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VOICES from the VILLAGE:

Improving Lives though CARE's Sexual, Reproductive, and Maternal Health Programs

Uzazi Bora: Meeting the Maternal Health Needs of Post-Conflict Kasongo District, DRC

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Introduction

Older people in the district of Kasongo remember the 1980s, when the health system worked fairly well. Medicine and supplies were available then, they say. Indeed, many things were available, and goods and people traveled easily on roads and the Lubumbashi-Kindu Kasongo train line. Kasongo, in short, was connected to Maniema province and the Democratic Republic of the Congo (then called Zaire). By the 1990s, however, corruption and neglect had left Kasongo in isolation. Basic services languished as rail lines, roads and telephone lines collapsed. In the early 2000s, war overran Kasongo. Military and rebel factions alike killed, raped and looted, profoundly traumatizing people already burdened by poverty and seclusion.

Need Source: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Though peace was restored around 2004, Kasongo's socioeconomic profile remains one of protracted post-crisis. Today, residents rely largely on their ingenuity to survive. Government and donor investment in development have been scant, and the district remains physically cut off from the rest of the country. For the health system, this means insufficient supplies, underpaid workers and little access to information. Kasongo's people — about 192,700, including almost 40,500 women of reproductive age — bear the consequences, although quantification is difficult. The national maternal mortality rate is 549 deaths per 100,000 live births,[1] but in war-affected eastern DRC, it might be double that.[2] Child mortality in Maniema province, where Kasongo is located, is 219 deaths per 1,000 live births,[3] the highest in the DRC.

CARE has worked in Kasongo and Maniema province since 2002, promoting reconciliation, combating malaria, increasing food security and working to improve the reproductive health (RH) of women and men.[4] Uzazi Bora, described in this case study, is the most extensive of CARE's health interventions in Kasongo to date.[5]

The Uzazi Bora Project

Launched in Kasongo in mid-2007, Uzazi Bora — "better childbearing" in Swahili — aims to ensure comprehensive RH services to reduce maternal and newborn mortality, placing emphasis on:

- Births in health care facilities, with skilled attendance;
- Emergency obstetric care (EmOC), including post-abortion care (PAC);[6]
- Family planning.[7]

Uzazi Bora combines facility-based and community-based activities, bolstered by interactive monitoring, use of data for decision making and advocacy with power holders at many levels. CARE's primary collaboration is with Kasongo's Health Zone Office (bureau central de zone, or BCZ), which is the local representative of the Ministry of Health.[8]

Training and Supportive Supervision of Health Workers

Competency-based training of health workers is at the heart of Uzazi Bora. At least one worker (and often all workers) from each of the zone's 22 facilities attended most of the medical training topics the project offered (see table, right). Doctors and nurses from the referral hospital and the three basic EmOC facilities traveled to Burkina Faso to learn emergency obstetric care from the African Institute for Reproductive Health (Institut Africain de la Santé de la Reproduction). This and other off-site training in the cities of Goma and Kinshasa were, according to Dr. Martin Tshipamba-Mukongo of the BCZ, "doubly rich, because participants also connected with other health workers, exchanged experiences, and learned at that level, too."

Training gains have been solidified via regular, supportive supervision. CARE and the BCZ use project data (see quarterly reviews below) to create monthly supervision plans, and jointly visit each facility and health worker. Uzazi Bora trains each facility's health committee (CODESA)[9] in management, analysis and advocacy skills, and trains traditional birth attendants to accompany women in labor to health centers for delivery.

LEVEL OF CARE	# FACILITIES
Referral hospital: comprehensive EmOC; family planning; STI treatment; VCT/ARV; care for rape survivors, including post-exposure prophylaxis (PEP).	1
Health centers designated as first-tier referrals: basic EmOC; family planning; STI treatment; VCT; care of rape survivors, including PEP.	3
Health centers: normal deliveries; family planning; STI treatment; VCT, care for rape survivors, including PEP; referrals for EmOC.	2
Health Centers: normal deliveries, family planning, STIs, rape survivors; referrals for EmOC, VCT, PEP.	16

TRAINING TOPIC	# HEALTH WORKERS
EmOC	38
PAC	15
Family Planning	25
Infection Prevention	17
Syndrome Tx of STIs	24
Drugs Management	25
Anethesia & Recovery	10
Lab Analyses	24
PMTCT	24

Rehabilitation, Logistics and Supplies

CARE collaborates with the German Agency for Technical Cooperation (GIZ, formerly GTZ) to rehabilitate health facilities, build maternities linked to referral health centers, ensure adequate sanitation and infection prevention systems, and provide supplies such as delivery beds and obstetric instruments. CARE and the BCZ employ numerous tactics to prevent stockouts and minimize the consequences of the DRC's chronic drug-supply shortfalls (see "Challenges").

Behavior Change Communication (BCC)

Uzazi Bora's BCC package educates and motivates individuals, and helps communities define and create new social norms around RH. CARE researches and tests health messages, then collaborates with a wide array of actors — they have included radio journalists, musicians, dancers, theater troupes and Kasongo's most popular comedian — to develop and deliver information. Because these "communicators" have learned the basics of RH they are able to truly inform their audiences, in a participatory and dynamic way, rather than merely parrot messages. Uzazi Bora also hones the knowledge and communication skills of some 360 community-appointed health educators (known as relais), who help keep the subject of RH alive in their communities. C-Change, another CARE health project, borrowed elements of the Uzazi Bora BCC package and expanded their use in four more provinces of western DRC via 3,000 relais, 100 community leaders, theater groups and local radio stations.

The *Orchestre NoKas* uses traditional music and original songs about health topics. Their family planning lyrics create a memorable image:

Don't be like the careless snake, whose babies scatter in the forest without sense, without guidance.

Finally, CARE taps into influential community groups, including misadi (women who are native to a village and hold some authority in social matters), mitonge (the village chief's male counselors) and the lubunga (the chief and his counsel, who make socio-political decisions for a community). These individuals and groups are powerful persuaders. They reinforce health messages and can both set and enforce expectations that new behaviors will be adopted.

Quarterly Reviews and Data for Decision Making

Uzazi Bora convenes two review sessions each quarter: one for health workers, the other for the many types of lay people (e.g., village chiefs, misadi, CODESA leaders, relais and representatives of local NGOs) who collaborate with the project. CARE and the BCZ present service-use and other data from throughout the health zone, and guide analysis and problem-

solving conversations. At the health worker session, for example, attendees might discuss why a health center is seeing fewer deliveries than expected, and then identify how to improve services. At the community session, attendees may use the same data to devise a parallel plan to increase outreach and step up involvement of lubunga and misadi in the catchment area.

> "Uzazi Bora is the first time CARE has done this kind of review in the DRC, and it has been exceptionally useful. In fact, it's the very definition of primary health care: the full participation of society at each stage of development."
>
> — **Dr. Louis Rukengeza, *CARE Health Advisor***

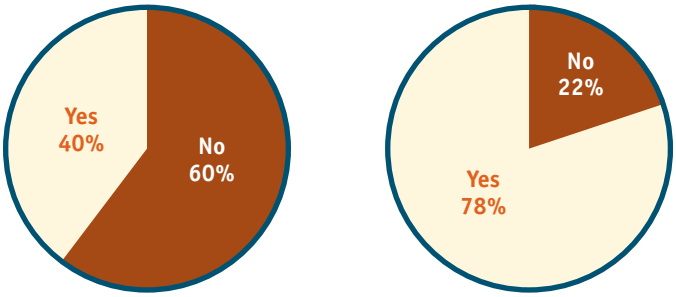
Results[10]

Professionally Assisted Births: A Sharp and Sustained Increase

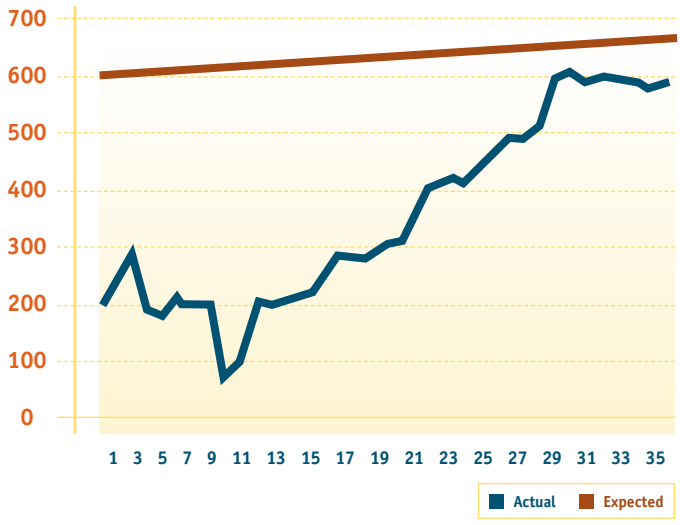
When Uzazi Bora began, only 40 percent of women in the project area reported that their most recent birth had been attended by a trained health worker. In just 2.5 years, that figure had nearly doubled, to 78 percent (see graph, right). Data from health facilities show this increase month-to-month and compare the number of assisted births to the number of expected births (see graph, right). The expected births figure — a population-based calculation[11] — is an important planning tool in a place like Kasongo, where the health system does not necessarily capture all actual births.

Data also show that women are responding to the improved health services and communication strategies. The proportion of actual to expected births at facilities reached a high of 90 percent in August 2010 and averaged 88.5 percent over the second half of that year.

LAST BIRTH ATTENDED BY A TRAINED HEALTH WORKER



ACTUAL V. EXPECTED BIRTHS AT FACILITIES PER MONTH



Increased Access to and Use of Emergency Obstetric Care

In the absence of a population-based survey to measure maternal mortality,[12] CARE and the BCZ use EmOC indicators[13] to measure the project's effect on women's wellbeing. These indicators include:

- **Availability of EmOC services.** Of Kasongo's 22 health facilities, one offers comprehensive EmOC and three offer basic EmOC. Four more centers provide almost all basic EmOC services. Thus the health zone, with fewer than 200,000 people, now well exceeds minimum international standards, which call for one comprehensive and four basic EmOC facilities for every 500,000 people.

- **Caesarean section as proportion of expected births.** Zero percent of women reported having had a caesarean section at project baseline; two percent did at endline. This is a shift in the right direction, but the percentage remains dangerously low. More progress is needed to reach the accepted range of 5–15 percent.

- **Met need for EmOC.** Met need is the proportion of all women with direct, major obstetric complications treated in EmOC health facilities. While this figure increased threefold — from 28 to 88 percent — over the course of the project, reaching the minimum acceptable standard of 100 percent will take a great deal of additional time and effort.

Post-Abortion Care Presentations Rise

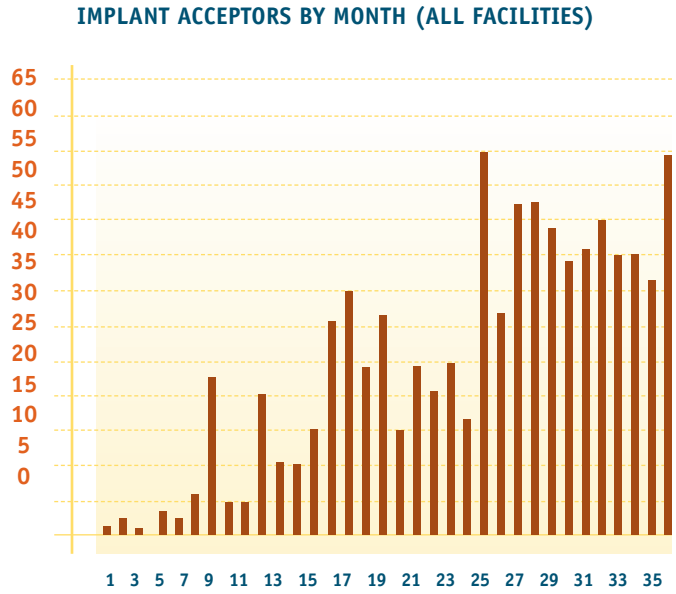
Another notable improvement was the increase in the proportion of PAC cases presenting at facilities (among all obstetric cases presenting) — from two percent when the project began to eight percent after 30 months. Globally, approximately 13 percent of maternal deaths are due to unsafe abortions, so PAC is a life-saving intervention.

Steady Uptake and Growing Acceptance of Family Planning

Uzazi Bora's family planning component shows positive trends. The number of people using modern methods for the first time increased and has remained elevated throughout the project. The average monthly number of new users is 325, about half of whom choose condoms.

> Aruna Saleh is head nurse at Kilometer 18 health center, and speaks for his peers when he says, "I'd had exposure to contraceptives before, and knew the technical aspects of most methods. But with the Uzazi Bora training, I am far more likely to *promote* family planning."

The contraceptive prevalence rate (CPR) for all modern methods rose from 2.8 percent (baseline) to 5.9 percent 20 months later. This was a strong achievement in a short time, especially given the chronic difficulty of ensuring that supplies are available in Kasongo (see "Challenges" section). Anecdotal evidence of family planning acceptance and uptake, expressed by health workers and community members, is discussed in the "Changing Ideas" section below.



Implants are especially popular. They make up 95 percent of long-acting or permanent methods accepted in the project area and 25 percent of all methods accepted, excluding condoms. Clearly, a significant proportion of women and couples are taking firm steps to achieve desired family size, yet may have reservations (linked to religion, finances or even modesty) about the IUD or surgical sterilization, which are also offered but far less often accepted. According to Kamamu Kalubwa Masumbuko, head nurse in Mufala village, "There were rumors at first. Some said that implants would sterilize you. But people's own peers provide the best evidence. To cite one case, a woman had her implants removed and became pregnant the very next month."

Changing Ideas, Changing Behavior

While Kasongo's health services are attracting more clients, changes are also underway in people's knowledge, behaviors and attitudes. CARE is observing new social norms for RH, and anecdotal evidence points to Uzazi Bora's extensive BCC activities and actors as the catalyst. "CARE's approach differs from that of others," says Dr. Tshipamba-Mukongo of the BCZ. "CARE does not just come along and tell. Instead, it asks, invites, encourages debates, provides examples and truly helps people change their minds with new information."

- **Dismantling myths.** Gaby Kapunga, CARE's BCC Officer in Kasongo, mentions the causérie educative (educational chat) as one effective way to help people harness their own knowledge to dispel misperceptions. For example, he cites a commonly held idea that "a pregnant woman with swollen feet is going to have twins. We know that swelling is actually a danger sign. When we talk people through the logic, they swiftly acknowledge scores of cases — the majority of cases — where such a woman does not bear twins. As they apply reason to myth, they replace myth with fact: A woman with swollen legs should immediately consult a health worker."

- **Inspiring others.** Recognizing the particular effectiveness of peer-to-peer persuasion, CARE arranges for Mbayo Maendeleo members (see text box, right) to visit neighboring villages and hold their own educational chats. Their passion for saving the lives of women and children, combined with their personal testimony about prenatal care, assisted deliveries and, in some instances, family planning, make them especially inspirational. Dr. Tshipamba-Mukongo notes, "We see a sharp rise in assisted births after Mbayo Maendeleo visit a village."

- **Establishing new social norms.** "We used to assume that a woman's death (in childbirth) was God's will, and beyond our control," reflects Lububula Gudula, chief and namesake of Lububula village. "With Uzazi Bora, people understand it was really human error." By using new information to make RH decisions, individuals and influential groups, including Chief Gudula and his lubunga, are

A Positive Direction

Misadi are women born (rather than married) into a village, and they wield a certain influence in social affairs. In 2004, the misadi of the village of Mulangabala decided to expand their role in a truly innovative way: Dubbing themselves Mbayo Maendeleo ("moving in a positive direction"), they added a mutual aid component to their association. "If someone is sick, we organize their care," says President Amida Assani. "If there is a death, we help with the funeral. And we work together in each other's fields."

This mutual aid aspect of women's groups may be common elsewhere in Africa, but not in Kasongo. "Women's associations are rare here," says Kapunga. "Women tend to be isolated at home; men's assumption is that if women gather, they will encourage each other to rise above their station."

"When CARE arrived to introduce Uzazi Bora, we were taken with their message and wanted to join in," continues Assani. "We wanted to play our part in reducing women's and children's deaths." Mbayo Maendeleo received training from CARE and now influences change in Mulangabala as well as surrounding villages.

And the group has innovated yet again: Original members retain the traditional influence of misadi, but they welcome all villagers' participation when it comes to matters of development and progress. "We include the women who married into Mulangabala and all our daughters. Even the men — they may wear pants, but they can be misadi," concludes Assani. "We are all misadi when it comes to development. In this way, Uzazi Bora's work will live on."

establishing new social norms. Today it is expected, says the chief, that women attend prenatal clinics and give birth in health facilities. It is expected that a good husband facilitates his wife's access to these services. It is expected that traditional birth attendants collaborate with the health system to ensure women's care.

Shifting norms are also apparent when it comes to family planning. Rumors within communities are increasingly supplanted by new ideas. "Men feared that modern family planning would throw women into lives of debauchery," says Amadi Assani of Mulangabala village, herself an implant user. "Yet everyone acknowledges that we have historically tried to space pregnancies and that we have a host of traditional methods. Now, households that plan serve as an example to others." In fact, people have been most responsive to BCC messages that position family planning as a path to prosperity and peace, and contrast the planned family to the stress and burden of a large household. Chief Gudula explains, "When farmers sow and harvest and immediately sow again, that's called kabadi-badi. It's a bad practice, of course, because the quality of soil and plants both suffer." Applying the phrase to procreation, he continues, "We've reached the point that kabadi-badi makes a woman feel ashamed, and the lubunga will call the man in and tell him he is behaving irresponsibly."

Challenges

Remote, Isolated Kasongo

"The people of Kasongo are ready for development. Yet operationally, this is still a post-crisis environment," says CARE's Dr. Louis Rukengeza, underscoring the near-absence of investment in Kasongo, despite nearly eight years of peace. Kasongo's remoteness discourages donor and government resources that could help it move from post-crisis to development, thereby ending its isolation and attracting further investment. CARE understands this phenomenon: Simply put, there is nothing easy about working in Kasongo. "Access is hugely difficult," continues Rukengeza, pointing out that all staff and supplies must travel via small plane from Goma, and overland travel within the zone is extremely arduous. "It takes a tremendous amount of resources, and logistics work by CARE in Goma and in Kasongo, just to make the project run. Staff find themselves working seven days a week to make up for delays caused by poor conditions.

"The greatest challenge to Uzazi Bora is Kasongo's isolation."

Drug Supply

Maintaining a sufficient stock of supplies and contraceptives is likewise a chronic problem in Kasongo, and one that has plagued CARE and the BCZ since their collaboration began in 2002. Maniema's provincial capital lacks a central pharmacy, so supplies must be routed from Kinshasa directly to district capitals, such as Kasongo. These shipments can easily go astray or, because their volumes are smaller, fall to the bottom of the priority list. Yet even a provincial pharmacy would do little to affect the problem-riddled national supply system.

Lessons Learned

Drug Supply (Continued)

One of CARE's global operating principles is to seek sustainable solutions to pressing problems. As a result, CARE typically works to strengthen, support and improve existing systems within countries and communities, rather than create parallel, unsustainable systems for the sake of expediency. But in the DRC, the drugs supply system is broken. CARE concedes the need to act expediently and has sourced supplies directly from the United Nations Population Fund (UNFPA) and a neighboring province, because the alternative is no supplies and ultimately no services. At the same time, CARE advocates, and helps others advocate, to influence the government and donors to implement the policies they have devised to reform the broken system.

Systems Strengthening or Service Delivery?

Kasongo's health system desperately needs support after decades of decay, war and ongoing post-crisis challenges. CARE has pursued an intensive partnership with the BCZ to build skills and reconstitute systems, especially as they relate to RH. Effective partnerships

> "(W)hen I arrived, there was hardly a health system at all. Today, there is tangibly a system (in south Maniema), and it is recognized as such by those in it and those outside it. And our best maternal health and FP outcomes are in Kasongo health zone, because of our interface with CARE."
>
> **— Dr. Antonio Lozito, *GIZ***

demand prodigious amounts of time and patience if they are to achieve their desired ends, and CARE's partnership with the BCZ is no exception. Yet at the same time, the need for improved services and health outcomes is pressing. CARE, health care providers, donors and, above all, the people of Kasongo, are anxious for better care and better lives.

Uzazi Bora is challenged every day to meet these frequently competing needs. Like any development project, its constraints (money, time, staff, donor priorities) often seem larger than its resources and mandate.

Next Steps and Future Opportunities

Uzazi Bora begins a second phase in late 2011. In the ensuing two years, CARE will continue to strengthen health systems, improve RH service delivery and engage communities in Kasongo. CARE will also expand the project to include parts of nearby North Kivu province, which is still plagued by war.

The Community's Role Grows

CARE staff and partners in Kasongo like to debate the relative weight of the project's work within the health system and its work in communities. "Uzazi Bora's most visible success is the vastly increased skills of the health care providers," says Dr. Tshipamba-Mukongo of the BCZ. Gaby Kapunga of CARE counters, "The community has truly adopted this project, and that is why we have such good results. We have done marvelous things on the technical side because of the community." Both arguments, of course, are correct, and Uzazi Bora's second phase will continue its work in the health system and with communities.

The project amply confirms that, in a country where governance skills and will are inadequate at most levels, communities do have structures that form a solid platform for good governance. These include the lubunga, the misadi (especially the expanded membership and development focus described in the text box, page 7) and the CODESA. CARE will introduce the "Partnership Defined Quality"[14] methodology to help communities further refine their roles and goals, and to provide a framework for even better interaction with the health system. The methodology will guide the creation of community-managed referral systems, for example, and link all players in a functioning referral network, especially for EmOC.

Health Systems and Social Structures

CARE's global empowerment framework compels us to pay close attention to the structural and relational underpinnings of poverty, even as we build the skills of individuals and introduce high-quality technical inputs.

In the context of a project like Uzazi Bora, people who are marginalized are only partially served by better health care and health knowledge. They must also exercise control over what happens to their bodies, gain access (financial, physical, decision-making) to health care, and live within family and community structures that recognize and support their rights to both.

In Uzazi Bora's first phase, CARE opened the door to empowerment work via BCC activities and by supporting medical care for survivors of sexual violence. These small first steps were met with interest, mostly positive, that foretell the second phase's much broader attention to the gender norms and structures that perpetuate the inequities that women face and that threaten their health. Uzazi Bora will make widespread use of effective CARE approaches, like Social Analysis and Action[15], to deepen community understanding of gender norms, and will support the replication of the Mbayo Maendeleo women's association in other Kasongo villages. Changing social norms will, in turn, further drive demand for and use of quality health services. "There is still much work to be done," reflects Guy Joseph Imbanza, CARE's Advocacy Officer. "Women must fully occupy the position of speaking up for their own health and making decisions about their own lives."

"The change I want is freedom of expression, and understanding between the sexes," says Tiba Madua of Kasongo's Mulangabala village. "A man used to take all the money, even when the woman worked the fields, too. He would even use the money from her labor to buy a second wife. Now she can keep some of her own earnings, and a brave woman might even to go the lubunga to express herself."

Madua's hopes for the future align with CARE's contention that women's empowerment must address multiple aspects of women's and men's lives. Women must change ("a brave woman might go to the lubunga"). Relationships must change (the man allows the woman to "keep some of her own earnings"). And structures must also be laid bare and addressed: In this case, the social and even religious structures that support polygamy and unequal relations within marriage, and the notion that men purchase women. In Uzazi Bora's second phase, CARE will help participants examine the social, cultural and economic opportunities and limitations that their society attaches to women and men; how these socially constructed gender norms improve or impoverish lives; and how they can be changed.

A Framework for Broad, Deep Change over Time

Sustainable changes to health systems and social structures take more time than the lifespan of a typical development project, such as Uzazi Bora. This is why CARE is adopting a framework for addressing underlying causes of poverty among carefully chosen, historically vulnerable groups. In the DRC, one such group is poor and vulnerable women and adolescent girls. In practical terms, this means that over a 10-year period, CARE will cluster its technical interventions,

choose its partners and boldly advocate for an integrated, comprehensive package to meet the diverse needs of this group. Women and girls (and the men and boys in their lives) in Kasongo will benefit not only from better health services and information, but from a cohesive platform of actions that aim for social justice, equity, protection and the realization of human rights for all people.

According to CARE's Dr. Rukengeza, "We are seeing that women now stand up and speak up. They talk about the violence done to them, for example, and understand it is an abuse.[16] But the changes we have seen are not yet permanent. People will revert to their traditions, where women have no voice. But if our interventions — and here I mean not only CARE but partners and communities — go on for another eight or 10 years, I am confident that women's lives will have changed 100 percent."

A proverb that you will hear around here is mimba yote ni kaburi. Every pregnancy is a grave waiting to be filled. The Uzazi Bora project arrived at the right time, and with the right interventions. It truly responds to the needs of the people.

— Awazi "Jogo" Mbavu, one of two DHO nurse supervisors in Kasongo

[1] Ministère du Plan and Macro International. 2008. Enquête Démographique et de Santé, République Démocratique du Congo 2007. Calverton, Maryland, USA, page 203.

[2] Coghlan, B. et al. (2006). "Mortality in the Democratic Republic of Congo: A nationwide survey." Lancet 367(9504): 44-51.

[3] Ministère du Plan and Macro International. 2008. Enquête Démographique, page 189.

[4] From 2002-04, CARE provided training, facilities rehabilitation and supply logistics (ECHO funding); from 2004-07, its Family Planning Project supported RH in all health zones of southern Maniema Province (USAID funding). At present, CARE is only one of three development organizations present in Kasongo.

[5] RAISE, a joint initiative of Columbia University's Mailman School of Public Health and Marie Stopes International, catalyzes change in how RH is ad dressed by all sectors involved in emergency response, from field services to advocacy, from local aid providers to global relief movements. Each of its six projects on three continents is implemented by a different organization; in the DRC's Kasongo, it is CARE. Columbia University provided M&E technical assistance to the Uzazi Bora Project.

[6] Both spontaneous miscarriage and induced abortion (illegal in the DRC). "Health workers learn to treat women in either situation, without judgment," according to Dr. Martin Tshipamba-Mukongo of Kasongo's BCZ. "But the provider needs to know which, because (an amateur) abortion can be a much more complex and risky situation."

[7] *Uzazi Bora* also devotes attention to: syndromic treatment of sexually transmitted infections (STI), prevention of mother-to-child transmission (PMTCT) of HIV; medical care for survivors of sexual violence; and advocacy at multiple levels. These smaller interventions produced important outcomes but are not the topic of this case study.

[8] Kasongo is the name of a district within Maniema province, the name of the district's capital city, and the name of a health zone within the district. Uzazi Bora works throughout the health zone; unless otherwise noted, Kasongo refers to the health zone in this document.

[9] *Comité de Santé;* a government-mandated body whose citizen members represent communities' needs to each health center.

[10] Numerical results are drawn from monthly service data, carefully defined and collected at each health facility, and Uzazi Bora's baseline andendline surveys. Columbia University through the RAISE Initiative provided extensive technical support in monthly data collection and analysis as well as conducting and analyzing the surveys.

[11] The World Health Organization recommends using four percent of the total population as the proportion expected to give birth in any year, divided by 12 months.

[12] The next Demographic and Health Survey will occur in 2012; it will calculate maternal mortality at the *national* level.

[13] These are process or output indicators that measure the actions that prevent maternal mortality and morbidity. See WHO et al.'s *Monitoring Emergency Obstetric Care: A Handbook,* at www.unfpa.org/public/publications/pid/3073.

[14] http://www.coregroup.org/our-technical-work/initiatives/diffusion-of-innovations/83.

[15] http://www.care.org/careswork/whatwedo/health/downloads/social_analysis_manual.pdf.

[16] Violence perpetrated against women within households is mind-numbingly routine: 94 percent of female respondents to CARE's baseline survey reported that they had experienced violence at the hands of their partners in the year preceding the survey; that figure decreased to 91 percent at endline.

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