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Brianna Backes Date

Leveraging the power of religious leaders to promote family planning:
Evidence from a CARE reproductive health project in Chad

By

Brianna Backes
Master of Public Health

Hubert Department of Global Health

_____

Roger Rochat, M.D.
Committee Chair

_____

Jean Jose Nzau, M.D.
Committee Member

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By

Brianna Backes

Bachelor of Arts
University of Wisconsin, Madison
2013

Thesis Committee Chair: Roger Rochat, M.D.

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Abstract

Leveraging the power of religious leaders to promote family planning:
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Brianna Backes

Background Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAFPAC) has supported governments in Sub-Saharan Africa by integrating essential sexual and reproductive health services into new and ongoing humanitarian emergencies since 2011. SAFPAC's work in Chad aims to reduce unintended pregnancies and deaths from unsafe abortion. A key component of the SAFPAC project's community engagement strategy is to engage religious leaders in committees in order to transform restrictive social norms around modern contraceptive use and access to post-abortion care. This evaluation seeks to document the unique aspects of SAFPAC's experience engaging religious leaders in Chad.

Methods We conducted a thorough desk review of program documents and publications. We also synthesized key themes and identified guiding questions to inform key informant interviews and open- ended surveys with leadership from CARE Chad and CARE USA (N=17).

Results SAFPAC put actions in place to expand on motivations and overcome barriers to family planning and PAC support, which resulted in religious leader committees impacting their communities as agents of social change. Key strategies included: 1) Increasing knowledge and technical skills in reproductive health; 2) Investigating religious texts and traditions through participatory dialogue; 3) Creating interfaith committees guided by consistent supportive supervision; and 4) Linking religious leaders with the health system.

Conclusion Community engagement approaches, like SAFPAC's strategy in Chad, that leverage religious leaders of different faiths to support family planning and post-abortion care are a key strategy for challenging restrictive norms and informing behaviors to increase contraceptive uptake in crisis- affected settings, like Chad. Religious leaders are trusted and respected in communities, and thus have the ability to promote or prohibit reproductive health access. Further research is needed as to how religious leaders can be transformed from prohibitors to promoters of sexual and reproductive health and rights.

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I am grateful to all the members of the Sexual and Reproductive Health and Rights (SRHR) team at CARE USA, especially Dora Curry, Jesse Rattan, Feven Tessaw, Erin Dumas, and Elizabeth Noschesky for their participation and guidance in compiling and editing this thesis project.

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Table of Contents

Acronyms

CE	Community Engagement
CHWs	Community Health Workers
CPR	Contraceptive Prevalence Rate
DRC	Democratic Republic of Congo
FBO	Faith-Based Organization
FP	Family Planning
GBV	Gender-based Violence
HTSP	Healthy Timing and Spacing of Pregnancies
IUD	Intrauterine Device
IGAs	Income- Generating Activities
LARC	Long-acting Reversible Contraceptives
PAC	Post-Abortion Care
RLs	Religious Leaders
RLC(s)	Religious Leader Committee (s)
SAA	Social Analysis and Action
SAFPAC	Supporting Access to Family Planning and Post Abortion Care
SBCC	Social and Behavior Change Communication
SEM	Socio-Ecological Model
SRHR	Sexual and Reproductive Health and Rights
VCAT	Values Clarification and Attitudes Transformation
WASH	Water, Sanitation and Hygiene

Introduction

Chad has faced many barriers to increasing women's access to quality reproductive health services, including an ongoing humanitarian crisis, frequent and consistent stockouts, and limited domestic resources allocated to family planning (FP) (FP 2020, 2018). In 2015, the modern contraceptive prevalence rate was only 5%, while the unmet need for FP was 18.6% (DHS, 2015). Nevertheless, the Government of Chad hopes to double women's contraceptive uptake and has committed to increasing modern contraceptive utilization to 8% by 2020 (FP2020, 2018).

In line with CARE's commitment to the needs and rights of women and girls, Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAFPAC) supports governments by integrating essential sexual and reproductive health services into new and ongoing humanitarian emergencies. SAFPAC's work aims to reduce both unintended pregnancies and deaths from unsafe abortion in these settings. Currently, SAFPAC focuses on four countries with critical needs - the Democratic Republic of the Congo (DRC), Mali, Nigeria, and Chad (CARE, 2018). SAFPAC is funded by an Anonymous donor and received US $27,712,672 from 2011-2015 (CARE, 2015).

SAFPAC has employed innovative strategies to increase women's knowledge and access to contraceptives. In Chad, the SAFPAC team decided to directly target religious leaders (RLs) as a key component of the community engagement (CE) strategy. Working closely with these influential community members was a way to overcome the initial reluctance of communities to talk about family planning, and the related but taboo subjects of sex and gender power. SAFPAC continues to prioritize working with RLs in Chad, namely through Religious Leader Committees (RLCs).

The goal of this evaluation is to investigate how CARE SRHR programming engages RLs using an exploration of CARE SAFPAC in Chad as a case study. For the past eight years of programming in Chad, SAFPAC has found this approach to be hugely successful. Looking at preliminary data from provinces where the RLCs are active, there is a significant comparative increase in modern contraceptive uptake. From 2011-2013, SAFPAC provided reproductive health services to 21,191 new users of modern contraceptives, where 72% of new users chose a LARC (Curry; et al., 2015). With this success in mind, this study seeks to better understand what ultimately led to the change in attitudes in the RLs and how could this approach be replicated by CARE and in other contexts to advance the sexual and reproductive rights of women and girls.

Background

Chad

Chad is a large, landlocked country (more than three times the area of California) situated in Central Africa (World Factbook, 2019). Since gaining independence from France in 1960, Chad has faced significant internal and political instability, including internal conflicts, spillover conflicts from neighboring countries, and instability due to climate change including drought and impacts on Lake Chad (World Bank, 2018). They have been involved in twelve wars; additionally, conflicts across borders in neighboring countries have resulted in a flood of refugees (over 400,000 from Sudan and Central African Republic, representing 4% of the total population) that further stress Chad's already limited resources (World Bank, 2018).

Oil and agriculture are the largest economies in Chad; oil provides more than 60% of export revenues, followed by cotton and livestock (World Bank, 2018). The discovery of oil nearly doubled Chad's GDP within 10 years (World Bank, 2018). In spite of its rich natural resources, half the population lives below the poverty line. The country is extremely vulnerable

to global oil prices, and the country was deeply impacted by the 2014 drop in oil prices. According to the World Bank, "This is reflected in cuts in public expenditure, low foreign direct investment, and a loss of income caused by the disruption of cross-border trade with Nigeria in livestock" (World Bank, 2018).

Chad is ethnically and culturally diverse. There are approximately two hundred ethnic groups; the largest of which is the Sara (World Population Review, 2018). Over one hundred languages are spoken throughout the country, with French and Arabic being the most widely spoken languages. Chad is approximately 52% Muslim, 24% Protestant (largely Evangelical), and 20% Catholic (World Factbook, 2019). Generally, the north practices Islam, while most southerners practice Christianity.

Figure 1. Map of Chad

CARE International, 2019

Reproductive, Maternal, Neonatal, and Child Health (RMNCH)

Family planning is one of the most important tools to improving maternal health and wellbeing. In 2008, contraceptive use averted approximately 44% of maternal deaths around the world (Ahmed, 2012). There are a number of reasons for this connection- contraceptive use reduces the overall number of births, including births to adolescents, consequently reducing the

overall number of maternal deaths. Additionally, contraceptives help to avert unwanted pregnancies, and thus unsafe abortions- a huge contributor to maternal mortality globally (Ahmed, 2012).

At 6.4, Chad has the second highest total fertility rate (average births per woman over their lifetime) in the world (PRB, 2018). Consequently, the percent of youths in the country age 15-24 is projected to more than double by 2050 (PRB, 2018). Unfortunately, health services are not adequate to meet this need; there is less than one qualified health worker per 1,000 people. Moreover, in Chad, 33 percent of children aged 12-23 months are not vaccinated against childhood diseases (UNICEF, 2018). The country also has the highest rates of malnutrition in the Sahel and West Africa region.

Women and girls in Chad are particularly vulnerable to health complications as demonstrated by poor maternal and child health outcomes. In 2015, the country had the 3rd highest maternal mortality ratio in the world, at 856 deaths per 100,000 live births (UNFPA, 2019), and only 20% of all births are attended by skilled personnel (DHS, 2015). Moreover, more than half of young women age 20-24 gave birth to their first child before age 18, and adolescent birth rate is 179 per 1,000 women aged 15 to 19. (DHS, 2015). Notably, a government report in Chad estimated that, at nearly 19%, abortions were the most common cause of obstetric complications (Le Breton & Orengo, 2012). Unmet need for modern family planning among women married or in a union is 24% (UNFPA, 2019), nearly five times the contraceptive prevalence rate in 2015 (DHS, 2015). Chad also has a high infant mortality rate at 123.2 per 1,000 live births (UNICEF, 2017).

In late 2015, the government imposed a state of emergency in the Lake Chad region following multiple attacks by the terrorist group Boko Haram (World Bank, 2018). Because of

the impact of instability on sexual and reproductive health outcomes, Chad remains one of the priority countries in CARE's Supporting Access to Family Planning and Post-Abortion Care (SAFPAC) project.

CARE International

Since 1945, CARE has delivered emergency relief and long-term international development projects around the world (CARE, 2019). It is one of the largest and oldest humanitarian aid organizations focused on fighting global poverty and promoting gender equality. Today, CARE works around the globe to save lives, defeat poverty and achieve social justice. CARE has three priority focus areas: the rights and empowerment of women and girls, resilience and adaptation to climate change, and humanitarian assistance (CARE, 2019).

Sexual and Reproductive Health and Rights (SRHR)

CARE International aims to support 100 million women and girls to exercise their right to sexual, reproductive and maternal health by 2020 (CARE, 2019). CARE's work is embedded in human rights principles, including the right to reproductive self-determination and bodily integrity. CARE's SRHR programming seeks to create the conditions – personal, social and structural - that enable all individuals to realize these rights (CARE, 2019). Evidence and learning from SRHR projects are used to influence policy change and scale up effective solutions.

The SAFPAC Project

In Chad, CARE has implemented emergency and development programming since 1974 (CARE Chad, 2018). They have a head office based in the capital city of N'djamena. CARE programs in Chad have a focus on: providing humanitarian assistance, water, sanitation and hygiene (WASH), psychosocial support and gender-based violence (GBV), and integration of

Chadian refugees from neighboring countries. The country office also seeks to improve reproductive health access, mostly through the SAFPAC and other projects.

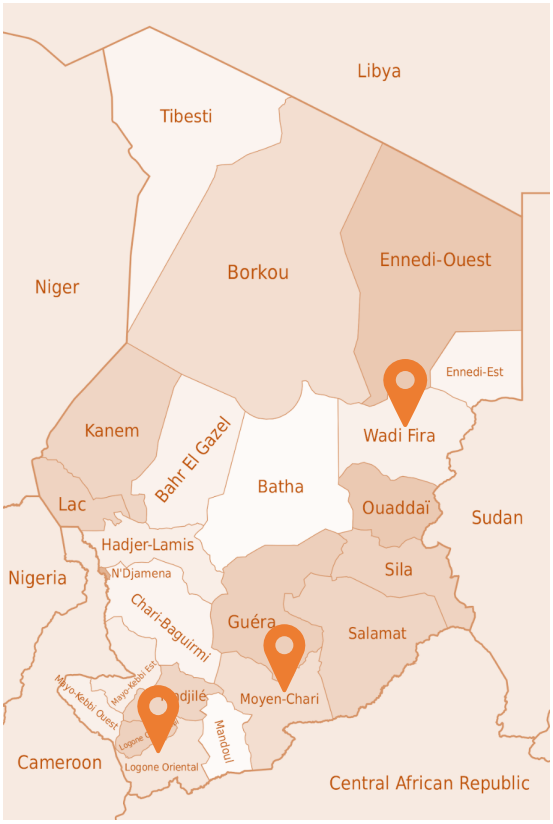
CARE's SAFPAC program furthers their commitment to the rights and needs of women and girls around the world with programs set up in Chad, Mali, Nigeria, Pakistan, Djibouti, and the Democratic Republic of the Congo. The SAFPAC project was first implemented in Chad in 2011 and supports 14 health centers across three main sites. SAFPAC aims to, "build CARE's organizational leadership and capacity to support provision of family planning (FP), post-abortion care (PAC) and reproductive health services in emergencies, all while improving access to and quality of FP and PAC services in emergency-affected settings" (CARE, 2019). The initiative focuses on improving voluntary access to highly effective, easy-to-use long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and implants.

The CARE staff team in Chad includes a project manager, a coordinator for each district, a clinical training coordinator, a clinical officer who leads supportive supervision, in collaboration with government management, and a community mobilization and behavior change communication officer. All SAFPAC services and commodities are provided free to the local communities, and health workers are trained by the project team in counseling and clinical aspects of reproductive health services.

The SAFPAC project is timely for the context in Chad. As aforementioned, sexual and reproductive health context in Chad is severely challenged. In the communities where SAFPAC is active, misconceptions, rumors, and cultural and religious beliefs regarding sexual and reproductive health are prominent; women and girls often have limited access to correct information (SAFPAC, 2017). There are, moreover, limited mechanisms or capacity to hold government systems accountable to the communities they serve (Le Breton & Orengo, 2012).

These communities, especially the vulnerable women and girls, are rarely equipped to challenge hierarchical social power relations and advocate for their sexual and reproductive health rights (SAFPAC, 2017).

Figure 2. Map of CARE SAFPAC Project in Chad



RGPH2, 2009

Target Population

SAFPAC aims to increase the access women and girls of reproductive age living in crisis-affected settings to quality family planning and post-abortion services (SAFPAC, 2017). With a total population of 15.8 million, there are approximately 4 million women of reproductive age in Chad (PRB, 2018). During SAFPAC Phase 1, the project in Chad specifically targeted women and girls living in the Logone Oriental and Moyen Chari provinces in Southern Chad and the Wadi Fira province in Eastern Chad. Today, during Phase 3, the SAFPAC Chad project

continues to be implemented in 45 health facilities in Southern Chad, throughout the same provinces.

In general, women and girls in these areas face a lack of accurate knowledge on reproductive health, including family planning options and the availability of reproductive health services (Le Breton & Orengo, 2012). They may also have low literacy and levels of education. According to UNICEF, 4 out of 5 girls age 15-24 in Chad are illiterate (UNICEF, 2013). This is both precipitated and fueled by societal and cultural norms, such as early marriage and female genital cutting, that negatively impact women and girls (Population Council, 2018).

Women in these districts face societal and cultural pressures to have high numbers of children. For instance, according to the most recent Demographic and Health Survey, women in Logone Oriental province have had an average of 8.3 children by age 40-49 (DHS, 2015). Moreover, women and girls in Chad may be reliant on "gatekeepers" who decide when, how, and what contraceptive services they can access. Traditional, cultural and religious practices require women to seek permission from their husbands before accessing health services (FP 2020, 2018).

Many of these women and girls are refugees fleeing conflict. Chad hosts more than 300,000 refugees. By nationality there are approximately 79% Sudanese, 18% Central Africans, and 2% Nigerians. Women make up 55.9% of the total refugee population, and nearly 60% are youth under the age of 18 (UNHCR, 2018). In addition to the psychological trauma that accompanies displacement, Amnesty International has reported on particularly high levels of sexual and gender violence faced by women and girls in Chad, especially in refugee camps (Amnesty, International, 2009).

Community Engagement (CE) Strategy

A High Impact Practice (HIP) identified by USAID as a "promising practice" is Community Engagement (CE). According to USAID, what separates CE apart from other social and behavior change (SBC) strategies, is that it works with and through existing community groups in order to influence social norms, and ultimately individual behaviors (Johns Hopkins University, 2019). A number of studies using multivariate analysis have confirmed that combining CE with other SBC and service delivery improvements can result in higher contraceptive use (Speizer and Lance, 2016).

SAFPAC defines Community Engagement (CE) as, "A holistic approach to collaborating with communities to identify and address social and gender norms that inhibit women and girls to access information, counseling, and sexual and reproductive health services" (SAFPAC, 2017). The aim of SAFPAC's CE approach is to contribute to the creation of a supportive environment that allows women and girls access to correct information and choice-based counseling so that they can make informed decisions and so that they can access sexual and reproductive health services. With this in mind, the CE approach has two principal objectives (SAFPAC, 2017):

1) To create a supportive environment that allows women and girls the rights to access correct information, counseling, and services.
2) To assist communities in breaking down barriers so that they are able to hold health care providers and decision makers accountable.

To accomplish both objectives, but especially Objective 1, SAFPAC engages and trains "influencers" in target communities to address restrictive power dynamics. In restrictive environments for reproductive health, influencers, or "gatekeepers", may be the ultimate decision

makers that control whether women are able to access contraceptive services (SAFPAC, 2017). In addition to RLs, other influencers might include husbands, mothers-in-law, traditional leaders, and/or law enforcement. SAFPAC guides these influencers through an iterative process of exploration, training, implementation, connection to the health facility, and finally, reflection.

CARE uses several approaches to accomplish CE. One notable approach is Social Analysis and Action (SAA). SAA works in communities to provide an overview of key influencers and barriers, drivers, motivators and demotivators, power dynamics, and gender dynamics. Integral to SAA is staff reflection and transforming staff values. The goal of SAA is "to catalyze a community-led change process through which community members challenge restrictive norms and act together to create more equitable gender norms as well as community support for sexual, reproductive and maternal health and rights" (SAFPAC, 2017). SAA is characterized by a cycle that begins with reflection, which leads to challenging and exploring, and finally community learning and growth. Below is a figure outlining the SAA Program cycle.

Figure 3. The SAA Program Cycle

CARE, 2007

Mobilizing RLCs

Prior to implementation, the CARE SAFPAC team in Chad conducted health facility assessments and extensive community mappings in order to determine why there was a low uptake of family planning services across the country and to evaluate challenges and opportunities. The assessments revealed that a major reason for low levels of service utilization was a lack of CE, particularly around men and male leaders.

Initial health care provider trainings launched in November 2011, resulting in a major initial increase in the number of new users. However, the SAFPAC team wanted to ensure that these improvements were scalable and sustainable. While there was not a CE strategy already written into the project grant, the team in Chad began to realize that they would need to develop a plan to increase demand in target communities.

During an SAA meeting in Chad, one community member reflected that "*We knew from the beginning that family planning would be a very controversial topic for the community, especially the religious leaders"* (SAFPAC, 2017). CARE Chad, therefore, decided to hold a meeting with RLs in target districts in order to gauge RL interest in collaborating to improve the health of women and girls. Recognizing through community mappings that RLs were a barrier to FP access and that RLs hold high levels of power and influence in their communities, the SAFPAC team ascertained that the involvement of RLs would be essential both to promote services and increase acceptability of FP in communities.

Next, CARE invited ten to fifteen RLs – Both Christian and Muslim, at least one from each catchment area of a health facility- from each target community to a three-day workshop around basic FP and communication skills. While RLs were given salaries, CARE provided each RL with a per diem to cover expenses and meals. For many of the attendees, this meeting was

their first opportunity to meet the other RLs in the community and to discuss issues that were important to their congregations. The attendees were grouped into Religious Leader Committees (RLCs) to promote family planning in their respective communities, to lead outreach activities and make referrals for FP, and to communicate with other stakeholders and provide feedback on service provision in their communities. Each RLC then developed a detailed three-month action plan about their planned activities.

After their initial recruitment, the RLC members introduced themselves to the head of their respective health facilities and to attend the facility's monthly performance review meetings. During the monthly meetings, CARE team members, providers, and community members were able to come together to review the performance of family planning services.

Looking back, the CARE Chad team found that the attendance of the various stakeholders increased the accountability of everyone involved around potentially sensitive issues. For example, RLs heard complaints from women, that they previously referred to the health center for family planning, if the women were unable to obtain quality services.

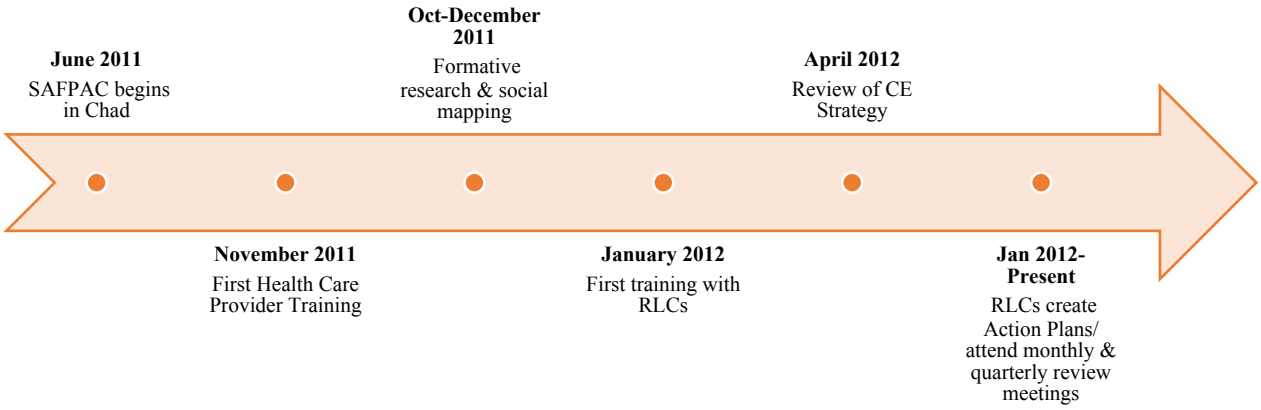
RLCs were also invited to quarterly review meetings. These meetings were facilitated by CARE and Health District staff and were attended by an even broader range of community members. Providers interfaced with leaders in their communities, including village chiefs and representatives of community organizations. During the quarterly meeting, all stakeholders discussed and reviewed reports from the past three months. The meetings spread awareness about the availability of free contraceptives and provided a space to review community health successes and challenges and to brainstorm local solutions. For instance, when a discussion revealed that electricity in one health facility was a problem, one of the RLs contributed a generator to solve the issue.

Today, nearly eight years after the first cohort of RLCs, the SAFPAC team in Chad continues to engage with RLs and sustain the committees. For the most part, the process continues to look the same. RLCs continue to engage in community mobilization activities and attend trainings. The most notable difference is that the RLCs are more diverse than they were initially; RLCs now recruit some women and young people from their congregations to join their discussions and community outreach. RLCs still attend monthly meetings and quarterly review meetings.

RLC Timeline

Phase 1 of the SAFPAC project began in Chad in June 2011. The initial budget did not include funding for community engagement. In November of 2011, the first health care provider trainings took place. The team noticed that there was not enough demand for family planning commodities. From October -December 2011, the first social mappings took place. Results from these mapping revealed that RLs held significant power and influence in their communities, and they were identified as "gatekeepers" to contraceptive access. In January of 2012, the first training with RLs took place over three days. Afterwards, the groups created three- month action plans and began participating in monthly review meetings with health care providers. They also convened at quarterly review meetings with other RLC groups by district. A CE review was conducted in April 2012, because Chad was the first SAFPAC country to institutionalize its CE strategy, including project tools, reporting, and supervision. Learnings from this review were adapted to fit other contexts and inform the final CE strategy developed in 2017 (SAFPAC, 2017).

Figure 4. RLC Formation Timeline (SAFPAC Phase 1)



Literature Review

Virtually everywhere in the world, faith and religion play an important part in family decision making. This is especially true in Sub-Saharan African countries. A poll of nineteen African countries found that 79% have confidence in religious institutions, beating out banks and financial institutions, healthcare institutions, and even media (Tortora, 2007). It was nearly double the percentage of people who had confidence in their own national governments. RLs, therefore, have a huge amount of responsibility and opportunity because they have been given a significant amount of trust by their communities (Burket, 2006).

Religion and public health do not simply operate in two individual silos; beliefs about religion influence how and when people decide to seek care (Rogers and Konieczy, 2018). Studies have shown that when reflexive partnerships are created with religious institutions, they can be huge catalysts for change (Rogers, 2018). RLs can be physical, as well as spiritual, leaders in their communities (Burket, 2006). Understanding that religion is an important part of the social fabric of society and exploring religious positions on sexual and reproductive health is critical to developing strategies that create a supportive environment for women (Adedini, 2012).

Engaging RLs is an important strategy in engaging men and boys. Most RLs are male; they also make up the husbands, fathers, and partners that are invested in women's health. Studies indicate that men often facilitate contraceptive use for their partners (Shattuck, et al., 2011). Therefore, interventions that seek to increase women's access to contraceptives also need to change the opinions and attitudes that men hold about FP. RLs are in an influential position to set an example for the men and boys hold about FP and to challenge traditional ideologies about masculinity and decision making.

While we were unable to find studies on RLs in Chad, a number of different interventions in sub-Saharan Africa have utilized religious leaders to impact SRHR outcomes. One popular example includes "Husband Schools". Husband Schools have been shown to be hugely transformative in Niger, where they were implemented in conservative Muslim communities by UNFPA (Women Deliver, 2013). After conducting a study to better understand gatekeepers to reproductive health services, UNFPA discovered that men in Niger often determine whether their female family members can access health services. Therefore, they launched eleven Husband Schools to educate and inspire men to advocate for women's reproductive health. The husbands meet in traditional community groups called "fadas" that are often held at religious institutions. The project has been successful to date and group attendance continued even after the initial UNFPA project ended. According to Women Deliver, use of family planning services has tripled in communities where the schools operate (Women Deliver, 2013). Variations of this program are being implemented across West Africa, including "Future Husband Schools" for unmarried men and boys.

Another example can be found in Kenya, where the Institute for Reproductive Health taught RLs about the benefits of Healthy Timing and Spacing of Pregnancies (HTSP). They then provided training in advocacy, communication and social mobilization skills to reach their congregations and communities with HTSP and FP messages (FHI, 2012). Before initiating a 2009 pilot project on family planning, RLs in Kenya's Ijara district were educated about the Standard Days Method and the concept of healthy birth spacing. Trainers also guided the leaders to recognize that FP does not conflict with religious teachings. Subsequently, these leaders encouraged their communities to view FP favorably (FHI, 2012).

A final example is in Nigeria led by Johns Hopkins University and funded by the Bill and Melinda Gates Foundation. The Nigerian Urban Reproductive Health Initiative (NURHI) aims to increase modern contraceptive method use, with a focus on the urban poor, through advocacy, demand creation, and service delivery (Adedini, 2018). As part of their demand creation strategy, the project targeted RLs. A cross sectional study conducted in 2018 found significantly higher contraceptive uptake among women who had exposure to family planning messages from the RLs trained by NURHI than women with no exposure (Adedini, 2018). The study concluded that engaging RLs as change agents in order to transform negative opinions about modern contraceptives are critical to increasing the CPR in Nigeria.

Globally, RLs remain underutilized as a key resource for reproductive health promotion. Many Christian and Muslim leaders accept FP and are engaged in activities related to FP (FHI, 2011). Both groups view health as an important gift from God that should be celebrated, and both emphasize the important of the family unit and making informed choices for the good of family well-being (FHI, 2011). Health is intricately linked to religion, and in many contexts, religious hospitals are the only providers of health care (FHI, 2011).

In conclusion, an increasing number of projects are utilizing RLs in health promotion, especially for sensitive topics like family planning and reproductive health. Nigeria, Niger, and Kenya are all similar examples to Chad, where they have a conservative environment and high social value placed on religion. In areas of high conflict or weakened states, RLs may take on even more critical roles. NURHI's experience in Nigeria is especially relevant to the SAFPAC project in Chad, because they are similar humanitarian contexts. These examples point to the importance of involving and engaging RLs in FP interventions and community outreach at the community and even national levels.

Often, religion is framed as a barrier to reproductive health, especially in light of conservative positions on sex outside of marriage and abortion (Mbeba, et al., 2012). Religion can exacerbate existing cultural norms and be used as a tool to perpetuate negative beliefs and stereotypes (Mbeba, et al., 2012). However, evidence is beginning to emerge to show how interventions can target RLs as change agents to transform negative attitudes towards contraception and create more favorable environments for women and girls to access reproductive health services (Abedini, 2018). More research is needed into how RLS can be used to transform negative belief systems from the inside out and to promote new ways of thinking and behaving.

While previous research has been conducted into the benefits of engaging RLs to support FP, there is a gap in understanding successful strategies to engage RLs, especially in conflict settings. We still have a limited technical understanding of why RLs make the choice, sometimes after long careers of opposing reproductive justice, to become women's health champions in their communities. In order to better inform training, design, and scale-up of projects aimed at working with and through religious communities, it is important to have an evidence-based understanding of why RLs support (or do not support) FP and how to better involve RLs in sexual and reproductive health programming.

Theoretical Grounding

Behavior health and health promotion theories can help to understand and explain health behavior. For the purposes of this study, relevant theories were explored in order to investigate the role of RLs in reproductive health program planning and community engagement. Ideation, Social Ecological Model (SEM), and Diffusion of Innovation are three frameworks that can be used to better situate these concepts. These models are useful in understanding both why RLs are

critical to community norms change and how we can better motivate RLS to champion reproductive health. We reviewed a combination of modern and traditional behavior theories.

Table 2. Behavioral Theories

Behavioral Theories			
Theory	**Description**	**Relevance**	**Founder**
Ideation	Describes how new behaviors are diffused through a community by means of communication and social interaction among individuals and groups (HC3, 2019).	RLs influence a population's behaviors through their thoughts, beliefs, and values, as well as wider environmental conditions that facilitate behavior.	Health C3 Adapted from Kincaid in 2000
Socio-ecological Model	Considers the relationship between individual, relationship, community, and societal factors (CDC, 2018).	RLs are important community leaders who influence all levels of the SEM.	Urie Bronfenbrenner's in the 1970s
Diffusion of Innovation	Explains how a behavior, skill, or attitude gains momentum and diffuses through a specific population over time (LaMorte, 2018).	RLS can act as early adopters or proponents of FP.	E.M. Rogers in 1962

Ideation Theory

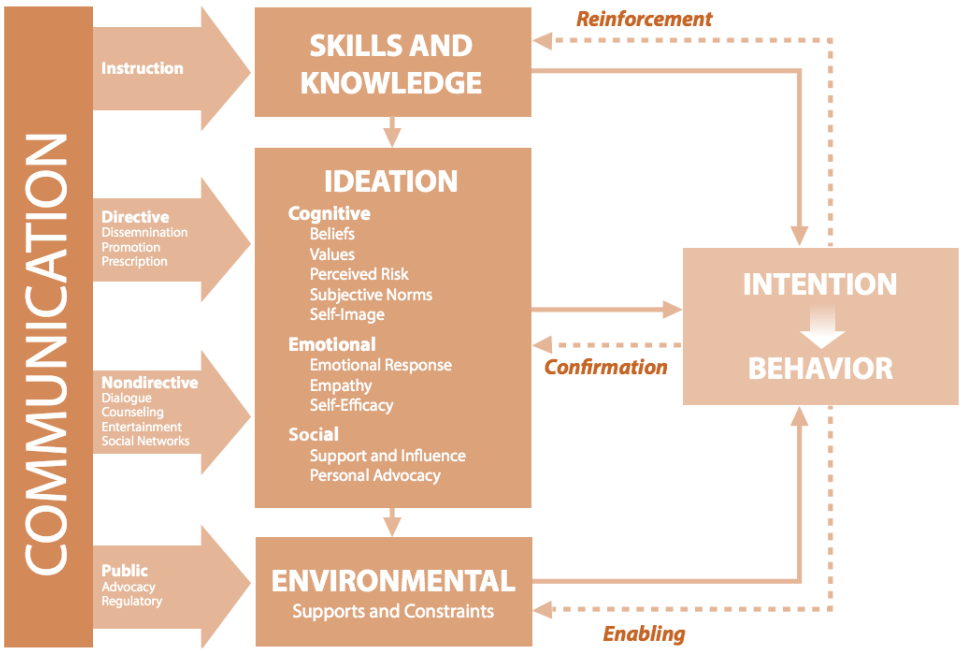
Ideation is a new framework developed by researchers at Johns Hopkins University to describe how new behaviors are diffused through a community by means of communication and social interaction among individuals and groups (HC3, 2019). The figure below (Figure 3.) demonstrates how different communication channels impact a community's environment, skills and knowledge and "ideation" (HC3, 2019). These three categories can help predict whether or not an individual will adopt a behavior. Ideation refers to the "creative process of generating, developing, and communicating new ideas" (Merriam Webster Dictionary, 2019). Hopkins grouped ideation into three main categories: cognitive, social, and emotional.

For example, a woman in a community attends an event where she learns more about FP. She then begins to reflect on the why or why not she herself might want to adopt a modern

contraceptive method. The environment around her might support her in that decision; maybe her husband is supportive of her decision to adopt a certain method. Ultimately, all of these processes have an impact on whether or not that woman will decide to use pursue contraceptive use.

RLs influence a population's behaviors through their teachings, thoughts, beliefs, and values, as well as wider environmental conditions that facilitate behavior (Abedini, 2018). As community thought leaders and respected moral teachers, RLs are in a position to help guide the ideation process within communities. They can play a role in upholding traditional beliefs and/or generating new ideas. In the SAFPAC project, RLs were also given new skills and knowledge to inform their personal ideation process. During trainings, their own values and beliefs were challenged. They used this ideation process to begin to change the environment in their communities.

Figure 4. Ideation



HC3, 2019

Socio-ecological Model

The Socio-ecological Model (SEM) is a commonly used framework to understand the interrelated and multifaceted factors that ultimately determine behaviors. Individuals do not make decisions about their health in a vortex. They arrive at certain behaviors because of intersecting, multi-faceted pulls from individual, interpersonal, organization, community, and policy levels (Figure 4.).

For example, a woman may have enough knowledge about what FP is and where she could go to get it, but if her friends and family (interpersonal level) condemn contraceptives, she may ultimately decide against adopting a method. Furthermore, an adolescent may want to use contraception, but if there are community norms or policies that do not allow adolescents to use contraceptives, they will have a more difficult experience accessing it.

RLs play an important part in the SEM. Religion has an influence on culture and community values and norms. RLs are, therefore, significant community leaders whose decisions, opinions, and attitudes can create either positive or negative environments for FP. Conversely, RLs whose attitudes, opinions, or behaviors fall outside of religious norms, face greater scrutiny because of their position. RLs are also in a unique position as community advocates to be able to advocate for policy changes on behalf of their congregations.

Figure 5. The Socio-Ecological Model

CDC, 2018

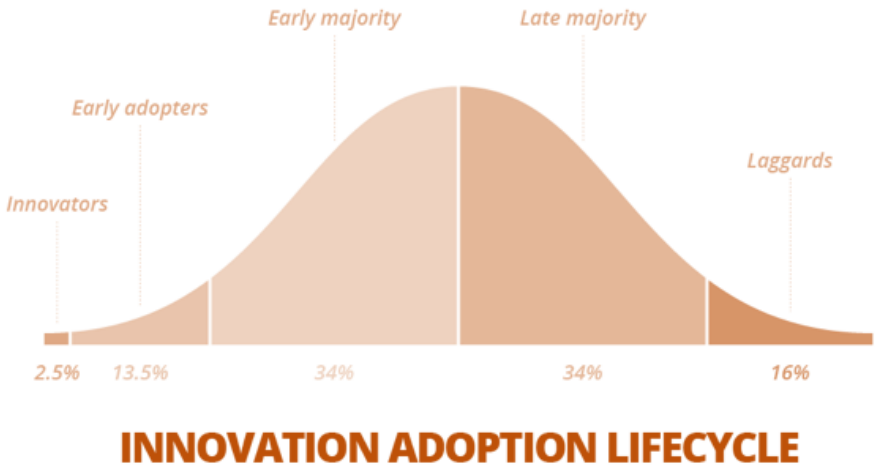
Diffusion of Innovation

In a population, individuals do not all automatically adapt new ideas or behaviors. Rather, over time, some people are more likely to adopt over time. People who are more likely to adopt these new innovations have certain characteristics (Figure 5.). For instance, a woman decides to get an IUD. This woman is typically interested in taking risks and exploring new ideas. The woman has a good experience with her method, so she encourages other women to learn more about FP. More and more women begin to adopt this new method after they gain more evidence that contraceptives are safe and effective. There are some women in the community who are very conservative, so they remain skeptical about FP; they may even deter other women from learning more.

Both as individuals and as community leaders, RLs can fall at various points throughout this spectrum. RLs who act as early adopters or proponents of FP and can have a huge impact on

diffusing knowledge and stories about FP. In other words, they can speed up the diffusion process. Conversely, they could also discourage families from learning more about SRHR.

Figure 6. Diffusion of Innovation



LaMorte, 2018

Methods

While research has been conducted into the effects of engaging RLs to support FP, there is a gap in understanding successful strategies to engage RLs, especially in conflict settings. We have a limited understanding of why RLs choose, sometimes after long careers as prohibitors, to become promoters of women's health. In order to better inform training, design, and scale-up of projects aimed at working with and through religious communities, it is important to have an evidence-based understanding of why RLs support (or do not support) FP and how to better involve RLs in sexual and reproductive health programming.

To fill this gap, we examined the strategies used by CARE Chad to design and implement the community engagement strategy for the SAFPAC Project in Chad. Here, we will not examine the programs' coverage, quality or effectiveness, or the effects of the programs on knowledge, behaviors, or health, as these topics have been documented elsewhere. Rather, we seek to document the unique aspects of SAFPAC's experience engaging RLs in Chad.

We drew from the SAFPAC program's documents and publications to synthesize information and extract strategies for building community support, overcoming barriers, and advancing contraceptive access. Building on this desk review, we designed an open-ended survey for CARE staff in Chad and conducted in-depth key informant interviews with CARE USA leaders. Their expert testimonies provided critical insights and allowed for a focused discussion on CARE's experiences of overcoming resistance and leveraging religious leaders to support family planning in Chad.

First, key informant interviews were conducted with CARE Headquarters staff from the SRHR team (N=6). The semi-structured interviews were conducted in March 2019 and lasted approximately 30 minutes to 1 hour. In general, questions followed a basic order and were asked

in a similar manner. Probes were adjusted based on the participant's experiences with project implementation. Some participants had more significant experience working on the ground in Chad than others. These were conducted in English both in the person at the Atlanta office and via Skype. All interviews were recorded.

Secondly, open-ended surveys were conducted with CARE staff in Chad (N=11). Surveys were chosen over interviews in order to simplify the translation process. All team members who participated in the surveys are currently working directly with RLs. Participants were asked not to discuss their answers with other participants and to complete their responses as thoroughly as possible. The surveys were written in French and then translated into English.

In order to analyze the data, interviews and surveys were transcribed into text memos. After transcription and translation, de-indentified transcripts were uploaded onto MaxQDA analysis software. Data were then analyzed both inductively and deductively using pre-determined themes from the literature and project communication materials.

An initial codebook was developed by the author. A second reviewer was then used the codebook to analyze a qualitative survey in order to enhance internal validity. It also confirmed that all definitions were clear and that codes were sufficient and useful. This process resulted in a final codebook.

Using this codebook, both qualitative interviews and surveys were analyzed. Coded segments were retrieved and examined for breadth, depth, nuance, and context. Memos were created throughout this process in order to contextualize data. Finally, both methods of qualitative data were triangulated against the literature and project implementation and training documents, which resulted in final recommendations for the CARE SRHR team.

A proposal was submitted by the evaluator to the Emory IRB early in the development of this project. The IRB determined that no review was required for this project because it was a special studies project. Because the findings are only meant to be generalizable to CARE, the project is not considered human subjects research. Thus, we are confident that this project met full ethical standards.

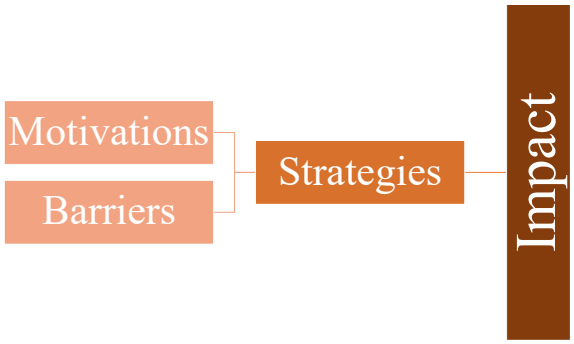
Results

Results from the surveys and interviews were grouped into four thematic areas: 1) Motivators, 2) Barriers, 3) Strategies, and 4) Impacts. Motivators refer to factors identified by study participants that were reasons for RLs joining in RLCs and/or staying engaged in RLCs.

Motivators were the factors that helped to change RLs minds about supporting and advocating for FP. Barriers, on the other hand, refer to the factors that prevent or discourage RLs from supporting FP and SRHR and from joining and/or staying engaged in RLCs. Strategies denotes the specific tools or tactics that CARE staff employ in order to recruit and/or keep RLs engaged in RLCs and SRHR advocacy. Finally, impacts represent the benefits and/or results of RLs being engaged in RLCs and/or FP and SRHR advocacy.

Understanding these four thematic areas help to paint a more holistic picture of how and why CARE Chad has included RLs in their SAFPAC CE strategy. In other words, when projects capitalize on the motivations of RLs and challenge the barriers preventing RLs from supporting FP and reproductive health, they are better able to develop participatory strategies to engage RLs that have far reaching impacts. The figure below outlines describes this framework.

Figure 6. Results Framework



Motivators

CARE team members outlined a wide array of motivators that encourage RLs to become involved in RLCs with SAFPAC. One Chadian team member pointed out that it is easier to recruit RLs because they are already engaged in volunteer work and have relationships with their congregations. Other notable motivations are 1) Compassion for their families and communities, and 2) Increased status and community visibility.

Responsibility for families and communities

RLs are not just leaders, they are also community members with families and friends of their own. RLs want to ensure that their wives, sisters, and mothers are healthy A Chad team member pointed out that, *"[RLs] themselves are concerned because in their families they have also known maternal deaths related to pregnancies."* When RLs are convinced that their own families and friends are impacted by negative health outcomes, they can better understand the importance of accessing quality reproductive health services.

A similar motivator identified is to improve the health of their communities. When talking with RLs, one staff member recounted saying, *"People come to you in your mosque, in your church, and they are sick. And all you can do is prepare them to go to paradise? No. We want you to advise them on other things too."* RLs have a responsibility to care for families in their congregations. Several participants noted that, when confronted with alarming statistics related to maternal mortality and complications, RLs were spurred to action. Given the well-established relationship between modern contraception and maternal and child health, RLs were reported to be motivated to promote family health and well-being.

According to CARE team members, when RLs are included in community discourse and strategies on maternal and child morbidity and mortality reduction, they may be more likely to

support FP and PAC. As one Chadian team member summarized, *"Support for family planning is a result of knowledge about the benefits of using FP methods on the health of the mother, the family, and the community as a whole, and ultimately the reduction of maternal mortality."*

Increased status and community visibility

Another motivator is status. Becoming a member of the RLCs is a source of pride for many RLs and gave them increased recognition in their communities. The RLCs offer them a platform to build their leadership and communication skills. For example, CARE includes the RLCs in monthly meetings, which helps to build their relationship with other community groups, including the health center. RLs also received training in facilitation sills, counseling, and monitoring. Moreover, RLs were often given t-shirts and other supplies that increased their visibility. Anecdotally, one CARE staff speculated that the training that RLs received from CARE actually boosted their ministries. More people appeared to be attending services and seeking out RLs for counseling.

Another benefit included opportunities to build their income and make their groups sustainable. One team member said that, "*To ensure the sustainability of community interventions, committees must be made autonomous. That is to say, accompany them by setting up self-management mechanisms through income-generating activities (IGAs).*" IGAs can help RLs to build skills that they can use to help their own families and religious communities.

Barriers

The CARE team also described barriers which discourage RLs from supporting FP and PAC. Staff pointed out two major barriers: 1) Restrictive traditional religious norms, 2) Myths about FP and the RLCs, and 3) Lack of resources.

Restrictive religious norms

All CARE team members noted the complexities of working against restrictive religious norms that often inform religious beliefs in Chad. One Chadian team member reported that, *"Initially the FP issue was not well understood by the community because of the weight of religion, the dogma of certain religions and socioreligious norms."* Abortion and PAC was noted as a particularly divisive issue. Other issues arose around adolescents accessing contraceptives, sexual activity outside of a religious covenant, and wives accessing contraceptives without the permission of their husbands. Participants also pointed out differences between religions and religious denominations. Chadian team members specifically mentioned Catholic leaders, especially priests and nuns, as being greater barriers to FP use.

Myths and misconceptions

Not all barriers were related to religion. When recruiting RLs, the Chad team encountered a number of myths and misconceptions related to FP and reproductive health. Some of these misconceptions were due to lack of information and knowledge of women's health. For instance, some RLs believed that using a FP method could have an effect on women's fertility. A Chadian staff explained that RLs traditionally conflated FP methods with abortion, stating *"Getting them to understand that FP methods did not involve abortions was not easy to pass on to religious leaders."* There was also confusion about different side effects of FP. Finally, because RLs are predominantly male, some dismissed FP as being a "woman's issue."

One staff member recalled that during a training with a group of RLs, RLs stated that they believed that women's genitalia are unclean. When pushing the RLs as to why they believed that, the RLs responded that it was because women urinate through their vaginas. By explaining the female anatomy to RLs and equipping RLs with the necessary knowledge to combat harmful stereotypes, they were able to challenge the RLs perceptions.

The CARE team also noted that contraceptives are sometimes seen as a Western practice. One Chadian staff stated that, *"It was difficult in the beginning to motivate the leaders to support family planning because many say that methods of family planning is the affair of the whites, not of the Africans (in Africa to having many children is a show of wealth)."* One way that CARE staff combatted this myth was to challenge RLs to think about traditional methods of birth spacing.

Lack of resources

Several CARE Chad team members also pointed out the challenge or working with limited resources. RLs may have to travel long distances and overcome significant challenges in order to participate in the RLCs. One Chadian staff mentioned that RLs will walk over 25 km to attend RLC meetings. RLs are not a homogenous group; they vary in age, socioeconomic status, and training and literacy levels.

Strategies

The process to engage RLs has been an organic process in Chad. In other words, it was not written into the original grant proposal, but evolved over time after extensive social mapping conducted during Phase 1 of the project in 2011. Strategies identified by CARE staff include: 1) Increasing knowledge and technical skills, 2) Investigating religious texts and traditions, 3) Linking RLs with the health system, and 4) Creating interfaith committees.

Increasing knowledge and technical skills

CARE staff knew from the beginning that they needed to overcome the myths and misconceptions around FP in order to decrease stigma in SAFPAC communities. Before receiving training from CARE, most RLs had extremely limited of knowledge of reproductive health and were often uncomfortable discussing it. "*Religious leaders needed to better*

understand this new theme, family planning, before committing to it," explained one CARE staff member.

Recognizing that RLs were deeply passionate about the health and well-being of their communities, CARE staff started their trainings by justifying the need for reproductive health services in Chad. RLs needed to understand the enormity of the reproductive health challenges, like maternal and infant mortality, facing their communities, including knowledge about how to fight these inequities. A CARE Chad staff member said that, "*For a successful SRHR project, you have to go to the bottom to identify the most listened to leaders and put them in front of the facts to find solutions to their problems."* In other words, when confronted with the challenges facing their communities, RLs will work to find community solutions.

Next, CARE staff trained RLs in technical skills. They started with basic knowledge about male and female anatomy, menstruation, fertility, and contraception. One CARE staff member recounted the importance of showing the physical contraceptives to RLs. By being able to touch and feel the actual contraceptives, it reduced fear and apprehension about what contraceptives are. Overcoming stigma time and patience from facilitators. While the 3- day trainings appeared to have an initial strong impact on the RLC attitudes, CARE staff agree that the consistent supportive supervision offered every month to the RLCs for the past 8 years has been important to growing knowledge and cultivating attitude transformation.

Investigating religious texts and traditions

CARE staff also had to overcome the restrictive norms. While restrictive religious norms often prevent RLCs from supporting FP, the SAFPAC team found that religious texts can be integrated into project curricula in order to transform negative ideas and challenge traditional ideologies about FP and reproductive health. A Chadian staff stated that *"[As a result of*

SAFPAC] many Bible verses and suras in the Koran have given religious leaders confidence in supporting family planning." The idea of RLs being confident came out strongly in the surveys. Importantly for CARE staff, RLs not only gained knowledge and skills in reproductive health, but also had the confidence to defend newfound beliefs and test them against religious texts and doctrines through discussion and values clarification.

A major theme mentioned in both the Koran and the Bible is rest. Chadian staff pointed out that, in Genesis, God rested on the seventh day. Similarly, they explained, RLs came to understand that when farming, farmers do not plant the soil every year but give it time to recover. This became a metaphor about women and childbirth used to explain the need for birth spacing to the RLCs. After giving birth, women also need to let their bodies and families rest and recover before being pressured to have more children. During a training, one staff member told RLs*, "So you prefer to protect your river, you prefer to protect the land, but you are doing nothing to protect your wife! You are doing nothing to give some rest to the uterus of your wife. That's family planning! So you are doing family planning for hunting, for the river, for agriculture, but you are not doing family planning or birth spacing."* Challenging RLs to think critically about their values and attitudes towards FP was key to shifting their beliefs.

Another Bible verse that was mentioned by staff is 1 Timothy 5:8. This verse states that, "But if anyone does not provide for his relatives, and especially for members of his household, he has denied the faith and is worse than an unbeliever" (ESV). RLCs used verses, like this one, and Koranic surahs to discuss some of the economic and social benefits of child spacing.

Linking religious leaders with the health system

Prior to SAFPAC, many religious institutions were seen as separate from the health system. According to CARE staff, religious leaders felt uncomfortable addressing doctors and

midwives, and lacked confidence in their ability to advocate for health needs. Once the RLCs were formed, the groups began participating in quarterly review meetings held with health staff and community leaders. By facilitating a relationship between health leaders and RLs, CARE was able to open up a new line of communication. As a result, RLs were better able to hold the health facility accountable.

This relationship proved beneficial for the health facilities as well. Before the SAF-PAC program helped subsidize contraceptives and made reproductive health services free of charge, health facilities charged fees for their services. Some of the women who had been referred for free reproductive health services by RLs later returned with complaints that they had been charged for these services at the health facilities. CARE was then able to use that feedback to decide that a fixed financial incentive would be provided to all health facilities on a monthly basis to discourage providers from improperly charging a fee.

Creating interfaith committees

Another strategy was to provide RLS with social support and relationship building with other RLs through the RLCs. RLs of the same faiths were already meeting together informally; CARE institutionalized these groups into committees and facilitated relationship building. The committees gave RLs a chance to learn from different faiths and share ideas and setbacks.

Committee facilitation was important for providing a platform for participatory discussions and meaningful social supports. Several CARE staff noted the importance of the groups being safe spaces, where religious leaders can freely express themselves. Values clarification and attitudes transformation (VCAT)[1] exercises were integrated into training

[1] Tools originally developed by IPAS for abortion providers (Turner, 2008).

manuals to challenge RLs to think critically about their own opinions and beliefs about FP and reproductive health.

An example of a VCAT exercise mentioned by the CARE Chad team is “Cross the Line”. During this activity, participants stand in a horizontal line, and a facilitator reads a statement. If the statement describes the participant, then they should step forward crossing an imaginary line. Typically, the statements will become continuously controversial throughout. The activity is meant to challenge participants to explore their own identities and reflect on their personal values, and how their identities match or differ from those around them (Turner, 2008).

The committees were also a key strategy for sustainability. Working in groups, RLs were able to challenge one another and hold each other accountable through three- month action plans. RLCs were also trained to be self-sustainable. A CARE staff member explained that, “To ensure the sustainability of community interventions, committees must be made autonomous. That is to say, we need to help them by setting up self-management mechanisms through IGAs, training, and follow-up, in order to provide for the function and motivation of the members.” This took considerable commitment from the Chad team.

Organizing the RLCs also took strategic leadership from the CARE Chad team. For the past eight years, they have conducted extensive community and social mappings in target communities, recruited new RLs and sustained existing groups, and trained RLCs. They have responded to the needs of RLCs by providing transportation, per diems, and IGAs to help sustain the RLCs. Working with the RLs takes considerable leadership, patience, and understanding. When choosing facilitators, the CARE team recommends recruiting strong managers who have both technical experience in reproductive health, including a background in Islamic and/or Christian theology.

Impacts

When projects have strong strategies in place that expand on motivations and overcome barriers, RLs can have impressive impacts on communities as agents of social change. RLs were referred to by many of the Chadian staff as "*agents of demand creation."* In other words, RLs help to increase the number of people who are seeking contraceptive services. A number of staff members explained that RLs are both influential and trusted and listened to by their communities. One staff member said that, *"We wanted to make sure that the CE strategy was creating last change; and the only ones who could really influence communities, influence individuals, and influence households, to change and adapt some things that were really controversial were religious leaders."* Two major reasons why RLs are able to achieve this kind of impact are 1) Reach and 2) Trust.

Reach

A Chadian staff member said that, "*CARE Chad…worked with religious leaders because religious entities constitute the communication system."* A number of CARE staff pointed out the importance of working with RLs because they speak regularly with large numbers of people. Hundreds of people attend Sunday services and Friday Jum'ah prayers every week. As a result, RLs are often able to pass on health messages to the population more efficiently than the doctors and midwives already working in the health system. Another Chad staff member pointed out that *"[Working with RLCs] has allowed us to be more efficient and reach [community members] through specific, audience-oriented messages."* RLs and religious events and holidays are a major channel through which news and communication spreads in rural Chad.

CARE Chad staff had a number of stories demonstrating the importance of engaging RLs. One emotional story described how a RL refused to allow his family to use contraceptives.

Eventually, his daughter became pregnant. Out of fear, she tried to have an abortion, but ended up losing her life. The RL ultimately encouraged the rest of his daughters to take contraceptives. The CARE staff then pointed to a traditional saying that states, "*Consequence corrects better than advice."* When RLs meet together in their committees, they are better able to share ideas, experiences, and firsthand stories from their own lives and their community's lives. They can then share these messages with their congregations and wider audiences.

Trust

Because they are already in place in their communities, RLs are often seen with more trust than organizations coming from outside. A CARE staff member stated that, "*This group of people, key people, help people to keep hope when the government is not trying to fix your health conditions, at least religious leaders are there to organize people, to galvanize movements, and to keep them, you know, in a mindset of hope that things can improve."* In other words, RLs are agents of hope even in difficult circumstances.

A number of Chadian staff members also pointed out that RLs are highly listened to by both their congregations and by political leadership. Many powerful people in communities turn to RLs for moral authority. A Chadian team member confirmed that, *"Religious leaders are considered the Light of the community. In other words, these men [or women] are anointed or blessed by God and must speak the truth for the good of their community."* Another staff said that CARE chose to work with RLs because of the "*sensitivity of the [sexual and reproductive health] messages to pass on."* Because of religious traditions and texts, RLs often hold considerable sway over their congregations.

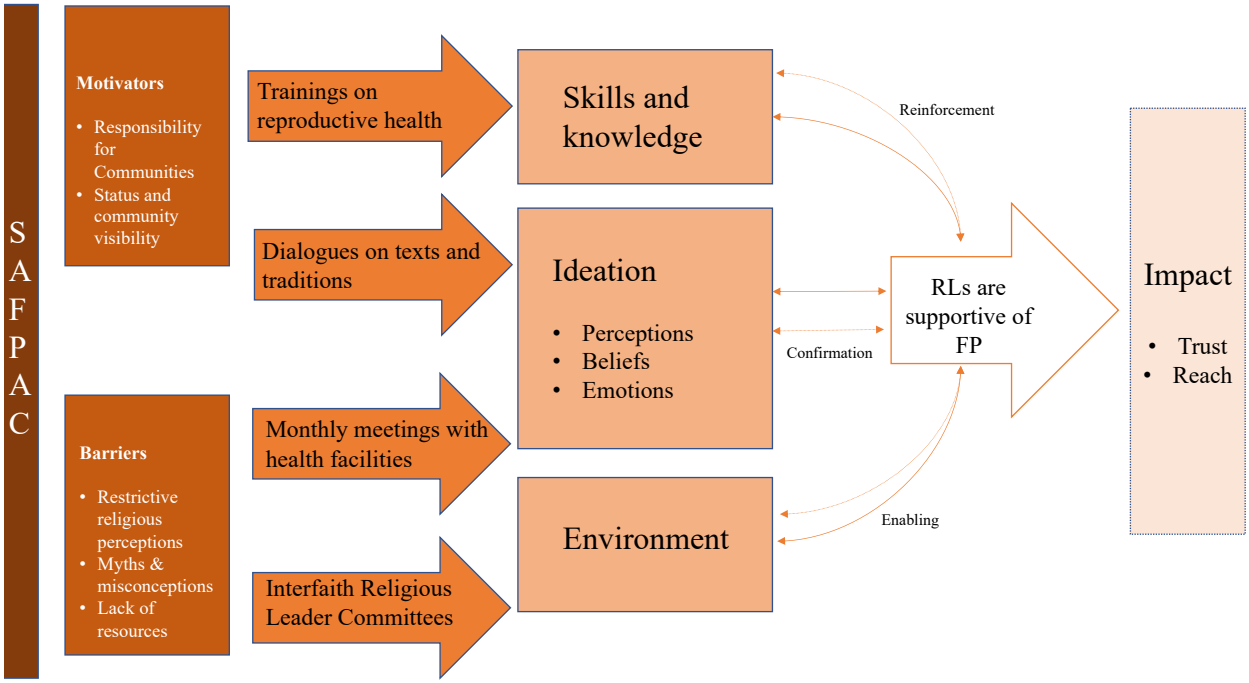
Discussion

Given the ever- shifting political climate around the world that is increasingly split by progressive and conservative worldviews, it is more important now that ever to invest in approaches that transform the social environment for women and girls from the bottom up. Chad is a unique context. The country has suffered from the spillover of complex humanitarian emergencies and has a very low contraceptive prevalence. Nevertheless, the region, and the SAFPAC program in particular, boast important examples of how RLs can be engaged as community bridge builders in complex social environments.

Engaging with RLCs is just one aspect of the CE strategy embedded in SAFPAC. It is clear through this investigation is that RLs are significant influencers to include, especially in Chad. When engaged using effective strategies, they can help not only make FP more socially acceptable, but also help to hold the health system more accountable to women and families. This is just one project demonstrating that religious leaders are influential and powerful community members who can either act as promoters or prohibitors of family planning (Abedini, 2018). We need further research on diverse strategies to build community support for family planning and respond to resistance in a variety of settings.

As mentioned above in the literature review, NURHI used the Ideation Framework to explain how ideas and feelings influence women's decision-making through their beliefs, perceptions, and emotions (Abedini, 2018). The CARE SAFPAC project in Chad illustrates how, before the messages reach women themselves, we can use the same process to influence RLs to support SRHR. We adapted the Ideation Framework developed by the HC3 team at Johns Hopkins University to explain how SAFPAC engaged RLCs (HC3, 2019).

Figure 7. RLC Ideation Framework



Based on the Ideation Model (HC3, 2019)

In this ideation model, we can see how various predictors make RLs more likely to support FP; namely, when they have adequate skills and knowledge, when there is a positive environment, and when they reflect on their beliefs, perceptions, and emotions. Individuals and groups who have more ideational factors are more likely to adopt new intentions and behaviors. When CARE communicated new ideas about FP to the religious leaders, they used a range of different strategies. They increased knowledge and technical skills, engaged RLs in dialogues and participatory trainings, they connected RLs to the health centers, and created social networks that offered the RLs social support.

These strategies were ultimately successful because they led the RLs through the ideation process. In other words, CARE ultimately was able to recruit and retain RLs as champions for FP

because they: reinforced RLs skills and knowledge, confirmed their beliefs, perceptions and emotions, and finally they created an enabling environment. This is an iterative, not a linear, process that happens first with individual RLs, then within RLCs before RLs act as change agents to impact their communities.

The impact result was also not a linear transformation. While we now have data indicating that SAFPAC did increase access to contraceptives in target regions[2], we cannot assume causation. The CE strategy is just one piece of the overarching SAFPAC project. What does become clear through this investigation is that RLs are important people to include, and when engaged using effective strategies, they can help to not only make FP more socially acceptable, but to help hold the health system accountable to the women and families in its coverage area. This impact is especially poignant when considering the sensitive nature of sexual and reproductive health and the moral role that religion plays in Chadian culture.

The impact that RLs can have in promoting women's health is especially pertinent in areas that are traditionally devout and have a weaker state. In conflict areas, RLs may need to play an even greater role in their communities to ensure that their congregations have their basic needs met. When systems fail, religious leaders often step in to provide health services, schools, and other community needs. Therefore, by engaging RLs, interventions are not creating a new strategy, they are most likely capitalizing on a strategy that is already taking place. In other words, they are giving the RLs the information, skills, and resources to better provide for their communities, a role that they were likely already filling.

We must remember that CE with RLs is not enough. Ultimately, RLs, who are typically male, are still ultimately making the decision about whether or not women can and should access

[2] From 2011-2013, SAFPAC reached 21,191 new users of modern contraceptives in Chad.

certain methods. likewise, all projects working to engage men and boys approach their FP programs from a reproductive justice framework. This means that RLs might be necessary to engage in order to shift the environment to being tolerable to contraceptives, but RLs are not sufficient by themselves. CARE SRHR projects, and all women's health projects, must remember that our ultimate goal is not merely to increase the number of women on a contraceptive method, but to ensure that all women have their unmet need for contraception met with whatever method they choose.

It is necessary to remember that RLs, who are typically male, still exercise control and power over whether or not women can and should access certain methods. Whenever we engage influencers, we must remember to uphold sexual and reproductive health rights. In other words, we must move from a structure of "power over" to "power with". CARE projects, and all women's health projects, must remember that our ultimate goal is not merely to increase the number of women on a contraceptive method, but to ensure that all women can access contraceptives if, when, and how they choose, and that they have autonomy to make informed decisions about their reproductive health.

Limitations

We were confronted with several limitations throughout this study. Due to constraints in obtaining IRB in Chad within the timeframe of this project, we were limited to conducting interviews with CARE team members. All communication with CARE staff in Chad was done via Skype and email. Interviews and/or focus groups are preferable methods to surveys because they allow for greater opportunities to probe. Moreover, it would have been preferable to conduct the evaluation on the ground in Chad with both staff, religious leaders, service providers, and program participants, including women.

Another major limitation was language. While we believe that the main ideas and messages were able to be conveyed, word choice and connotations may have been compromised during the translation process. Ideally a native speaker would be conducting and translating all interviews.

Finally, significant amounts of time have lapsed between initial project implementation and the time of the study (eight years). As with all large non-governmental organizations, knowledge management and internal memory were barriers. While we have attempted to bridge that knowledge gap through this study, some learnings may be lost to time and follow- up.

Conclusion

RLs are trusted and respected in communities, and thus have the ability to promote or prohibit reproductive health access. Community engagement approaches, like SAFPAC's strategy that engages RLs of different faiths to support FP and PAC are a key strategy for shaping norms and informing behaviors to increase contraceptive uptake in conservative countries in crisis affected settings, like Chad. CARE SAFPAC in Chad recognized that it is not enough to run effective education programs if the programs are not accepted locally and by society at-large. Further research is needed as to how RLs can be transformed from prohibitors to promoters of FP and PAC. Further sharing of challenges and successes working with religious leaders in family planning programs is needed in order to develop a toolbox of additional strategies for community engagement.

Recommendations

Findings from this study inform a number of recommendations for CARE projects, especially the SRHR team, and donors around including RLs in their community engagement strategies. Our recommendations for CARE projects and other organizations seeking to advance the rights of women and girls through reproductive health access include:

Pay attention to context

In Chad, extensive social mapping showed that RLs were one of the most influential actors to engage around FP. RLs hold high social power and decision making in their communities. Projects need to recognize when RLs are barriers to reproductive health and should engage them where appropriate. All of the below recommendations are equally dependent on context.

Engage RLs as men first

When interventions elevate RLs above community members, they miss out on the opportunity to engage RLs as men first. RLs are themselves potential users of FP services. They have their own sexual and reproductive health needs. Many of them are facing gaps in their knowledge and ability to access services. When RLs are inspired to make changes in their own lives, their communities notice, and they are more empowered to counsel their congregations.

Choose leadership wisely

Leaders should clearly identify and invest in building sincere relationships with RLs. Changing attitudes takes time. Part of engage RLs is relating to them first as individuals and genuinely connecting with them. This requires trust. It is important that project leaders have a strong understanding of their own values and attitudes and is knowledgeable about sexual and reproductive health. It is also useful if leaders have experience in theology and working with religious texts and belief systems because it can give depth and credibility to religious debates.

Start with transforming attitudes through participatory dialogues

In order to reduce backlash or discomfort, it is important to foster ownership and passion. Training can use tools, like VCAT, to help RLs clarify their own knowledge, attitudes, and values. Dialogues can help RLs move past fear and mistrust when talking about sensitive issues like sexual and reproductive health. They can also help foster compassion in a group that is already committed to community moral development.

Link religious leaders with the health system

RLs need to understand the reproductive health challenges that their communities are facing Projects should use data and statistics to give RLs a full picture of women's health challenges; we should not assume that RLs are not interested in health because they work on religion. Finding ways to bridge this gap between religious institutions and health centers can be

a mutually beneficially relationship, offering RLs and health leaders' insight into community needs and experiences. Facilitating this relationship also gives RLs confidence that they know how and where to get the answers to their own questions, leading to greater confidence in their ability to refer future patients to the health system.

Organize and support leaders in interfaith coalitions

Interfaith coalitions offer a rich opportunity for joint exploration. Bringing RLs together in interfaith groups, where appropriate, opens RLs up to new mindsets and allies in their communities. It can challenge groups to think about the greater role of religion in reproductive decision- making. Bringing people together in groups can motivate and inspire them to spread messages and hold one another accountable.

Adopt a reproductive justice framework[3]

Increasing access is necessary, but not sufficient. Involving RLs in FP promotion can be effective at increasing demand for modern contraceptives. A CARE Chad team member explained that "RLs can contribute to creating a favorable environment for FP which can increase the demand for sexual and reproductive services." In other words, where FP might not have been an option for women in very restrictive settings, the support of RLs might open up the opportunity for her to begin to explore her contraceptive options.

Nevertheless, we need to remember that by empowering religious leaders, we are reinforcing the power structures that previously prevented women from accessing services. Encouraging RLs to adopt a reproductive justice framework- wherein women are encouraged to choose for

[3] The reproductive justice framework was first introduced at the, now infamous, International Conference on Population and Development in Cairo in 1994. Reproductive justice asserts that all women, no matter their income, marital status, age, or religion, have a right to bodily autonomy and make their own informed decisions about their reproductive health (SisterSong, 2018).

themselves where, how, and what method they will use without pressure or coercion- is an important step towards recognizing the full reproductive health rights of women.

Continue the conversation with RLs

Ultimately, interventions, like SAFPAC, that engage RLs of different faiths to support FP and PAC are a key strategy for shaping norms and informing behaviors to increase contraceptive uptake and in Chad. Donors should continue to invest in projects that offer learning as to how RLs can be transformed from prohibitors to promoters of FP and PAC.

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Appendix

Qualitative Interview Guide

I. Introduction

Thank you for agreeing to participate in this interview. My name is **<insert name>**. I am conducting this interview on behalf of **CARE** to evaluate the experience of the SAFPAC project's work with religious leaders in Chad. The purpose of this interview is to help us better understand the motivators, barriers, and impact of working with religious leaders.
It is important that you understand that your participation in this interview is entirely voluntary.

You may choose not to answer a specific question and/or end the interview at any time. If you are comfortable, we will also be recording this interview. The recordings will not be shared and will be deleted after interviews have been analyzed. Please say "yes" if this is acceptable to you. Thank you!

II. Introduction

1. What is your current position?
2. In what capacity have you interacted with the SAFPAC Project in Chad?

III. Interview Questions

3. In Chad, SAFPAC has used CLRs to increase community acceptance and participation in family planning. Do you believe this approach has been effective? Why or why not?
   Prompt, as necessary:
   Why are religious leaders important to communities in Chad?
4. What do you think was the biggest success factor that ensured that CLRs were effectively engaged?
   Prompt, as necessary:
   a. What motivated religious leaders to join CLRs?
   b. What motivated religious leaders to support family planning?
5. What do you think were the biggest barriers to engaging religious leaders?
   Prompt, as necessary:
   a. What was difficult about motivating religious leaders to join CLRs?
   b. What was difficult about motivating religious leaders to support family planning?
6. What advice would you give to another project planning to engage religious leaders to promote reproductive health?
   Prompt, as necessary:
   What should a project do to engage religious leaders?

Qualitative Survey Guide

I. Introduction

Merci d'avoir accepté de participer à cette enquête. Nous menons cette enquête au nom de l'équipe SRHR globale de CARE pour évaluer l'effet du projet SAFPAC sur les leaders religieux au Tchad et leur implication. Le but de l'enquête est de nous aider à mieux comprendre l'effet des interventions du projet SAFPAC sur les participants, leurs organisations religieuses affiliées et la santé sexuelle et reproductive en général.

Nous vous demandons de bien vouloir répondre à cette enquête avec autant des détails que possible. C'est l'occasion de mettre en valeur le travail important que CARE Tchad a accompli avec le reste de CARE. Utilisez autant d'espace que nécessaire et soyez le plus complet possible.

II. Informations personnelles sur le répondant.

1. **Quel est le nom du projet avec lequel vous avez travaillé avec les leaders religieux ?**

   _____

2. **Avez-vous travaillé directement avec les leaders religieux ?**

   1. OUI 2. NON

III. Questions d'entrevue

1. Au Tchad, SAFPAC a utilisé les Comités des Leaders Religieux (CLR) pour améliorer l'acceptation et la participation de la communauté à la planification familiale. Que savez-vous de cet aspect du projet SAFPAC ? Quels sont les éléments clés de ce travail avec les leaders religieux ?

Dans votre réponse, veuillez également inclure :
Croyez-vous que cette approche ait été efficace ? Pourquoi ou pourquoi pas ?
Quel est le rôle des leaders religieux dans les communautés au Tchad?
Pourquoi CARE a-t-il décidé de commencer à travailler avec des leaders religieux ?

2. Quelles ont été les meilleures stratégies utilisées par l'équipe de CARE au Tchad pour engager les leaders religieux ?

Dans votre réponse, veuillez également inclure :
Qu'a fait CARE pour engager les leaders religieux ?
Qu'est-ce qui a motivé les leaders religieux à rejoindre les CLR ?
Qu'est-ce qui a motivé les leaders religieux à soutenir la planification familiale ?
Selon vous, quel a été votre plus grand succès en mobilisant les leaders religieux ?

3. Selon vous, quels ont été les principaux obstacles à la participation des leaders religieux ?

Dans votre réponse, veuillez également inclure :
Pourquoi était-il difficile de motiver les leaders religieux à rejoindre les CLR ?
Pourquoi était-il difficile de motiver les leaders religieux à soutenir la planification familiale ?

4. Quels sont les choses que CARE faisait qui peut avoir motivé les leaders religieux dans leur travail ?

Dans votre réponse, veuillez également inclure :
Matériels ? formation ? Compensation/perdiem et /ou incitation ? Supervision ?
Quelle était l'efficacité de ces appuis ?
CARE a-t-il fourni un soutien adéquat aux leaders religieux ? Pourquoi ou pourquoi pas ?
Comment CARE pourrait-il améliorer son soutien aux leaders religieux ?

5. Quelles sont les meilleures stratégies à utiliser lors de la formation des leaders religieux ?

Dans votre réponse, veuillez également inclure :
Quelle est l'importance des formations pour l'attitude des leaders religieux à l'égard de la planification familiale ?
Comment les formations ont-elles modifié l'attitude des leaders religieux à l'égard de la planification familiale ?
Qu'est-ce qui est difficile dans l'engagement des leaders religieux?

6. Quels conseils donneriez-vous à un autre projet de CARE prévoyant de faire participer les leaders religieux à la promotion de la santé en matière de reproduction ?

Dans votre réponse, veuillez également inclure :
Que doit faire un projet pour engager les leaders religieux ?
Comment la participation / l'engagement des leaders religieux a-t-il contribué au succès du projet?
Comment les leaders religieux sont-ils encore impliqués dans le projet? Comment assurez-vous la durabilité lorsque vous travaillez avec des leaders religieux ?

7. Avez-vous des histoires de votre travail avec les leaders religieux que vous voudriez partager ?

Dans votre réponse, veuillez également inclure :
Qu'est-il arrivé ?
Pourquoi pensez-vous que c'est arrivé de cette façon ?
Qu'est-ce qui vous a surpris dans cette situation ?

C'est tout ce que j'avais comme questions à vous poser aujourd'hui et vous remercie de votre appui.

8. Souhaitez-vous formuler d'autres commentaires ?

Merci beaucoup pour votre temps !

Codebook

Themes	Codes	Sub-codes	Definitions	Examples
Motivators			Factors which encouraged RLs to join RLCs and/or support SRHR	
	Family well-being		FP supports family wellbeing/ can decrease maternal mortality and poor health outcomes in communities	Use alarming data on SR issues during project presentation
	Sharing experiences		RLS learn from the experiences of other community members and other RLs.	They continue to do community dialogue activities. We advised them to expand by involving more women and young people.
	Status		Being a member of the RLC increases RL respect and authority in the community.	Their political, social and cultural influence has increased.
	Availability		RLS have time to participate in RLC activities.	RLs are already used to doing volunteer activities.
	Responsibility	*Ownership, leadership, sustainability*	RLs feel like it is their duty and that they are equipped to educate their congregations about FP.	The greatest success in mobilizing religious leaders is that there is good community ownership in family planning and PAC.
	Funding	*Income generating activities (IGAs), AGR*	RLs are given extra funding opportunities to increase their revenue.	To ensure the sustainability of community interventions, committees must be made autonomous. That is to say, accompany them by setting up self-management mechanisms through income-generating activities (IGAs).
	Knowledge		RLS are given information and learning that they can share with communities	Intense training on the development of fetuses until the birth of the baby
	Tools	*Bikes, per diem, training, equipment, materials*	RLs are given specific means to accomplish their Action Plans set by the RLCs.	Equip them with materials (bike, backpack, candy, sugar, visibilities ...)
	Community Engagement	*Participation*	RLS are active and involved in their communities.	Weak involvement in community participation of religious leaders in health activities, programmatic and implementation of projects and programs
Barriers			Factors which discouraged RLs to join	

			RLCs and/or support SRHR	
	Finances	*Volunteer, bribes*	RLs are not paid for their services.	It was a bit difficult to motivate these leaders to join the RLCs because it is hard work and voluntary. We all know that nowadays all work deserves a salary.
	Post-colonial	*White, Un-African*	FP is an imported concept and goes against community norms.	Many said that FP methods are the affair of the whites not of the Africans (in Africa to have a lot of child it is the wealth)
	Restrictive religious norms	*Abortions, Adolescents*	Traditional and/or conservative beliefs that seem at odds with SRHR	Initially the FP issue was not well understood by the community because of the weight of religion, the dogma of certain religions, and socioreligious norms.
	Myths	*Misconceptions*	Things that communities and/or RLs believe about FP that are not scientifically accurate	Good information on FP that has broken down misconceptions, myths and rumors about FP.
	Culture	*Taboo, talking openly*	FP is not in line with traditional community values and should not be discussed.	Some RLs do not accept the use of modern methods of FP and have not integrated RLCs because their cultural beliefs / values do not allow them.
	Rumors	*Gossip, bribes*	Untrue stories told about RLs and RLCs in the community	Outsiders think that the RLs have committed themselves to FP for money… this propagates the rumors
	Travel		RLs have to go long distances in order to receive training, per diem, and/or other tools	They cannot make a long distance because the 4 bikes with SAFPAC 2 are all down
Strategies			Approaches and tactics used by the CARE team to change RLs negative perceptions, opinions, attitudes, etc. about SRHR	
	Social mapping	*Formative research*	Understanding more information about a community before implementing a project	To engage religious leaders in the promotion of reproductive health, CARE must continue to carry out the social mapping of the churches and mosques of the intervention zones at the beginning of the project and update them
	Religious texts	*Bible, Koran*	Documents that inform culture and belief systems	The belief of the community is contraindicated by religious doctrines, I quote "... multiply and fill the earth ...". Genesis 9: 1.

			Many Bible verses and suras in the Koran have given religious leaders confidence in supporting family planning
VCAT	*Attitudes, value, line crossing*	Materials and/or activities that help RLs to reflect on their beliefs about abortion and/or FP	Exercise of clarification of the values for the transformation of the bad attitudes in the supply of service in SRHR (FP / SAA ...)
Dialogue	*Group Work*	Talking to other people about FP/SRHR	The best strategy to use when training religious leaders is to do group work
Partnership		Working together with RLs	It is very important to have strategies that involve religious leaders/ Involve leaders in activities from the start of the project
Data		Using numbers and figures about health in communities to change RLs opinions and attitudes	Use alarming data on SR issues during project presentation
Communication Skills	*Advocacy, Facilitation skills*	Helping RLs to improve their ability to teach others about FP	Te best strategies used for training are to communication techniques
Selection	*Literacy*	Choosing the best RLs to undergo training and join RLCs	Selection criteria must be strict (reading and writing is also very important).
Testimonials	*Stories*	Using personal narratives to influence RLs opinions and attitudes towards RLCs	The acquisition of new knowledge with regard to practical cases / testimonials ... can influence the transformation of attitudes.
Committees		Forming RLs into groups	
Training	*IEC materials, journaling*	Teaching RLs more knowledge, skills and attitudes about FP/SRHR	Also training and follow-up in order to provide for the functioning and motivation of the members.
Supportive supervision	*Organization, coaching, leadership skills*	Providing sustained assistance to RLs to ensure that they are prepared to succeed in RLCs	Monthly, quarterly and semi-annual supervision. This support mobilized the leaders effectively.
Per diem	*Transportation, drink, soap, tea, sugar, snacks, badges, "visibilities, certificates*	The necessary provisions given to RLs to ensure that they are able to participate in RLCs	CARE can continue to assist leaders with soap, tea and periodic sugar during rainy season
Awards	*Excellence, champions, reward, certificates*	Recognizing RLs that are especially active and/or effective	CARE can continue to provide awards for excellence

Impacts			Influence or results of RLs supporting SRHR in their communities	
	Trust	*Respect*	Confidence placed in RLs by their communities	Religious leaders are highly trusted personalities who reach the people and understand the rural areas of well-supplied urban hospitals.
	Reach		The number of people that RLs are able to impact given their positions as RLs	Religious leaders are influential people in communities, which is why they can positively and negatively influence a mass of people.
	Goodness	*Holy, God, moral*	The status given to RLs in communities given their positions as RLs	SAFPAC's community-based approach to using RLs has enabled the SAFPAC project to reach many people (especially women) and accept the choice of family planning because RLs are considered the Light of the community. In other words, [they are] anointed or blessed by God and can only speak the truth for the good of their community.
	Interfaith	*Christian, Catholic, Muslim*	Bringing together more than one religious background	A best strategy is the establishment of RLCs to reinforce inter-religious cohesion.
	Demand		Increasing the number of community members who want access to FP services	The main role of RLCs is to create demand.
	Referrals		Increasing the number of community members who go to clinics seeking FP services	I can safely say that more than 50% of users of modern methods of contraception, were referred by the RLCs [to health centers] from 2013 to 2015.