** In the preparation of project documents, existing information, available studies and relevant statistics were reviewed. At the same time, culturally sensitive issues and ways in which those sensitivities could be approached were clearly identified. The negative consequences of neglecting a high rate of population growth, reproductive health and rights issues, and women's hardships and grievances were clearly explained, emphasizing their negative impact on the country as a whole. It was also pointed out that socio-economic development and stability will not be attained until lower population growth is achieved. This can be accomplished only with the participation of local people, especially women. Thus, a number of issues such as reproductive health and family planning, women's empowerment, capacity-building, and women's rights were addressed at the same time. The Government has realized the significance of those issues for the future of the country.

- ***Synchronize the UNFPA Country Programme with the national development plan.*** A review of the aim, goals

"Empowerment and capacity-building have been UNFPA's prime concern in regard to advocacy for women's rights in reproductive health. . . . Often, women, even educated women, are unaware of their own capabilities. . . . they do not know how to approach government agencies to ask for their rights, reproductive rights included. In this regard, study tours have proved effective. Capacity-building and empowerment are also helpful for women to realize their own capabilities. Through empowerment they discover their potential and how that potential can be materialized. Also, interaction with the United Nations Country Team on women's issues has been important."

—UNFPA Assistant Representative in the Islamic Republic of Iran

and objectives of the Islamic Republic of Iran's Third Five-Year Development Plan clearly shows the importance and relevance of the UNFPA assisted programme, the aims of which are identical to those of the national plan.

- ***Launch well-targeted awareness campaigns.*** Before and during project implementation, religious and community leaders, officials of concerned NGOs and faith-based organizations, along with the media and experts from related disciplines came together to discuss reproductive health and family planning, women's empowerment, capacity-building and women's rights from different viewpoints. Those occasions created the opportunity to address culturally sensitive issues and arrive at appropriate ways to address them.

- ***Collect and research religious positions on the ICPD Programme of Action.*** The collection of progressive edicts by partner organizations and distribution of them in target areas assured local communities that project objectives did not contradict religious teachings.

- ***Present issues in a technical and scientific framework.*** The emphasis on research and hard data on health and health-related issues helped mobilize both the general population and government agencies towards acceptance of project objectives. Such an approach was also helpful in generating cooperation and avoiding controversies of any kind.

- ***Demonstrate persistence, transparency and a clear agenda.*** Being patient, never giving up, and being sensitive to partner organizations' concerns are the qualities that were important for effective implementation of UNFPA-supported programmes in the Islamic Republic of Iran. Within the country office, there is a belief in teamwork, an understanding of the importance of project outcomes for the country and its people, especially those most marginalized.

- ***Involve a wide spectrum of actors at different project phases.*** Genuine efforts were made to involve NGOs, well-known experts, faith-based organizations and others who could contribute to the projects from the preparation stage to completion. Including diverse groups helped to build confidence in UNFPA among influential groups in the country.

In addition, UNFPA, along with other organizations and agencies, supplied technical assistance to NGOs, which in turn carried out research funded by UNFPA in the Islamic Republic of Iran. The United Nations took an important step in instituting close collaboration with NGOs in the country. Indeed, the establishment of many different NGOs, with "green" and women's NGOs in a leading role, in a relatively short period of time, was one outcome of the social change movement sweeping the country. All United Nations organizations and agencies in the country have been working with these NGOs on a regular basis. To coordinate those activities, a Theme Group on NGO Relations was formed and has met regularly both with its members and with other NGOs and related entities. UNDP, UNFPA, FAO, UNDCP, WHO, UNHCR, WFP, UNICEF and UNIDO are members of this group. For a couple of years, the group was chaired by UNFPA and was extremely active. Apart from the Women's Project, the Centre for Women's Participation and UNFPA worked on women's issues initiated by the group. A situational analysis of Iranian NGOs has been published with support from UNDP.

- ***Support valuable research to advance the well-being of Iranians.*** In a relatively short period of time and with little money, UNFPA was able to support a number of important research studies. This enabled it to use data

and information gathered for defining useful projects and also to act as a facilitator by using the data to generate debates on culturally sensitive issues. The results of such activities strengthened the reputation of UNFPA as an organization with visible concern for the welfare of all Iranians.

- ***Establish mutual trust.*** After the Islamic revolution, both the Government and most Iranians were, for a time, suspicious of foreigners, including foreign organizations. At first, no distinction was made between international organizations such as United Nations agencies and those organizations with direct links and affiliations to other Governments. Thus, trust was lacking, which made cooperation with the Iranian Government and its various organizations difficult. Establishing mutual trust was a painstaking and sensitive process. Demonstrating transparency and ensuring full access to information were ongoing elements of the UNFPA strategy to establish mutual trust.

"The most important lesson to be learned is that through its patience and cultural sensitivity an organization working within a very complex context, at a time when foreigners were regarded with suspicion, has been able to address sensitive issues among the most disadvantaged groups of the country and to implement projects now regarded as success stories. UNFPA is regarded as a trustworthy partner by both the conservative and the liberal partners in Iran. This is what United Nations organizations should be about."

—A professor at Tehran University

3 WINNING SUPPORT FROM SOME OF UGANDA'S CUSTODIANS OF CULTURE: ELDERS, BISHOPS AND KINGS

Several UNFPA-supported projects in Uganda have been seeking to raise awareness of reproductive health issues, promote healthier behaviour and eliminate harmful practices that are deeply rooted in the country's diverse cultures. The projects are being carried out in partnership with the Sabiny Elders Association, the Kinkizi Diocese of the Church of Uganda and the Bunyoro and Tooro Kingdoms. In addition, a major effort is under way with the country's Muslim community to increase awareness and utilization of reproductive health services (see following section, page 40).

In all cases, well-established "custodians of culture" were enlisted in the non-controversial goal of improving reproductive health. As trust developed, addressing more sensitive subjects, such as family planning and female genital cutting, became possible. Using the communications channels and physical structures of local institutions streamlined project implementation, encouraged broad community participation and enhanced receptivity to the health messages and suggested behavioural changes.

UGANDA: COUNTRY CONTEXT

Uganda has a decentralized system of governance, and several functions have been ceded to local control. However, the central government retains responsibility for policy-making, standard-setting and supervision as well as for national security. The economy is predominantly agricultural, with the majority of the population dependent on subsistence farming and light agro-based industries. Although the country is self-sufficient in food, distribution is uneven.

From 1962 to 1970, the period immediately following independence, Uganda had a flourishing economy with gross domestic product (GDP) growth rate of 5 per cent per annum. However, throughout the 1970s and early 1980s, the country faced civil and military unrest, resulting in the destruction of the economic and social infrastructure. This seriously impeded economic growth and the provision of social services, such as education and health care.

Since 1986, the Government has implemented reforms that have steadily reversed these setbacks and put the country on a path towards economic prosperity. Consequently, between 1996 and 2000, the country's GDP grew at an average rate of 6.2 per cent per year. These gains, however, are being undermined by civil strife in some parts of the country, rapid population growth and the effects of the HIV/AIDS pandemic.

HIV/AIDS control remains a priority in Uganda and it is the most visible success story in combating the epidemic in Africa. The national prevalence has continued to decline, with a current rate of 2 per cent for males and 4.65 per cent for females aged 15 to 24, according to UNFPA's *State of World Population 2003*. Efforts to prevent the transmission of HIV and to reduce the impact of the epidemic are being expanded, especially in rural areas. These efforts include voluntary testing and counselling for HIV and the prevention of mother-to-child transmission. Work is ongoing to develop a comprehensive HIV/AIDS policy, monitoring and evaluation framework and a condom-distribution strategy. A proposal for accessing financing through the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria is also in preparation.

In addition to its work in the area of HIV/AIDS, the Government of Uganda has instituted several policies to improve the health status of its people. In 1995, for example, it adopted a National Population Policy for Sustainable Development, which aims at increasing the life expectancy of the population by reducing infant and child mortality, maternal mortality and fertility. Other policies and guidelines have been drawn up to address

SELECTED INDICATORS: UGANDA

Total population, 2003	25.8 million
Average population growth rate, 2000-2005	3.2%
Life expectancy for females	46.9 years
Life expectancy for males	45.4 years
Total fertility rate, 2000-2005	7.1
Births with skilled attendants	38%
Contraceptive prevalence for women aged 15–49, modern methods	18%
Contraceptive prevalence for women aged 15–49, any method	23%
Infant mortality per 1,000 live births	86
Maternal mortality ratio per 100,000 live births	910
Illiteracy rate for females over 15 years	43%
Illiteracy rate for males over 15 years	23%
HIV/AIDS prevalence rate for females 15–24 years	4.65%
HIV/AIDS prevalence rate for males 15–24 years	2.0%
Gross national income per capita (PPP$), 2001	$1,250
Access to safe water	52%

Source: UNFPA, State of World Population 2003.

national reproductive health, adolescent sexual and reproductive health, nutrition, universal education, gender issues, decentralization, poverty eradication, modernization of agriculture, and privatization.

UNFPA PROGRAMME

Since ICPD in 1994, the Population Secretariat of Uganda, with support from UNFPA, has assumed a leadership role in advocacy on issues related to gender and sexual and reproductive health and rights. An advocacy subprogramme was established in the Fourth Government of Uganda/UNFPA Country Programme, which aimed at winning support among an identified group of stakeholders, including parliamentarians, policy makers, members of professional associations and the media, and cultural and religious leaders. Implementation of advocacy activities and establishment of partnerships with NGOs began in 1998.

The Fifth Country Programme (2000-2005), now being implemented, includes an advocacy subprogramme designed with the following objectives:

- To strengthen capacity for resource mobilization in support of population and development, reproductive health and gender programmes at national, district and subcounty levels;
- To strengthen the capacity of national, district and subcounty institutions and cultural and religious organizations to advocate on issues concerning population and development, reproductive health, adolescent reproductive health, harmful cultural practices and gender; and
- To promote understanding among policy and decision makers, along with religious, community and cultural leaders, of the links among sociocultural, economic and political factors and population and development, reproductive health, adolescent reproductive health and gender.

The following UNFPA-supported projects were selected for analysis because of their unique approach to reproductive health in a culturally complex context.

Partnering with a Non-governmental Organization: The Sabiny Elders Association

The Sabiny Elders Association was formed in 1992 and brought together the elders of the 161 Sabiny clans to promote the development and welfare of the Sabiny people and to preserve their language and culture. The Association has been actively promoting HIV/AIDS prevention, the development of traditional medicine, children's education and environmental conservation.

UNFPA entered into partnership with the Association in 1995 during the Third Country Programme. The goal of the initiative was to enhance the reproductive health of women and young girls and to eliminate the harmful practice of female genital cutting. At the same time, it sought to promote the cultural values of the Kapchorwa district community. The partnership culminated in 1996 in a project called the Reproductive, Educative and Community Health (REACH) project.[1] Underlying the success of the project was the understanding that female genital cutting, like any other harmful traditional practice, can be discarded without necessarily destroying the social values associated with it. Previous efforts to eradicate the practice had met with considerable resistance and were neither successful nor sustainable. These efforts were predominantly based on health, legalistic and human rights considerations and did not take into account deeply rooted cultural references.

A Culturally Sensitive Approach

An inclusive approach, sensitive to the local culture, was developed during the preparatory and design phases. This approach entailed efforts to do the following:

- ***Separate cultural practices from cultural values.*** It is easier to challenge a harmful traditional practice if community values are understood and respected;

- ***With the community, analyse the negative impact of the practice,*** and, in so doing, share knowledge and create awareness;

- ***Carry out social mobilization to create an environment conducive to change while reaching out to the opposition;***

- ***Implement careful and evidence-based advocacy among policy makers*** to reinforce positive positions with regard to issues rather than acceptance of specific project objectives;

- ***Propose acceptable alternatives*** so that people's values and social prestige are not compromised or undermined when the practice is discarded;

- ***Integrate advocacy campaigns into generally acceptable goals***, for example, improvements in reproductive health, rather than tackling specific controversial issues head on;

- ***Line up and network with relevant stakeholders*** and bring stakeholders on board at the beginning of the programme. In the case of REACH, stakeholders included members of the school system, health network, the local administration and the legislature;

- ***Establish contacts with well-placed indigenous allies interested in advocating against the harmful practice.*** In May 1995, the UNFPA Representative contacted a woman representative from Kapchorwa district and the Deputy Minister for Local Government, both of whom had become involved in trying to reverse a by-law that made female genital cutting compulsory for all women in the district. They agreed to hold a brainstorming meeting on the issue at the district level; and

- ***Ensure the involvement of the local community in the design of projects so that strategies and advocacy messages are culturally acceptable.*** The district took the lead in drafting the project document, with close technical support from UNFPA and the Population Secretariat. A review team for the project agreed on the project title, "Reproductive, Educative and Community Health", which was considered broad enough to have general appeal but did not focus exclusively on female genital cutting.

The following approaches were adopted during the project implementation phase:

- ***Proving by action that the project does not threaten local customs and culture.*** For example, to reinforce the importance of local traditions, the project promoted the idea of celebrating an annual "Culture Day" in Kapchorwa district;

- ***Establishing an "ally group" of peer educators.*** A peer education programme was carried out to support girls' education and to disseminate messages about repro-

1 Much has been documented about the partnership, most notably the recent publication by UNFPA, *Eradicating Female Genital Cutting: The Ugandan Experience.*

TYPICAL TOPICS AND PRESENTERS IN SENSITIZATION WORKSHOPS

- Programme staff provided information on reproductive health issues;
- An elder related the history of female genital cutting in Kapchorwa;
- An elder presented the socio-economic aspects of male and female circumcision;
- A facilitator from the Department of Health discussed the medical consequences of female genital cutting;
- Programme staff discussed possible next steps.

A number of women came to the workshops to share their experience of female genital cutting and subsequently became resource persons. In general, women were not reluctant to share information since their experience of genital cutting had already been publicly acknowledged.

ductive health. At the same time, peer educators were trained as change agents against female genital cutting; and

- ***Engaging and involving traditional and other health service providers.*** Traditional birth attendants (TBAs) in the district were trained and equipped with basic kits and encouraged to refer women with complications to health units. Midwives, persons in charge of the health units and nurses' aides were also trained. Included in the training was a component on identifying harmful traditional practices in general. The specific topic of female genital cutting was gradually introduced, along with ways to eliminate it.

The advocacy process that led to these activities included the following:

- A conference for elders, in which 295 people participated out of 300 invitees. During the conference, programme staff were able to identify allies and adversaries of the programme. They took particular note of one suggestion made by some women elders: that female genital cutting was a women's issue and that women were best equipped to deal with it;
- A two-day workshop was organized for women only. It was decided that the project should target youth primarily, including candidates for female genital cutting and adolescent boys, since this is the group that will have to decide eventually whether to marry uncircumcised girls;
- The next step involved one-day workshops at the sub-county level for about 100 people each. Participants included members of women's and youth councils, school headmasters and religious leaders; and
- Half-day institutional seminars were also held in secondary schools.

By the end of 1996, the project had successfully brought on board the majority of the elders.

Achievements

- ***Female genital cutting has been demystified and its harmful impact is now discussed publicly.*** In addition, the members of the Sabiny Elders Association who were strong supporters of the practice before the REACH programme was implemented have come out publicly to reject the practice and are spreading the word about its harmful consequences among community members.
- ***The number of girls subjected to female genital cutting has decreased.*** An evaluation conducted 15 months after the project was launched reported that female genital cutting had decreased by 36 per cent. In a more recent study, in 2002, 630 girls out of 12,000 eligible candidates (5.25 per cent) had been subjected to cutting.
- ***Pressure groups have spontaneously formed against the practice.*** Male youths have formed pressure groups to

oppose the practice. Among the strategies they employ are refusing to participate in cutting ceremonies and confiscating cutting equipment.

- ***Surgeons, TBAs, mentors and guardians have begun to organize themselves to oppose the practice.*** One such group, in Kongasis county and Chesower subcounty, has formed an association with TBAs and are prepared to stop cutting, once they gain the support of the community's leaders.

- ***The Sabiny Elders Association has been internationally recognized.*** The association won the United Nations Population Award in 1998. The award ceremony, held at United Nations Headquarters in New York, was attended by the Association's Chairman, who was presented with a gold medal, a certificate and $12,500. The money was used to construct a block of office buildings for the Association and the REACH project in Kapchorwa. The structure includes a conference hall and other offices that can be rented out as a source of income. The new structure has increased the integrity of the Association, its visibility in the district, and its sustainability over the long term.

- ***Increased flow of resources to the district and a greater number of development activities.*** REACH has given the district considerable visibility. Before the programme, there were no NGOs in Kapchorwa. Now there is ActionAid, the Family Planning Association of Uganda, World Vision and many functioning community-based organizations. The National Committee on Traditional Practices in Uganda is putting up a school building in Kabei subcounty and has a craft shop in Kapchorwa town. The Government has paved the road to the district, an achievement that could, to some extent, be attributed to the REACH project. The project has attracted numerous visitors, including the country's President.

- ***Improvement of reproductive health service delivery.*** The project has rehabilitated and equipped four dilapidated health units and the maternity wing of Kapchorwa Hospital.

Lessons Learned

- ***Emphasizing, when addressing harmful traditional practices, that there are harmful and positive practices in all cultures.*** Furthermore, it is important to demonstrate respect for the community and its values during all project phases so that addressing a harmful practice is not misinterpreted as a value judgement on a society or its culture.

- ***Eliciting strong community involvement at the inception of a culturally sensitive project is important*** to raise curiosity, motivate the community to ask questions about the value of the project, dispel fears and lay the groundwork for future ownership and sustainability.

- ***Publicizing the project's successes and achievements creates a sense of pride*** within the community and reinforces the values and messages the project is aiming to transmit.

- ***Ensuring, wherever possible, that culturally sensitive projects are managed by local personnel,*** or by others who have a high degree of acceptance within the community, is a way of promoting community ownership of the project.

- ***Pursuing a non-prescriptive approach, an inclusive project design process and the active engagement of local people*** who have experienced the practice (either directly or indirectly) in both the design and implementation of the project is a key to community ownership of the project and its eventual success.

- ***Maintaining transparency on the part of UNFPA is important since it enhances partnership*:** people eventually

"Normally, during the cutting season, boys and girls dance together. But in 2002, the boys in Tegeres subcounty refused to dance with the girls and saved them from the knife. The youth council had resolved that there would be no cutting in their area and ended up cutting only two women out of a potential 600 candidates. And in five other subcounties, no women or girls were cut."

— REACH Programme Manager

came to see that the initiative supported by UNFPA served the community's interests.

- ***Providing hard evidence on the negative health impact of female genital cutting*** helps a community internalize the need for change and make informed choices.

- ***Involving girls who were candidates for female genital cutting, male youths and the education system***, particularly the teacher training college, multiplied the spread of advocacy messages.

Partnering with a Religious Institution: The Kinkizi Diocese

The collaboration of UNFPA with the Kinkizi Diocese of the Church of Uganda began in 1999-2000, during the Fourth Country Programme. In the Fifth Country Programme, the two partners developed a five-year project with the goal of increasing access to education on human sexuality, responsible parenthood and sexual and reproductive health and rights among adolescents in and out of school.

A Culturally Sensitive Approach

The following strategies were used in the design and implementation phases of the project to generate maximum acceptability of the project and its objectives:

- ***Making serious efforts to identify the needs of the community.*** The project was conceived in response to numerous reproductive health problems. These included early adolescent sexual activity; sexually transmitted infections, including HIV/AIDS; teenage pregnancy; school leaving; and early marriage. The problems were compounded by a low level of awareness and little support of reproductive health programmes for adolescents;

- ***Facilitating consensus-building among different actors whose work has an impact on the project.*** The project was formulated with the involvement of all Diocesan heads of departments, who were brought together to discuss their views. Consultations were also carried out with the Population Secretariat over a period of four months until the project document was finalized. The project covers half of the Kinkizi Diocese, or 30 parishes out of a total of 62;

- ***Utilizing the positive values of community volunteerism, ensuring that openness and the involvement of all stakeholders guide the project's implementation.*** The Diocese is using its administrative and service structure to deliver advocacy messages to the general community and to the school system. Such structures include confirmation classes, youth clubs, boys' brigade, mothers' and fathers' union, schools and health units, and drama clubs. Various methods are used to disseminate messages to a range of target audiences (Table 1);

- ***Reaching out through popular culture.*** Music and dance are among the most popular cultural expressions in Africa and have been used creatively by the Kinkizi Diocese to disseminate messages about sexual and reproductive health, including HIV/AIDS, to all socio-economic and age groups; and

- ***Establishing structures that can create multiplier effects in delivering advocacy messages within the community.*** The Diocese identified 32 established drama groups in the community and briefed their leaders on basic reproductive health issues. This helped communicate the goals of the programme and enabled groups to decide on the various themes to be included in songs and drama. The groups were encouraged to form theatre troupes using locally available materials and traditional instruments, such as African drums. The Diocese organized musical competitions to ensure that the messages to be conveyed were correctly packaged and understood. Ten groups participated in the competition and are performing and carrying these messages to various parts of the Diocese.

"This group of young singers, using African drums and African music, go around singing the merits of family planning for the family's well-being and the dangers of HIV/AIDS for the future of Uganda. They move from one village to another, singing in weddings, after the Sunday sermon, and on national days. People listen to them in churchyards and public squares, and they start discussions on these issues."

— Bishop of the Kinkizi Diocese

The resulting productions have made a big difference in communities. People are drawn to entertainment and, at the same time, acquire new information. As a result, reproductive health messages have reached a larger share of the community than would have been possible had other methods, such as posters or one-to-one methods, been used.

The musical and dramatic pieces have been recorded and are also broadcast on radio. This has had a multiplier effect: five new drama groups have spontaneously joined the programme after listening to what other groups had produced. In view of these achievements, the Diocese wants to strengthen the groups so that they can reach out to the entire community.

TABLE 1: DIOCESE PROGRAMME ACTIVITIES, FOCUS AND TARGETS

Methodology	Target	Purpose
Training workshops	Pastors, parents, schoolteachers, school administrators, union leaders, youth leaders	To increase awareness of reproductive health and rights.
Youth camps	Youth	To allow interaction and guided sharing of reproductive health information and experiences among youths.
Adolescent recreation centre/audio-visual learning (a video deck and TV screen and generator are used on a rotational basis in 10 centres)	Youth and the general community	To allow interaction and guided sharing of reproductive health information and experiences using visual aids among youths.
Theatre and drama groups	School and general community	To use songs, drama and poems to sensitize youth in schools and the general public. Ten groups have been organized at the primary, secondary and post-secondary level.
Educational radio programmes	General	To use local radio, specifically the Voice of Development Rukungiri Radio, to target parents with messages emphasizing their supportive role to children through guidance and counselling. Topics covered include behaviour and sexuality, counselling and guidance skills, communication skills, life skills, family planning, career guidance, and sexually transmitted infections, including HIV/AIDS. The radio staff, programme officials and adolescents themselves present the programmes.
Church masses for youth	General public and youths	Guest speakers knowledgeable about adolescent reproductive health and rights are invited to talk to adolescents once every three months in all churches of the Diocese.
Peer educators	Adolescents in school	Thirty peers are trained each year and 20 are retrained. The goal is to reach adolescents through members of their own peer group and foster behavioural change.
Meetings	Facilitators	To bring together facilitators to plan activities and enable the management team to evaluate their effectiveness.

Achievements

The Diocese has noted significant achievements among various social groups, including district and school administrations, the church network and general community. On the whole, there is clear evidence of increased awareness of adolescent sexual and reproductive health and HIV/AIDS issues among all age groups. The following achievements can be singled out and are directly and indirectly linked to the project objectives:

- ***Prevention of early marriages.*** A new by-law, passed by the Diocese during the Fourth Country Programme and requiring couples to be 18 or older before they are married in the Church, has continued to be enforced in the district among Church of Uganda followers;

- ***Increased access and retention of girls in school.*** As a way of discouraging early marriage and ensuring equal opportunities, the Diocese has started an education programme emphasizing the importance of girls' education. Parents are being sensitized to the importance of keeping their girls in schools and warned about the problems associated with early marriage;

- ***Increased opportunities for female dropouts to continue their education.*** The programme has also encouraged vocational education for girls and has advocated continuing education for both girls and boys after they drop out of school. While the main reason for leaving school is poverty, some girls drop out because of pregnancy. Girls are now allowed to continue school after becoming pregnant and giving birth;

- ***Increased recognition of the relationship between health and socio-economic well-being.*** The programme has integrated other development concerns into its activities, including programmes for skills development and income generation. Funding for these activities is supplemented by the Diocese;

- ***Openness, confidence and self-esteem among girls and women.*** As they continue appearing in public, the peer educators and members of the drama groups have been forced to become role models for others. Children are more open to talking about their problems with their teachers and among peers—and finding solutions. Women have also become leaders in their communities (see box below);

- ***More young people are now demanding voluntary and confidential testing and counselling for HIV.*** In the words of one 16-year-old boy: "I would like to know my sero status. When I know the results, I will know whether I can look for a negative, protected partner in the future. In case I find I am positive, I will know how to behave."

Lessons Learned

- ***Successful collaboration with "custodians of culture" contributes to smooth project implementation at the community level.*** The strong involvement of religious leaders in this project led to noticeable changes in the community's perceptions, especially in regard to the right of girls to remain in school and to refuse early marriage.

- ***Addressing issues that both UNFPA and its faith-based partner consider important establishes the ground for trust and helps to create synergies that expand project achievements.*** Concern on the part of the Diocese and UNFPA about the dangers of early marriage created a common understanding that led to agreements in other areas, including gender-related issues and youth sexuality.

- ***Targeting a specific gender-related issue often leads to action in other areas.*** In targeting early marriage, the Diocese started a programme emphasizing the importance of girls' education, especially among grass-roots

Lydia Byaruhanga is 34-year-old Roman Catholic who is married with four children. Lydia is a trained community family planning provider and is now a woman representative and a Deputy Speaker for Rugyeyo subcounty. She has put together a drama group of 37 people, mostly women, to disseminate reproductive health messages in the subcounty and in both the Catholic and Church of Uganda communities. Lydia feels she is a better person and housewife as a result. "Now I can buy salt and paraffin," she says. "I can grow a lot of food and sell the surplus and I have used the money to buy pigs. Next I want to buy goats. My husband has also become interested in the programme, and men and other fathers are calling upon him to share with them what is happening in our family."

communities. At the same time, female dropouts were encouraged to acquire vocational skills to improve their employment options.

- ***Advocacy approaches based on a deep understanding of a community's culture create an environment for sustainable policy change.*** The implementation of a new by-law, requiring couples to be 18 or older before marriage, was strengthened during the Fifth Country Programme.

- ***Working with Church networks and physical and organizational structures contributes to the rapid spread of the programme at minimum cost*** and, most importantly, to the ownership of the programme by the Diocese. In the words of one bishop and programme manager: "As the Church, we do not need to explain why we are calling people for an activity. They just come."

- ***Convincing faith-based partners to jointly fund the project, even with a symbolic budget, sends a message to the community*** that the project has real value and increases its chances of sustainability. Furthermore, the Diocese's resources can be used to supplement external assistance or to fall back upon when other funding takes time to materialize.

Partnering with a Cultural Institution: The Tooro and Bunyoro Kingdoms

Before 1967, Uganda was composed of five kingdoms that had strong political, economic and cultural influence on the populations within their respective regions. In addition, there were numerous chiefdoms throughout the country. Kingdoms in Uganda functioned like present-day federal states. They had full control of resources within their regions, including revenue, and had their own chiefs, who were in charge of day-to-day governance. The central government had a skeleton staff representing its interests, mainly security and political mobilization.

In 1995, the Government, upon repeated requests from kingdom constituencies, decided to re-establish the kingdoms on the condition that kings and tribal chiefs would serve exclusively as cultural leaders. Their main role would be serving as custodians of local cultures and mobilizers for development purposes. They were not to engage in political activities, nor would they have representation in the Government or collect revenue. Under the king are various chiefs, in charge of counties, subcounties and, in some kingdoms, parishes.

Under current arrangements, the Government is working in close collaboration with the kingdom representatives, particularly in the social sector, and especially in immunization campaigns, the promotion of reproductive health and HIV/AIDS prevention. Some government departments and development partners are also channelling funds to kingdoms on a project basis. For example, HIV/AIDS campaigns are being funded by the Uganda AIDS Commission and adolescent reproductive health programmes are supported by UNFPA.

The collaboration with the Tooro and Bunyoro Kingdoms began during the Fourth Country Programme (1995-2000). As the kingdoms operated in similar ways and their citizens faced common problems, the design process for both projects was carried out collectively.

The original projects, which were included in the Fourth Country Programme, were broad in focus and target. In Bunyoro Kingdom, the issues addressed included advocacy for immunization and a whole range of reproductive health issues, such as early marriage and pregnancy, maternal death and sexually transmitted infections. In Tooro Kingdom, support for girls' education was used as a strategy to delay early marriage. The projects in the Fifth Country Programme address two cross-cutting issues, namely early marriage and cultural practices that expose adolescents to the risk of contracting HIV/AIDS and other sexually transmitted diseases.

Project activities, which are being implemented in three districts in Tooro and one district in Bunyoro, include the following:

- Research on cultural practices that impact adolescent sexual and reproductive health;

- Advocacy sessions, in the form of seminars and workshops, for kingdom leadership and opinion and youth leaders (see list of discussion topics and targets for advocacy sessions on the following page);

- Radio programmes on local stations featuring cultural leaders who support adolescent sexual and reproductive health and testimonies by young people who are living with HIV; and

- The formation of youth groups to hold discussions on adolescent sexual and reproductive health.

A Culturally Sensitive Approach

The following approaches were developed in the design phase of the project to create an environment receptive to change:

DISCUSSION TOPICS AND TARGETS FOR ADVOCACY WORKSHOPS AND SEMINARS

Topics	Targets
Early marriage and related cultural practices	Kingdom parliament
High rate of school dropouts	Kingdom ministers
Sexually transmitted infections, including HIV/AIDS	Clan leaders
Life skills	Local government staff
Communication skills	Youth
Behaviour and sexuality	Women
Advocacy skills	
Parenting	
Drug abuse	

- ***Identifying an effective agent of change within the potential partner institution.*** One King's Secretary, well aware that the topic of family planning would not be well received, was instrumental in guiding the Population Secretariat of Uganda and UNFPA in the content of their presentation to the King;

- ***Using non-threatening language to introduce ICPD Programme of Action areas of concern.*** Family planning is a sensitive issue in the sparsely populated Bunyoro Kingdom. Taking this into account, the UNFPA-supported project focused on "improvements in the quality of life of the population" in its presentation to the King, including discussions on the contribution of family planning to the well-being of the Bunyoro Kingdom's population;

- ***Providing hard evidence on the quality of life in the kingdom through sensitization processes that targeted decision makers.*** A one-day workshop was held at a rural training centre for the representatives of Bunyoro Kingdom. During the meeting, officials from the Population Secretariat and UNFPA made several presentations about the population situation in Bunyoro Kingdom—bringing out key statistics to describe the quality of life there. In Tooro Kingdom, the workshop provided evidence on the links between girls' education and the rates of early marriage. During formulation of the projects, a five-day workshop was organized in which cross-cutting issues affecting the kingdoms were discussed.

  The Population Secretariat provided data that guided the prioritization of the various reproductive health concerns. All participating institutions collectively developed the project document during the workshop, which was subsequently refined by the Population Secretariat through consultative meetings with the kingdoms; and

- ***Documenting the nature of the partnership to dispel fears and establish a clear basis for the partnership.*** Both UNFPA and the top-level representatives of the kingdoms later signed agreements reached during meetings. The agreements noted that the meetings produced the terms of reference for the partnership, and a memorandum of understanding stated that no party had unduly influenced the other in a particular direction.

Achievements

The kingdoms acknowledge numerous achievements and benefits as a result of the partnership with UNFPA, as follows:

- Tooro Kingdom instituted a by-law stipulating 18 as the earliest age of marriage, which was adopted also by Buganda, Bunyoro and Busoga kingdoms;

- Tooro Kingdom is spearheading the passage of a bill (the "girl-child ordinance 2000") seeking to promote girls' education and discourage early marriage;

- The kingdoms acquired sophisticated advocacy tools during the implementation of the project that will empower them to expand their advocacy activities in the social sector. Since kingdoms were only recently reestablished, many of the country's young people are not fully aware of their significance. The UNFPA programme gave the kingdoms a chance to "sell" the

institution to its people, especially young people, and to mobilize them for health improvements. Kingdom leaders and staff now have advocacy skills that can be used to present issues to the Government and within communities. Other donors are starting to approach the kingdoms for partnership in other activities, such as HIV/AIDS prevention;

- The local government budget for youth programmes in Masindi district (Bunyoro Kingdom) has increased more than fourfold in the last two years, from $1,500 to $7,000; and

- Youth have organized themselves into groups and can now access funds from a community-led HIV/AIDS initiative under the AIDS Control Project of the Ministry of Health.

Indirect benefits ("by-products") of the project include the following:

- Increased use of drugs for sexually transmitted infections;

- Less stigma surrounding HIV/AIDS. According to one elder from the Masindia district, in the past, people "never talked about diseases that bring shame to the family like madness, epilepsy." Today, he says, "people are more open about HIV/AIDS"; and

- Greater respect among community members for women's legal rights.

"It is difficult for an institution which is not financed to mobilize people, but being a cultural institution that has deep roots in the history of the kingdom, we can do it. The UNFPA project has helped us to interact and dialogue with the people in the kingdom on reproductive health and girls' education. The King has agreed to start a royal conservatory of local music and reproductive health messages will be infused with the music played from the royal trumpets."

—The Personal Secretary of the King of Bunyoro Kingdom

Lessons Learned

- ***Patience and perseverance are needed to engage custodians of culture rooted in old traditions on issues that have been widely considered almost taboo.*** The preparation phase of a project may be long if the project addresses issues considered culturally sensitive. A great deal of investment in dialogue and sensitization may be needed to break new ground.

- ***An effective strategy during the project preparation phase is to provide evidence of the "value added" to the community from the project's expected outputs.*** Once a cultural partner begins to understand the contribution the project can make to the well-being of their constituency, they can play an extremely important role in advocating for services among grass-roots communities. This is possible because of the respect people have for these leaders and institutions.

- ***It is important to understand the thinking of both your allies and your adversaries.*** Within every culture or subculture there are bound to be groups that adhere to old traditions as well as more pragmatic groups that are receptive to change. It is important to understand both groups in order to develop strategies appropriate to each of them, and be ready to engage adversaries continually.

- ***Identifying allies who see the value of ICPD-related projects and are thus willing to provide their support*** can help lay the groundwork for smooth and amicable negotiations.

- ***Using culturally appropriate language*** to describe a project and its activities is instrumental in negotiations at the preparatory phase.

"You must not rush cultural leaders. You have to bring to them all possible options necessary to change the negative practices and give them time. After a great deal of reflection on how each will affect their community, you get positive results."

— Programme Manager, Tooro Kingdom

PARTNERING WITH UGANDA'S MUSLIM COMMUNITY FOR BETTER REPRODUCTIVE HEALTH

Careful sensitization of Muslim leaders in Uganda has helped open up the previously taboo subject of sexual and reproductive health. An important first step was to counter the fear that family planning was a way of reducing Muslim populations. With the support of the Mufti of Uganda, the highest Islamic religious leader in the land, reproductive health services have been improved and are being more widely used by the community. To ensure that these efforts were in line with Islamic thinking, reproductive health messages were studied and compared with teachings of the Koran and the Hadith. Specific strategies were also designed to reach women.

INTRODUCTION

Uganda's national population policy was developed through a participatory approach involving many sectors of society, including the Uganda Muslim Supreme Council. Nevertheless, the Muslim community did not fully participate in the population and reproductive health activities that the new policy, launched in 1995, stimulated. The Uganda Muslim Supreme Council began to make inquiries as to why this was the case and approached the Mufti of Uganda for assistance. The Mufti, in turn, contacted the UNFPA Country Office to seek its advice.

In response, the Director of the National Population Secretariat was invited to brief the Mufti about the population policy in Uganda, and it was agreed that the Muslim Supreme Council would develop a project proposal to be presented to UNFPA for funding. In the meantime, a committee appointed by the Mufti was tasked with finding out why the Muslim community was not taking full advantage of the reproductive health services being offered.

Although the UNFPA Third Country Programme was drawing to a close, the Supreme Council obtained the Fund's support to implement a series of workshops aimed at Muslim religious leaders to explore some of these issues. Carried out at national, district and community levels, the workshops enabled religious leaders to talk openly about issues they had never discussed before. Moreover, they helped leaders gain a better understanding of reproductive health in the Muslim context. The workshops identified the following as factors inhibiting Muslim participation:

- An inability to reconcile specific population and reproductive health issues with the precepts of Islam;
- Confusion about the difference between reproductive health and "birth control";
- Low priority for health issues in religious leaders' programmes;
- Absence of strong, evidence-based information and technical skills with which to promote health; and
- Poor management of the Council's health infrastructure.

The Muslim Supreme Council was invited to attend the Fourth Country Programme's planning and review meetings to discuss the project proposal it had developed. The main objective of the project, according to the Council, was to put the national population policy into action within the Muslim community.

UNFPA PROGRAMME

The project, accepted as part of the Fourth Country Programme, included the following components:

- *Advocacy* to give higher priority to reproductive health issues in the work of religious leaders;
- *Behaviour change communication (BCC)* to inform the Muslim community about reproductive health and

rights and encourage men and women to utilize available services; and

- *The enhancement of services* at Muslim health units to provide higher quality care and to make reproductive health services accessible, affordable and appealing to the community.

As a result of the project, the Muslim Supreme Council renovated and equipped four health units, increasing the accessibility of reproductive health care in the community. Despite these improvements, the utilization of antenatal care clinics and obstetric services remained low. A rapid appraisal by the Muslim Supreme Council revealed that the cost of these services was prohibitive for most women. In response, the project launched the *Ndimugeni Mwete* ("Guest of the Centre") initiative. This initiative allowed expectant mothers to receive antenatal, delivery and post-delivery services free of charge and greatly increased the number of women attending antenatal care clinics and delivering in health facilities.

> *"It was an extremely sensitive project. People thought that the project had come to promote family planning and further reduce the small numbers of Muslims, and they were determined to fight it till it failed."*
>
> *—Uganda Muslim Supreme Council Reproductive Health Programme Coordinator*

The success of this partnership led to the involvement of the Muslim Supreme Council in another UNFPA-supported effort: the African Youth Alliance. A programme funded by the Bill and Melinda Gates Foundation, the Alliance aims at improving adolescent reproductive health in four African countries. Under the project agreement, the Muslim Supreme Council was to implement the policy and advocacy component of the programme, the goals of which were to sensitize religious leaders to adolescents' reproductive health, with special emphasis on HIV prevention and to create an environment in which sexual and reproductive health among youths could be effectively addressed.

Once again, the commitment of top religious leaders for the new project was sought through a series of sensitization workshops for the *imams* (Muslim clergy) at national and district levels. The workshops not only raised the religious leaders' awareness of reproductive health issues but also highlighted their role in addressing them. A resolution declared by the Mufti of Uganda and adopted by Muslim leaders declared their commitment and support to adolescent sexual and reproductive health on a priority basis.

Culturally Sensitive Approaches

The following strategies were adopted to maximize the success of the reproductive health project in a culturally complex environment:

- ***Objectively consider the impact of religious sensitivities on people's behaviour.*** The recognition of sensitive religious issues and the willingness to address them in a gradual and appropriate manner created an environment of trust and mutual respect between the partners. Before the project, discussions on any aspect of sexuality, family planning or reproductive health in public were taboo in the Muslim community. The Muslim Supreme Council, together with UNFPA, realized that religious leaders needed to understand fully the benefits of incorporating reproductive health activities into broader health services. Once they were sensitized to the issue, religious leaders spread this message to the entire Muslim community;

- ***Make a special effort to reach women.*** All Muslim religious leaders in the country are men. Workshops for religious leaders therefore meant that women, who are important beneficiaries of reproductive health activities, were excluded. The strategic approach to reaching women without alienating them from their husbands was, first, to offer workshops specifically for men. At the end of the workshops, which provided evidence-based information about the benefits of reproductive health services, the men were requested to support the participation of their wives in similar workshops. They did so willingly, and the turnout of women was overwhelming;

- ***Use Islamic references to ensure acceptability of the project by religious leaders and the community.*** Because the Muslim Supreme Council is a religious organ, Islamic texts were researched and consulted during the project design and implementation. Under the guidance of the Mufti of Uganda, religious scholars, in a series of participatory meetings involving religious leaders at various levels, studied specific reproductive health messages and related them to Koranic texts;

- ***Identify religious leaders as potential agents of change and involve them from the outset.*** The project's involvement of religious leaders at all levels was essential in gaining access to the Muslim community. *Imams* have

since included reproductive health messages in their sermons in the mosques;

- ***Base the project strategy on a deep understanding of community values and needs.*** A three-pronged approach proved effective in carrying out the strategy. An advocacy component prepared the ground for dialogue on sensitive issues; a behaviour change communication component primed the community to use the new services provided; and a service-delivery component addressed the most salient health problems of the community in a practical way;

> *"We never thought that the Mufti of Uganda would open a reproductive health workshop. We were overwhelmed by this gesture. It does not happen every day to have religious leaders discuss sexuality and its outcome openly. Even mere attendance would mean a great deal."*
>
> *— UNFPA Programmer Officer*

- ***Reinforce complementarities between religious leaders and health workers.*** The project employed a strategy of comparative advantages. Religious leaders were asked to concentrate on preaching and the health workers handled what they did best—the technical aspects of population and reproductive health activities such as family planning and HIV prevention, including condom use and distribution. This division of labour resulted in complementarity rather than competition;

- ***Ensure the commitment of top leadership.*** The support of Uganda's Mufti, who encouraged religious leaders at the grass roots to market the project among their followers, was key to the project's success. UNFPA and the top management of the Population Secretariat showed equal commitment to the project;

- ***Institutionalize the project within the existing infrastructure of an established national partner.*** The Mufti and the Uganda Muslim Supreme Council designated the Population Committee as the standing committee in charge of the project. Similar structures at the district level were put in charge of delivering reproductive health services, and the Supreme Council housed the project's health units;

- ***Create publications on reproductive health that use language and content to which the community can relate.*** Issues raised in each of the workshops were compiled, edited and published in a handbook entitled *Towards a Happy and Prosperous Family: Reproductive Health: Guide for the Muslim Community in Uganda*. The handbook, based on source material from the Koran and the Hadith, discusses marriage, reproductive rights, the size of the family, and adolescence and sexually transmitted infections, among other issues. The handbook is being used as a reference tool by Muslims throughout Uganda;

- ***Provide evidence-based data on controversial issues through operational research.*** The project commissioned operational research on Muslim women and fertility that enabled the Supreme Council to design more effective approaches to reproductive health. The objectives of the study were to establish the factors that determined the status of married Muslim women, their knowledge of or attitudes towards the use of contraceptives, their involvement in decisions relating to fertility regulation, and the effects of their status on contraceptive use;

- ***Provide technical assistance promptly when needed.*** The project received much-needed technical assistance in areas of planning and monitoring from the UNFPA Country Technical Services Team. This helped build the capacity of the Muslim Supreme Council, especially among project staff;

- ***Build capacity for sustainability.*** Sustainability was achieved through the training of key project actors. Health service providers and peer educators were trained in relevant reproductive health skills. Members of the Health Unit Management Committees were also trained to manage those components of the project that fell within their districts; and

- ***Involve the community.*** The Muslim Supreme Council involved the community throughout the project. For instance, it encouraged the community to provide the health unit buildings, which created a sense of ownership. The Health Unit Management Committee and local council executives mobilized the community to use the health services, ensured that the services were of an acceptable standard and saw to it that they were well maintained.

ACHIEVEMENTS

- ***Reproductive health and rights have become part of the agenda of the Uganda Muslim Supreme Council.***

- ***The project has now been institutionalized in the Council's operations.*** Debate on sexuality and reproductive health is ongoing in the Muslim community, but these subjects are no longer taboo among the Muslim leadership and the community at large.

- ***The community is committed to the issue as a result of encouragement by religious leaders.*** The Mufti not only attended reproductive health workshops but encouraged other religious leaders to support adolescent sexual and reproductive health activities, thereby encouraging community ownership of the project.

- ***A handbook on reproductive health has been published to address questions posed by the Muslim community.*** As an advocacy tool, the handbook has helped to create an environment in which Muslim communities have come to appreciate the value of available health services.

- ***Collaboration has continued.*** The reproductive health project started with support for two health units in two districts and has expanded to four health units in three districts. The fact that the Muslim Supreme Council is now implementing a component of the Africa Youth Alliance programme will further strengthen the sustainability of the original project.

- ***The delivery of health services has improved.*** The most tangible success of the project is the provision of health services to communities with greatest needs. Improvements to four Muslim health units have contributed to noticeable improvements in health, for which community members are grateful.

Indirect Achievements

- ***Study tours.*** Project managers and staff have had an opportunity to participate in international study tours and conferences in other Muslim countries such as Egypt, Indonesia, Malaysia and Niger, where they shared their experiences and lessons learned.

- ***Greater unity in the community among people of many faiths.*** Health services provided by the Muslim Supreme Council are offered to all community members, irrespective of their religion, which has helped to establish good relations in the community.

Long-term Impact

- A stronger reproductive health structure and the integration of reproductive health into other social services.

- The Uganda Muslim Supreme Council has followed up its commitment by budgeting and allocating resources of its own for reproductive health activities.

Sustainability

A number of measures have been put in place to ensure the sustainability of project activities. For example, partnerships have been created with the Directors of Public Health Services in their respective districts. This has enabled Muslim health units to benefit from government assistance, including financial support through the Poverty Action Fund, provision of essential drugs, allowances for outreach activities and training through various workshops organized by the districts.

LESSONS LEARNED

- ***Top-level commitment is critical to the successful implementation of the project.*** Commitment on the part of the Mufti of Uganda, the UNFPA Representative and Director of the Population Secretariat motivated project managers to work tirelessly to overcome initial resistance and continued challenges.

- ***Patience and perseverance are key factors in realizing a change in cultural and religious norms.*** To succeed, project managers had to be cautious and patient, as many activities, messages and strategies had to be repeated over and over again, or even changed altogether.

- ***Advocacy is necessary, especially in projects involving cultural and religious sensitivities.*** The Muslim community feared that the project would threaten religious teachings. Careful advocacy reassured the leaders that health messages were in line with religious teachings and made them more receptive to the project.

"We cannot find appropriate means of expressing how thankful we are for this gift of life. So many mothers died in childbirth, and our children were not immunized. Malaria killed the young and the old alike as we helplessly looked on. This thing [the project] works. Women no longer die in childbirth as they used to."

— Muslim community leader

- ***Advocacy tools must be tailored to community values and norms.*** In Islam, the family is the most revered institution, and programme activities tailored to promote family values were accepted and relevant to the target audience. In the reproductive health project, a normative goal, code-named "Towards a Happy and Prosperous Family", was successfully adopted and a handbook with information on family and reproductive health with that title was produced.

- ***The respect of donors and development partners for a community's values and their flexibility in addressing the community's perceived needs promote acceptability of the project.***

- ***Peer education facilitates the sharing of accurate information*** on sexual and reproductive health and on "life skills", both of which are crucial in helping adolescents make informed choices.

- ***Training for peer educators, including development of skills, methodologies and knowledge, builds confidence*** among peer educators and enables them to interact freely with their colleagues and health workers.

- ***Places of worship (in this case, mosques) are viable venues for spreading reproductive health messages among the community.*** Similarly, *imams* are effective agents of change.

- ***In disseminating messages on sensitive topics such as family planning and polygamy, choosing the most credible persons to deliver the information is key to success.*** In the reproductive health project, the Muslim community was particularly responsive to information from knowledgeable *sheikhs,* or Muslim leaders, who proved to be the most credible communicators.

- ***The project works better if the roles of the various players are clearly defined.*** Those religious leaders who were not knowledgeable enough about specific technical issues were encouraged to share their views on family values and refer other issues to informed technical staff.

"They used to say that Muslims do not go to school, but we have championed health services delivery to all community members, even non-Muslims. This project has acted as a unifying factor for Muslims and other members of the community. We mobilize all women to come for services, free of charge. Expectant mothers who used to walk long distances to attend antenatal care clinics are now getting the services nearby."

— Chairperson of the Health Unit Management Committee of Kiwaani

- ***Different, but complementary, messages from different players in addressing specific and sensitive issues such as HIV prevention should be acknowledged and respected.*** For example, the mandate of religious leaders in preventing HIV/AIDS was found to be stronger in the area of promoting family values, abstinence and faithfulness in marriage than in promoting condom use. The religious leaders were encouraged to follow their mandate but, at the same time, not to undermine those whose mandate it was to promote condom use for HIV prevention.

- ***Promotion of controversial messages is best handled by specialists in the particular field.*** The *sheikhs* and *imams* were asked to concentrate their efforts in certain areas where they were qualified to speak and to let government and service providers handle the rest. For example, it was easy for religious leaders to encourage breastfeeding for two years. Modern methods of contraception, however, were better handled by those with expertise in that area.

- ***Improvement in health service delivery in communities through renovation, staffing and equipping of such units should be complemented by training for health unit managers.***

- ***Where government health-sector policies are favourable to private health service providers, collaboration between private providers and the Government is better and the sustainability of health programmes and activities is enhanced.*** In Uganda, a public-private mix has enabled private providers to benefit from a government-sponsored Poverty Action Fund to sustain their activities.

- ***Achieving project goals is a collective effort.*** Successful implementation of a project requires support from stakeholders at all levels.

- ***Refresher courses for health workers improve their knowledge dramatically along with the quality of care they provide.***

4 RESTORING THE SEX-RATIO BALANCE IN INDIA BY ENDING SEX-SELECTIVE ABORTION

This chapter highlights advocacy efforts since 2000 to discourage sex-selective abortion and other practices in India that are resulting in fewer female births. In collaboration with the Ministry of Health and Family Welfare, UNFPA set up a partnership group responsible for a national advocacy strategy against sex selection.[1] These and other efforts, stimulated in part by research funded by UNFPA, helped pass key legislation to enforce existing laws and bring about greater awareness of gender-based discrimination and its consequences.

INDIA: COUNTRY CONTEXT

Fertility levels in India have been steadily declining, and the total fertility rate now stands at just below 3, while population growth rates have declined to less than 2 per cent per annum. Nearly half the married population in the reproductive age group in India uses contraceptives.

A review of the Government of India's Reproductive and Child Health Programme indicates that acceptance of reversible contraceptive methods is going up in the country. Motherhood still remains unsafe with two thirds of deliveries taking place at home; the maternal mortality ratio is 540 deaths per 100,000 live births.

The sex ratio is a powerful indicator of the social health of any society and reflects the state of gender relations. Socially and economically advanced societies have sex ratios that are favourable to females. In the case of India and some other South and South-East Asian countries, this has not been the case. In 1901, for example, there were 972 women in India for every 1,000 men; by 2001, the ratio had dropped to 933 women for every 1,000 men.[2]

In most regions in India, having a son is considered important because of issues related to kinship, inheritance, marriage, identity, status, economic insecurity and lineage. A preference for sons cuts across caste and class and results in social, cultural and political discrimination against the girl child even before she is born. If she is born, discrimination continues throughout her lifetime. With son preference and a history of female infanticide in some regions, India is now faced with a declining sex ratio attributed to excessive female mortality and to the misuse of new technologies for sex selection.

Sex Selection

Declining Sex Ratios

Birth histories collected during India's first and second National Family Health Surveys show an unusually large proportion of male births in some population groups. (Usually, about 105 boys are born for every 100 girls in a population, resulting in a sex ratio at birth of about 952 girls to 1,000 boys). In India, the sex ratio at birth was 943 during 1978–1992, the 15-year period covered by first health survey. It declined to 926 during 1984–1998.[3]

The national sex ratio in India has shown recent improvement, moving from 927 in 1991 to 933 in 2001. Nevertheless, the overall trend over the last hundred years has been towards fewer girls. Moreover, the juvenile sex ratio (ages 0-6) has declined considerably in many states. In 1961, the juvenile sex ratio in India was 976 girls to 1,000 boys, which fell to 927 girls to 1,000 boys by 2001.[4]

1 The term "sex selection" includes pre-conception sex-selection technologies and post-conception detection followed by sex-selective abortion.

2 http://www.censusindia.net/results/resultsmain.html.

3 Retherford, R.D., and T.K. Roy. 2003. "Factors Affecting Sex-Selective Abortion in India." *National Family Health Survey Bulletin*, No. 17. International Institute for Population Sciences and the East-West Center, Population and Health Studies.

4 http://www.censusindia.net/results/resultsmain.html.

The shrinking female population has been explained by higher death rates due to neglect of girls' nutrition and health-care needs, female infanticide and male bias in the enumeration of the population. It has also been suggested that the low sex ratios could be the consequence of sex selection. An accelerated fall in the child sex ratios after 1981, in fact, could be attributed largely to the diffusion of prenatal sex-selection techniques in regions with well-entrenched gender bias.[5]

There is considerable variation in the sex ratio at birth among certain population groups. This variation is especially high in certain western and northern states, in families that have daughters but no sons, and among women with a high level of education and media exposure.[6]

Furthermore, considerable variations exist in the overall female-to-male sex ratio from one state to another. The only state in which the overall sex ratio is above 1,000 is Kerala (with a figure of 1,032 women to 1,000 men in 1991). The states of Karnataka, Tamil Nadu, Andhra Pradesh, Orissa, Goa, Jammu and Kashmir and Himachal Pradesh have an overall sex ratio of between 950 and 1,000 women for every 1,000 men.

Child sex ratios have also declined in the south of India, except in Kerala.[7] The sex ratio in the 0-6 age group is most unbalanced in Punjab (793), Haryana (820), Gujarat (878), Himachal Pradesh (897) and Delhi (865). Compared with national statistics from other countries, Punjab has one of the lowest sex ratios at birth in the world (females to males), suggesting a very high level of sex selection.[8]

Sex-selective Abortion

Abortion was legalized in India in 1971 with the Medical Termination of Pregnancy Act.[9] In the years that followed, methods for determining the sex of a foetus became available through the private sector.

In India as a whole, an estimated 5 million to 6 million abortions occur annually. Sex-selective abortion is a two-step process involving determination of the sex of the foetus, followed by abortion if the foetus is not of the desired sex. Much of the evidence on the spread of sex-selective abortion is anecdotal, since there are no reliable statistics on the practice at either the state or the national level, and research on the subject is limited. A study conducted by UNFPA, however, estimated that from 1996 to 1998 in Haryana and Punjab, sex-selective abortions accounted for 81 per cent and 26 per cent of total induced abortions, respectively.[10]

Socio-economic Factors

During the period covered by the first National Family Health Survey (1978-1992), there were greater disparities in the sex ratios for second and higher-order births in urban areas than in rural areas. During the second National Family Health Survey (1984-1998), the sex ratio at birth was the same in both urban and rural areas. This indicates that the practice of sex selection was spreading from India's cities and towns to rural areas. Women who are educated and exposed to mass media are probably more likely to have sex-selective abortions than other women because they have more information and access to sex-determination and abortion facilities. In a group of western and northern states, the predicted sex ratio was also skewed for second and higher-order births among women in families with a high standard of living. These states are Haryana, Punjab, Gujarat, Delhi, Maharashtra and Himachal Pradesh.[11] These states are economically well developed and have fairly high literacy rates.[12]

The preference for sons in the next few decades may turn out to be a major determinant of sex ratios and may outweigh expected demographic gains.[13] Unless sex determination and sex-selective abortions are halted, there is a distinct possibility of loss of females.

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5 Mari Bhat, P.N. 2002. "On the Trail of Missing Indian Females II: Illusion and Reality." *Economic and Political Weekly* 37(52): 5244-5263.

6 Retherford and Roy 2003.

7 Bose, A. 2001. "Census of India 2001 and After." *Economic and Political Weekly* 36(20): 1685-1687.

8 Retherford and Roy 2003.

9 As revised in 1975, the Act allows medical termination of pregnancy (that is, abortion) for any of the following reasons: (1) the pregnant woman has a serious disease or medical condition that would endanger her life if the pregnancy were to continue; (2) the foetus has substantial risk of physical or mental handicap; (3) the pregnancy resulted from rape; (4) the socio-economic circumstances of the mother would endanger the health of the newborn child; or (5) the pregnancy occurred because of failure of a contraceptive method.

10 UNFPA. 2001. "Sex Selective Abortions and Fertility Decline: The Case of Haryana and Punjab." New Delhi: UNFPA.

11 Retherford and Roy 2003.

12 Premi, M.K. 2001. "The Missing Girl Child." *Economic and Political Weekly* 36(21): 1875-1875.

13 Krishnaji, N. 2001. "The Sex Ratio Debate." Pp. 28-35 in: *Enduring Conundrum: India's Sex Ratio,* edited by V. Mazumdar and N. Krishnaji. New Delhi: Rainbow Publishers.

SELECTED INDICATORS: INDIA

Total population, 2003	1,065.5 million
Average population growth rate, 2000-2005	1.5%
Life expectancy for females	64.6 years
Life expectancy for males	63.2 years
Total fertility rate, 2000-2005	3.01
Births with skilled attendants	42%
Contraceptive prevalence for women aged 15–49, modern methods	43%
Contraceptive prevalence for women aged 15–49, any method	48%
Infant mortality per 1,000 live births	64
Maternal mortality ratio per 100,000 live births	540
Illiteracy rate for females over 15 years	55%
Illiteracy rate for males over 15 years	32%
HIV/AIDS prevalence rate for females 15–24 years	0.71%
HIV/AIDS prevalence rate for males 15–24 years	0.34%
Gross national income per capita (PPP$), 2001	$2,450
Access to safe water	83%

Source: UNFPA, State of World Population 2003.

Campaigns and Legal Initiatives Against the Practice

In 1986, a group of health and human rights activists launched a campaign against sex determination and sex pre-selection in Maharashtra. Two years later, it became the first state in the country to ban prenatal sex determination. Similar efforts at the national level resulted in the enactment of the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, or PNDT, in 1994. The law became operational on 1 January 1996. One immediate effect was that blatant advertising promoting pre-birth sex determination ended.

The Act provides for the "regulation of the use of prenatal diagnostic techniques for the purpose of detecting genetic or metabolic disorders, chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of misuse of such techniques for the purpose of prenatal sex determination leading to female foeticide and for matters connected therewith or incidental thereto." Except under certain conditions, no individual or genetic-counselling centres, laboratory or clinic can conduct prenatal diagnostic techniques, including ultrasonography, for the purpose of determining the sex of the foetus. Moreover, "no person conducting prenatal diagnostic procedures shall communicate to the pregnant woman concerned or her relatives the sex of the foetus by words, signs or in any other manner."

The PNDT Act, however, proved difficult to enforce. This was partly due to a lack of political will, as most activists and non-governmental and civil society organizations gave little importance to the issue.

A breakthrough occurred in February 2000, when concerned health activists filed public-interest litigation on non-enforcement of the PNDT Act in the Supreme Court. In May 2001, the Court issued directives to various levels of Government to see that the law was carried out. In April of the following year, the Secretary of the Department of Family Welfare was instructed to file an affidavit indicating the status of actions taken.

As these legal issues were being sorted out, advocacy on the issue continued to grow:

- The Indian Medical Association, in collaboration with UNICEF and the National Commission for Women, held a meeting of religious leaders in 2001 at which sex selection was widely condemned. The *Akal Takth,* a Sikh religious body in Punjab, issued a dictum to the Sikh community to stop the practice;

- Other NGOs, including international organizations, became involved in advocacy and capacity-building on the issue;

- The Ministry of Health and Family Welfare undertook several behaviour change communication activities to increase awareness of the Act through government media channels; and

- United Nations agencies, including UNFPA, UNICEF and WHO, worked on the issue in partnership with international NGOs and the Ministry of Health and Family Welfare. Directly or through partners, the United Nations agencies mobilized resources to build media interest and concern, create networks, sensitize the health system, train partners, conduct research, support civil society groups, and develop training and advocacy materials.

Many joined hands with the United Nations organizations to advocate for the speedy passage of amendments to the PNDT Act, in an attempt to give "teeth" to the bill. The amendments, originally proposed by Ministry of Health and Family Welfare in 1994, expanded the definition of "prenatal diagnostic techniques" to include pre-conception techniques. In addition, fines of up to $2,000 would be imposed and medical practitioners could face cancellation of their registration should they be found in violation of the Act.

The amendments were approved by both houses of parliament in December 2002 and the attached rules in February 2003. The Act is now entitled the Prenatal Diagnostics Techniques (Regulation and Prevention of Misuse) Amendment Act 2002. It prohibits determination and disclosure of the sex of the foetus, prohibits advertisements related to pre-conception and prenatal determination of sex, and prescribes punishment for violators.

UNFPA ADVOCACY EFFORTS

UNFPA played a major role in strategy formulation and coalition-building in combating sex selection.

Advocacy Campaigns

In partnership with the Ministry of Health and Family Welfare, UNFPA helped launch an awareness campaign that included the commissioning of videos and TV spots and the creation of a web site sponsored by a registered charitable trust. UNFPA also supported advocacy among media groups, including the Press Institute of India, and a project with the Indian Association of Parliamentarians on Population and Development, which held workshops with members of legislative assemblies and parliament on population issues.

Study on Sex Selection and Fertility Decline in Haryana and Punjab

In 1999, UNFPA commissioned a study on sex selection in Punjab and Haryana to ascertain the determinants of recent fertility decline. The study highlights the extent to which sex selection had an impact on fertility rates and how son preference perversely led to fertility decline. The extensive practice of sex selection, the study maintains, was an indicator of gender discrimination and inequity and demanded a response.

The study, which was widely disseminated, coincided with the publication of the provisional reports of the 2001 census, which highlighted the decline in the child sex ratio in India. The two reports together helped generate a climate of concern among policy makers, programme managers, the media, religious leaders and women's groups.

To stimulate action on the issue, UNFPA convened a series of brainstorming meetings, attended by specialists and representatives from the Government, NGOs, academia, the Human Rights Commission and the National Commission for Women. As a result, a section on policy implications was added to the study, which was published in September 2001. In a second meeting, the group agreed on related areas that needed research and identified strategies to address them.

Of the four interventions proposed at these meetings, advocacy and communication were considered the most important in bringing about long-term change.

Coalition-building

In 2001, the Ministry of Health and Family Welfare convened a national-level partnership group under the chairmanship of the Secretary of the Department of Family Welfare. The group, which is still in existence, is composed of members of key government departments, bilateral and multilateral agencies, international donors, NGOs, human and legal rights activists and gender experts. The group engages in information-sharing and networking to develop strategies for combating sex-selective abortions. It also provides support for related activities and advocacy.

Formulation of a National Advocacy Strategy

At the third partnership meeting, held in April 2002, UNFPA volunteered to head a core group, composed of nine partners, to formulate a national advocacy strategy that was eventually titled "The Pre-birth Elimination of Females: Ending the Practice, Changing the Mindset".

The idea of developing an advocacy strategy emerged from a need to address the issue at various levels, includ-

ing state and district levels. Moreover, UNFPA believed that there was need to go beyond legal aspects and address the structural issues that contributed to the continuation of the practice. The advocacy strategy, submitted to the Ministry of Health and Family Welfare in June 2002, provided an overarching national framework from which new initiatives could be planned.

The purpose of such a framework was to ensure that "advocacy and behaviour change interventions, undertaken by and with different groups, are synergistic, coordinated and non-contradictory." The document acknowledges that the most effective way to change behaviour requires a deep understanding of the mindset of target audiences, selecting media channels that are appropriate to each audience, and handling communication in a creative and culturally sensitive way that involves the participation of those they intend to reach.

The advocacy strategy presents short-, medium- and long-term goals to address the issue from a perspective of gender equity. It suggests linking all activities geared to the prohibition of sex selection to the achievement of gender-equality goals. It also addresses structural issues of gender discrimination and presents activities that would be "imbued with human rights principles, particularly non-discrimination on the basis of gender."

The Government of India accepted the advocacy strategy and plans to circulate it to all states for their comments. UNFPA has already translated the document into Hindi; after it is finalized, it will be translated into all regional languages. It is expected that the advocacy strategy will be adapted and operationalized by state governments.

Sensitization of Law Enforcement Machinery to the PNDT Act

Another area of collaboration involving the Ministry of Health and Family Welfare, UNFPA and state governments was the sensitization of medical officers designated responsible for implementing the PNDT Act. With technical and financial support from UNFPA, the ministry held regional workshops to alert authorities about the provisions of the Act and their role and responsibilities in implementing it.

Two regional workshops for the southern and northern regions were implemented in April 2002 and included authorities from eight states, four from each region. Ministers and political leaders, the Secretary of the Ministry of Health and Family Welfare, and secretaries from each of the participating states attended the workshops, signaling the Government's commitment to the issue.

Linking Population Policy, Human Rights and Development

The National Human Rights Commission, in collaboration with UNFPA and the Ministry of Health and Family Welfare, organized a colloquium on population policy, development and human rights in January 2003. The main objective was to initiate a dialogue on the implementation of population policies at national and state levels and on mechanisms to carry them out. The platform presented an opportunity to discuss sex selection as both a human rights and reproductive rights issue.

An exploratory study on the implications of the two-child norm, commissioned by UNFPA, was also presented and discussed. The objective of the study was to undertake an assessment, from a gender perspective, of the two-child norm introduced in certain states in India and to present the implications and consequences for *panchayati raj* institutions. The study also looked at the impact of the two-child norm on governance, fertility decisions and reproductive rights. The study concludes, among other things, that the two-child norm increases health risks for women due to unsafe abortions, increases sex-selective abortion, reduces attention to maternal health and increases the vulnerability of marginalized women from minority groups.

The study also highlights the inherently coercive nature of the two-child norm versus that of informed choice and reproductive rights. Colloquium participants found such coercive measures disempowering and a violation of human rights, and their enforcement discriminatory. The contradiction between informed choice and the imposition of a two-child norm became clear. It also became clear that disincentives for having large families are not helpful, because pressure on public health functionaries tends to result in coercive behaviour. The quality of reproductive health services also becomes worse and there is pressure on women to undergo sterilizations. These policies, it has been suggested, would be counterproductive in the long run, even for population stabilization measures.

A declaration on development and human rights in the context of population issues was adopted unanimously at the end of the colloquium. The declaration highlights the need for education and economic empowerment, especially among women, and for making health-care services available and accessible. It affirms the reproductive rights of women based on dignity and integrity and calls for the removal of incentives and disincentives from state population policies. As a result of these deliberations, the Secretary of the Ministry of Health and Family Welfare wrote to respective state governments discouraging the use of disincentives as part of their population policies.

ACHIEVEMENTS

Stronger Commitment to the Implementation of the PNDT Act

Below are some of the results of the partnership group *vis-à-vis* the legal process:

- The Ministry of Health and Family Welfare provided regular progress reports on the implementation of the PNDT Act, followed by discussions that helped speed up the process;
- UNFPA, along with the Ministry of Health and Family Welfare, conducted regional sensitization workshops for medical officers designated to implement the Act at state, district and subdistrict levels;
- Members of a core group, facilitated by UNFPA, developed a national advocacy strategy for the speedy passage of the PNDT amendment bill;
- The amendment to the PNDT Act was approved by parliament in December 2002; and
- The Minister of Health wrote letters to the Indian Medical Association and the Federation of Obstetric and Gynaecological Societies of India requesting their help and cooperation in working towards the eradication of sex selection.

Research and Advocacy

Some of the results of the partnership beyond the legal process include the following:

- The Ministry of Health and Family Welfare set up a resource centre on sex selection;
- With the assistance of local NGOs, international NGOs and others have expanded advocacy efforts in 13 states among elected officials, the media, medical professionals, and civil society coalitions and alliances. Plan International is carrying out media advocacy in Andhra Pradesh through a private communications agency. CARE-India has been mainstreaming the issue of sex selection into all of its ongoing projects. The National Foundation of India is funding journalists and researchers working for gender equity and social justice. The Embassy of the Netherlands is also supporting media activities, which it has defined as a critical activity. WHO has integrated the issue of sex selection into its gender and reproductive health training courses;
- A web site developed by a member of the partnership group enables users to lodge complaints under the PNDT Act, which are automatically communicated to the concerned authorities;
- The Ministry of Health and Family Welfare allocated funds for research on the impact of gender bias on the 0-6 age group; policy implications for restricting gender balance; and "missing" girls in Delhi;
- UNICEF organized a meeting with religious leaders on sex selection and has funded research on related issues, including gender equity;
- The Registrar General of India has developed maps on the sex ratio in different states for dissemination;
- UNFPA conducted a population colloquium with the National Human Rights Commission and the Ministry of Health and Family Welfare that brought the issue of the two-child norm and its relationship with sex selection to centre stage; and
- UNFPA has prepared maps depicting sex ratios in India in 1991 and 2001, along with a brochure entitled "Missing". These will be available in English, Hindi and Punjabi and will be later translated into Gujarati, Telugu and Marathi.

LESSONS LEARNED

- ***Legal action by itself is not effective in addressing harmful practices that are embedded in cultural beliefs and are influenced by social and economic factors.*** To become effective, legal action must be an integral part of a broad and integrated campaign. It is clear that although the Government of India enacted the PNDT, it was ineffective in addressing the issue or even in raising active public debate over it until it was integrated into relevant government programmes;
- ***Partnerships provide a forum for networking among specialists in their field and can be a starting point for coalition-building.*** The partnership group that formed around the issue of sex-selective abortion presented an opportunity for networking with other groups and specialists in their field, which resulted in numerous spin-offs. It is a good example of what can be achieved

among public and private actors, including multilateral and bilateral donor agencies, international NGOs, activists, the judiciary and central and state governments. The coordinating role of UNFPA was commended by a number of partners as non-bureaucratic and task oriented, which helped move the process forward and eventually led to the formation of a coalition;

- ***A broad coalition of actors is needed to address harmful practices that are national in scope, each bringing its own expertise to create awareness of the negative impact of the practice and to reflect on a way forward.*** The decision of the Ministry of Health and Family Welfare to establish a national-level partnership group for combating sex selection and to provide support for related activities and advocacy was taken nearly eight years after the enactment of the PNDT Act. The facilitation of coalition-building and strategy formulation by UNFPA helped to create the momentum for the legal process resulting in the amendment of the Act and the development of a broader advocacy strategy that was crucial to the Act's enforcement. The strategy was also important in bringing the issue to the level of national policy-making and in moving it forward at district and village levels; and

- ***Research and effective dissemination of research findings was necessary to bring the issue of sex selection to the forefront—not purely as a cultural issue but as one that has social and economic dimensions.*** It was also through such research that sex-selective abortions were placed in the context of human rights and gender discrimination. The sensitization of government officials on gender and legal aspects of the issue was one result, which opened the door for discussion of other major policy issues.

ENTRY POINTS FOR FUTURE COLLABORATION

- ***Bringing about behaviour change.*** Generally speaking, changing the behaviour of individuals is a complex and challenging task. Ultimately, however, all social change depends on the changed behaviours of groups and individuals, be they policy and decision makers, civil society organizations, service providers or service seekers. Behaviour change can be undertaken through designing appropriate interventions, taking into account existing and specific knowledge of the particular target groups. Behaviour change interventions should be periodically evaluated and examined for effectiveness. They should also be synergistic and coordinated, with the use of a "common voice" and a "common platform" in order to stand out in the modern-day upsurge of information. To target various groups effectively, interventions should include principles of human rights as a part of all communication materials, and the approach, language and symbols used should be culturally sensitive and comprehensible. Within this framework, policy programming and advocacy can target the following groups:

- The Service Recipient: The woman who is pregnant or due to conceive who can seek the service out of her own free will, or because she is influenced by the next group of immediate motivators. The service includes several procedures that may be detrimental to her physical and psychological well-being;

- Immediate Motivators: A husband or other family members, peers, local health providers, religious figures and others who motivate, inform, permit, encourage, pressure, threaten or support the woman to seek out the service;

- Service Providers: Allopathic doctors, paramedics and other health-service providers who promote, provide, conduct, aid and abet sex-determination services and influence, advise and enable women to undergo sex-selective abortions;

- Social Catalysts: The action of actors such as local leaders, medical bodies and fraternities, social activists, NGOs and women's groups, social development agencies, academics, journalists, manufacturers, marketers and other civil society groups is imperative in bringing about social change by creating public opinion, advocating with policy and decision makers, providing support services and through other means;

- Policy Makers and Implementers: Parliamentarians and legislators, social policy and decision makers and law enforcers; and

- Social-environmental Influences: Including the mass media, which plays a critical role in shaping the way people think and behave, and which can be encouraged to portray more progressive images of women and men and to challenge stereotypes through both entertainment and critical analysis. The media, especially print and audiovisual, have a critical role to play in highlighting the issue of sex-selective abortions. This group also

includes the larger social reality, which consists of the entire complex of cultural and religious values, beliefs, norms and practices directly or indirectly linked to social behaviour.

Within this framework of behaviour change, future collaboration would contain the following entry points:

- ***Continue the campaign.*** Social and family pressures to produce a son in India are immense. However, a sustained campaign and interventions focused on bringing about behavioural and social change could substantially alter the situation. The agencies involved in the partnership group should focus on social awareness and work together with civil-society activists to build up a social movement. At the same time, the campaign focusing on the PNDT Act must also be sustained, because implementation of the Act must be adequately monitored in order to be effective;

- ***Conduct further research on the socio-economic and cultural roots of the practice.*** Many partners expressed the need for further research to support interventions against sex selection, including research to further clarify the sociocultural and economic determinants of the practice.

- ***Solicit the involvement of custodians of culture and opinion makers.*** Advocacy efforts should be expanded among wider, more influential circles:

  — Map groups that could be effective at the national or local level, including human rights and women groups;

  — Strategically involve religious and spiritual leaders who are influential in shaping public opinion;

  — Use the network of NGOs involved in the Government of India's Reproductive and Child Health Phase II programme to disseminate relevant messages regarding sex-selective abortions; and

  — Use the National Human Rights Commission as a platform for the issue.

- ***Sustain sensitization of state machinery and medical practitioners.*** State-level sensitization workshops could also be conducted for members of legislative assemblies and the panchayats. The Population Foundation of India and Plan International have plans to do so in eight states over the next two years. Sensitization at the state level should continue through meetings and consultations with appropriate authorities. Sensitization of the medical community, both public and private, is also crucial; and

- ***Encourage non-coercive population policies and focus on quality of care.*** Population policies that prescribe a two-child norm encourage male preference and sex selection and should be abolished. It has been suggested that these coercive policies are also counterproductive, even as a means of population stabilization.

The International Conference on Population and Development reinforced a commitment to client-centred approaches to population, focusing on the quality of care as the main criterion rather than on demographic numbers. These issues—quality of care, client satisfaction, widening the range of choices, and assessment of a community's needs—should be part of any advocacy strategy against sex selection. Moreover, the Government of India's Reproductive and Child Health Phase II programme should incorporate sufficient checks and balances to ensure that women's health is not compromised.

5 STRENGTHENING TIES WITH A RELIGIOUS NETWORK IN GHANA THAT PROMOTES INTERFAITH UNDERSTANDING AND BETTER PROSPECTS FOR YOUTH

An innovative network, launched a decade ago with support from UNFPA and the Planned Parenthood Association of Ghana, has raised awareness among Ghana's major religious groups about reproductive health and population issues. The network has grown from four to a dozen faith-based institutions that now provide education and services to local communities, ranging from raising awareness about HIV/AIDS to preventing teenage pregnancies.

This chapter explores the possibility of building partnerships with other Ghanaian "custodians of culture", namely the tribal chiefs and queen mothers who wield a great deal of influence at the local level in various regions of the country. The chiefdom institution is engaged in advocacy and service delivery in the social sector, especially in the fight against HIV/AIDS.

GHANA: COUNTRY CONTEXT

Political and Socio-economic Background

Ghana is rich in minerals and other natural resources and enjoys double the per capita output of poorer West African countries. Still, the income of its citizens is among the lowest in the world, and 40 per cent of the population live in poverty. At independence in 1957, the economy was based on gold and cocoa, and the country was relatively prosperous, with a good education system and efficient civil service in place. After the mid-1960s, with weak commodity demand and foreign debt, the economy stagnated. Today, it is heavily dependent on international assistance.

Religion[1]

The Constitution of Ghana provides for freedom of religion, and the Government makes an effort to promote interfaith understanding. At official functions, there is generally a multi-denominational invocation led by religious leaders from various faiths.

According to the 2000 Population and Housing Census, 69 per cent of the population are Christian, 16 per cent Muslim, and 9 per cent follow traditional indigenous religions or other faiths, including Buddhism, Judaism, Hinduism and some spiritual churches or cults that include elements of Christianity and traditional beliefs.

Various Christian sects have influenced the education system of the country and most of them have established formal schools, especially in administrative and trading centres. After independence, one of the Government's priorities was to establish free primary education. However, this did not eliminate the schools run by the various religious institutions. At the same time, other religious groups, including Muslim sects, started to expand their educational network.

Traditional Leadership Structures

The system of chieftains in Ghana wields a high degree of influence in the community. Kings, different levels of chiefs and queen mothers are considered the custodians

1 U.S. Department of State. 2002. "International Religious Freedom Report 2002." Washington, DC. Website: http://www.state.gov/g/dri/ris/irf/2002/13835.htm.

of culture at both the local and the national level. These positions are hereditary and matrilineal in most of Ghana. Several hundred traditional councils elect members to Regional Houses of Chiefs, which send representatives to a National House of Chiefs. The Chieftaincy Division of the President's Office provides administrative staff to the chiefs.[2]

Many of the chiefs carry out activities to improve the economic and social status of the community. In fact, chiefs have spearheaded local development, although they are barred from political participation. Political leaders and government officials often go through the chiefs to reach the local population.

There is a female equivalent to the chief who is also elected from the same family. The queen mother has to possess certain leadership qualities and could be the aunt, sister or mother of the chief. They are the moral leaders of the community and are represented at the House of Chiefs, but not in regional and national councils. Queen mothers are involved in the nomination and selection of chiefs. They advise chiefs, particularly on issues related to the welfare of women in their communities and assist in adult literacy, agriculture and business ventures. They also disseminate information on maternal and child health. In 1984, the queen mothers mobilized for legislation to protect widows from harassment.

Reproductive Health

According to the 1998 Ghana Demographic and Health Survey, the total fertility rate declined from 5.5 children in 1993 to 4.6 children in 1998. Total fertility has further declined to 4.1 for the period 2000-2005, according to UNFPA's *State of World Population 2003*, and contraceptive prevalence rates for all methods have increased to 22 per cent (13 per cent for modern methods). The infant mortality rate in Ghana currently stands at 58 per 1,000 live births and the maternal mortality ratio is 407 per 100,000 live births, according to the UNFPA report. Despite disparities throughout the country, there has been an overall improvement in the health status of the population.

The average life expectancy has improved to reach 56.5 years for men and 59.3 years for women as compared with 45 years in 1960. This has been attributed to the Government's focus on primary health care and the building of health facilities across the country.

There is growing concern about pregnancies among adolescents and women aged 15 to 25, which account for one third of all births and are usually associated with early marriage; early sexual activity; lack of information and knowledge about reproductive health, including family planning; lack of access to quality reproductive health services; and poverty. Again there are disparities, with the incidence of adolescent pregnancy in rural areas twice that of urban centres.

National statistics indicate that there are 33 abortions per 1,000 pregnancies. Seven out of 10 women have induced abortions, and women in the age group 20 to 24 average one abortion in four pregnancies. Septic abortion cases are 25 times higher among adolescents than adult women.

Young people in the age group 10 to 25 years account for more than half of all reported AIDS cases, and it is estimated that 1.2 million people will be infected by the year 2005.[3] There is grave concern about the potential increase of HIV/AIDS in Ghana because neighbouring countries—Burkina Faso to the north and north-west, Togo to the east, and Côte d'Ivoire to the west—all have high incidence rates.

UNFPA PROGRAMME

Partnering with Religious and Traditional Leaders

UNFPA has been assisting Ghana since the early 1970s. The Third Country Programme (1996–2000) emphasized reproductive health and population and development, along with advocacy. An important component of this programme was sensitization of and advocacy training for 3,840 religious leaders from eight religious organizations on reproductive health, including adolescent reproductive health and gender issues.

There was also collaboration with traditional leaders. The King of the Asante spearheaded traditional leaders in the fight against HIV/AIDS. The chiefs have participated in many UNFPA-supported activities in their communities and upheld the Fund's mandate.

UNFPA also supported and facilitated the Population and Housing Census 2000 and provided assistance in

2 International Development Research Centre. 2001. Enhancing the Role of Traditional Leaders in African Governance. Website: http://www.idrc.Aca/reports/prn_report.cfm?article_num+874.

3 UNAIDS. July 2001. "Country Profile: The Response to HIV/AIDS in Ghana." Geneva: UNAIDS.

SELECTED INDICATORS: GHANA

Total population, 2003	20.9 million
Average population growth rate, 2000-2005	2.2%
Life expectancy for females	59.3 years
Life expectancy for males	56.5 years
Total fertility rate, 2000-2005	4.1
Births with skilled attendants	44%
Contraceptive prevalence for women aged 15–49, modern methods	13%
Contraceptive prevalence for women aged 15–49, any method	22%
Infant mortality per 1,000 live births	58
Maternal mortality ratio per 100,000 live births	407
Illiteracy rate for females over 15 years	37%
Illiteracy rate for males over 15 years	20%
HIV/AIDS prevalence rate for females 15–24 years	3.0%
HIV/AIDS prevalence rate for males 15–24 years	1.38%
Gross national income per capita (PPP$), 2001	$1,980
Access to safe water	73%

Source: UNFPA, State of World Population 2003.

the expansion of health facilities offering reproductive health and outreach services to underserved communities. Population and family life education, including information on HIV/AIDS prevention and reproductive health, were integrated into the curricula of primary, secondary and teacher training schools.

The Fourth Country Programme (2001-2006) includes two subprogrammes, on reproductive health and on population and development strategies, with advocacy and gender concerns integrated into both. The focus of the reproductive health subprogramme is to meet the reproductive health needs of adolescents and to combat the spread of sexually transmitted infections, including HIV/AIDS. Given the economic and social disparities of the northern and southern regions of the country, UNFPA is focusing on 24 districts in three northern regions.

Partnering with the Planned Parenthood Association of Ghana

In 1994, the Planned Parenthood Association of Ghana, within the context of the country programme, initiated a programme to respond to the challenges most religious institutions faced in dealing with reproductive health issues, especially modern family planning methods. Although there was no organized religious opposition to family planning in Ghana at the time, there were many misconceptions about the use of modern family planning methods that created pockets of resistance. Also, there was a lack of knowledge among religious organizations on issues concerning population, health and development.

The initiative held promise since leaders of religious organizations are well respected in Ghana and have a great deal of influence among their followers. Moreover, the majority of Ghanaians are religious and participate in religious activities regularly. According to baseline research carried out by the Planned Parenthood Association of Ghana in 2001, the majority of the respondents (78 per cent) attends a religious programme at least once a week.[4] The network of religious organizations is large and well structured, from the capital city down to the grass roots. Churches, mosques and missions are scattered throughout the country, along with religiously affiliated schools, hospitals and community centres.

4 Planned Parenthood Association of Ghana. May 2002. *Strengthening the Participation and Implementation of Reproductive Health Services by Religious Institutions.*

THE PLANNED PARENTHOOD ASSOCIATION OF GHANA

- The leading NGO in the provision of quality family planning services, education and advocacy in sexual and reproductive health and responsible parenthood;
- Established in 1967 as an affiliate of the International Planned Parenthood Federation (IPPF). Has pioneered many projects, including family life education for youth, community-based services and male clinics, and has integrated family planning into community development projects; and
- Has focused on reproductive health, targeting youth, since 2001.

Why UNFPA and the Planned Parenthood Association decided to partner with faith-based organizations:

- Majority of Ghanaians are affiliated with religious institutions that have a large network from the national down to the village level;
- Religion has great influence on the lives of Ghanaians;
- To clear misconceptions about family planning and methods; and
- Need to prevent teenage pregnancies and HIV/AIDS.

Why faith-based organizations decided to partner with UNFPA and the Planned Parenthood Association:

- To reach out to youth on issues related to their needs;
- To prevent high rates of teenage pregnancy and HIV/AIDS; and
- UNFPA provided framework and funding to work for welfare of people.

It is against this background that the main religious organizations in Ghana agreed to work together with UNFPA and the Planned Parenthood Association to incorporate sexual and reproductive health along with population and family life education into their activities. At the beginning, UNFPA and the Planned Parenthood Association approached four religious organizations to collaborate with them; as the programme expanded, other faith-based organizations approached the two secular organizations to include them in the programme.

To enter into the partnership, the religious organizations signed a memorandum of agreement with the Planned Parenthood Association of Ghana, which coordinates and manages the programme. The objectives of the programme are related to reproductive health and population objectives: to bring down the fertility rate to 3.0, to increase the contraceptive prevalence rate to 50 per cent, and to reach a population growth rate of 1.5 per cent by 2020.

The programme utilizes various strategies to reach the community. The focus depends on the religious organizations, which are dictated by their own doctrines and the level of awareness and needs of the community. UNFPA, the Planned Parenthood Association and its partners, however, agreed upon the following general strategies:

- ***Sensitization of religious leaders in the preparatory phase of the programme:*** a top-down approach was used to bring about policy changes and commitment by the religious leaders to implement the programme;
- ***Capacity-building:*** for pastors, *imams*, peer educators and other religious leaders through workshops, seminars and training;

"Despite the fact that we are Muslims or Christians, we are all Ghanaians, confronted with the problem we have to solve together. We examined the problem using the different religious beliefs that we have. And we understand each other. In Ghana there is a lot of intermarriage, and we live together as Muslims and Christians. It is easy to come together."

—The Ahmadiyya Muslim Mission

- ***Service delivery:*** the provision of counselling, referrals, non-prescriptive contraceptives, strengthening of existing youth centres and establishment of new ones;

- ***Peer education:*** training of female porters, truck drivers, youth groups and pastors' wives;

- ***Outreach:*** home visits, participation in World AIDS Day, Valentine's Day, Christian Home Week celebrations;

- ***Research, monitoring and evaluation:*** surveys, baseline, mid-term, end of project collection of process indicators;

- ***Production of behaviour change communication materials:*** TV advertisements, flyers, radio programmes, print media; and

- ***Provision of livelihood development skills:*** vocational and other skills training.

ACHIEVEMENTS

- ***The leaders and staff of religious institutions representing most of the country have been sensitized to issues concerning reproductive health and population and development.*** The programme, which started out with four organizations, has expanded to a dozen. Initially, emphasis was placed on sensitization through advocacy and capacity-building workshops, training and study tours.

- ***Religious organizations are going beyond capacity-building to service delivery, peer education, outreach, research, monitoring and evaluation, production of communication materials, and provision of livelihood skills.*** During the Fourth Country Programme, focal points and peer educators in each religious organization are working with three communities to carry out activities at the local level. Some of the organizations, if their doctrines allow, also distribute condoms or refer clients to health centres. Some assist in income-generating activities. These activities are included in the project document. However, identifying what is to be done is decided at the community level.

- ***The programme is an interfaith programme in the true sense, that is, it serves the needs of the whole community.*** Each organization is responsible for reaching out to three nearby communities, regardless of the community's religious affiliation. The project coordinator is a staff member of the religious organization; one focal point and 20 peer educators are selected for each community and undergo the necessary orientation and training. If problems arise that are related specifically to another religion, the project coordinator or focal point consults with or refers them to another organization in the religious network. Otherwise, the activities reach out to the entire population of each community.

- ***The programme has resulted in a network of religious organizations collaborating on reproductive health and other social issues.*** Religious organizations, representing diverse traditions, have been brought together to interact, plan and discuss issues of mutual concern. Leaders and staff of the organizations have been invited to one another's events as resource persons. The focal points and peer educators sometimes face issues they cannot deal with since they have to work with the whole community and not just those of the same faith. In such cases, they consult with and receive assistance from another organization in the network.

- ***The programme has attracted people to the various religious groups because the activities they sponsor deal directly with people's sexual and reproductive health needs.*** Being part of the programme has increased the credibility of participating religious organizations and has actually led to an increase in their congregations. Youths recognize that the institutions are concerned with the realities of young people and the welfare of the community as a whole.

- **Reproductive health, including the prevention of teenage pregnancies and HIV/AIDS, and the prevention of harmful practices, such as early marriage and female genital cutting, have been incorporated into the regular training of religious leaders.** The college for training Christian pastors and the Ahmadiyya

RELIGIOUS ORGANIZATIONS PARTICIPATING IN THE UNFPA/PLANNED PARENTHOOD ASSOCIATION PROJECT (SEE ANNEX 1)

Name of Faith-Based Organization	1992 – 1993	Second Country Programme 1994-1995	Third Country Programme 1996-2000	Fourth Country Programme 2001-2006
Christian Council of Ghana	X	X	X	X
National Catholic Secretariat		X	X	X
Seventh Day Adventist	X	X	X	X
Ghana Pentecostal Council		X	X	X
Church of Pentecost		X	X	X
Ahmadiyya Muslim Mission		X	X	X
Muslim Family Counselling Services	X	X	X	X
Community Development & Youth Advisory Centre			X	X
Muslim Relief Association of Ghana			X	X
Inspirational Youth Choir				X
Salvation Army	X	X	X	(a)
Adventist Development and Relief Agency			X	(a)
The Heartsquad			X	(b)
Black Heritage			X	(b)
Rockson King Productions			X	(b)

Note: a. Receiving funding from other donors. **b.** Organization has closed.

Muslim Mission College will be incorporating reproductive health and related issues into the training of new leaders. A draft curriculum has been forwarded to UNFPA for technical comments.

- **The programme has helped develop project-management and budget-preparation skills within participating organizations, enabling them to attract funding from other donors.** Some of the partners have been able to obtain funding from other donors and are no longer part of the programme in terms of funding and project work, although they continue to have a relationship with the programme.

- ***Success in getting religious organizations involved in reproductive health, including family planning and***

HIV/AIDS prevention has led to support for related initiatives from other organizations. The United States Agency for International Development is supporting a public education campaign called "Stop AIDS, Love Life". The Ghana Social Marketing Foundation, in collaboration with Johns Hopkins University, is implementing the programme. The Christian Council of Ghana is coordinating the religious groups in the campaign. Religious leaders will be trained to set up compassionate programmes for people living with HIV or AIDS. Television and radio spots quoting directly from the Bible and the Koran on compassionate responses will be aired to reduce the stigma associated with HIV/AIDS.

"HIV/AIDS, like violence against women, has no religious boundaries."

—The Christian Council of Ghana

LESSONS LEARNED

- ***Before designing advocacy work for grass-roots communities, it is important to ensure that leaders of these communities are approached, sensitized and "neutralized" or "won".***

- ***Dialogue, sensitization and joint programming with faith-based organizations should be an ongoing process that goes beyond a single programming cycle.*** This will allow for the maturing of the partnership and can create possibilities for other joint activities. During the Third UNFPA Country Programme, nearly 4,000 religious leaders were sensitized and trained in reproductive health, including adolescent reproductive health. This helped to clarify misconceptions and dispel any fears. The eight organizations to which the religious leaders belonged were prepared to engage in programming work with UNFPA and the Planned Parenthood Association by the time the next country programme approached. The UNFPA office in Ghana seized the opportunity and continued its collaboration with faith-based organizations, knowing fully that through these groups it would be able to reach large sectors of the population.

- ***It is vital to find ways and means to mainstream some activities into the work of the partner, so that such activities become part of their regular programme.*** The incorporation of the curricula on reproductive health in the colleges of Christian pastors and the Ahmadiyya Muslim Mission College is one example, which will help to ensure sustainability of sensitization of new clergy to issues relating to reproductive health.

- ***Providing hard data is one of the best advocacy tools to win over a faith-based partner.*** Data on maternal mortality, which threatens a significant segment of the constituencies of religious organizations, was a key motivating factor in convincing them to collaborate to address the issue.

ENTRY POINTS FOR FUTURE COLLABORATION

- ***Integrate reproductive health and rights and gender concerns in all interventions.*** The structures and teachings of religious organizations tend to be male oriented and hierarchical. Added emphasis could be placed on gender-sensitization in advocacy programmes and on providing women with choices and strategies to negotiate safer sexual relations.

- ***Find ways to work with leaders of charismatic new churches.*** Many new churches are attempting to reach out to youth, particularly through mass media. Often, however, their influence does not lead to medical attention. Their attempts to aid the sick rely on prayers rather than referrals to health clinics. People with HIV or AIDS are attracted to leaders of charismatic churches but, as a result, end up coming to clinics too late to receive help. Reaching out to these organizations could be an important way for all stakeholders, including the Planned Parenthood Association of Ghana and its religious partners, to advance their objectives in the area of reproductive health and rights. Meetings could be held with the leaders of charismatic churches to find out their attitudes on reproductive health, and their participation solicited in the activities of reproductive health partners.

- ***Pursue collaboration with traditional structures.*** In addition to partnering with religious organizations, further

"Because of our project, other donors are also coming in—USAID, Family Health International, UNICEF. Initially they thought that religious bodies would not be responsive to reproductive health. They saw what was happening and are now assisting some of the organizations."

—Project Director of the UNFPA/Planned Parenthood Association Programme

"Johns Hopkins Communication Center is supporting the Compassionate Campaign with the Council as a lead with other religious organizations. This is a result of the work we are doing together in this UNFPA/Planned Parenthood Association of Ghana programme."

—The Christian Council of Ghana

collaboration with chiefs and other traditional leaders is essential. Whenever there is a possible entry into a community, religious organizations could also approach traditional leaders for cooperation and support.

- ***Link academic and research institutions studying traditional leadership with policy makers and traditional leaders.*** There has been considerable research on traditional African leadership structures by academicians, especially in Africa, Europe and North America. However, there needs to be more coordination and consultation among policy makers, researchers and traditional leaders, and development agencies. Meetings could be held to discuss the strengthening of partnerships among international organizations such as UNFPA with traditional leaders and research institutions.

- ***Tap the influence of the chiefs and queen mothers to work together for better reproductive health and gender equality.*** The male orientation of the chieftain structure is slowly changing, and a number of current chiefs are women. The queen mothers have influence on the chiefs but are often considered only secondary leaders, even though they have the power to select as well as dispose of the chiefs. Support to queen mothers could be instrumental in helping to curtail teenage pregnancies and prevent HIV/AIDS.

- ***Promote the expansion of current work under way by chiefs and queen mothers on HIV/AIDS, including awareness-raising and related activities.*** Chiefs have been active in HIV/AIDS-prevention campaigns in their communities. They have participated in World AIDS Day, promoted voluntary and confidential testing for HIV, and invited resource people to talk to their communities on HIV/AIDS prevention. The Asante King himself has been involved in these campaigns and has declared HIV/AIDS the greatest threat to all Ghanaians. During meetings, special events, individual consultations or whatever other opportunity presents itself, chiefs should be encouraged to speak out on HIV/AIDS and other reproductive health issues, and be able to provide accurate information and support to health workers and others.

- ***Support chiefs and queen mothers who are interested in going beyond advocacy and awareness-raising in preventing HIV/AIDS.*** Chiefs and queen mothers identified the need to implement income-generating activities to keep youths from migrating to the cities, where they are exposed to high-risk behaviours. These traditional leaders are supporting programmes sponsored by the Government and NGOs but want to play a more active role. The suggestion has been made to establish offices in each district to work with chiefs on advocacy, capacity-building and the provision of services.

Some chiefs and queen mothers have arranged for the training of youths in various income-generating activities; others are trying to establish agribusiness ventures so that young people can earn a livelihood in rural communities. Queen mothers in one region are providing foster care for children orphaned by AIDS. The Mano Krobo Queen-Mothers Association in the eastern region of

LINKING RESEARCHERS, POLICY MAKERS AND TRADITIONAL LEADERS

The Traditional Authority Applied Research Network brings together researchers, governments, NGOs, policy makers and chiefs to discuss development issues based on research. The Network communicates through a discussion group on its web site, publications and meetings. With funding from the International Development Research Centre, members of the Network have been studying the role and contribution of traditional leaders in various development issues, including education and health reform, particularly in Botswana, Ghana and South Africa.

RATIONALE FOR PARTNERSHIP BETWEEN UNFPA AND GHANA'S CHIEFTAINS

- Many of the chiefs and queen mothers are already carrying out activities to improve the economic and social status of the community;
- The chiefs and queen mothers meet regularly with their people on an individual and community level;
- The chiefs and queen mothers are respected and wield influence in the community as well as in the national Government;
- The structure of the chieftain system is countrywide, extending from the community to the regional and national levels;
- UNFPA is a source of technical information as well as funding for advocacy and training;
- A partnership can provide an opportunity to exchange views with traditional leaders, health providers and district administration of other communities; and
- Concerted efforts are needed to prevent teenage pregnancies and HIV/AIDS in their communities.

Ghana is working on HIV/AIDS projects in public education, income-generation training for young women and assistance to children orphaned by AIDS.

- ***Continue support for regional sensitization workshops for chiefs, opinion leaders, religious leaders, reproductive health promoters, regional administration and health management teams, which can lead to opportunities for further collaboration.***
- ***Approach traditional leaders to get their support for any community intervention and continue consultations thereafter.*** NGOs have recognized the importance of these initial encounters for some time. Interaction with traditional leaders can entail extensive consultations, including sensitization and motivation workshops that will help to ensure support, clear up any misconceptions about family planning and provide a sense of ownership on the part of the community that will help to ensure sustainability.

ANNEX I: NOTES ON SOME OF THE RELIGIOUS ORGANIZATIONS INVOLVED IN THE NETWORK

Christian Council of Ghana: Part of the World Council of Churches, comprised of 14 different churches. Activities include training of trainers, provision of reproductive health counselling and services, production of behaviour change communication materials, dissemination of sexual and reproductive health messages by church members, establishment of Teen Clubs, family life educators and counsellors.

National Catholic Secretariat: Activities include training of service providers and peer counsellors in natural family planning and training for Youth Alive Club members in HIV/AIDS and other sexually transmitted infections along with other sexual and reproductive health issues. Serves as a resource on natural family planning for other religious organizations.

Seventh Day Adventist Church: Activities include seminars, crusades, home visits, marriage week celebrations, development of behaviour change communication materials, promotion of sexual and reproductive health among church membership, and training for church leaders, pastors, pastors' wives and selected church members as family life educators and counsellors and as home health visitors and counsellors to carry reproductive health and other health-related messages to the community.

Ghana Pentecostal Council: Umbrella organization with membership of 155 churches. Activities include seminars and training workshops targeting pastors, church leaders and their wives, youth leaders, women leaders, steering committee leaders and evangelists.

Church of Pentecost: Activities include rallies, production of behaviour change communication materials and training, formation of Family Life Clubs. The church is part of the Ghana Pentecostal Church, one of the fastest growing churches with membership of around 1.7 million.

Ahmadiyya Muslim Mission: Issues they advocate for include girls' education, empowerment of women, natural methods of family planning, prevention of drug and substance abuse, HIV and other sexually transmitted infections, and teenage pregnancies. Those trained include missionaries, residents, *imams*, youth and women leaders.

Muslim Family Counselling Services: NGO working within Muslim communities. Activities include education on HIV/AIDS and other sexually transmitted infections, counselling and skills training, distribution of non-clinical contraceptives. Targets are *imams*, other Muslim leaders, youth and women. Contributed to eradication of female genital cutting in Northern Volta.

Salvation Army: Member of the Christian Council of Ghana. Activities include training of women leaders, youth leaders and district officers in reproductive health issues, including teenage pregnancy, HIV/AIDS and other sexually transmitted infections, family planning, integration of reproductive health issues into adult literacy and agriculture extension workshops and activities.

Community Development and Youth Advisory Centre: Muslim NGO working in the upper eastern and upper western regions. Activities include workshops, seminars, drama groups, community rallies, counselling, training of trainers, radio discussions, programmes for in- and out-of-school youths, *imams* and religious leaders, the rights of Muslim women, and income-generating activities to stop migration of northern girls to southern towns and cities to serve as porters.

Adventist Development and Relief Agency: NGO reaching out to market women, long-distance truck drivers, cart pushers, female porters. Activities include training of trainers and dissemination of reproductive health messages, emphasizing HIV/AIDS and other sexually transmitted infections along with family planning.

6 FINDING COMMON GROUND WITH THE CATHOLIC CHURCH IN BRAZIL

Based on a shared interest in improving maternal and child health in Brazil, and responding to the needs of its young people, UNFPA formed a partnership with Pastoral da Criança, a grass-roots Catholic organization. Pastoral's volunteers (mostly mothers) reach over a million families across the country with information on issues including child survival and family planning. Though the partnership with Pastoral da Criança has ended, it provided important lessons in forging alliances with faith-based organizations whose members are close to the realities of Brazil's rural and urban poor. The strategy for working with such groups is one of "selective collaboration": identifying and working together in those areas where interests and goals coincide, while demonstrating mutual understanding and respect for each other's mandate.

BRAZIL: COUNTRY CONTEXT

Brazil is the largest country in South America and is composed of 26 states and one federal district. From 1964 to 1985, the Brazilian economy was characterized by intensive industrialization, economic growth and a huge foreign debt, which resulted in large disparities between the poor and rich. Beginning in the mid 1980s, Brazil suffered from economic instability, recession and inflation for over a decade. In 1998, the Government was able to check inflation, but poverty and gross inequalities continued to grow. A joint study carried out by UNFPA and the Brazilian Institute for Geography and Statistics in 2002 shows that the poorest 40 per cent of the population received only 10 per cent of the total national income, while the richest 10 per cent of the population received 46 per cent.[1]

Besides wealth and income disparities, Brazil is challenged by racial and social inequalities. In the north-east region, where 70 per cent of the black and mestizo population live, literacy rates are the lowest in the country and maternal mortality ratios and infant mortality rates are the highest.

In October 2002, a newly elected Government announced its intentions of improving the use of public funds, creating employment opportunities, increasing public security and alleviating poverty. The "Zero Hunger Project" was launched, based on the premise that low income is the major cause of chronic hunger in Brazil. The project's long-term objective is to reduce the population's dependence on immediate aid and assistance programmes.

Religion

Brazil is the largest Catholic country in the world, with over 5,000 churches and chapels, 2,600 clergy, 2,000 nuns, 500 schools, and over two dozen seminaries.[2] Seventy-four per cent of the population consider themselves Roman Catholics.

Brazilians are usually baptized and married in the Roman Catholic Church, but only 20 per cent of nominal Catholics attend mass and participate in church activities, according to the National Conference of Brazilian Bishops. Women attend mass more often than men, and the elderly are more active in church than the young.

In recent decades, Protestantism has grown rapidly. The proportion of the population considered evangelical increased from 3.7 per cent in 1960 to 6.6 per cent in 1980. The 1991 census showed a proportion of 19.2 per cent, or 28.2 million followers.

Evangelical Protestantism, particularly Pentecostalism, has replaced Catholicism in thousands of urban shanty-

1 UNFPA Brazil. 2003. *Brazil Annual Report 2002.*

2 *Catholic Encyclopedia: Brazil.* Website: www.newadvent.org/cathen/02745c.htm.

towns. The Pentecostal Church reaches out to the poor through faith-healing and poverty-alleviation measures.

In the 1990s, charismatic forms of Catholicism used unconventional approaches, along the lines of those used by Pentecostal protestant groups, to attempt revitalization and to increase active participation.

The Catholic Church

The National Conference of Brazilian Bishops

Formed in 1952 by progressives within the upper hierarchy of the Church, the National Conference of Brazilian Bishops (known as the CNBB from its Portuguese acronym) spoke forcefully for nearly two decades on important social and political issues. In the 1970s, the National Conference played a role in the defence of civil and political rights against the military dictatorship and became one of the most important opposition forces in the country. It defended the poor and acted as an advocate for those who were politically persecuted.

More recently, the National Conference of Brazilian Bishops called for cuts in foreign debt, denounced inequalities in wealth, and urged the Government and international financial institutions to make fundamental changes in economic policy.

Millions of grass-roots Brazilians believe that the Catholic Church plays a crucial role in their lives. Not only does it provide spiritual support and social assistance but it also responds to emergencies and, in some cases, provides financial assistance. To reach people, the Church organizes groups that are effective in addressing people's needs. The largest and most important of these groups is Pastoral da Criança. Similarly, the National Conference of Brazilian Bishops has been instrumental in promoting the Communidades Eclesiais de Base.

Communidades Eclesiais de Base

In the 1970s, the Church's activists for social justice declared a "preferential option for the poor". Members of the Church's clergy and laymen and laywomen, inspired by the religious discourse known as "liberation theology" and as a reaction to the military regime during that period, initiated a movement called the Communidades Eclesiais de Base, or CEBs. Priests, nuns and ordinary citizens worked on mobilizing communities around political and social issues such as land reform, popular participation in governance, education and health. Scholars acknowledge that the Communidades Eclesiais de Base may well have been the most widely recognized innovation in the Brazilian Church.[3]

The Church and its members have formed hundreds of CEBs—approximately 60,000 to 100,000 small cell-like organizations—throughout the country. The CEBs became a venue for the articulation of collective and organized protests against political repression and social injustice during this period.

In the process of organizing cells, the liberationist message emphasized by members of the clergy, nuns and laypersons was that the exploitation of the poor as workers was directly aimed at poor men. Ironically, women were more likely to respond to this message than their husbands. Thus, in 1994, women represented about 55-60 per cent of CEB members.

The CEBs have organized women and have given them the confidence to demand that their basic needs are met, by improving health services and water supplies, for example, and lowering of the price of basic commodities. The CEBs also worked on raising awareness of grass-roots and marginalized women and men—that is, they have raised their ability to understand the dynamics of, and to participate in, class struggles. Political activism, which the CEBs encouraged, led to the organization of unions and the mobilization of grass-roots organizations and communities to empower these groups to advance their cause.

Interactions between the Church and State

In 1988, Brazil adopted a new Constitution. The Church lobbied vigorously, but without success, for the inclusion of the right to life of the foetus from the time of conception. Moreover, the Constitution guarantees family planning as a universal right based on the freedom of couples to decide freely on the size of their families.

With respect to reproductive health issues, the National Conference of Brazilian Bishops adheres to the Catholic Church's basic teachings on sexuality, contraception, abortion and the role of women in society. In 2000, the Conference adopted the Catholic Church's policies against the use of condoms as a contraceptive method and a barrier to the spread of HIV/AIDS.

Many priests, however, especially those working with grass-roots communities, understand the devastating

3 Brunea, T. C., and W. E. Hewitt. 1992. "Catholicism and Political Action in Brazil: Limitations and Prospects." In: *Conflict and Competition: The Latin American Church in a Changing Environment,* edited by E. L. Cleary and H. Stewart-Gambino. Boulder, Colorado: Lynne Rienner Publishers.

SELECTED INDICATORS: BRAZIL

Total population, 2003	178.5 million
Average population growth rate, 2000-2005	1.2%
Life expectancy for females	72.6 years
Life expectancy for males	64.0 years
Total fertility rate, 2000-2005	2.2
Births with skilled attendants	92%
Contraceptive prevalence for women aged 15–49, modern methods	70%
Contraceptive prevalence for women aged 15–49, any method	77%
Infant mortality per 1,000 live births	38
Maternal mortality ratio per 100,000 live births	277
Illiteracy rate for females over 15 years	13%
Illiteracy rate for males over 15 years	13%
HIV/AIDS prevalence rate for females 15–24 years	0.48%
HIV/AIDS prevalence rate for males 15–24 years	0.64%
Gross national income per capita (PPP$), 2001	$7,450
Access to safe water	87%

Source: UNFPA, State of World Population 2003.

effects of teenage pregnancies, unsafe abortions, single-headed households and large families. They are also sympathetic to the dilemma that religious people must face on reproductive health issues.

The Church and Women

Grass-roots and working-class women have participated in the activities of the CEBs. For example, women in the 1970s mobilized for the first time against the military regime and, with the support of the Church, demanded health care, education and better working conditions.

The feminist movement formed a close alliance with the Catholic Church during the military dictatorship in the 1970s. For example, they rejected a state proposal on family planning because they believed that the problem of poverty had to be solved by changing social structures rather than by instituting population control measures.

During the early 1980s and the beginning of democratization, however, feminists began to demand reproductive and sexual rights, including the right to abortion. This created tensions between the feminists and the Church, and the alliance effectively ended.[4]

Reproductive Health and Rights

As evidenced by the above, the Catholic Church is not monolithic. There are members of the clergy who follow the doctrines of the Church as announced by the Vatican. On the other hand, there are members of the clergy whose beliefs and practices support those principles, strategies, and activities in line with the ICPD Programme of Action. And there is a larger group of clergy who support members of their congregation in making reproductive health choices.

Grass-roots women may be religious, but when confronted with the realities of life, they often decide to use contraceptives in the interests of their own health and the well-being of their families.

Family Planning

Use of contraceptives in Brazil is high, as compared with other countries at the same development level. There has been a drop in total fertility rate from 4.5 children in 1980, to 3.5 children in 1984, to 2.2 children in the period 2000-2005. This reduction was due to methods used by a large number of Brazilian women: female sterilization and oral contraceptives, which have a prevalence rate of

4 Rosado-Nunes, M. J. 2002. "Women, Religious Practices, and Democracy: Gender, Social Change, and the Catholic Church." In: *Revista: Harvard Review of Latin America.* 2(1): 66-68. Alvarez, S. E. 1990. *Engendering the Democracy in Brazil: Women's Movements in Transition Politics.* Princeton: Princeton University Press, p. 63.

44 per cent and 41 per cent, respectively. This reduction in fertility has affected positively the health status of women in Brazil.[5, 6]

Teenage Pregnancies

A major reproductive health issue is the high number of teenage pregnancies. Fertility among adolescents aged 10 to 19 years of age was 74 per 1,000 in 1999. According to the UNFPA Brazil office, between 1993 and 1998 there was a 31 per cent increase in deliveries among young girls between 10 and 14 years of age in government hospitals and clinics. Some 700,000 births were recorded for adolescent girls in the age group 10 to 19, representing about one-fourth of deliveries in 1998.[7]

HIV/AIDS

During the early 1990s, Brazil had one of the world's largest numbers of AIDS cases. By 1995, AIDS was the number one cause of death for young women in São Paulo and second among men. The estimated number of people infected by HIV in 2002 was 610,000, over one third of whom were women. The estimated number of deaths due to AIDS in 1999 was 18,000, and the number of children orphaned by AIDS was 41,000. Since 1996, there has been a levelling off of new HIV infections.[8]

The initial spread of HIV/AIDS, from 1982 to 1986, was mainly among highly educated homosexuals. Modes of transmission changed in 1987 to 1992, from sexual relations between men to injecting drug use and heterosexual relations. Since 1993, heterosexual transmission is on the rise, especially among men in lower income groups who have transmitted HIV to their wives and partners.[9]

The ratio of HIV/AIDS is growing fastest among married women in low-income groups. The ratio of men to women with the virus used to be 30:1. Currently it is 1:1 and, in some parts of the country, 1:2.[10]

Brazil's HIV/AIDS programme is considered one of the most effective in the world and has become a model for other countries. The programme was a pioneer in incorporating the health reforms of the 1980s, which aimed at extending health care and prevention to the entire population, with social participation and oversight reserved for NGOs. The strategic thrusts of the Government to control the spread of HIV/AIDS are prevention, treatment and care.

Preventive efforts: Prevention of HIV has focused on intensive health education, media campaigns and behaviour change programmes. Target audiences in these campaigns include high-risk groups such as military personnel, factory workers and young people. Activities to carry out these campaigns include training high school teachers to teach HIV/AIDS-prevention courses; providing condoms and confidential HIV testing and counselling for military personnel; working with the management of factories to provide confidential HIV testing; and counselling and making condoms available in the workplace.

Treatment: By supplying antiretroviral drugs to nearly 105,000 HIV/AIDS patients, Brazil has cut mortality among people with AIDS in half and hospital admissions by 80 per cent since 1996. Due to the programme's marked success, the Ministry of Health intends to scale up the programme in coming years. Its immediate objective is to expand coverage in regions where care continues to fall short, like the impoverished north and north-east.

Civil society—including NGOs, faith-based organizations, the Church, community movements and corporate foundations—have spearheaded these efforts. Moreover, they have pressured the Government to support programmes to assist people living with HIV or AIDS to have stringent procedures to test blood and other prevention programmes.[11] The involvement of an estimated 600 NGOs implementing about 1,000 projects involved in prevention, care, social mobilization, and monitoring of the Government's response has been one of the key elements to the success of the Brazilian programme.

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5 Arilha, M. 2003. "Contraception, Empowerment and Entitlement: A Necessary Crossroads in a Woman's Reproductive Life." In: Reflections on Gender and Fertility in Brazil: Abstracts. Family Health International. Web site: http://www.fhi.org/en/rh/pubs/wsp/brazilabstracts.htm#Contraception

6 Giffin, K., and S. H. Costa. 2002. "Contraceptive Practices and Abortion in Brazil," pp. 7-9.

7 UNFPA. 2001. *Annual Report 2000*. New York: UNFPA.

8 U.S. Centers for Disease Control and Prevention (National Center for HIV, STD and TB Prevention). "Brazil." Web site: http://www.cdc.gov/nchstp/op/gap/countries/Brazil.htm.

9 Garrison, J., and A. Abreu. 2000. "Government and Civil Society in the Fight Against HIV and AIDS in Brazil." Washington, D.C.: IESE and the World Bank.

10 "Brazil Winning Against AIDS." Web site: http://www.oneworldnet/tapestry?story=114.

11 Garrison and Abreu.

THE LARGEST UNFPA PARTNER AMONG FAITH-BASED ORGANIZATIONS

UNFPA has been providing assistance to Brazil since 1973. Before 1992, over 85 per cent of the funding supported the maternal and child health programmes of the Ministry of Health. This included training of health professionals and procurement of contraceptives. The objectives of the First Country Programme (1992-1997) were widened in scope to help reduce maternal and child morbidity and mortality rates, strengthen family planning services, reduce unwanted pregnancies, improve the Government's technical capacity for demographic analysis and enhance the status of women.

The Second Country Programme (1998-2001) was developed in accordance with the national population policies formulated by the National Commission on Population and Development. The goal of the programme was to improve the quality and access to reproductive health services, with special focus on selected northeastern states characterized by high poverty indicators and unmet reproductive health needs. One of the main aims of the reproductive health subprogramme was to reach out to youth in order to reduce unwanted pregnancies and abortions by promoting responsible sexual behaviour and providing reproductive health services. One of the projects funded during this cycle was an information and communication project with Pastoral da Criança.

Pastoral da Criança

Pastoral da Criança, a voluntary, grass-roots organization, has been working for 20 years with a mission to ensure that every child has a right to live. The organization came into being as a result of a discussion in 1982 between the Cardinal Archbishop of São Paulo and James Grant, former Executive Director of UNICEF, on the role of the Catholic Church in saving thousands of children from avoidable deaths. The next year, the National Conference of Brazilian Bishops commissioned the task of creating a new organization, Pastoral da Criança, which started its activities in 1983. The organization is considered the social action arm of the National Conference of Brazilian Bishops.

Pastoral da Criança has 153,000 unpaid volunteers, mostly grass-roots mothers, who help poor children survive by teaching families ways to take care of them. The organization reaches some 1.6 million children under six years of age and 77,000 pregnant women in about 3,000 municipalities around the country.[12]

Pastoral da Criança began its involvement in information, education and communication activities in family planning as early as 1985. The types of family planning methods presented to the volunteers of Pastoral da Criança followed the teachings of the Catholic Church—that is, natural family planning and breastfeeding. At that time, the emphasis of UNFPA advocacy work was on spacing pregnancies for better maternal and infant health. UNFPA methods of birth spacing included natural and modern family planning methods. Thus, there was common ground between UNFPA and Pastoral da Criança, and this was sufficient justification for the two organizations to begin to work with each other.

In 1991, UNFPA, jointly with UNICEF, agreed to provide additional funding for a radio programme sponsored by Pastoral da Criança. The organization agreed that the broadcast could include talks on reproductive health and family planning, in addition to maternal and child health, which was already part of the programme. For 18 months, radio programmes, audiovisual and printed materials were produced dealing with the various aspects of fertility regulation, including birth spacing through natural methods of family planning and breastfeeding, as well as modern methods of contraception. Other issues discussed during the broadcast were harmony in the home and the role of fathers, an important message since there was and is a large number of female-headed households in Brazil.

Pastoral da Criança also provided information on modern contraceptive methods in its other activities with volunteer health and community workers. This information was then conveyed to women during home visits. Although Pastoral da Criança never became involved in the distribution of contraceptives, it provided information as to where people could obtain them.

An evaluation of UNFPA work with Pastoral da Criança pointed out the need to broaden interventions on family planning and to reach a consensus on controversial issues such as population and development. In addition to the evaluation, UNFPA funded a needs assessment on family planning, competency and sexuality of the people who participated in the activities of Pastoral da Criança. The issues identified were similar to other assessments conducted in the larger community and included abortion,

12 Pastoral da Criança web site: http://www.pastoraldacrianca.org.br.

sexually transmitted infections, single motherhood, teenage pregnancies, abandoned children, gender violence, and misconceptions and taboos about sexuality. The research created much interest among the members of Pastoral da Criança, and many wanted to participate in interventions to provide information and education on reproductive health. At the same time, Pastoral da Criança realized that youths were not listening to the broadcasts on sexuality. This was a target group that both UNFPA and Pastoral da Criança wanted to reach due to the increasing number of pregnancies and abortions among young girls. There clearly needed to be a change in message to communicate with this important audience.

The timing seemed right for further collaboration between the two organizations. UNFPA could assist in developing approaches and messages to reach out to the community, especially youth, on reproductive health and rights issues. Pastoral da Criança had a network of volunteers and staff throughout the country with which to do so.

The joint effort was beneficial to both organizations: It would give UNFPA a certain legitimacy and facilitate its involvement with grass-roots communities in order to promote the ICPD Programme of Action. For Pastoral da Criança, it would expose its members to new concepts, widen their perspective and thinking on reproductive health, and give them a new approach to dealing with issues of interest to communities.

A New Participatory Approach

During this same period, the UNFPA Country Technical Services Team in Mexico had developed a unique community education approach called Rodas de Conversa (Chat Roundabouts). The method is based on Church discussions, drawing on religious teachings, with experts on various topics facilitating the sessions. With contributions from religious, technical and laypersons, the discussions aired a number of diverse points of view.

The three stages of the Rodas de Conversa are based on the Catholic process of "see, judge, act, evaluate and celebrate". The first stage is problem perception that corresponds to "see", and the participants are encouraged to talk about their feelings and experiences in relation to affection and sexuality. The second stage is equivalent to the "judge", the analysis of reality to expand our vision and capacity to decide, leading us to "act" in a responsible way. During the third stage, each group "evaluates" what has happened during the three stages and presents, or "celebrates".

The Rodas de Conversa method ensured active participation, which led to open discussion of various topics related to family relations, health and reproductive health, including modern family planning methods. The diversity of opinions was what made the method unique and rich. The Church was always invited to talk, present and argue its position. Lay and professional people also presented their opinions. The environment guaranteed respectful commentary, and people were encouraged to freely express themselves.

The project with Pastoral da Criança was about to be expanded to other provinces. However, in 1999, UNFPA was going through a major financial crisis which forced it to cut back the activities of this project and to terminate it. The Pastoral president wrote a letter to UNFPA highlighting the benefits of the programme, particularly the

RODAS DE CONVERSA: HOW IT WORKS

First stage: problem perception: Participants organized into age groups talk about their experience, feelings and doubts about affection and sexuality. Facilitators encourage discussion and write down a list of questions raised by the group.

Second stage: exchange of information: The same group continues discussion on the issues raised during the first stage, and advisers provide information to clarify any doubts. An important process throughout is respect for individual values and the diversity of attitudes.

Third stage: plan for action: The same group goes deeper into the issues and chooses the most relevant one, forming an opinion that can be the basis for decision-making in life. The group presents this in a creative way to the other groups. The third stage ends with a mass with a homily on an issue discussed during the Rodas de Conversa.

SOME OF THE ISSUES DISCUSSED DURING RODAS DE CONVERSA

- respect, justice, gender inequities
- importance of education
- importance of family
- role of men and women
- domestic violence
- sexuality and reproductive health
- responsible parenthood and family relationships
- maternal mortality
- strategies to reduce poverty
- poverty and reproductive health

method of Rodas de Conversa, and reassured UNFPA that it would replicate the use of this method in other places throughout the country while tapping other sources of funding, including Brazil's Ministry of Health. It is significant that Pastoral da Criança continues to use the Rodas de Conversa approach. According to its 2000 annual report, the main topic of discussion is the prevention of adolescent pregnancy. The Adviser on Sexuality for UNFPA-funded projects continues to work as an adviser to Pastoral da Criança.

LESSONS LEARNED

A number of lessons can be drawn from this experience that could help shape future collaboration in Brazil.

- ***Explore opportunities to dialogue with the Catholic Church.*** The Catholic Church, like other religious institutions, is not monolithic. Within it are different schools of thought, some of which may take a different view of the Church's current position on reproductive health issues. Religious teachings are also affected by the cultural, social and economic context in which they operate, as can be seen in Latin American and African countries.

- ***Adopt a strategy of "selective collaboration", which has worked in Brazil for some time, and in other countries as well.*** Such collaboration is based on the premise that all partners agree to respect one another's mandates and beliefs, while demonstrating the openness and willingness to work with one another within the space set by each institution.

- ***Design creative advocacy tools to which local people can relate by linking them to local beliefs, cultures and religions.*** The use of the Catholic process, to "see, judge, act, evaluate and celebrate", drawn from Catholic teachings, proved to be an effective methodology in raising awareness of reproductive health issues. Use of the process has continued long after the partnership ended.

- ***Make advocacy interventions inclusive and maintain a transparent agenda.*** The Rodas de Conversa method ensured active participation and mutual respect, which led to open discussion of various topics related to family relations, health, and reproductive health, including modern family planning methods.

- ***Capitalize on a creative advocacy methodology that has succeeded in reaching a wide audience.*** Rodas de Conversa is an important advocacy tool that can be adapted to local contexts and has proved effective in reaching a cross-section of the target group.

7 OPENING THE DOOR TO REPRODUCTIVE HEALTH IN YEMEN

Half of Yemen's children are undernourished, and the maternal mortality ratio in the country is one of the highest in the world. Yet efforts to improve the health status of the Yemeni people have been constrained by economic factors and rapid population growth in this complex, often inaccessible tribal Islamic society.

In recent years, UNFPA has worked closely with Yemen's Ministry of Awqaf and Religious Guidance to provide a national framework and plan of action on population issues. The challenge now is to broaden these efforts to include other government ministries and non-governmental sectors to reach the entire Yemeni population with health services, including reproductive health and family planning services and emergency obstetric care.

YEMEN: COUNTRY CONTEXT

Despite some economic gains, over one third of the Yemeni population still lives below the poverty line. The country suffered from the Gulf War in 1991 with the termination of much of its foreign aid and remittance income from hundred of thousands of Yemenis abroad. In addition to the negative repercussions of civil war, oil prices fell and the population grew rapidly.[1]

The health status of the Yemeni people is one of the lowest in Western Asia and North Africa. Fifty per cent of children are undernourished, and malaria and tuberculosis are taking a heavy toll on the health-care system. Less than half the population have access to health facilities.[2]

Fertility is high, and the estimated maternal mortality ratio is 488 per 100,000 live births, according to UNFPA's *State of World Population 2003*. Poor reproductive health services are the result of lack of coverage, regional disparities and low levels of family planning practice, despite increased awareness of reproductive health issues. Levels for HIV/AIDS are low, with only 900 cases reported in 2001. However, the incidence is expected to increase due to insufficient screening of blood before transfusions and a lack of information and education on HIV/AIDS.[3]

The prevalence of female genital cutting in 1997 was 23 per cent for women between the ages of 15 and 49. The prevalence rate varied, however, ranging from a high in the coastal region of 69 per cent to 15 per cent in the mountainous region and 5 per cent in the plateau region.[4]

The 1990 Constitution declares that Islam is the State religion and that Islamic law is the principal source of legislation. Ninety-nine per cent of the population are Muslims.

UNFPA PROGRAMME

UNFPA began its assistance to Yemen in 1979. In 1992, two years after unification of the former People's Democratic Republic of Yemen and the Yemen Arab Republic, UNFPA assisted the Government in establishing the National Population Council to develop a national strategy and plan of action on population. The involvement of the National Population Council lent a great deal

1 World Bank. September 2001. Yemen in Brief; US Department of State. January 2002. Background Note: Yemen. Web site: http://www.state.gov/r/pa/ei/bgn/5302.htm.

2 World Bank. 28 March 2002. "World Bank to Support Health Reform in Yemen." Press Release No: 2002/262/MENA.

3 UNFPA. 2002. Recommendations by the Executive Director to the Governing Board: Assistance to the Government of Yemen.

4 US State Department. 2001. Yemen: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC).

of legitimacy to the national population programme, which gained the support of the highest levels of Government.

UNFPA involved *imams* (Muslim clergy) and other religious leaders in various activities. The most significant of these was the preparation of the Strategy and Plan of Action on Population. Throughout this period, UNFPA consistently engaged the Ministry of Awqaf and Religious Guidance, because this institution significantly influenced the wider population's acceptance or rejection of family planning as a means of reducing poverty and decreasing population growth.

In the 1990s, UNFPA continued to provide support for capacity-building of various sectors of the Government, for example, the capacity of the Statistical Office, which is mandated to carry out the national census and training activities to strengthen the skills of health-services providers.

In the late 1990s, the Government adopted the Second Country Programme (1998-2001), which reflected the comprehensive approach of UNFPA to reproductive health, population and development, along with advocacy. This resulted in the updating of the National Population Policy in line with the recommendations of International Conference on Population and Development (ICPD).

The Second Country Programme included a two-year project, Population and Reproductive Health in the Context of Islam, which the Ministry of Awqaf and Religious Guidance implemented. The project's objective was to reduce the sociocultural and legislative barriers that women faced in accessing health and education services and participating in political and socio-economic processes. Activities were geared to building the capacity of religious officials of the Ministry of Awqaf and Religious Guidance, *imams*, and other religious leaders to implement the Population Strategy and Plan of Action more strategically and effectively. Activities included the preparation of advocacy materials, training for religious leaders and health-service providers, study tours to Egypt and the Islamic Republic of Iran, and work with the media to produce TV and radio programmes on reproductive health and family planning.

One of the major lessons learned from the Second Country Programme was the need to be strategic on the involvement of religious leaders in the conceptualization, design and implementation of the project. The original rationale for involving religious leaders was to increase their exposure and that of the ministry staff to the experience of other Muslim countries and to foster exchange among Muslim religious leaders and scholars in different parts of the world. Such exposure was expected to deepen the understanding of religious leaders and scholars concerning different interpretations of the Koran relevant to women, gender relations and sexuality.

For the Third Country Programme (2002-2006), UNFPA support focuses on reducing poverty through the integration of population, gender and reproductive health into development planning. The country programme is identifying certain geographic and underserved areas where the Government can implement programmes and establish models that can be replicated elsewhere.

ACHIEVEMENTS

- ***Continued involvement with the Ministry of Awqaf and Religious Guidance.*** Although the Third Country

THE ROLE OF THE MINISTRY OF AWQAF AND RELIGIOUS GUIDANCE

- Establishing dialogues on family planning with religious leaders, sociologists and other experts;
- Promoting gender equity and equality based on the participation of women and men in all spheres of family and community in line with Islamic legislation and jurisprudence;
- Educating women regarding their legal rights;
- Creating public awareness of the problems of divorce and the adverse impact on family cohesiveness;
- Increasing the role of mass media and cultural fora as well as religious meetings, conferences and seminars in promoting awareness of population issues;
- Holding specialized seminars dealing with population issues in the context of Islam; and
- Involving religious leaders and *imams* in public awareness creation from an Islamic perspective.

Source: The National Strategy and Plan, drawn from a UNFPA project document.

SELECTED INDICATORS: YEMEN

Total population, 2003	20.0 million
Average population growth rate, 2000-2005	3.5%
Life expectancy for females	61.1 years
Life expectancy for males	58.9 years
Total fertility rate, 2000-2005	7.0
Births with skilled attendants	22%
Contraceptive prevalence for women aged 15–49, modern methods	10%
Contraceptive prevalence for women aged 15–49, any method	21%
Infant mortality per 1,000 live births	71
Maternal mortality ratio per 100,000 live births	488
Illiteracy rate for females over 15 years	75%
Illiteracy rate for males over 15 years	32%
HIV/AIDS prevalence rate for females 15–24 years	NA
HIV/AIDS prevalence rate for males 15–24 years	NA
Gross national income per capita (PPP$), 2001	$770
Access to safe water	70%

Source: UNFPA, State of World Population 2003.

Programme includes no projects that deal specifically with religious leaders, UNFPA has long recognized that partnerships and consensus-building among religious leaders in Yemen are indispensable to ensuring common understanding on issues such as reproductive health, family planning, adolescent reproductive health and HIV/AIDS.

The purpose of UNFPA collaboration with the ministry is to support it in making the general public aware of reproductive health and family planning issues as well as to prevent practices that violate the dignity and the physical and emotional well-being of girls and women. Such practices include female genital cutting, violence against women and forced early marriages. The Ministry of Awqaf and Religious Guidance has been influential in moving this agenda forward. Engaging the ministry in all activities and at all levels is essential to strengthening its commitment and mobilizing the religious community to pursue the Third Country Programme;

- ***Production of advocacy materials.*** In 2002, together with the Ministry of Health and Population, the Ministry of Awqaf and Religious Guidance prepared a sourcebook on family planning and reproductive health based on the Koran and the Hadith.

  That same year, UNFPA assisted in the production of a film, with credits given to the Ministry of Awqaf and Religious Guidance. This film demonstrates the tools and opportunities that education affords to girls, both to fulfil their potential and to contribute to the country's development. The Ministry of Awqaf and Religious Guidance enthusiastically gave the film its approval, and it has been publicly screened in urban areas and broadcast on television;

- ***Outreach to parliamentarians.*** In addition to its work with the Ministry of Awqaf and Religious Guidance, UNFPA has been making every effort to foster closer ties with parliamentarians, some of whom are tribal and religious leaders. Such efforts include support for policy tours of Yemeni parliamentarians to Egypt and the Islamic Republic of Iran, where they held important talks on reproductive health with these countries' national population and planning officials. The parliamentarians also had an audience with the Grand Mufti and visited *imams* and other religious leaders. These activities are expected to pave the way for more frequent dialogues and exchanges; and

- ***Advocacy on HIV/AIDS.*** The Yemeni Cabinet endorsed the National Strategic Framework for the Control and Prevention of HIV/AIDS, which seeks to engage youth and the various ministries in making the public aware of HIV/AIDS and to implement programmes to halt its spread. The Ministry of Awqaf and Religious Guidance

SOURCEBOOK ON REPRODUCTIVE HEALTH

UNFPA provides support for the production of a guide for *imams* and other religious leaders during their ministrations and encounters with their followers. The sourcebook relates family planning and reproductive health to the Koran and stresses the Prophet's teachings on the equality of women and men. Forced early marriage, domestic violence and the prevention of young girls from attending school all reflect women's low status. Islamic laws have slowly adapted to societal changes and increasingly recognize the role that women play in the twentieth century. For the first time, the Ministry of Awqaf and Religious Guidance has officially recommended that marriage be delayed until at least the age of 20.

actively participated in developing the framework on HIV/AIDS and has also prepared advocacy sessions for *imams* and other religious leaders and parliamentarians. UNFPA chairs the theme group on HIV/AIDS, composed of representatives from the Ministries of Planning, Health, and Awqaf and Religious Guidance, donors and NGOs.

LESSONS LEARNED

The following activities have been found important:

- ***Identify individuals in civil society and academia who are knowledgeable about Islamic positions on issues relating to population, poverty and reproductive health, and who are influential in reaching out to policy makers.*** These individuals should be continually supported through the NGO or institutions with which they are affiliated, via dialogues, seminars, training and information;

- ***Engage religious leaders at the country and possibly intercountry level in discussions about population, gender and reproductive health.*** A major lesson learned from the Second Country Programme was the need to involve religious leaders in the conceptualization, design and implementation of a project. The original rationale behind involving religious leaders was to increase their exposure and that of the Ministry of Awqaf and Religious Guidance to the experience of other Muslim countries and to foster exchange among Muslim religious leaders and scholars in different parts of the world;

- ***Forge partnerships with influential religious establishments, not as a one-time pre-programme activity but as part of ongoing capacity-building and dialogue.*** Although the Third Country Programme does not include projects dealing specifically with religious leaders, UNFPA continues its involvement with the Ministry of Awqaf and Religious Guidance. UNFPA has long recognized that partnerships and consensus-building among religious leaders in Yemen are indispensable to ensuring a common understanding on issues such as reproductive health, family planning, adolescent reproductive health and HIV/AIDS;

- ***Invest in identifying those power structures and mechanisms that perpetuate the status quo and those that support change.*** This implies the need to a) recognize that change threatens existing structures and is feared by many, not only by those who hold power, and b) invest resources in participatory sociocultural research, including gender analysis. Such research is critical in helping stakeholders and UNFPA itself understand the cultural or religious values that support and/or constrain reproductive rights and women's empowerment; and

- ***Recognize that not all conflicts can be solved to everyone's satisfaction and that behaviour change is slow in traditional societies.*** Incremental changes are possible, however, and often enduring in the long term.

HIGHLIGHTS OF THE STRATEGIC FRAMEWORK ON HIV/AIDS

- Special emphasis on women and youth as the groups most vulnerable to HIV/AIDS;
- The de-stigmatization of those living with or affected by HIV/AIDS and their right to the care and services they need; and
- Consistent use of male and female condoms in the context of Islamic laws and teachings.

8 TAPPING THE POTENTIAL OF BUDDHIST MONKS AND NUNS IN CAMBODIA TO HALT THE SPREAD OF HIV/AIDS

Cambodia today is in the process of healing and spiritual renewal. Part of this process involves the rebirth of Buddhism, which still constitutes an important part of daily life for the vast majority of the population. This social transformation presents a number of strategic entry points that could be used to promote reproductive health and prevent the spread of HIV/AIDS, which has already assumed alarming proportions in Cambodia. Nuns and monks, who are a symbiotic part of Cambodian society, are already contributing to this effort. However, the potential is there for them to become even more engaged, especially in reaching young women, who are often the unwitting victims of sexual violence and trafficking.

This case study, unlike some others in this report, is forward-looking. Rather than documenting successful results, it identifies areas of action in which UNFPA and partner organizations could employ culturally sensitive approaches to the greatest advantage in combating HIV/AIDS.

CAMBODIA: COUNTRY CONTEXT

Cambodia has a population of 14.1 million. In terms of both ethnic and religious distribution, the country is relatively homogeneous (90 per cent Khmer and 95 per cent Theravada Buddhists). Over three fourths of the total work force are engaged in the agricultural sector, with rice cultivation being the primary activity.[1]

With a population growth rate of 2.4 per cent and a total fertility rate of 4.77 (2000-2005), the population is expected to more than double by 2050. Currently, 44 per cent of the population are under 14 years of age. Twenty per cent of males and 43 per cent of females over the age of 15 are illiterate, and only about half of the population have access to basic health care. As 82 per cent of the population live in rural areas, the Government faces not only financial but also geographic and infrastructural obstacles in attempting to improve the health and education systems.[2]

Religion

Most ethnic Cambodians are Theravada Buddhists, and there is a close association between Buddhism, Khmer cultural traditions and daily life. The remainder of the population includes approximately 700,000 Muslims, predominantly ethnic Chams, who are located mostly in towns and rural fishing villages on the banks of the Tonle Sap and Mekong rivers and in Kampot Province.

The country's Christian community constitutes less than 1 per cent of the population. More than 100 separate Christian organizations or denominations operate freely throughout the country. Other religious organizations with small followings include the Vietnamese Cao Dai religion and the Baha'i Faith, with approximately 2,000 practising members in each group.[3]

Buddhism in Cambodia

Buddhism is the dominant religion. However, the Constitution provides for freedom of religion, and the Government

1 Khmer Buddhist Educational Assistance Project (KEAP). http://www.keap-net.org/buddhism_cambodia.htm

2 Ibid.

3 US Government. *2002 Annual Report on International Religious Freedom: Cambodia.* Web site: http://www.state.gov/www/global/human_rights/irf_rpt/irf_cambodia.html

SELECTED INDICATORS: CAMBODIA

Total population, 2003	14.1 million
Average population growth rate, 2000-2005	2.4%
Life expectancy for females	59.5 years
Life expectancy for males	55.2 years
Total fertility rate, 2000-2005	4.77
Births with skilled attendants	34%
Contraceptive prevalence for women aged 15–49, modern methods	19%
Contraceptive prevalence for women aged 15–49, any method	24%
Infant mortality per 1,000 live births	73
Maternal mortality ratio per 100,000 live births	404
Illiteracy rate for females over 15 years	43%
Illiteracy rate for males over 15 years	20%
HIV/AIDS prevalence rate for females 15–24 years	2.50%
HIV/AIDS prevalence rate for males 15–24 years	0.99%
Gross national income per capita (PPP$), 2001	$1,520
Access to safe water	31%

Source: UNFPA, State of World Population 2003.

respects this right in practice. The Government promotes national Buddhist holidays, provides Buddhist training and education to monks and others in *wats* (temples or pagodas), and modestly supports an institute that performs research and publishes materials on Khmer culture and Buddhist traditions. Monks can move around the country without restriction.[4]

The Buddhist tradition is widespread and active in all provinces. The cornerstones of Cambodian Buddhism are the Buddhist monk and the *wat*. Traditionally, each village has a spiritual centre—a *wat*—where as few as 5 and as many as 70 monks reside, the number varying according to the size of the local population. In all, the country has about 4,100 *wats* that range in size from tiny to vast, some spreading over many hectares, with temples, living quarters and dozens of *stupas*—conical family memorials that hold the cremated ashes of generations. Almost 54,000 monks live in the *wats*. About 80 per cent of the monks join the monkhood temporarily; boys and young men join for various reasons since the *wats* provide shelter, protection and education, both Buddhist and vocational.[5]

Role of Monks

Monks are generally perceived as occupying a high moral ground in Cambodia, and their influence is pervasive. Although monks are supposed to be non-political and cannot vote, they do have political influence. During periods of conflict, they have participated in civil disobedience and have marched in the streets rallying for peace, human rights and social change.

Monks have also taken an active part in the construction of medical centres with villagers. More and more, monks are undertaking such initiatives as a service to the community[6] and have the potential to play a critical role in public education and in social development, including the promotion of reproductive health and HIV/AIDS prevention.

4 Ibid.

5 Information from UNICEF in Cambodia.

6 Kalab, M. 1994. "Cambodian Buddhist Monasteries in Paris: Continuing Tradition and Changing Patterns." In: *Cambodian Culture Since 1975: Homeland and Exile,* edited by Ebihara, Mortland and Ledgerwood. Ithaca, New York: Cornell University Press, p. 69.

Most of the population support the monks and monasteries nearest their homes. The monks, in turn, cater to people's physical and spiritual needs. People go to different monasteries for different purposes—for intellectual discussions with scholars in one monastery and for cures to illness in another.[7]

Reproductive Health and HIV/AIDS

The Spread of HIV/AIDS

The spread of HIV/AIDS in Cambodia, which may have begun between 1988 and 1990, is fuelled largely by unprotected heterosexual contact. According to UNFPA's *State of World Population 2003*, 0.99 per cent of men and 2.5 per cent of women aged 15 to 24 in Cambodia are living with HIV or AIDS. UNAIDS in Cambodia notes that risky behaviours are widespread among those who engage in commercial sex, their clients and young people, and the highest rates of infection have been identified in female sex workers. Transmission through drug injection seems to be limited.[8] Blood transfusions and surgical procedures may be significant sources of infection.[9]

The virus may have entered Cambodia across the Thai border, where soldiers from Thailand and Cambodia frequent brothels. It could also have come through ships along the southern coast, which provides fuelling stations and rest ports for fishing crews from Myanmar, Thailand and Viet Nam.[10] Commercial sex and the trafficking of women and children are on the rise in Cambodia, facilitated by the low status of women in society.

HIV/AIDS among Youths

Due to the devastating effects of war, the social structure of Cambodian society has crumbled, leaving adolescents in poverty and vulnerable to negative influences. There are no organized youth organizations in the country, apart from a few political ones.

Premarital sexual relations are common. Yet knowledge of sexually transmitted infections and contraception among 11- to 20-year-olds is lower than that of the population as a whole. Moreover, 80 per cent of the young men and women surveyed believed that they could not contract HIV.

All of these factors help to create fertile ground for the spread of HIV/AIDS, which is already assuming alarming proportions in Cambodia. An ever-improving surveillance system suggests that HIV is well established in the general population in all provinces. According to UNAIDS, in 1999, in a population of 10.6 million, there were 180,000 cases of HIV infection, about 90 per cent of which were among people aged 15 to 35.

Few of the ongoing reproductive health programmes focus on the specific needs of adolescents and on the comparative advantages of NGOs in dealing with these issues. Fewer still deal with the problems and consequences of commercial sex and the trafficking of women in Cambodia.

Involving Monks in HIV/AIDS Prevention

In the context of the emerging HIV/AIDS epidemic, the importance of reaching out to youth who are most vulnerable to HIV has become a strategic priority. One of the ways of reaching young people in Cambodia is through partnering with Buddhist monks and nuns, who have highlighted the importance of prevention and providing care and support to people living with HIV or AIDS. They have also been active advocates in reducing discrimination against people affected by the epidemic, including children orphaned by AIDS. The monks seldom talk directly about sexual issues but preach precepts such as refraining from sexual harassment and the virtues of fidelity and chastity, which have a bearing on sexual behaviour and HIV/AIDS prevention. One of the duties of monks is to bless newly married couples. During weddings, monks could use this opportunity to talk to couples about reproductive health issues and the dangers of HIV/AIDS.

The Supreme Patriarchs of the two monastic orders have highlighted the importance of HIV/AIDS prevention in their sermons since the early 1990s. They have participated in intercountry programmes and attended a conference on HIV/AIDS in the USA in 1997.

Before the involvement of UNFPA with monks and nuns in Cambodia, related initiatives were being carried out under the auspices of various international and national organizations, many of which are still ongoing:

7 Ibid., p. 61.

8 UNAIDS Cambodia. February 2000. *The HIV/AIDS/STD Situation and the National Response in the Kingdom of Cambodia. Country Profile.* Third Edition.

9 Beyrer, C. 1998. *War in the Blood: Sex, Politics and AIDS in Southeast Asia.* London: Zed Press, p. 56.

10 Ibid., p. 35.

- Since 1999, UNICEF has been organizing monks and nuns in HIV/AIDS-prevention strategies through its Buddhist Leadership Initiative in Cambodia, southern China, Lao People's Democratic Republic and Thailand. Working with the Ministry of Cults and Religion and the Ministry of Health, along with the National AIDS Authority, UNICEF supported the drafting and implementation of the National Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia, which provides detailed guidelines for monks on appropriate responses to HIV/AIDS;

- The Salvation Centre of Cambodia was the first local NGO to involve monks in community health education and HIV/AIDS prevention education;

- The Wat Norea Peaceful Children's Home, an orphanage run by a *wat* in Battambang Province, has been taking care of orphans and children living on the street since 1992. In 1998, in response to high HIV prevalence in the area, the monks of the Children's Home started educating the community on HIV/AIDS, providing counselling and working with families to accept and care for people living with HIV and AIDS. It also supported children orphaned by AIDS. It receives support from the Salvation Centre of Cambodia;

- Operation Enfants de Battambang has been working closely with monks and nuns and with Wat Norea to provide care to children who lost their parents to war and AIDS; and

- The Women's Organization for Modern Economy and Nursing has been raising awareness about HIV/AIDS in three squatter communities by undertaking information and education campaigns; recruiting peer educators who could conduct small-group discussions in these communities; conducting life-skills education activities intended to bring about behavioural changes; and initiating and maintaining dialogues with political leaders, monks and other key community members on their critical role in preventing the spread of HIV and in eliminating the stigma associated with HIV/AIDS.

UNFPA PROGRAMME

UNFPA opened its country office in Phnom Penh in 1994 and ran its First Country Programme from 1996 to 2000. Its Second Country Programme, covering the years 2001–2005, is focusing on priority reproductive health goals:

- Supporting the national reproductive health programme within the framework of the health-sector reform;

- Providing adolescent reproductive health information and services through NGOs;

- Using a multisectoral approach for HIV/AIDS prevention;

- Improving data utilization and analysis in planning; and

- Undertaking advocacy for population and development issues.

Reaching Out to Youth

In addition to its country programme, UNFPA coordinates a joint initiative with the European Commission[11] that targets adolescents and youth and issues associated with reproductive health and HIV/AIDS. The initiative's two main partners are international NGOs, Save the Children (UK) and Pharmaciens sans Frontières. These NGOs work through local partners, the Women's Organization for Modern Economy and Nursing and Operation Enfants de Battambang.

The initiative specifically targets:

- In-school and out-of-school adolescents;

- Children who engage in commercial sex and young girls vulnerable to sexual exploitation and trafficking;

- Rural adolescents;

- Youths who live on the streets;

- Young migrants;

- Young workers;

11 Since 1997, the European Commission contributes to an EC/UNFPA Initiative for Reproductive Health in Asia. This covers seven countries in South and South-East Asia, including Cambodia. The initiative's main strategy is to involve international, regional and local non-profit organizations in its implementation and have these partners work together towards a common goal. With this approach, the initiative hopes to bring reproductive health services within reach of populations in these underserved countries.

- Unemployed boys and young men;
- Young soldiers and policemen; and
- Young married couples, with or without children.

The initiative is based on research indicating that adolescent knowledge of reproductive and sexual health issues is low. There is also sufficient evidence to suggest that adolescents are engaging in unprotected premarital sex, with resulting unwanted pregnancies, high abortion rates and increased sexually transmitted infections, including HIV.

UNFPA Support to the Training of Monks

The strategy of the European Commission/UNFPA initiative is to work with the two international NGOs and, in turn, their local partners, who have had previous involvement with monks and, more recently, nuns, in HIV/AID-related activities. These include prevention, awareness-raising, care and support to people living with HIV or AIDS, and reduction of the stigma and discrimination associated with HIV/AIDS.

Through its local and international partners, the initiative involves monks and nuns in four main types of activities: preventing the spread of HIV/AIDS through information and education campaigns inside and outside monasteries (for example, when performing rituals and sermons or visiting homes); providing care and support to people living with HIV and AIDS and to orphan boys in the monasteries and in other shelters supported by the monasteries; training other monks on ways to deal effectively with young people on the subject of HIV/AIDS; and eliminating the stigma of HIV/AIDS through preaching the teachings of the Buddha, emphasizing compassion and easing of the burdens of those affected by the epidemic.

Through the initiative, monks are trained by the local NGOs on issues related to reproductive health and HIV/AIDS. Their knowledge, in turn, will be transferred to other young monks and youth living in the temples. Monks also talk to the public about HIV/AIDS during home visits and public ceremonies. In addition, nuns are trained to talk with young girls, especially orphan girls under their care.

LESSONS LEARNED

Cambodia is still in the process of healing and spiritual renewal. Efforts to help this process along, in the context of the rebirth of Buddhism, have been discussed by the two monastic orders and the relevant government agencies. This makes it an opportune time to introduce concepts and interventions that are aligned with Buddhist teachings and UNFPA's own mandate. These include:

- ***Strengthening the role of nuns in the Buddhist* sangha *(monastic order)*** and involving them in efforts to reach out to adolescent girls and women on issues related to reproductive health, trafficking, commercial sex and prevention of HIV/AIDS;
- ***Dialogue, training sessions, study tours abroad, and exchanges of ideas with monks*** who live in different parts of the world could also be facilitated by UNFPA. This would expand their knowledge and encourage positive attitudes in the areas of sexuality, women, and reproductive health and rights; and
- ***A review and documentation of existing programmes in terms of processes and results are crucial*** in maximizing the gains that result from engaging with monastic orders.

ENTRY POINTS FOR FUTURE COLLABORATION

The Constitution of the Kingdom of Cambodia, the Law on the Prevention and Control of HIV/AIDS, and the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia constitute the framework for all activities of the Government of Cambodia, including those which refer specifically to HIV/AIDS and the monastic orders. This framework defines the mandates of the various agencies of the State and sets the parameters within which legislation, policy-making and implementation take place.

There are no government policies banning Buddhist organizations from working on reproductive health and HIV/AIDS issues. Nor does Buddhism prevent monks from leaving the confines of the temples to help people in need.

In addition, the Supreme Patriarchs of the two monastic orders have spoken of the urgent and enormous need to curb the spread of the HIV/AIDS epidemic. They have been exhorting monks and nuns to provide services to their communities. All of these factors have helped to create an environment conducive to positive action in the area of HIV/AIDS prevention and reproductive health.

Supporting Efforts to Reform the Buddhist Educational System

The re-emergence of Buddhism in Cambodia presents a number of strategic entry points that could be used to

bring about greater awareness and action in the areas of reproductive health and prevention of HIV/AIDS.

One entry point is the Buddhist educational system. Assistance could be provided to the relevant ministries and to the monastic orders in mainstreaming issues such as poverty alleviation, population and development, gender equity and equality, reproductive health and HIV prevention into the new curricula. Lessons could be drawn from other programmes that have adopted similar interventions elsewhere in the world, using culturally appropriate approaches.

Integrating Reproductive Rights, Reproductive Health and Gender Concerns in All Interventions

While recognizing the small role that monks have played in UNFPA-supported programmes to date, the organization acknowledges the position that monks and their monastic orders occupy in the country, the potential force they represent and the changes they can initiate and sustain. Engaging Buddhist monks in promoting reproductive health and rights, preventing HIV/AIDS, reducing the trafficking of women, and utilizing their access to the most remote parts of the country could go a long way towards increasing the reach and effectiveness of UNFPA programmes.

For example, the HIV/AIDS Religious Response Programme that began in 2002 and is managed by the Ministry of Cults and Religions is active in nine of Cambodia's 24 provinces. The programme relies solely on the cooperation of the monastic orders and the efforts of monks and, to a lesser extent, nuns. With more than 4,000 temples and an estimated 54,000 monks, the potential reach of the programme is enormous, especially after activities are expanded to all provinces.

Precisely because of this enormous potential, it could be beneficial to collaborate closely with the monastic orders and the Ministries of Cults and Religions, Education, Health, and Women and Veteran Affairs in a series of reproductive-health and gender-sensitivity training sessions, which these structures plan to implement.

Integrating gender perspectives into the Five Precepts (which urge all Cambodian Buddhists to be faithful to their husbands and wives and to refrain from sexual harassment, telling lies and cheating, drugs and alcohol, gambling and stealing) is strategic because it would make efforts to prevent HIV/AIDS much more effective. Ensuring that the Five Precepts are gender-sensitive would not only infuse HIV messages with gender concerns but also inform the discourses of the monks as they preach to their constituents and counsel individuals and couples on HIV/AIDS prevention, care and support for people with HIV and AIDS, and efforts to diminish the stigma associated with the epidemic.

Integrating gender perspectives into community education on HIV/AIDS, behaviour change communication materials, training of trainers and other interventions will bring to the forefront the need for women to be able to make their own choices and negotiate their own terms.

Re-framing HIV/AIDS Education and Training

Preaching and counselling to stop the transmission of HIV/AIDS are often framed in moralistic judgements that tend to condemn rather than empower. In fact, such judgemental attitudes have sometimes driven a wedge between the monks and their constituents. People who want to know more about HIV/AIDS and people living with HIV and AIDS tend to see these attitudes as a barrier to seeking help.

Efforts to involve monks in HIV/AIDS have focused on activities such as raising awareness, care and support, and prevention efforts that respond to people's practical needs. The monks, however, could also be encouraged to frame HIV/AIDS within a strategic context, such as enabling women to make their own reproductive choices.

Senior monks have been advising political leaders in different periods of Cambodia's history. Monks, therefore, have the potential to serve as advocates at all levels of government for policies and programmes supportive of the UNFPA mandate.

Involving Monks on Issues Related to HIV/AIDS

The local chain of transmission for HIV/AIDS in Cambodia, as in the rest of South-East Asia, is mainly through commercial sex, and the epidemic continues to spread.[12]

Gender-based violence in Cambodia is also prevalent, which makes women extremely vulnerable to HIV/AIDS. Gender-based violence eliminates a woman's ability to negotiate safer sex, prevents her from exercising her right to refuse sex, and increases her risks of acquiring HIV/AIDS because of forced sex with partners who engage in risky behaviour.

12 Beyrer, p. 129.

Dealing with commercial sex and trafficking is an enormous problem that presents multiple entry points for cooperation, in partnership with government agencies and other power structures, such as monks and nuns, as well as with women's groups in Cambodia. Monks and nuns, for example, could be mobilized to counsel their *sangha*, those who engage in commercial sex, and brothel owners about HIV/AIDS. Together with them, they could work out arrangements to ensure the availability of condoms. The Thai experience in this area is informative.

By preaching a gender-sensitive version of the Five Precepts and by emphasizing the merits earned through non-violence, monks and nuns could prevent violence from occurring at home and assist women in seeking legal and medical help.

Under its advocacy programme, UNFPA has been working together with local NGOs and the Ministry of Women and Veterans Affairs to promote gender equity and prevent domestic violence and the trafficking of women and girls. These efforts could also be extended to the Ministry of Cults and Religion.

Research could also be initiated on monks' involvement in combating trafficking and HIV/AIDS. There is a paucity of research in this area, and evidence-based analysis and recommendations could serve as the basis for policy and programming interventions.

9 PARTNERING WITH RELIGIOUS, CULTURAL AND FAITH-BASED INSTITUTIONS IN MALAWI: AN UNDERUTILIZED FORCE IN THE FIGHT AGAINST HIV/AIDS

Religious and faith-based organizations have been on the front lines of the HIV/AIDS crisis in Malawi for nearly 15 years. Churches are a major source of health care and other social services. In addition, religious and faith-based institutions are among the only organizations in Malawi that have structures capable of reaching many rural areas. In some cases, however, these institutions have not fully understood the complicated nature of the epidemic and thus were unable to promote support for those living with HIV. This inadvertently fuelled the stigma and discrimination associated with HIV/AIDS.

Still, the faith community and traditional leaders represent a vast, largely untapped resource that must be effectively mobilized if HIV/AIDS is to be successfully combated at the grass roots. Religious, cultural and faith-based institutions have the trust and respect of their communities, which is critical in successfully promoting culturally sensitive behaviour change. Efforts to find common ground are urgently needed to address the desperate situation in Malawi. One promising approach is the development of HIV-sensitive theological training.

This case study, like that of Cambodia, looks at the potential of culturally sensitive approaches in dealing with the enormous problem of HIV/AIDS.

INTRODUCTION

According to the World Health Organization, 60 per cent of Africans seek health advice and treatment outside the public sector, including from faith-based institutions in both rural and urban areas. In Malawi, religious institutions provide an estimated 40 per cent of health services.

UNFPA assistance to Malawi, including that in the area of HIV/AIDS, has focused mainly on support to the public sector through the Ministry of Health. This chapter looks at the role of religious and cultural institutions and faith-based organizations in combating HIV/AIDS and ways in which UNFPA might expand its work with these potential partners to complement its ongoing programmes of assistance.

The research covered 10 religious institutions and faith-based organizations in rural and urban areas, representing the majority of the country's religious denominations whose operations include programmes to combat HIV/AIDS. It also covered six traditional authorities representing all three regions of Malawi. Traditional authorities are former chieftains who serve as the local government throughout the country.

MALAWI: COUNTRY CONTEXT

Malawi is one of the poorest countries in the world, with a gross national income of about $620 per capita.[1] According to UNFPA's *State of World Population 2003*, illiteracy is estimated at 26 per cent for males and 53

1 UNFPA. 2003. *State of World Population 2003*. New York: UNFPA.

SELECTED INDICATORS: MALAWI

Total population, 2003	12.1 million
Average population growth rate, 2000-2005	2.0%
Life expectancy for females	37.7 years
Life expectancy for males	37.3 years
Total fertility rate, 2000-2005	6.1
Births with skilled attendants	55%
Contraceptive prevalence for women aged 15–49, modern methods	26%
Contraceptive prevalence for women aged 15–49, any method	31%
Infant mortality per 1,000 live births	115
Maternal mortality ratio per 100,000 live births	1,936
Illiteracy rate for females over 15 years	53%
Illiteracy rate for males over 15 years	26%
HIV/AIDS prevalence rate for females 15–24 years	14.9%
HIV/AIDS prevalence rate for males 15–24 years	6.35%
Gross national income per capita (PPP$), 2001	$620
Access to safe water	52%

Source: UNFPA, State of World Population 2003.

per cent for females over the age of 15, which has contributed to poverty and underdevelopment. (Malawi ranks 162 out of 175 countries on the gender-related development index, according to UNDP's *Human Development Report* 2003). Agriculture is the backbone of the economy, employing 85 per cent of the population and accounting for more than one third of the country's gross domestic product.

About 80 per cent of Malawians are Christian; 13 per cent are Muslim; 5 per cent subscribe to traditional African religions; and 2 per cent are Hindu or other faiths.

Churches are vocal and influential on matters ranging from politics and policy to health and development, and they command a faithful following countrywide. Collectively, they have an infrastructure that is even more vast than that of the Government, covering every district, town and village in the country, and functioning as a source of education, health, agricultural and financial information and service delivery.

HIV/AIDS in Malawi

The first confirmed case of HIV infection in Malawi was in 1985. Since that time, cases have been steadily rising. According to 2001 figures from UNAIDS, the HIV prevalence rate is 14.9 per cent for females between the ages of 15 and 24 and 6.35 per cent for males in the same age group.

HIV in Malawi is spread primarily through heterosexual sexual relations (90 per cent), mother-to-child transmission (8 per cent) and other modes (2 per cent), including blood transfusions and body piercing, according to the country's National AIDS Control Programme.

Mother-to-child transmission is responsible for the majority (90 per cent) of HIV-positive children in the country. The virus is passed on mainly at birth and through breastfeeding, which is culturally the most accepted and practised form of infant feeding.

The highest risk group is between the ages of 15 and 30, which accounts for approximately 40 per cent of all new reported cases. Among new cases, four young girls aged 15-19 are infected for every boy in the same age group. In the 20- to 24-year-old age group, three women are infected for every man. This pattern indicates "age-mixing", or sexual relations between older men and younger women. After age 30, new cases of infection are primarily among men.

AIDS is the leading cause of death in the 15- to 49-year-old age group, and the most affected population is between 15 and 24 years old. Life expectancy has declined significantly in recent years and currently averages 37 years, compared to 65 years 15 years ago. The World Bank estimates that, by 2005, at least a quarter and up to a half of professionals in urban centres in Malawi will die from AIDS.

As in other African countries, the number of people living with HIV is grossly underestimated due to limited access to medical facilities and HIV testing centres, inaccurate diagnoses and the fact that many cases are never reported. It is generally estimated that for every reported HIV case, 10 have gone unreported. Therefore, in 1996, the Ministry of Health and Population, at the recommendation of the National AIDS Control Programme, decided that symptomatic diagnoses of HIV/AIDS would be sufficient for official records.

Why HIV/AIDS Continues to Spread

Although recent surveys indicate that nearly all Malawian men and women are aware of HIV/AIDS, this is not sufficient to prevent its spread. Contributing factors in the spread of HIV include the hidden nature of HIV, cultural beliefs and practices, political change and the devastating effects on the society as a whole.

Hidden Nature of HIV

Because the onset of AIDS can take as long as 8 to 10 years after infection with HIV, many people overlook the threat of death and tend to their more immediate needs. During this incubation period, people look and feel normal, even though they can infect others.

Cultural Beliefs and Practices

Deeply rooted customs and practices in Malawi have facilitated the spread of HIV, including polygamy, widow inheritance, initiation rites, "hyena" culture,[2] last death rites, circumcision and the application of healing, love and prosperity charms. The latter are used, for example, by a woman who wants her husband's undivided love and gets charms from a traditional healer. The condition for the charm's effectiveness, however, could be engaging in sexual relations with the traditional healer. If a family is having difficulty in childbearing, they could engage the services of another member of the hyena society to have sexual intercourse with the woman at night. In some communities, youth are trained to engage in sexual relations when they reach a certain age and are encouraged to practise what they learn. These customs have unwittingly exposed many people to HIV.

Political Change

Although HIV has been present in Malawi for nearly two decades, the recent transition of the Government to a multiparty democratic system and the opening of trade borders have opened the country to regional business and travel. It has also exposed travellers to cross-cultural sexual relationships. At the same time, democracy has brought with it a greater awareness of human rights and freedom. Greater freedom and openness today have also brought an increased risk of HIV/AIDS and other sexually transmitted infections.

No End in Sight

HIV/AIDS has affected every aspect of life in Malawi. Households have lost their breadwinners and been emotionally shattered by the ordeal; communities have lost their leaders and their most productive members; the Government has lost its most educated officials. Churches and other religious institutions have lost their leaders as well as members of their congregations. The labour force has been decimated, and the use of child labour is on the rise. Productivity is low due to AIDS-related illnesses. The health sector is being strained as it tries to respond to the crisis, and the number of children orphaned by AIDS is increasing at an alarming rate. Malawi's development goals have been set back by at least 30 years.

HIV in Malawi has reached epidemic proportions with no end in sight. If the situation is going to get better, major institutions, including governmental, non-governmental, faith-based and cultural organizations need to be mobilized to create a collective, coordinated and scaled-up response.

THE ROLE OF RELIGIOUS INSTITUTIONS IN THE HIV/AIDS CRISIS

The arrival of Arab merchants and the British in Malawi brought with them Islam and Christianity, respectively. The famous missionary David Livingstone is one of the fathers of Christianity in Malawi. The early Christian missionaries not only spread their religion but also provided social services such as schools and hospitals. Christian churches grew quickly and, in some cases, were looked upon more as vehicles for modernization than as spiritual entities. To this day, religion in Malawi, especially Christianity, has a strong service and development dimension. Christian churches and organizations in Malawi boast over 159 health facilities, 200 schools, numerous successful businesses, farms, recreational facilities and a myriad of churches. The clergy are respected and highly esteemed members of society. Apart from providing

2 Refers to a custom in which a male takes on the role of having sexual intercourse with different women as a way of meeting certain needs, such as childbearing or initiating adolescents into womanhood.

services, churches also play a major role in policy-making and in influencing the political direction of the country.

Faith-based organizations and religious institutions are actively involved in many HIV/AIDS-related activities across Malawi, but face considerable challenges, obstacles and limitations.

The Present Situation: Activities by Faith-based Organizations

Sensitization

Increasing awareness about HIV/AIDS has been a major activity of faith-based organizations for nearly 15 years. As the number of church members and clergy contracting HIV increased, faith-based organizations had no alternative but to respond to the crisis. Sensitization is still concentrated on explaining what HIV/AIDS is, how it spreads and how to respond to those who are HIV-positive. This has taken place through religious meetings, personal interactions, radio programmes and the distribution of booklets and flyers.

Sensitization efforts carried out by faith-based organizations have been heavily oriented towards abstinence education. Issues such as condom use, as another component for HIV prevention, have to a certain extent been ignored, limiting the impact of sensitization efforts.

Diagnosis and Treatment

Forty per cent of the Malawian population depend on faith-based organizations for their health care. Through more than 159 facilities countrywide, the Christian Hospitals Association of Malawi has been dealing with HIV/AIDS since the crisis began and continues to offer HIV testing and counselling and treatment of AIDS-related illnesses.

Home-based Care

Faith-based organizations have been at the vanguard of providing home-based care for people living with HIV and AIDS. Through numerous churches and mosques, communities have mobilized to show their compassion and care for the sick. This care has consisted mainly of counselling, prayer and moral support, the creation of income-generating activities and the provision of basic medicines. Because most health facilities are filled to capacity and are too expensive for many individuals, home-based care has been a viable alternative. Family, church and community members are given basic training in caring for the sick and are encouraged to do so in their communities. Community and church committees have been set up to ensure that the programmes run smoothly and continue to function effectively.

Targeting High-risk Groups

Religious institutions involved in fighting HIV have targeted high-risk groups, including young people and women, in an effort to reduce the spread of HIV (see box below).

Orphan Care

The number of children orphaned by AIDS in Malawi exceeds 300,000, and some 60,000 children are HIV-

HIGH-RISK GROUPS TARGETED FOR PREVENTION EFFORTS

Young people are considered the group at highest risk of contracting HIV and have been targeted for sensitization. Churches and other faith-based groups have organized youth clubs, drama groups and musical events to educate young people on HIV and how it can be avoided. Young people have been encouraged to take over the running of such programmes. Young people who have already made up their minds to live responsible sexual lives are positively influencing their peers.

Women are becoming aware of HIV/AIDS and how it can be avoided through programmes by the women's guild and women's ministry. Older women are encouraging younger women and adolescents to avoid risky sexual behaviour. The Adventist Development & Relief Agency and the PREM-HIV project of the Upper Room Ministry have initiated a promising new programme to make women aware of their sexual rights and how to exercise them.

Soldiers, policemen and prisoners are at high risk of contracting HIV due to their lifestyles and the communities in which they live. Many of them have already died of AIDS. The Adventist Development & Relief Agency and the Salvation Army have been working in army barracks and prisons, respectively, to reduce the spread of HIV. The primary thrust of these activities has been to awareness-building and encouraging positive behaviour change.

positive. Since HIV/AIDS is sexually transmitted, there is the likelihood that if one parent dies of AIDS, the other will also, leaving their children at the mercy of the extended family. The number of child-led households is also increasing. Out of necessity, faith-based organizations have been forced to deal with the crisis and, in some instances, have established orphanages that provide shelter, medical care, food, clothing and education. The majority of faith-based organizations, however, have chosen to integrate orphans within their extended families while providing for some of their basic needs. Four faith-based organizations in Malawi are running orphanages and at least 15 are caring for orphans within the extended family.

Neither solution is ideal, however. Orphanages effectively remove children from society and have other disadvantages, which are well known to policy makers. Most of these institutions are overcrowded, underfunded and lacking in qualified medical personnel. Nevertheless, in some cases, they are the only option. Placing orphans within the extended family also has its downside, since children are often exploited as domestic workers or exposed to sexual harassment. Many are denied education, decent clothing and health care.

Developing Theological Curricula that are HIV-sensitive

Most theological curricula were formulated well before the HIV/AIDS crisis. As a consequence, stigma against those with HIV/AIDS emanates from some religious concepts in the theology of many religious and faith-based institutions. Organizations such as World Relief and the Assemblies of God have begun setting up fora that are working towards the creation of theologies that are HIV-sensitive and that will help to neutralize the stigma that often accompanies HIV/AIDS.

Training Clergy

As the spiritual leaders of their community, priests, pastors, sheikhs and other religious teachers must be involved if activities related to HIV/AIDS are to be effective. As a start, clergy are being sensitized and trained in HIV/AIDS-related issues. Workshops, seminars and conferences have been organized and facilitated by faith-based organizations in an effort to get more clergy involved in the prevention and mitigation of HIV/AIDS.

This approach has demonstrated its limitations. Workshops and seminars have been relatively few and have been carried out mostly in urban centres. Moreover, in many cases, the training still reflects aspects of religious intolerance that only serve to further the stigmatization associated with HIV/AIDS. An estimated 65 per cent of the clergy in Malawi are still poorly informed about HIV/AIDS.

Using Mass Media

Religious institutions have adopted the mass media in their communications about HIV/AIDS. The Adventist Development & Relief Agency, Muslim Association of Malawi and the Catholic Development Commission, for example, have produced numerous radio programmes that are aired throughout the country. In addition, churches have produced booklets, magazines and flyers through which they disseminate a wealth of information to their congregations and the community at large. The Assemblies of God AIDS Response Programme, Catholic Development Commission and the Adventist Development & Relief Agency have carried out large-scale distributions of booklets and flyers on HIV/AIDS-related topics.

One constraint in this area is that the number of radio programmes produced so far has been limited. The programmes are generally short, in the format of talk shows, and do not provide comprehensive coverage of the issues.

Collaborating with Cultural Leaders and Traditional Healers

Most religious institutions have isolated themselves from cultural leaders and traditional healers. The PREM-HIV Project of the Upper Room Ministry is the only faith-based organization in Malawi to date that has developed a strategy and framework that targets cultural leaders and traditional healers. The project has just concluded its pilot work in the Mwanza district and is getting ready to launch activities in three regions of the country under the rule of traditional authorities. The programme begins by sensitizing leaders and communities on the issues, evaluating traditions and customs that could facilitate the spread of HIV, and initiating change, starting with local leaders. It is also working to educate women on their sexual rights, involve youth in rural areas to fight HIV and mobilize the community to respond to the plight of orphans and people living with HIV and AIDS.

Forming an Interfaith State Task Force on HIV/AIDS

Inspired by the National AIDS Commission, the faith-based community in Malawi has set up a task force to fight HIV/AIDS. The task force includes representatives from most Christian denominations and Muslim communities in the country and aims at streamlining efforts to fight HIV/AIDS nationwide.

Constraints Facing Faith-based Organizations

Lack of Medical Supplies and Hospital Beds

Although the Christian Hospitals Association of Malawi has established more than 150 health facilities countrywide, additional beds and medical supplies are needed for the growing numbers of AIDS patients, many of whom end up sleeping on the floor in hospital corridors.

Shortage of Trained Personnel and Volunteer Counsellors

The Christian Hospitals Association of Malawi has carried out training for some staff members but still lags behind in training the majority of its personnel, especially in areas such as counselling. As doctors and other medical personnel are often too busy to carry out counselling, the Association has had to depend on poorly trained volunteers.

Increased Exposure of Medical Personnel to HIV Infection

Over the years, many staff at the Christian Hospitals Association have died of AIDS as a result of HIV infections acquired while treating infected patients. Still, few hospitals have functioning infection-prevention committees, which are vital in controlling the spread of the virus. Most staff members have not been trained in infection prevention, and needed supplies are scarce. Sterilization equipment in most facilities has broken down, and there are no funds for replacement.

Limited Human Resources and Long-term Funding

Most religious institutions and faith-based organizations operate with skeleton staffs that, in most cases, are unable to carry out the mandates of the organizations satisfactorily. Those AIDS-related projects that do exist are also short-staffed, diminishing any potential impact the project might have. In addition, many of the newer projects, such as the PREM-HIV project of the Upper Room Ministry and the Assemblies of God AIDS Response Programme, lack sufficient and sustained funding, despite ambitious goals.

Stigmatization

Most faith-based organizations and religious institutions still view HIV/AIDS only from a moral perspective. This has resulted in the condemnation and rejection of the afflicted, and denial on the part of many that HIV/AIDS is on the rise. Although many faith-based organizations and religious institutions are making progress in this area, religious organizations still have a long way to go to reverse the discriminatory practices that they have helped to build up over the years.

The Condom Issue

The issue of condoms has been a source of heartache and conflict for religious organizations, which believe that the distribution of condoms is unacceptable because condoms encourage promiscuity and do not provide 100 per cent protection. The stance on condoms has resulted in criticism and rejection of religious organizations by the Government and some NGOs, making their work more difficult.

Profiling of Faith-based Organizations

Most faith-based organizations and religious institutions involved in HIV/AIDS prevention and care feel that they have been marginalized to a large extent by the Government and NGOs. Many international organizations regard faith-based organizations as extremist and untrustworthy, which has discouraged religious institutions and hindered the formation of long-term partnerships. The result is that many faith-based organizations have carried out their work without due attention and recognition. For the most part, faith-based organizations partner with international religious institutions of the same faith or denomination. In some cases, they are met with resistance in their search for partners and funding because of their stance on condoms.

COMBATING HIV/AIDS IN RURAL COMMUNITIES

Malawi is divided into 28 administrative districts. These districts all have traditional authorities, or former chieftains, who serve as the local government throughout the country. Every community falls under a traditional authority and has a village headman who represents that authority in the community. The traditional hierarchy in Malawi has a paramount chief, followed by traditional authorities who, in turn, reign over group headmen and, lastly, village headmen. The paramount chiefs sit on the chiefs' counsel as independent and autonomous representatives of their people.

In some areas governed by these traditional authorities, as many as a quarter of the population are estimated to be living with HIV or AIDS. Polygamy is common, and literacy rates are low. Although travel between rural and urban areas is common, the sick usually return to rural areas where it is less expensive to live, bringing the virus

with them. In general, traditional leaders have found that HIV has created problems for them that they are unprepared to handle. The number of orphans is steadily rising, and communities do not know how to respond appropriately. HIV/AIDS has also diminished productivity in rural communities; the sick are unable to work and many of those who are healthy are taking care of others.

Sensitization

Rural communities are aware of HIV/AIDS but lack basic information about how to prevent the disease. The information they do receive is mostly through a few radio programmes about HIV/AIDS that are limited in their coverage. Most NGOs and government efforts have been concentrated in urban areas where prevalence rates are higher; consequently, most rural areas have been neglected altogether. Exceptions are the Banja la mstogolo clinics, which have played a remarkable role in disseminating information about HIV/AIDS, especially among women.

Efforts by Traditional Authorities

The traditional authorities surveyed are generally well informed about HIV/AIDS but are not seriously involved in efforts to combat it. Their role is confined largely to attending court cases and funerals and collaborating with the Government on development initiatives.

Efforts by Religious Institutions

Few faith-based organizations are working on a continual basis in rural areas, with the exception of the Christian Hospitals Association of Malawi, World Relief, the PREM-HIV project of Upper Room Ministry, Church of Central Africa Presbyterian, Adventist Development & Relief Agency and the Catholic Development Commission. These religious institutions are carrying out sensitization campaigns, home-based care programmes and providing health services. Only the PREM-HIV project of the Upper Room Ministry targets traditional leaders, traditional healers and elders in society, who are essentially responsible for the preservation and propagation of cultural beliefs and customs.

Constraints in Rural Areas

Cultural Limitations

Over the years, increasing literacy levels in urban centres have left rural communities—specifically the traditional authorities, cultural leaders and traditional healers—as the custodians of culture and traditional practices. Such practices developed well before sexually transmitted infections were common or even known. Consequently, many of these practices include sexual activity with persons other than one's spouse. Customs such as the initiation of girls into womanhood involve sexual activity with older males, which today increases the risk of HIV infection.

Stigmatization

The culture of silence that surrounds sexuality has made the collection of data in rural communities an illicit exercise. People consider it taboo to talk about sexuality; hence, they avoid the issue that is at the core of the HIV epidemic in their country. The stigma associated with HIV/AIDS has meant that those who are living with HIV or AIDS are considered social outcasts. This has discouraged people from being tested for HIV and drives the epidemic further underground. Women who are infected with HIV have suffered more than their male counterparts. They tend to be ostracized by society and in the end move away from communities that are known and familiar.

The Condom Issue

Most rural communities oppose the use of condoms. For a start, the methods often used in distributing condoms have been culturally insensitive. Condoms have been given to anyone, anywhere. As a result, condoms have ended up in the hands of young children who use them as toys, or in the hands of adolescents, who regard them as a license for sexual relations. Many community leaders feel that condoms have increased the spread of HIV because they give users confidence in their safety that is not real. At the same time, male members of society maintain that a use of condoms is like "eating a sweet while it is still wrapped". This has discouraged many of them from using condoms. Rural community leaders are looking for other solutions to prevent the spread of HIV.

UNITED NATIONS SUPPORT TO RELIGIOUS AND FAITH-BASED ORGANIZATIONS

The Joint United Nations Programme on HIV/AIDS, or UNAIDS, was created to coordinate the efforts of many United Nations agencies in the fight against the epidemic, and is doing so in Malawi. In that country, UNAIDS serves as a clearinghouse for information and a source of educational material to other United Nations agencies, interested NGOs and religious institutions. UNAIDS has also been working with the National AIDS Commission and the Ministry of Health and Population in policy-making and implementation. Through the Interfaith State Task Force on HIV/AIDS, UNAIDS is encouraging further dialogue and collaboration between the Government and religious

institutions as they try to bridge the gap between them. It has also been actively involved in initiating and encouraging a behaviour change strategy that targets high-risk groups. In this initiative, UNAIDS has worked with faith-based organizations such as World Relief.

The Role of UNFPA

Over the years, UNFPA has had some involvement with faith-based organizations and religious institutions in the fight against HIV/AIDS. Although the Government of Malawi is the primary partner of UNFPA, individual faith-based organizations and religious institutions have approached the UNFPA Country Office and have been assisted where possible, mostly on a short-term basis. UNFPA assistance has included the following:

- The Scripture Union of Malawi received support for the training of 50 church elders from different denominations on sexual and reproductive health, with an emphasis on adolescents and HIV/AIDS. The goal was to empower church elders to guide youths safely into adulthood;
- The renovation of a health facility in Zenza was funded, sponsored by the Christian Hospitals Association of Malawi;
- An ambulance was donated to St. Luke's Hospital in Mangochi for a safe motherhood initiative;
- The Catholic Development Commission was funded to produce posters aimed at increasing awareness of HIV and reducing social stigma. The Commission is currently receiving funding to develop a gender-sensitive policy for the Catholic Church;
- A fellowship was funded for a staff member of the Christian Council of Malawi to undergo training in gender issues;
- The Fertility Awareness Support Unit of the Catholic Church was funded for the production of materials about reproductive health, enabling its director to attend a seminar on reproduction in Spain; and
- A project in Mzimba is being carried out called "Men, Culture and AIDS Project", which is addressing men's sexuality from a cultural perspective.

WHAT LESSONS CAN BE DRAWN?

- ***Faith-based organizations have come a long way since 1985 in helping to care for the spiritual, material and physical needs of those affected by HIV/AIDS.*** Moreover, this support is growing. In the last five years alone, at least 40 religious institutions have begun responding to the HIV/AIDS epidemic on a national and local level. The potential to expand this support through carefully formed partnerships is enormous.
- ***Religious institutions and churches, in particular, have a large infrastructure throughout the country.*** Their long presence in the country means that they can serve as a permanent partner to the Government and NGOs in fighting the epidemic. The humanitarian and service-oriented nature of most religious groups means that religious institutions are usually the best providers of volunteers and HIV/AIDS workers. Yet despite these strengths, religious institutions have been marginalized by other organizations working towards common goals. The opposition of religious institutions to condom use, in particular, has caused many organizations to turn a deaf ear to their efforts. Although the Interfaith State Task Force on HIV/AIDS has made some progress in bridging this gap, their efforts still have a long way to go in bringing about fruitful partnerships.
- ***Many religious clergy are well educated, well organized and capable of carrying out tasks to international standards.*** Some members of the clergy have training in fields such as medicine, law, social work and banking, giving them a professional edge in their approach to HIV/AIDS that could be used to greater advantage.
- ***Religious institutions are working in partnerships mainly with other faith-based organizations.*** This has limited the funding that is available to them and kept their efforts out of international view. Some religious institutions have been able to tap funding from sister organizations abroad, usually within the same denomination. Those without international connections have been forced to raise funds from the meagre resources available within Malawi.
- ***Some religious organizations are on the cutting edge of creating communities that are highly sensitive to HIV/AIDS.*** This is being carried out mainly through changes in theological curricula. For many institutions, this represents a large risk.
- ***In other cases, missionaries and top religious leaders have frustrated the desires and efforts of individual***

congregations to respond in a constructive way to the HIV/AIDS crisis. Even though local congregations have voiced their concerns, and money has been available, their efforts have been thwarted.

- ***Stigma is still very high among those in religious circles and in rural areas.*** Individuals do not talk freely about the disease. Even when people die, the community is often told that the cause of death was something other than AIDS. People living with HIV and AIDS are being rejected and, in some cases, viewed as burdens to society. Although people, for the most part, are caring for and accepting them, they are still subject to discrimination.

- ***The majority of religious institutions are concentrated in the south and central regions; HIV/AIDS-related efforts in the northern part of the country are scarce.*** Moreover, the work of religious organizations is concentrated in urban centres, in part because funds for HIV/AIDS projects are more readily available there. Rural communities desperately need long-term projects to fight HIV/AIDS, where the epidemic is spreading rapidly.

- ***Religious institutions and NGOs have generally ignored cultural institutions and traditional healers. As a result, traditional authorities lack specific programmes and activities to create awareness about HIV/AIDS in their communities.*** Nor are traditional authorities usually well informed themselves. The efforts by the PREM-HIV project to reach cultural institutions and traditional healers have been slow and are still a long way from realizing their desired objectives.

- ***Some traditional customs are still exposing people to the risk of HIV infection.*** Although some of these harmful practices have been discouraged, programmes are not in place to eliminate them permanently in communities.

- ***Over the past several years, the Government and NGOs have distributed millions of condoms in Malawi, but HIV infection and prevalence rates have continued to soar.*** Most community and religious leaders feel that the distribution of condoms should be reduced if not abolished. Or, if they are given out, distributors should be provided with strict guidelines on their use.

- ***The distribution of condoms has not been welcomed by rural and religious communities.*** In part, this is because those who have received them have not been educated in their use. In addition, condom distribution is thought to have increased promiscuity. The cultural roots of religion and tradition appear to be far stronger than many of the modern ideas and practices that are now being introduced in African communities without an understanding of the local context. In addition, although many people profess to be Christian or Muslim, many of them hold steadfastly to traditional practices.

ENTRY POINTS FOR FUTURE COLLABORATION

- ***Pioneering partnerships with religious institutions in their efforts to prevent and mitigate the impact of HIV/AIDS in Malawi.*** The comparative advantages are clear: UNFPA and other international organizations could bring their wealth of experience and resources while religious institutions could provide the human resources, vast infrastructure and credibility among their followers. Religious institutions should be given attention and support that is proportional to their size and capacity and treated as equal partners in defeating HIV/AIDS. To be avoided at all costs are attitudes that might be perceived as patronizing.

- ***Providing technical support to clergy and churches in their efforts to create an HIV/AIDS-sensitive theology.*** Such support could yield a new generation of teachers and leaders who could be instrumental in defeating HIV/AIDS.

- ***Partnering with religious and faith-based institutions that are working in rural communities,*** especially in the northern region of the country.

- ***In the case of numerous indigenous Pentecostal churches, working with the larger umbrella institutions,*** such as the Pastors Fellowship, Evangelical Association of Malawi, Malawi Council of Churches and other groupings. This would help to ensure accountability while filtering support to numerous smaller, community-based churches.

- ***Reviewing the effectiveness of condom distribution in preventing HIV in Malawi*** and coming up with methods of distribution that are more effective and culturally sensitive among religious and rural communities.

- ***Increasing support to the Christian Hospitals Association of Malawi to increase their capacity and replenish***

medical supplies. Urgent support is also needed to limit the spread of HIV among patients and hospital staff.

- ***Establishing partnerships with cultural and religious institutions in Malawi to alter customs, beliefs and traditional practices that are contributing to the spread of HIV.*** A strategy for working with these institutions to initiate cultural change needs to be devised and shared with United Nations organizations, the Government and NGOs.

- ***Encouraging collaboration among religious and cultural institutions and traditional healers to promote behaviour change and address harmful traditional practices that contribute to the spread of HIV/AIDS.***

- ***Supporting faith-based organizations that are willing to work among traditional healers and traditional African religious groups.***

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