



Trip Report

APAC's Meeting on Intensified Country Action Planning Process

Sixth African Population Advisory Committee Meeting

Nairobi, Kenya: May 24-30, 1994
Arusha and Dar Es Salaam, Tanzania: June 1-4, 1994

Lalla Touré M.D. M.P.H.
Population Adviser



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APAC'S Meeting on Intensified Country Action Planning Process

Preamble

The Intensified Country Action Planning Process (ICAPP) meeting took place in Nairobi, May 24–26, at the invitation of Kenya's National Council for Population and Development (NCPD). The meeting was jointly chaired by the Honorable Patrick Balopi, Minister for labor and home affairs of Botswana, chairman of the African Advisory Committee (APAC); and Ambassador S.B.A. Bullut, Director of the NCPD.

The meeting was well attended by 28 participants from Burkina Faso, Cote d'Ivoire, Ghana, Kenya, and Malawi. Nigeria was not represented, as planned, due to unforeseen travel problems. Participants served in the capacity of technical experts, and were also formally associated with government national planning councils, ministries, or in nongovernmental organizations providing health, family planning, and STD/AIDS prevention services. A list of participants list is attached as Appendix C.

The purpose of the meeting was to discuss the need for more intensified strategies for population and STD/AIDS prevention in countries of Sub-Saharan Africa (SSA), with particular attention to more effective implementation. Emphasis on "Intensified Country Action Planning Process (ICAPP) for Population and STD/AIDS Prevention" follows a recommendation by the Global Coalition for Africa (GCA) at its annual meeting in 1993. This was endorsed by the African Population Advisory Committee (APAC), and encouraged by several countries participating in APAC activities.

Discussions were guided by an overview paper prepared by the secretariat of APAC (see Appendix B). The overview paper presented the rationale behind ICAPP, its principles, and objectives. Discussions were further focused by six country studies. Each of these contained a preliminary and exploratory application of the ICAPP framework, and analysis of population programs and activities of the six countries represented at the meeting.

Framework of the Meeting

THE FIRST DAY started with a welcoming speech from the Kenya NCPD director followed by opening remarks by the Botswana Minister of Labor, current chairman of APAC. The latter gave an overview of APAC's history and its Population Agenda and explained the purpose of ICAPP.

Then all participants were taken on a field trip to Machakos, a district located 63 kilometers from Nairobi, to visit some pilot programs APAC is involved in. The purpose was to show a concrete example to participants of what has really been done in

Framework of the Meeting

the field, since Kenya was the first country to embrace and adopt APAC's first activity called "Agenda for Action to Improve Population Program Implementation" mostly known as "Agenda." Machakos is one of the four districts where the Agenda Process has been adopted and has made great strides.

In Machakos, participants were welcomed by a very committed and enlightened District Commissioner and a very dynamic District Population Officer (DPO) who spent the whole day taking us to four of their projects.

- ◆ The first project visited was a "Scout" program, an after school and weekend program for youth. It teaches young boys and girls how to protect the environment by developing agroforestry. It also has a component of family life education with a family planning and reproductive health sub-component. This project is fully sustainable through the money made by selling fruit and flower trees grown by youths.
- ◆ The second project visited was the "Kitathe Women's Group," a women's income-generating activity based on making and selling handcrafts. This empowered women's group was trained in family planning. Now they themselves train other women in the locality about family planning and its benefits through community outreach and home visits.
- ◆ The third project visited was a "women's energy-saving project". This income-generating activity develops women's autonomy and self-esteem by teaching them how to build and sell energy-saving stoves. They make money and save, at the same time, the quantity of wood needed in each household. This reduces the number of children needed (fetching water and wood is one of the reasons for large family size in rural areas). This women's group has also been trained and is used to expand family planning messages and methods among their peers.
- ◆ The fourth project visited was a "Scout Camp" run by the Scouts (boys and girls) that provides refuge and guidance to about 70 school drop-outs and street children, ranging in ages from 3 to 15 years. With their own labor and community participation, they have put up a building where the young children can meet and have food. The food is generated by planting vegetables and keeping small domestic animals. Arrangements were made to send the youngest to school by providing them the basic needs (shoes, clothes, and health care). The oldest of the group have been trained in peer counselling. As counsellors they inform and educate the young children through poems, songs, and sketches that address everyday concerns and threats to good health. Particular emphasis is on reproductive health (STDs, HIV/AIDS, teen pregnancy and family

planning). These counsellors will be used for community based distribution of contraceptives.

All these projects are beautifully coordinated by APAC, other NGOs, and several ministries: Health, Social Affairs, and Education.

THE SECOND DAY started with discussions and feedback about the field trip. Participants were positively impressed by the projects visited. They particularly mentioned the sustainability aspect, the harmonious and well functioning integration of family planning and development activities, and the excellent coordination in the field between the APAC task force, the District officers, and the different Ministries involved.

Then a presentation of the ICAPP paper was made. The rationale was a need for intensified efforts to energize national capacities and increase political commitment to population programs as well as promoting more cost-effective strategies to strengthen the link between reproductive health, family planning, and the prevention of STD/AIDS. The objectives were clearly stated as well as the goals for the framework: (i) help build national leadership, (ii) help build national capacity, and (iii) help shift the population process more under the control of government leadership. Then ICAPP's six-steps process was defined and explained to participants, and submitted for their discussion, amendment, and adoption or rejection. The ICAPP paper is attached in Appendix A, and the summary of the six steps are as follows:

- ◆ Step 1: assemble data on the concentration of population/FP services, activities, and financial resources by all major service providers.
- ◆ Step 2: analysis of data from Step 1, combined with information from qualitative assessments, to determine (a) complementarities in efforts by major players, and (b) supply/demand gaps that need to be filled to produce an intensified country action plan.
- ◆ Steps 3 and 4: prepare a national action plan with a consensus based on the results of the first two steps, with emphasis on improved service delivery, generating demand for services, and appropriate monitoring and evaluation.
- ◆ Step 5: carry district level consultations to present and discuss resulting Intensified Action Plans.
- ◆ Step 6: government-led consultation with donors and NGOs on Intensified Action Plans.

Framework of the Meeting

It was made clear that these six steps should not be a onetime exercise but continuous.

Lessons learned from the country studies were also summarized. The country studies were prepared by the APAC secretariat in Washington, based on the first two steps of the ICAPP process to gather donor information about what they are doing, and to mobilize data that can be objectively analyzed. The conclusions that can be drawn from the lessons learned are

- ◆ A strong partnership is required between Government, church, NGOs, and private organizations to launch ICAPP. Government should take the leadership.
- ◆ There is a great fragmentation and lack of coordination of FP/STDs/AIDS programs.
- ◆ There is a lack of transparency at the central level, of resource mobilization and planning.
- ◆ Nothing is known about households' out-of-pocket expenditure for family planning. This is a gap for the institution of cost-sharing to sustainable family planning and STD/AIDS services.

After the presentation on ICAPP a number of questions were addressed to participants (see ICAPP paper in Appendix A). Working groups then answered the questions and made recommendations to be taken to the GCA meeting in Harare the following week.

THE THIRD DAY started with six country studies presented by country representatives and focused on a preliminary and exploratory application of the ICAPP framework and analysis of population and STD/AIDS control programs and activities. Discussions followed on how the ICAPP process can be helpful to the countries, followed by specific recommendations. Major points of discussion and recommendations have been summarized and follow.

Major points of discussion

All participants were in agreement that the ICAPP framework contained essential steps to intensify national population and STD/AIDS prevention strategies and to make them more effective. The first two steps were seen as "baseline data collection and analysis" or "basis for determining action;" and the last four steps as "translation of data into action" or "means of taking action." But they suggested the need to add a seventh step, which is operations research. This last point was well taken by the APAC Secretariat.

Major Points of Discussion

Participants were very receptive to the six-step process envisioned in ICAPP that stresses the need for strong links between centrally planned activities, management at the decentralized levels, and involvement of beneficiaries in identifying, prioritizing, monitoring, and evaluating activities.

There was also agreement that some countries were further along than others in taking actions envisioned by ICAPP and linking “bottom-up” with “top-down” activities. A sharing of country experiences in this regard was therefore welcomed.

After the review of each country paper, participants agreed on six major points.

- ◆ First, all country groups agreed that the information sought in the ICAPP data tables (on providers, services, expenditures, geographical concentrations) was essential for good planning but rarely available as needed. There was agreement that greater endeavors to produce and maintain such databases would help reinforce managerial capacity and solidify the information base required for improved surveillance, assessments of complementarity of ongoing activities. Such information, it was agreed, would be particularly useful in determining the relative resources and strengths of the many players active in the population field, including government, NGOs, the private sector, and donors. Such information would also be important in the assessment of the cost-effectiveness of ongoing and future activities.
- ◆ Second, several country groups conveyed the importance of strong institutional capacity to carry out the planning process and actions envisaged by ICAPP. National Population Councils, or Population and Development Units within ministries of planning or health were identified as appropriate places to undertake ICAPP-type planning. However, several limitations and gaps were mentioned. One is that such Councils and Units often lack the technical expertise and resources required. For example, monitoring the flow of resources and assessing cost-effectiveness requires special skills that tend to be in short supply. Another concern was about the technical ability to design and manage more decentralized programs and grassroots activities with strong popular participation. Lessons learned and methodologies involved were familiar to some country participants due to their involvement in APAC’s Agenda activities, whereas they were not familiar to others. Therefore, APAC’s help would be greatly appreciated in this area.
- ◆ Third, and related to the importance of institutional capacity building, was a recognized need to promote public-private collaboration far more extensively. All country participants acknowledged that some kind of co-

Major Points of Discussion

ordinating mechanism had been established or advocated. Most of these brought government and donor representatives together. Sometimes consortiums of NGOs were operational. For the most part, however, true collaboration and coordination remains very weak. Furthermore, institutional capacity tends to be thought of only in terms of what government can do, rather than what the public sector can do in collaboration with its partners. Participants, therefore, welcomed the emphasis in ICAPP on identifying and developing the role that private voluntary providers and private-for-profit providers play in population and STD/AIDS prevention activities.

- ◆ Fourth, all country groups were concerned about sustainability of their population and STD/AIDS prevention programs. The predominant role played by donors in financing ongoing programs—as highlighted in the ICAPP tables—was particularly noted. Participants were concerned about the apparently small financial role of government, the paucity of information on household or out-of-pocket expenditures, and overall sustainability were donor sources to dry up. In this regard, APAC's Population Agenda activities were acknowledged to be particularly positive in view of their stress on sustainability at the district and community level, and their efforts to link population and STD/AIDS activities with technical assistance and seed money support to ongoing income-generating activities. A major goal of all population and STD/AIDS prevention activities—to render households more responsible and capable of taking actions to improve their own reproductive health—was therefore acknowledged as an appealing feature of Agenda activities.
- ◆ Fifth, country groups that have had extensive experience with Population Agenda activities—namely Kenya and Ghana—drew strong parallels between the ICAPP six step process and the structuring of the Population Agenda. It was pointed out that the Agenda process (though largely bottom-up and community based) stresses similar elements of planning, including (i) a detailed assessment of who is doing what at the subdistrict level; (ii) strong involvement of beneficiaries in identification of population and development concerns; (iii) consensus building in the form of beneficiary participation in the identification of programs/activities; (iv) use of community resources to help sustain programs (e.g., in-kind contribution of labor, materials); (v) close accountability for resources and expected impacts; and (vi) a natural blending of information, education, and communication on the relationship between family planning, reproductive health, and STD/AIDS prevention. Each of these elements was viewed as a key component of an enabling environment for population

and STD/AIDS activities. In the Agenda process, it was pointed out, projects featuring the above elements initially served as "entry points" for initial discussion of population issues and family planning methods.

- ◆ Furthermore, expansion of Population Agenda activities into a larger number of districts was viewed as a way of reinforcing government decentralization plans and stronger involvement of district management and community participation. Government participation was viewed as instrumental, and, once activities had incubated, it was felt they could appropriately serve as a symbolic illustration of what could be done, or turned over to national or local-level NGOs to manage.
- ◆ Sixth, all country participants felt the exploratory country applications of ICAPP represented a good start, as they were a fruitful way of organizing and presenting material, thus laying the groundwork for a more informed approach to strategy development. The country studies were acknowledged to be understandably incomplete and decision for further work on them by national experts was made, with a tentative timetable.

Recommendations

In support of further action on ICAPP, the group adopted the following general recommendations:

1. The group adopted the concept and process of ICAPP as discussed during the meeting. The group believes that the ICAPP approach of combining bottom-up with top-down approaches has the potential of substantially improving the implementation of population and STD/AIDS prevention programs.
2. In view of the above, and to begin preparatory work to carry the process forward, each country group described a number of actions that would be taken in-country, with an accompanying timetable (see Appendix B).
3. Since resources, political commitment, and technical assistance will be essential for the support of in-country work on ICAPP, the group requests APAC to help its member countries in these respects through its contact with the Global Coalition for Africa (GCA), donors, and other agencies.
4. Databases for performance assessment as well as for training in different aspects of programs (particularly management) are important gaps in countries seeking to expand on the ICAPP process. Therefore, APAC should form a subcommittee to focus on these aspects and organize technical and financial support to them.

Recommendations

5. The group found the Population Agenda approach to be potentially useful in adapting people-oriented approaches, and thus reducing existing schisms between preferences and issues identified at the community level, and the more objectively defined goals that often form the basis of nationally formulated programs. They would like APAC to continue to strengthen and to expand the Agenda.
6. As STD/AIDS prevention and population programs have considerable common interests, they should be closely coordinated in the effort to expand on the ICAPP process, so as to ensure synergy and make the best use of resources available to both programs.
7. Both for STD/AIDS prevention and for population programs, a steady supply of contraceptives (particularly condoms) will be critical. APAC may wish to define the role it can play in assuring such supplies, such as contacting donors and facilitating assessment of local production of condoms.
8. Exchange of information on successes and failures among countries that aim to intensify their population and STD/AIDS prevention programs (akin to the process in ICAPP) will be useful, and therefore APAC should organize meetings similar to the present one every two years.
9. To carry out the above activities, APAC should strengthen its Secretariat by additional manpower and resources.

**Sixth African Population Advisory Committee (APAC) Meeting
May 28 to 30, 1994**

This annual meeting took place in Nairobi, at the invitation of the Kenya APAC Country Advisory Team led by the chairman of the National Council for Population and Development (NCPD). The meeting was chaired by the Honorable Patrick Balopi, Minister of Labor and Home Affairs of Botswana, chairman of the African Population Advisory Committee (APAC).

The meeting was well attended by 30 participants from five of the six APAC Agenda exercise countries namely Burkina Faso, Cameroon, Ghana, Kenya, and Senegal (Nigeria could not make the trip due to last minute problems). Participants were members of APAC Country Advisory Teams (CAT) or country task forces, and are generally technical experts who have launched and followed the Agenda exercise in their respective countries. The meeting was also attended by representatives of several donor agencies namely USAID, World Bank, UNFPA, Rockefeller Foundation, IPPF, and the Netherlands Embassy.

The meeting started with a welcoming speech by the Honorable Balopi, followed by official opening remarks from the Kenyan Vice-President and Minister for Planning and National Development, the Honorable Professor George Saitoti. Professor Saitoti stressed the importance of population matters in African countries' economic development and the need for actions to decrease the high rates of population growth. He also emphasized that implementation of population programs in Africa has faced several difficulties including lack of political commitment by some governments, lack of adequate financial resources, and the absence of a strong institutional framework in some countries. But the succession of important population meetings in Africa—1984 in Arusha, 1992 in Dakar/Ngor, and the coming Cairo International Conference on Population and Development—indicate the seriousness with which African governments are now taking issues related to population and development.

Dr. Fred Sai made a briefing on the latest in the population field internationally. He pointed out that the consensus is to put emphasis on development, poverty alleviation, and environmental protection in addition to population programs. Population should be focused on expressed need, not be target driven.

Dr. Benjamin Gyepi-Garbrah, from the APAC Secretariat, gave an overview of Agenda activities so far in 100 communities in six countries, with emphasis on the launching, process, design, and implementation. The constraints faced by the Agenda were also stressed: shortage of resources, lack of manpower at the secretariat level, inadequate dissemination of Agenda activities, and lack of reliability

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among donors. He also made a summary of the ICAPP process and the nine recommendations made by the participants of the preceding ICAPP meeting.

Then a detailed presentation of Agenda activities was made by each country team. These country activity reports gave background information on localities chosen for the activities, an overview of the institutional base for the Agenda, as well as the roles and responsibilities of the Task Forces and Country Advisory Teams, the Agenda process, and its findings. A description of the projects (implementation and fieldwork activities) and a preliminary assessment of the impact of the process were also made by presenters, followed by recommendations for future directions, based on lessons learned. Some of the lessons learned are as follows: (i) Communities are willing to contribute their resources toward development programs they themselves identified, if they are involved in the design and implementation. (ii) Communities are aware of the relationship between population increase and cost of living. But unless family planning is integrated with development issues in development programs, it will not make substantial progress. (iii) The Agenda process is cost-effective because it combines research and implementation. (iv) There is still a gap in knowledge on population issues among implementers, therefore training should be emphasized in the Agenda process. (v) There is a need for intersectoral collaboration. (vi) If communities are given guidance about using their funds, they move very quickly in using them correctly.

A monitoring and evaluation framework was presented by the chairman of the monitoring and evaluation committee. The committee developed a detailed scope of work and methodology of evaluation to look at country Agenda activities and assess what value the Agenda exercise brought to the areas where it has been established. After evaluation, the committee will be able to say exactly what has been achieved. The plan is to send external evaluators to evaluate activities in one or two francophone countries and one or two anglophone countries and summarize findings. Some participants expressed a preference for a cross-country evaluation by people who are already familiar with the Agenda process. The final decision was to have both external and cross-country evaluations to be scheduled for the next few months.

A decision was made to try to have an APAC symposium at the ICPD in Cairo in September 1994. This will allow APAC the opportunity to present to the international community their initiative and what they learned about implementation of population programs in Africa. A second decision was that the main committee should take the document prepared and present it to the governments.

Comments were made by sponsors/donors who were at the meeting: UNFPA, Rockefeller Foundation, IPPF, the Netherlands Embassy, USAID/REDSO, and the World Bank. They all are willing to consider further financial assistance to APAC,

but they would like to see the planned evaluation carried out, and would like to be kept informed on a regular basis on APAC activities. They support the APAC initiative and would like to see it presented at the Cairo conference.

A new APAC chairman was elected in the person of the Honorable Professor George Saitoti, Vice-President and Minister for Planning and Development of Kenya, for a one-year term.

APAC's future, membership, and legal status were also discussed. Should APAC become an international nongovernmental organization, an intergovernmental organization, or keep the same status? It was agreed that, since it has proved to be useful, it should continue with the same status. But if activities expand and if financial resources follow the same growth, the Secretariat should plan to move to Africa (from Washington/World Bank). The following achievements and recommendations were made:

- ◆ APAC is responding to one of the development needs: full involvement of people in their development planning and implementation.
- ◆ Resources need to be intensified: need to mobilize internal resources from national, nongovernmental, and other organizations, in addition to funds from the Secretariat.
- ◆ APAC should be seen as one of the tools for implementing national population programs. It should fit upward in policies and downward in the grassroots.
- ◆ There is a need to advocate for the Agenda.
- ◆ The long-term goal is to expand the Agenda process to other countries and internalize it within institutions and programs. It is a labor-intensive approach; there should be good coordination between national programs and APAC.
- ◆ Evaluation has been pushed to a secondary level, there needs to be an effort to put it high on the list of activities.
- ◆ The link with the Global Coalition for Africa is positive.

Contacts in Kenya

Contacts in Kenya

During my stay in Nairobi and Tanzania, I met with representatives from several organizations.

African Association for the Promotion of Adolescent Health (AAPAH)

AAPAH was launched at the first Inter-African Conference on Adolescent Health held in 1992 in Nairobi. This meeting was jointly organized by Center for Study of Adolescent (CSA), Center for African Family Studies (CAFS), and National Council for Population Development (NCPD) and was funded by a group of donors: Rockefeller Foundation, Carnegie, Dutch, World Bank, Population Council, Pathfinder International, and the former Center for Population Options (CPO). It sponsored 400 delegates comprised of researchers, policy makers, and youth-serving organizations from 40 African countries including South Africa.

AAPAH encourages the formation and activities of organizations on adolescent issues. It aims at coordinating continental activities through newsletters, seminars, and workshops to raise issues concerning young people with African leaders. OAU participated at the first conference, and expressed its willingness to include issues raised by AAPAH in the General Secretariat's office for presentation to Ministries of Health and Foreign Affairs.

AAPAH currently encourages the creation of a national association in each country to bring together all organizations working on adolescent issues. The national association will be the local chapter of AAPAH. For example, Kenya already launched the Kenya Association for the Promotion of Adolescent Health (KAPAH), hosted by CSA and comprised of representatives from different organizations. See Appendix D for objectives and participants list. KAPAH is already very active at the national level and would like to share its experiences with other countries.

GAPAH, the Ghanaian Association for the Promotion of Adolescent Health, has also been launched and is working on its agenda. Several other countries (Tanzania, Uganda, and Zambia) would like to launch their local chapters by organizing a national meeting but are lacking funds.

AAPAH, through its committee chaired by a Kenyan medical doctor, is currently seeking funds to strengthen its ability to communicate with other countries and to help organize national meetings to launch local chapters. The Kenyan chapter (KAPAH) has a number of studies on adolescent issues it would like to share with other countries. Among those studies are a big report from the first Inter-African Conference on Adolescent Health and a summarized version on presented case studies. KAPAH would like also to share some videotapes on adolescent issues with

other countries. Helping in the editing, printing, and disseminating of this information will inform and stimulate other groups. This AAPAH group, if strongly supported by donors, will, I believe, make a big contribution to raising adolescent issues and finding national and regional solutions, particularly with the support of OAU.

Center for Study of Adolescence (CSA)

CSA is a nongovernmental organization created in Kenya in 1986. This group of professionals and researchers came together to share research findings, identify research gaps, and conduct research activities to promote advocacy at the policy level. They already conducted several studies and would like some help in disseminating the findings. See list of research topics in Appendix E.

The Medical Women's International Association (MWIA)

MWIA is a very old association that started in 1919 in the United States (New York) when women doctors were constrained in many ways. The legal Head Office of the Association is in Geneva, Switzerland, where the Association was first incorporated.

The general objectives are (i) to promote the cooperation of Medical Women in different countries, to promote the general interests of Medical Women, and to promote friendship and understanding between Medical Women throughout the world; and (ii) to offer Medical Women the opportunity to meet so as to confer about questions concerning the health and well being of humanity.

It is a nongovernmental organization. The Association is politically neutral and nonsectarian. It has non-profit-seeking aims. It is affiliated with National Associations in several countries and accepts individual members from countries that do not have an affiliated national association.

The first Regional Congress of the MWIA for the Near East and Africa Region was held in Nairobi in December 1993 on the theme "The Health of Women and Safe Motherhood." Action plans and recommendations arose from the meeting as well as a consensus on the need for a mechanism to follow up on these actions in countries. A proposal for such a mechanism is to have an African Regional Women's Health Network that specifically addresses issues related to the health of the African woman and coordinates all activities enhancing women's health. The MWIA is currently seeking technical and financial support from donors for a needs assessment to launch the African Women's Health Network. See Appendix F for action plans and proposal for a needs assessment for AWHN.

The Kenya Medical Women's Association, a chapter of the MWIA, was founded in March 1983. It is carrying several activities including (i) free services to needy com-

Contacts in Kenya

munities; (ii) continuing medical education for medical colleagues and other professionals in the field; and (iii) some projects and publications (e.g., they succeeded in the review and adoption of child laws by the Parliament in Kenya; they are carrying out a study on female genital mutilation, etc.). The Association does a lot of lobbying and advocacy for health in its wide aspect and includes children's issues in its agenda. See specific objectives and activities in Appendix F. (The KMWA joined KAPAH.)

Center for African Family Studies (CAFS)

A visit was made to CAFS to follow up on the urban family planning situational analysis. The analysis is already finished in Mombassa (Kenya) and the preliminary report is ready. The Blantaya (Malawi) and Boulawayo (Zimbabwe) study has started and will be finished soon. And the Dakar (Senegal) study is scheduled to start in a few months. CAFS is receiving technical support from the Population Council for this research.

Population Council

A brief meeting was held with staff from the Operations Research division to share HHRAA/SARA research interests. The Pop. Council is focusing on the integration of family planning and STD/HIV prevention. They are in the process of developing a proposal with an organization called BONASA (a network of NGOs) in Botswana. Population Council OR is planning to do some work on adolescent fertility in Kenya, on abortion, on quality of care, and on CBDs providing injectables in Tanzania and Ghana. They are planning to give technical assistance to IPPF in London, which would like to carry out research on reproductive health in six African countries, using a community approach to determine issues of interest by the community.

Representatives from several other organizations were also contacted:

USAID/REDSO for a briefing about the mission.

Family Planning Association of Kenya

AMREF

PATH

Contacts in Tanzania

Arusha: a visit was made to the Commonwealth Regional Health Community Secretariat for East, South, and Central Africa.

In the absence of Dr. Kinoti, responsible for the reproductive health research program, discussions were held with Professor A. M. Nhonoli, the regional Secretary and several other staff members on the research program in general and with SARA: reproductive health, abortion study and the communication program.

Dar es Salaam

USAID Mission was visited. A briefing about my trip was made to Dana Vogel, HPN officer, who also shared the Mission's health plan with me. They have a seven-year project to support FP management, training, IEC, research, and evaluation. They also have a national AIDS program through NGOs. See Appendix G.

UNFPA office in Dar es Salaam was visited to share HHRAA/SARA research interests. UNFPA, in collaboration with USAID (through SEATS), is funding a family planning unit which is an integrated MCH/FP under the umbrella of Primary Health Care. They help on service provision and management, training, IEC programs on the radio and family life education through rural communities. They are carrying out research on message delivery, trying to assess the impact of the IEC program in the project areas compared to control areas. They also are doing research on Norplant insertion in collaboration with the medical institution, the Family Planning Unit, and UMATI. WHO is planning to establish a data bank system for adolescent issues, and UNFPA is considering supporting it.

The Family Planning Unit of the Ministry of Health was visited. It is the coordinating body for all FP activities. It has a National Advisory Committee. It developed a research agenda with guidelines for application, and also a five year national strategic plan. A population policy was adopted in 1992; now they are in the process of developing guidelines for implementation (a revised form of the 1989 version).

At *Muhimbili University, School of Public Health* we shared common research interests. They are very active in giving technical assistance to the National AIDS Control Program. They would like to be involved in any STD/AIDS/FP research program suggested by HHRAA/SARA.

UMATI is a Tanzania nongovernmental organization involved in family planning. They work with several donors and have several programs: a peer counselling program in rural areas for youth on FP, STD, HIV; a broader operations research program for all ages in reproductive health counselling and services in three experimental areas with control areas; three teenage mothers' pilot programs (one in

Contacts in Tanzania

Dar es Salaam and two in other sectors) to rehabilitate teenage mothers and help them go back to school, and sex education. They would like to expand the programs to other areas. They also have a CBD program in some areas, focused on training, counselling, distribution of contraceptives and referrals.

Appendix A

Appendix A

List of Persons Contacted

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Appendix B

TECHNICAL MEETING ON ICAPP

Nairobi

May 24 - 26, 1994

- **Overview Paper**

- **ICAPP Country Applications:**

- **Burkina Faso**
- **Cote d'Ivoire**
- **Ghana**
- **Kenya**
- **Malawi**
- **Nigeria**

Draft for Discussion Purposes

INTENSIFIED COUNTRY ACTION PLANNING PROCESS (ICAPP) FOR POPULATION ACTIVITIES INCLUDING STD/AIDS PREVENTION

OVERVIEW PAPER

INTRODUCTION

The 1993 annual meeting of the Global Coalition for Africa endorsed a report by the African Population Advisory Committee (APAC) which noted progress in the implementation of population plans in the region and recommended actions to help intensify efforts. Emphasis was placed on increasing political commitment to population programs as well as on promoting more cost-effective strategies to strengthen the beneficial links between reproductive health, family planning, and the prevention of sexually transmitted diseases, including AIDS. This emphasis is fully consistent with recommendations and the sense of urgency attached to resolving population pressures at the Third Annual Population Conference in Dakar, in preparation for the 1994 United Nations International Population Conference.

APAC's report to the GCA annual meeting maintained that intensified efforts are needed to energize and contribute value-added to existing national capacities in view of the following realities;

- Growing numbers of African countries have adopted, or are in the process of adopting, national population programs, including prevention of STDs/AIDS, but commitments to operationalizing them still need strengthening. This has been compounded by weak implementation and critical shortages of people skilled in managing family planning and related population activities. This shortage is particularly evident with respect to the technical expertise required to monitor and evaluate the complementarity and cost-effectiveness of resource flows for population activities – for example through National Population Councils, Ministries of Health, Private-Voluntary Providers, Private-for-Profit providers, and Donors. Such information is critical to forming a clearer understanding of the current resource envelope for activities, the recurrent and capital budget requirements to provide quality services, the financial requirements to attain specific demographic targets, and mechanisms for tracking resource flows.
- Population programs are, in many countries, an assemblage of donor-run projects and activities, with little appreciation of their combined effects, and inadequate integration with national efforts. In many countries, duplication of donor-sponsored studies on policy, strategy formulation, and research issues is common, and considerable effort has to be expended to piece together the many activities, and how they may (or may not) be complimentary to government goals. This contributes to fragmentation of national programs, undermines national "ownership", and unintentionally compromises national capacity building in the process.

- Far greater public-private collaboration is required if national strategies to achieve demographic and reproductive health targets are to succeed. Programs, financing and facilities under the control of Ministries of Health and National Population Councils need be complemented by programs, financing and facilities under the control of Private Voluntary Missions (eg., church missions), international NGOs, Private Estates and Companies, and Private-for-Profit providers.
- Most countries are plagued by problems of implementation right down to the community level, suggesting that consensus building is needed on the bottlenecks involved and the kinds of partnerships required to overcome them. Stronger links are required between effective leadership at the central level, the district level, and with community change agents at the local level. It is when the financing and planning of national programs is made transparent, including clear government leadership, public-private collaboration, and consensus building at decentralized levels of implementation, that "ownership" of such programs can be established right down to the community level.

ICAPP OBJECTIVES

APAC is continuing to work with countries in the region to strengthen population activities through the development of an 'Intensified Country Action Planning Process (ICAPP) for Population Activities Including STD/AIDS Prevention'. ICAPP objectives include;

- Improve implementation of existing programs;
- Bring latest knowledge to bear on program development;
- Assess effectiveness of programs in terms of impacts on demographic and related indicators;
- Take additional action to intensify country efforts and their impact;
- Promote broader participation by households and Africanization of the planning and implementation process.

This overview concentrates on the planning process inherent in ICAPP. This process is seen as an outgrowth and extension of on-going country-level strategies and the importance APAC attaches to national capacity building in implementing successful population programs. At the heart of ICAPP is empowerment of the national planning process through more effective leadership, greater mobilization and allocation of resources, stronger partnerships and collaboration among providers of population services, and broader participation of communities and households. The balance of this paper addresses the following;

- To describe the planning process involved in the development of ICAPP.
- To impart some general lessons learned in preliminary and exploratory applications of ICAPP in Burkina Faso, Cote d'Ivoire, Ghana, Kenya, Nigeria and Malawi..
- To share and discuss ideas with African population experts and policy makers on critical next steps.

ICAPP ACTIONS AND GENERIC FRAMEWORK

The planning process inherent in ICAPP envisions several specific actions, and a six step process to achieve them. This is not to say, however, that one 'recipe' or 'generic framework' is suitable for all countries. The circumstances of each country vary considerably, with the strong implication that what follows will require modification to suit particular country circumstances. Furthermore, some countries are already well advanced in their population planning and are busy building on lessons learned in the past.

ICAPP Actions:

- To establish what is being done at the country level in terms of population/FP programs (including STDs/AIDS) , and how to do it better.
- To provide a framework to track the financial and other inputs of major providers of population/FP services – including Government, NGOs, and Donors – and how they are allocated to improve reproductive health.
- To assess complementarities in the inputs and expected outputs of major providers of population/FP services, and to determine critical gaps in facilities, personnel, programmatic concentration (eg., IEC, contraceptives), and geographical coverage.
- To lay the groundwork for preparing a more concentrated and cost-effective program of actions at country level, aimed at filling gaps, and assessing resource requirements.
- To empower the agency or department responsible for population activities (eg., National Population Council, Ministry of Planning, MOH) in its dealings with the Ministry of Finance to mobilize additional funds for population/FP activities, and to better discern where new Donor funding can have greatest value added..
- To build a broader base of support for population activities at decentralized levels of service delivery on the one hand, and sources of demand – namely at the household and community level – on the other.

Six Step Process:

Step 1: Assemble data on the concentration of population/FP services, activities and financial resources by all major service providers.

Requirements:

- Government and its partners determine an appropriate agency/unit within government or an appropriate NGO to serve as lead agency
- Agreement to be reached on the design of appropriate tables to monitor inputs/outputs
- Intensive initial efforts undertaken to collect information and complete the tables
- Provisions to up-date information in tables to reflect and evaluate changing programs/commitments over time

Expected Product or Outcome:

Critical Data Base for Assessing, Monitoring and Evaluating Population/FP Activities, identifying;

- Expenditures on Population/FP (including STDs/AIDS) by Source, and as a Share of Total Health Expenditures by Major Provider.
- Distribution of Population/FP Resources by Source by Major Service or Activity
- Distribution of Population/FP Resources by Source and Geographical Concentration

Step 2: Analysis of input/output data from Tables in Step 1, combined with information from qualitative assessments to determine (a) complementarities in efforts by major players, and (b) supply/demand gaps that need to be filled to produce an intensified country action plan.

Requirements:

- Government and its partners convene a workshop involving national experts from both public, private voluntary, and private for profit sectors
- Experts at the workshop formulate and agree on appropriate questions, issues, and methods of analysis
- A working team of experts undertakes analysis of sector reports on quality of current services
- The working team produces a technical report of findings as background study to drafting of ICAPP

Expected Product or Output

- Greater Government visibility in the monitoring and evaluation of all population/FP activities in the country
- Identification of service gaps and potential routes to fill them.
- Sharper policy analysis of on-going activities and cost-effectiveness
- Assessment of national capacity building in on-going activities
- Greater clarity on sustainability of funding

Step 3: Preparation or Strengthening of National Action Plan with Emphasis on Improved Delivery of Services, Factors Affecting Enhanced Demand for Services, and Appropriate Monitoring and Evaluation

Requirements:

- Government and its partners identify an appropriate agency/unit to take lead responsibility for formulating an action plan.
- Steering body is formed, comprising relevant policy-makers
- Collaborative effort commences, involving population/FP (including STDs/AIDS) national planners, PVOs, and inputs from country representatives of donor agencies.
- The steering body subsequently ranks priorities for action with assessment of (a) cost effectiveness, and (b) funding requirements to improve efficiency and quality..

- Government and its partners subsequently develop plans to establish baseline surveys on quantity and quality of key services , as well as baseline measures of client behaviors, thus setting the stage for monitoring and evaluation of intensified action plan impacts.

Expected Product or Output:

- Blueprint for implementation of activities to improve supply/demand gaps, and determination of resource requirements and time horizon to close gaps.
- Collaborative strategy to tackle supply/demand gaps with expected role of all providers/partners identified.
- Framework for appropriate monitoring and evaluation of (a) links in the delivery chain, and (b) impact on key indicators. Designation of who should monitor/evaluation what.
- Baseline mechanism to continue cooperative planning process that incorporates new information and adapts to new priorities over time.

Step 4: Enrichment of Country Action Plan by Factors Enhancing Demand for Services and Key Community Change Agents for Consensus Building

Requirements:

- Government and its partners take the initiative of promoting inter-sectoral collaboration with other ministries, PVOs, international NGOs, and others, whose activities impact on fertility correlates and thus demand for reproductive health services (eg., formal/non formal schooling, safe drinking water, nutritional practices, sanitation, the media)
- All partners identify community change agents effective in mobilizing households to recognize links between population and development issues, such as APAC's sponsored Population Agenda activities in Burkina Faso, Cameroon, Ghana, Kenya, Senegal, Nigeria.
- Fora to present the ICAPP to select communities (for example, those currently part of APACs Population Agenda initiative).

Expected Product or Outcome:

- Network of reinforcing interventions by ministries other than MOH, with comparative advantages in influencing important dimensions of household well being , attitudes to reproductive health, and demand for related services.
- Ownership of the principles of ICAPP by community representatives.

Step 5: District Level Consultations to Present/Discuss resulting Intensified Action Plans

Requirements:

- District level forum with representation by the Chairperson of the District Development Committees, District Health Management Team, and relevant District level population/FP (including STD/AIDS) officers, and Local Opinion Leaders and Beneficiary Representatives.

- Preparation of report based on District level consultations and modification of Draft ICAPP where appropriate.

Expected Product or Outcome

- Greater Ownership of intensified action plans among decentralized officials
- Clarity/Agreement on District level functions, responsibilities, and requirements
- Transparency
- Publicity

Step 6: Government Led Consultation with Donors and NGOs on Intensified Strategy

Requirements:

- Government would plan a National forum to communicate and discuss the intensified strategy
- Partners would arrange for combined government representation by lead agency for population/FP activities, Ministry of Planning, MOH, and Ministry of Finance
- Widespread donor representation would be invited (both country representatives and HQ representation).
- Widespread representation by national and international NGOs would be invited.

Expected Product or Outcome

- Government led strategy
- Clarity on Key roles to be played by domestic and international NGOs
- Clarity on where Donors are welcome, and greatest value added
- Improved communication among the major players

It is important to note that these six steps should not be interpreted as a "one time exercise". ICAPP represents a process that should be repeated, in iterative and dynamic fashion, as country circumstances evolve and new information sources become available.

EXPLORATORY ICAPP COUNTRY APPLICATIONS

APAC's exploratory application of the 'generic ICAPP framework' is modest in several senses. First, *it concentrates on only two of ICAPP's six step process*. The reason is simply that these steps are more akin to "objective" analysis of secondary data sources on financing and facilities. They could be undertaken at APAC headquarters with limited staff and resources, thus facilitating discussion and paving the way for more in-depth application at country level. In contrast, the remaining four steps of ICAPP are more akin to in-country strategy and political mobilization of resources, requiring the stewardship of country representatives.

This exploratory application of ICAPP is also modest in its selection of only a small number of countries. Indeed, the choice of Burkina Faso, Cote d'Ivoire, Ghana,

Kenya, Nigeria and Malawi has been dictated largely by prevailing work programs of APAC staff and their familiarity with on-going population and AIDS prevention activities in those countries.

Finally, none of the country applications presented here aim to produce definitive findings, conclusions, or policy recommendations. Emphasis, rather, is on experimenting with the ICAPP *process* to generate certain types of critical information, and to determine how such information might contribute to strategic national planning.

What do the exploratory ICAPP country applications tell us? With respect to the first two steps of ICAPP, the following has become readily apparent:

- It is clear that government financing/facilities represents only one resource component, with the implication that resources of all partners must be enumerated and enlisted if an intensified country action plan is to be meaningfully launched. For example, far too little information is available on private voluntary and for-profit providers, their location, and the services they offer. Gaps in these types of critical information prevail, making it extremely difficult to assess potential complementarities among public and private providers, and their potential cost-effectiveness in providing family planning, STD and AIDS prevention services.
- Reproductive health and population activities tend to be donor driven, with donors pursuing their own programmatic cycles, budgeting processes, monitoring and evaluation, and geographic concentrations. This situation prevails widely even though Donors often meet to discuss their various projects. One implication is that planning and coordinating of financial inputs on an annual basis – to correspond with government budgetary processes – is undermined. This has the effect of compromising government's ability to determine the country's "absorptive capacity" for new waves of funds. Another implication is that national planners have difficulty anticipating the budgetary implications of donor funded capital accounts for future salary, maintenance, and equipment requirements. To help resolve these problems, government may request donors to format and provide financial information on their activities in ways that better comply with annual Government budgeting processes.
- Fragmentation and lack of coordination of family planning, STD and AIDS prevention programs and projects – by MOH, PVOs, NGOs, and Donors – manifests in varying and sometimes unpredictable concentrations of funds on certain services – such as training of Community Based Distribution agents. This often results in parallel supply systems (such as for contraceptives), duplication of effort in procurement and planning, competition for scarce technical skills, and widespread management and administration problems. This places a premium on government leadership and coordination.
- Lack of clarity and transparency of central level resource mobilization and planning – by MOH, PVOs, NGOs, Donors – becomes even more blurred at different levels of geographical concentration where Regional and District Health Officers are attempting to address reproductive health and population issues. As a result, it is almost impossible to assess financial and other commitments to reducing poverty and inequities between rural and urban areas, or among regionally disadvantaged areas.

- Attempts to identify and mobilize financial resources for family planning and SDT/AIDS prevention are undermined by lack of information on out-of-pocket expenditures by households. This gap prevents assessment of the potential contributions of cost-sharing to sustainable family planning and STD/AIDS services. It also means that effective demand for services cannot be assessed – particularly as clients increasingly perceive benefits – and that potential links between client "willingness to pay" and provider "accountability" cannot be established.

WHERE TO FROM HERE?

Presuming this overview, as well as the country applications which follow, provide a reasonable introduction to ICAPP and its objectives, it now seems appropriate to deliberate on the following questions;

- a) Would the implementation of the ICAPP planning process, in-country, make a significant contribution to national population and AIDS prevention strategy?
- b) Who would be best suited/placed to undertake and maintain the kind of analysis required to make ICAPP an effective planning tool?
- c) What skill requirements would be needed, and are they available?
- d) What forums already exist to contribute to/or support an ICAPP planning process – for example public-private collaboration, donor consortium?
- e) What forums exist or would be needed to assure a broad participatory approach and consensus building in the development of ICAPP – for example district level representation, participation and inputs from community change agents?
- f) What kinds of monitoring and evaluation processes need to be set up to assess ICAPP's contribution to strategy design; the evolution of more cost-effective approaches; and impact on indicators family planning, SDT and AIDS prevention?
- g) How can ICAPP be structured as a 'dynamic process' so as to foster a continuous cycle of assessment, analysis, and action.
- h) How can APAC and Population Agenda Activities in selected countries contribute to the understanding and implementation of ICAPP planning processes?
- i) How can APAC's expertise and resources for ICAPP augment what countries are already doing?

Acknowledgments

This paper was prepared under the direction of the APAC Secretariat, with assistance of staff from the World Bank. Members of the team who contributed to the report include Paul Shaw (Task Manager), Mary Barberis, Najla Khattab, Nosa Orobato, Susan Scribner, and Barbara Shane. Benjamin Gyepi-Garbrah, Secretary of APAC, and Ishrat Z. Husain, World Bank, have been involved in all stages of the design of the ICAPP planning process, and have played an important role in undertaking this initiative.

ANNEX

Activities Planned by Participants at the ICAPP Meeting and Timetable for Completion Nairobi, May 24-26, 1994

BURKINA FASO

The following activities will be executed in the next 10 to 11 months:

- Undertake a deeper assessment of the preliminary ICAPP Burkina Faso country study presented at the meeting, revise it, and complete tables with missing data. To this end, the ICAPP country study will be submitted to the Burkina country team working on population and STD/AIDS issues, along with a "back to office" report on the ICAPP meeting.

- Develop an ICAPP action plan and submit it to APAC by March, 1995

- Carry out an in-depth study in some regions of the country on selected subjects identified by the ICAPP process, pertaining to family planning, STDs, AIDS -- exact studies to be specified upon consultation with country team upon return to Burkina Faso.

- Further harmonize Burkina Faso priorities and goals of its work program with conclusions of the 1994 International Conference on Population and Development, and inform APAC of the implications for future development of the country's population and STD/AIDS prevention programs.

- Recommendation: In order to be able to use the "bottom-up" and "top-down" approach and to have available the information necessary for the development of the ICAPP Action Plan, we recommend to the APAC permanent Secretariat, that it mobilize -- as soon as possible -- resources necessary for carrying out relevant in-country work.

COTE D'IVOIRE

The following activities will be carried out in the next 6 months:

- Prepare a short "back to country" report to acquaint those in the country who are concerned with population issues, on the activities of APAC and its new proposal for ICAPP.

- Prepare an ICAPP Action Plan to be submitted to APAC.

- Prepare a plan to initiate Agenda activities in two regions.

- Work with the various partners concerned with population issues to identify and prioritize activities to be carried out, and submit a list of prioritized actions to APAC for possible financial and/or technical support.

- Encourage the Ministry of Economy, Finances and Planning to keep the Population Unit, which was created for the preparation of the International Conference on Population and Development, as a functioning unit, and establish new objectives/responsibilities for it to carry

out. This unit (or another appropriate structure should Government decide not to retain the Population Unit), should be responsible for population issues, for carrying out studies, and developing a population policy. Some financing will be necessary for these activities..

GHANA

The following activities will be undertaken within the next 14 months;

- Conduct expanded Population Agenda exercises in 10 districts to add to the existing 3 districts in the Pilot Areas now with Agenda activities (within 6-12 months).

- Convene workshops at the national, as well as district level, to disseminate information on the Agenda process and its results (within 6-12 months).

- Identify new projects for Agenda type activities (after 12 months, and before 14 months).

- NPC Secretariat will take action to complete data tables in the preliminary ICAPP country application for Ghana. To this end, NPCs Technical Committees will take responsibility for establishing a data bank as a basis for ICAPP diagnostic analysis, monitoring and evaluation.

- Endeavors will be made to strengthen the institutional framework of NPC and links with its collaborators, so as to lay the groundwork for developing an effective plan of action - involving all partners – as stressed in the ICAPP framework.

- Take more effective action to mobilize more funds for population and STD/AIDs prevention activities, both internally and externally.

KENYA

The following activities will be undertaken in the next 6 to 12 months;

- Commence work on the ICAPP framework, for example, the completion of data bases needed for better diagnosis, monitoring and evaluation, as suggested in the exploratory ICAPP country application to Kenya.

- Organize workshops and seminars to more clearly think out and communicate the place of the Agenda activities in the overall ICAPP framework, and how the rationale and accomplishments of the Agenda both parallel, and complement, the broader ICAPP framework.

- Strengthen the monitoring and evaluation features of the Agenda process.

- Extend Agenda activities into 9 more districts, raising Agenda activities from 4 to 13 of the country's 41 districts.

MALAWI

Representatives were unable to be as specific as they would have liked, given the very recent change in government and implications for possible restructuring on offices responsible for population and STD/AIDS prevention. The following actions were, however to be taken within the next 8 to 18 months:

- Brief the office responsible for population and development on the ICAPP process and its relevance to Malawi's on-going population program activities (within 2 weeks).
- Re-affirm the new Government's position on population programs, including the newly adopted population policy since the new Government may want to re-appraise it to fit into the new Government set-up.
- Disseminate population policy to various actors, especially the rural people (beneficiaries). Integrate the ICAPP process into Action Plans on the National Population Policy, including the National Family Planning Strategy (6 to 9 months).
- Mobilize resources within existing program activities for purposes of completing the first two steps of the ICAPP process. This will be within whatever institutional framework the new government will have approved (12 to 15 months).
- Report on progress to APAC 9 months from now, and again in 18 months from now.

Appendix C

INTENSIFIED COUNTRY ACTION PLANNING PROCESSES FOR POPULATION
ACTIVITIES INCLUDING STDs/AIDS (ICAPP) CONFERENCE - NAIROBI, KENYA
24TH - 26TH MAY, 1994

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8. Mrs. Esther Apewokin
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10. Mme. Sira Seki
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20. Hon. Patrick Balopi
Chairman APAC
Minister of Labour
BOTSWANA

21. Amb. S.B.A Bullut
Director
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22. P.M.L. Kizito
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23. K. Kioga
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28. Mr. Ade Adelakun
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Appendix D

KENYA ASSOCIATION FOR THE PROMOTION OF ADOLESCENT HEALTH (KAPAH)

1. NAME

The name will be Kenya Association for the Promotion of Adolescent Health herein after referred to as KAPAH. This shall be a non-profit making, voluntary organization, non-political, non-racial, non-denominational. It will be the Kenyan chapter of AAPAH.

2. OBJECTIVES

To promote adolescent Health activities in Kenya by:

- (a) Recruitment of members
- (b) Supporting the establishment of adolescent health services including counselling, treatment and community centres.
- (c) Promotion of adolescent-friendly activities by encouraging, public education, primary health care and school education programmes.
- (d) Encouraging positive policies set by the government, Ministries and Local Authorities.
- (e) Networking and communicating with other bodies with similar interest locally and internationally.
- (f) Fund-raising to sponsor adolescent health care activities.
- (g) Supporting adolescent research projects.
- (h) Holding periodic workshops, seminars and conferences on adolescent health.

3. ADMINISTRATION

The objectives of the Association shall be carried out by:

- (a) General Assembly
- (b) A Board of Trustees
- (c) A National Executive Council
- (d) Additional Sub-Committees (standing) i.e

- * *Education and Information (IEC)*
- * *Fund-raising/Finance*
- * *Scientific and Research*
- * *Service Delivery*
- * *Advocacy and policy committee*

Sub committees shall be responsible to the National Executive Council.

LIST OF KAPAH MEMBERS

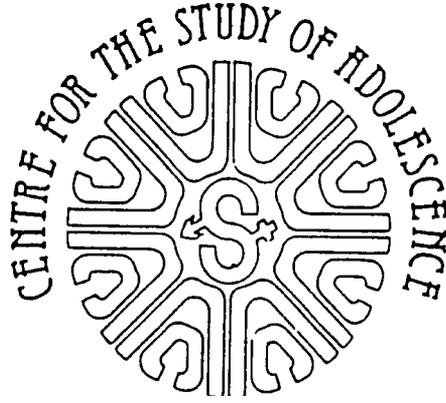
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34. RUTH OGWENO	FPPS	46042 NRB	224646

ABBREVIATIONS

1. FPAK Family Planning Association of Kenya
2. FPPS Family Planning Private Sector
3. DFH/MOH Department of Family health/ Ministry of Health
4. KMWA Kenya Medical Women Association
5. JHU/PCS John Hopkins University Population Communication Services
6. PSRI Population Service and Research Institute
7. NCPD National Council for Population and Development
8. KAYO Kenya Association for Youth Organization
9. SMAK Single Mother Association of Kenya
10. CSA Centre for the Study of Adolescence
11. PATH Program for Appropriate Technology in Health
12. AMREF African Medical Research Foundation
13. CPO Centre for Population Options
14. UON University of Nairobi

Appendix E



Centre for the Study of Adolescence
P. O. Box 19329,
Tel 562901
Jamhuri Crescent off Ngong/Kabarnet Road
Nairobi, Kenya

PROSPECTUS

BACKGROUND AND ORIGIN

Research interest in adolescent fertility is a relatively recent phenomenon throughout the world and especially so in Africa. This surge of interest has grown out of recognition that young people, during the period of transition from childhood to adulthood, exhibit distinct psychological features, which are characteristic of neither adulthood nor childhood. Therefore, adolescents constitute a group of individuals with their own special needs and problems, especially concerning sexuality and fertility.

The Kenya Medical Association, during its annual scientific conference in 1986, resolved to pioneer research on adolescent fertility in Kenya. Later that year a workshop was held at Kwale, Coast Province which brought together a cross-section of professionals: lawyers, demographers, physicians, sociologists, anthropologists, administrators and theologians to discuss issues related to adolescent fertility in Kenya.

The Centre for the Study of Adolescence (CSA) is a volunteer association of some 25 Kenyan researchers and academics. The CSA was formed at a workshop held at Duduville, Nairobi, in February 1988. It was originally called the Adolescent Fertility Group (ADOPEG). The Centre was registered as a non-profit making non-governmental organization on April 4, 1990.

EXISTING PROBLEMS

Kenya, like many other developing countries, lack comprehensive and representative data on adolescent fertility. Although the effects of increased adolescent sexuality and fertility have been felt and recognized by almost every Kenyan, the magnitude of the problem cannot yet be quantified. Therefore, there is an urgent need to make comprehensive data available and to disseminate the information to all Kenyans, and in particular to policy makers.

The demographic profile of Kenya indicates that 20 percent of the population is made up of persons aged 15 to 24 years. By 1985 there were 3.1 million persons in this age group, making it the fastest growing segment of the population. The problem of this significant group, especially those relating to fertility, cannot be ignored because the consequences are diverse and far-reaching.

Pregnancy among teenagers is increasing. In the early 1960s, the fertility rate among 15 to 19-year-olds was 141 births per

1,000 women. In the late 1970's, the rate for the same group had risen to 168, despite a decline in the number of married teenagers. Meanwhile, the average age of menarche has fallen, with the average girl reaching sexual maturity at age 13. Coupled with this is the high levels of sexual activity among adolescents, which also starts in early teens. Since most of these are unprotected, a good proportion of Kenyan women will have had at least one pregnancy by age 20; some of which end in child birth. The demographic implications are a shortened generation gap, an extension of reproductive age-span and high population growth.

Adolescent sexuality and fertility constitute certain health risks. Pregnancy-related deaths and sicknesses are very high and pregnancy outcome is commonly unfavourable. The risk of contracting sexually transmitted diseases is suspected to be very high, particularly among adolescents in urban areas.

OBJECTIVES

The overall goal of CSA is to reduce adolescent fertility and related problems in the long term through the following general objectives:

- to promote comprehensive policies and approaches in the management of adolescent health and related problems in Kenya

- to increase the understanding of the dimensions of adolescent health and its related problems in Kenya
- to create and promote a co-ordinated approach to understanding and managing adolescent health and related issues among the various interested persons and institutions.

In order to realise these objectives, the CSA uses the following strategies:

- collect, analyse and compile all the existing information on adolescent health
- be involved in carrying out researches in the area of adolescent health through its members.

- disseminate all the information obtained from the research to the relevant parties by means of publications, seminars and workshops.

- create and expand a network of interested individuals and organizations in order to ensure a co-ordinated and collaborative approach on issues related to adolescent health in Kenya

- establish a funding mechanism through its Secretariat to assist researchers interested in adolescent health.

PROPOSED PROGRAMME OF ACTIVITIES

Research is one of the two primary foci of CSA. Only a few studies have been conducted on adolescents in Kenya, and these have been limited in scope. Knowledge is essential for appropriate planning of intervention strategies such as sex education/family life education for adolescents.

As a reflection of the scope of information needed, the members of CSA are committed to undertaking multi-disciplinary and other varied approaches to research on adolescence. Five priority areas have been identified with their specific sub-topics:

1. *Adolescent Sexuality*
 - Extent of adolescent sexuality in Kenya
 - Determinants of adolescent sexual practices
 - Outcome of adolescent sexual practices
 - Evaluation of interventional measures
2. *Sexually transmitted Disease (STDs) among Adolescents*
 - Extent of the problem
 - Determinants of the STDs
 - Outcome of STDs
 - Evaluation of interventional measures
3. *Abortion among Adolescents*
 - Extent of the problems of abortion
 - Determinants of abortion
 - Types of abortion
 - Outcome of abortion

	Evaluation of interventional measures	youth sexuality, reproductive health and abortion in Kenya.	primary health care and school education programmes.
4.	Continuing Pregnancy Determine the magnitude of adolescent pregnancies Determinants of continuing pregnancies Determination of health services Legal and social status of adolescent mothers and their offspring Complications Evaluation of intervention measures	During its short existence, CSA has collected, analysed and compiled existing information on adolescent fertility and abortion in Kenya. Other research activities carried out by CSA and its members are attached (see list of researches by CSA members). Through dissemination seminars, the CSA has helped to create awareness of Adolescent Sexuality and Fertility issues among the scientific and NGO communities locally and abroad. The CSA initiated and helped to organize the First Inter-African Conference on Adolescent Health in Nairobi in March, 1992. Following this conference, the CSA has produced two video tapes which are available for use by interested parties.	(d) Encouraging positive policies set by the government, Ministries and Local Authorities. (e) Networking and communicating with other bodies with similar interest locally and internationally. (f) Fund-raising to sponsor adolescent health care activities. (g) Supporting adolescent research projects. (h) Holding periodic workshops, seminars and conferences on adolescent health.
5.	Contraception for Adolescents Extent of contraceptive use Factors which determine contraceptive use Evaluation of intervention measures	CSA is involved in compiling and editing the Conference proceedings.	The chairman and secretary of KAPAH are CSA members.

4. CSA will be involved in major Advocacy activities in conjunction with JHU/PCS, FPAK, CPO and PATH, beginning March, 1994.

Intervention Measures

The second focus of CSA is designing and implementation, of three intervention measures:

- educational programmes for adolescents, parents, community leaders and teachers
- counselling facilities
- public information on various aspects of adolescent health

Dissemination of research findings will be through periodic publications; conferences, symposia, seminar and workshop; and the large mass media, especially to target schools, the community at large and other institutions.

PAST AND ON-GOING ACTIVITIES

Since the mid-1980s, the CSA researchers have documented, through a variety studies the socio-medical problems associated with

OTHER ACTIVITIES

1. CSA has taken a leading role in the launching of the African Association For the Promotion of Adolescent Health (AAPAH)
2. In conjunction with PATH and CPO, CSA held the Joint Youth Initiative Workshop in Naivasha. This was a pre-advocacy workshop in preparation for the joint advocacy activities together with youth serving organization.
3. CSA in realizing the goal of networking with other organizations and individuals interested in adolescent health activities was instrumental in launching and hosting Kenya Association for the Promotion of Adolescent Health, the Kenyan chapter of AAPAH in Naivasha on February, 1994. The objectives of KAPAH are

To promote adolescent Health activities in Kenya by:

- (a) Recruitment of members
- (b) Supporting the establishment of adolescent health services including counselling, treatment and community centres.
- (c) Promotion of adolescent-friendly activities by encouraging, public education,

Executive Committee

Chairman:	Prof. H.W.O. Okoth-Ogendo CSA P. O. Box 19329 Nairobi
Vice- Chairman:	Dr. Khama O. Rogo Department of Obstetrics and Gynaecology, University of Nairobi P. O. Box 30588, Nairobi, Kenya
Executive Secretary:	Dr. Wangoi Njau Department of Sociology University of Nairobi P. O. Box 30197, Nairobi, Kenya
Treasurer:	Dr. Zibcon Muganzi Population Institute University of Nairobi P. O. box 30197, Nairobi, Kenya
Members:	Dr. Wanjiku Kabira Department of Literature University of Nairobi P. O. Box 30197, Nairobi, Kenya
	Dr. A. B. N. Maggwa CAPS P. O. Box 60054 Nairobi

There is a Board of Three Trustees for the CSA, registered under the Trustee (perpetual Succession) Act, Cap. 164, Laws of Kenya.

A modest Secretariat ensures proper execution of the services of CSA. This includes a full time executive director, who oversees all the programmes, a secretary-cum-administrator and a messenger/cleaner. This will be expanded to include an accounts officer, a research coordinator and other personnel deemed necessary by the Executive Committee.

Support Groups

The following organizations have supplied administrative support and funding for the inaugural workshop, past research and on-going research projects:

- Population Crisis Committee
- Population Council, New York
- GTZ Support Unit, Nairobi
- Ford Foundation, Nairobi
- AIDSTECH- Family Health International
- PATH - Programme for Appropriate Technology in Health
- Centre for Population Options

**CENTRE FOR THE STUDY OF
ADOLESCENCE (CSA)
RESEARCH PAPERS**

- Centre for the Study of
Adolescence: 1989 *Proceedings of workshop held in
Mombasa - Coast Province
April 28 - 30, 1989*
- Kidula, N : 1993 *A survey of knowledge, attitude and
Practice- Induced abortion among
Nurses in Kisii District*
- Koigi, K : 1988 *Proceedings of the inaugural
workshop held at Duduville -
Nairobi.*
- Lema, V. M, Kamau R. K
and Rogo, K. O: 1989 *Epidemiology of Abortion in Kenya*
- Lema, V. M and Njau,
P. W. 1991 *Abortion in Kenya. A traditional
approach to unwanted pregnancy.*
- Lema, V. M and Kabeberi
M. J 1992 *A Review of Abortion in Kenya*
- Magadi, MA and Kuyoh
M. A: 1993 *Abortion: Attitudes of medical
personnel in Nairobi.*
- Muruli, L. A, Ngumbi M
and Nguli, M. 1993 *A survey of knowledge, Attitudes
and Behaviour relating to sexual
and contraceptive.*
- Njau P. W and
Lema V. M: 1988 *A Review of Research in Adolescent
Fertility in Kenya.*

Set up a library on youth issues

Oniang'o R

Adolescent Fertility "Who chooses Abortion" Report submitted to the Population Council.

Rogo, K. O. 1993

Analysis and Documentation of Research on Adolescent sexuality and unsafe Abortion in Kenya.

Ongoing:

Compilation and Editing of the First Inter-African Conference on Adolescent Health.

Ongoing:

*Women and Health in Kenya.
Funded by the Netherlands Embassy.*

| Monograph on abortion in Kenya
done by CSA.
funded by Pop Council.

Epidemiology of

**BUDGET FOR PUBLISHING THE 1ST INTER-AFRICAN CONFERENCE
ON ADOLESCENT HEALTH, HELD AT SAFARI PARK HOTEL,
NAIROBI, KENYA IN FEBRUARY 1992**

Number of copies 1500

	<u>Ksh.</u>	<u>US \$</u>
Typesetting	72,000.00	1075
Colour separation	12,500.00	186
Cover Design	5,000.00	74
Printing	780,000.00	11,641
Postage	100,000.00	1,515
Total	Ksh. = <u>969,500.00</u>	US\$ <u>14,493</u>

See details next page

being a summarized version (smaller)

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BUDGET DETAILS

For 1500 copies

Report - 288 pages each

Size: A4

Extent: 12 pages

Material: 110 gm

Text: 1 colour

Cover: 4 colour

Copies: 1,500/=

Typesetting/layout/Design - 250/=pp

Cover Design: 5000/=

Priority Historical - 24 pages - 65,500

Type setting - 72,000

Colour Separation - 12,500

Cover Design - 5,000

PRINTING - 288 pages Ksh 65,500 per 24 pages = 780,000/=

Postage - 500 copies at Ksh. 200 per copy = 100,000/=

BUDGET FOR PRINTING OF THE FIRST INTER - AFRICAN CONFERENCE REPORT

Size : A4
Extent : 12 pages
Matereal : 110 gm
Text : 1 colour
Cover : 4 colours
Copies : A : 20
 B : 2000

Priority historical - Shs. 65,000 for every 24 pages

Document A: 150 pages (comprehensive report) - 20 copies
Document B: 60 pages (summary report) - 200 copies

	Ksh.	US\$
I. Type setting		
A:	45,000	818
B:	18,000	327
II. Cover design		
A:	3,000	55
B:	3,000	55
III. Printing		
A:	63,000	1145
B:	320,000	5818
IV. Dissemination and Postage of Document B	100,000	1818
TOTAL	552,000	US\$ 10,036

Exchange Rate Ksh. 55 to 1 US \$

Appendix F

DRAFT PROPOSAL FOR A NEEDS ASSESSMENT FOR AN AFRICAN WOMEN'S HEALTH NETWORK

INTRODUCTION:

In the last two decades or so, global attention has been focused on maternal illness and death. The Safe Motherhood initiative and other programs on health have sought to mobilize and expand efforts to improve maternal health services. The link between the health of women and social, cultural and economic factors has also been highlighted thus broadening the agenda for women's health.

The interest that has been awakened in women's health is evident by the many meetings held on women's health in Africa in the recent years. The first Regional Congress of the Medical Women's International Association (MWIA) for the Near East and Africa Region, was held in Nairobi from November 29 to December 3, 1993 on the theme: "The Health of Women and Safe Motherhood". During the congress planning activities it became clear that a mechanism to follow-up the action plans and recommendations arising from the congress, would be required if the congress was not to be an end in itself. It was envisaged that if felt necessary, such a mechanism a Regional Women's Health Network would emerge from the congress deliberations rather than be developed independently.

An African health network coordinated, controlled and owned by African women has great potential for enhancing the health of African women. For several decades, health needs of African women have been perceived and defined from external forces. The corresponding health services and other interventions have therefore been modelled along these external perceptions, values and training. If African women are to be expected to understand and resolve the numerous constraints to their health and well-being, the channels of communications from the grassroots level to the national and international levels have to be strengthened. Women have to begin to understand that their problems though unique to them are shared by other women on the continent. A health network will facilitate the sharing of information on problems and possible solutions. Such exposure and cross-fertilization of ideas and experiential exchange and linkage can bring a fresh perspective and much needed solidarity and pressure from the women themselves. Such a network has great potential for enhancing partnership between professional women and women at the grass-roots level. This has major implications for the development of programs that are sensitive to the needs of the intended beneficiaries. It is anticipated that the network will play a major role in enriching inter-disciplinary and inter-sectoral collaboration at all levels.

An effective health network will also play a major role in setting the health agenda for African women and as such would serve to remove some of the imbalances that currently exist, where African Women are relegated to the role of passive recipients of donor assistance whether such assistance is deemed by them to be appropriate or not.

Despite the fact that a consensus was reached on the need for an effective African Women's Health Network it was also acknowledged that some networks already exist in the region. Therefore in order for the network to systematically and qualitatively develop and operate, the first step would be to take stock of where African women are with networking and to identify existing gaps. While it is recognized that there are several national networks and a few region-specific ones, there is still no effective network that links up women's health advocates, program planners, policy makers and health professionals on the African continent. In keeping with the recommendations of the participants at the MWIA regional congress we therefore propose the following:

To develop an effective network for the African region that specifically addresses issues related to the health of the African woman.

In order to achieve this objective, it is necessary first to determine whether there is an actual need to establish a new network in the region or whether the strengthening and linking up of already existing networks would be a more logical course of action. It was therefore recommended that prior to action directed specifically at setting up a new network it is necessary to conduct a needs assessment. To facilitate this process, the Kenya Medical Women's Association (KMWA) was proposed as the coordinating body. Key persons in different countries would be identified to act as contacts for obtaining information on existing information on networks within each country in the region. The MWIA and the national medical women's associations were proposed as the umbrella bodies under which the coordinators were proposed as the umbrella from. Several participating countries at the first regional congress submitted names for the key contact person in their country.

Logistically setting up of the network is envisaged to take place in three phases. Phase I will involve conducting a needs assessment, analysis, and identification of modalities of the network, i.e. either launching a new network or strengthening linkages among existing networks. Phase II will include planning and establishing the type of network identified in Phase I. Ensuring sustenance, monitoring and evaluation of the network will form the main components of Phase III.

OVERALL OBJECTIVE FOR PHASE I

To conduct a needs assessment for the launching of the African Women's Health Network

SPECIFIC OBJECTIVES FOR PHASE I

1. Identify the existing health networks in the African region
2. List the objectives, goals, membership, structures and activities of the existing networks
3. Identify priorities of women's groups within the region
4. Identify the needs of these networks in relation to technical assistance, human resource and material needs
5. Identify needs, modalities and feasibility of establishing collaborative activities among the existing networks
6. Identify strengths and weaknesses of existing networks
7. Identify enhancing and inhibiting factors for establishing collaborating mechanism

To achieve the objectives for Phase I, the processes involved will include:

- a) Identification of country contact persons among participants to the 1st Regional Congress of MWIA Near East and Africa Region.
- b) The countries that were not represented during the congress were to identify contact persons within their national medical women's organization.
- c) Where it may take too long in countries without associations.

The role of the contact person will be:

1. To identify organizations both Governmental, Non governmental and international agencies that deal with women's health issues in their countries.

Process:
 1. Seek information from various United Nations office
 2. seek directories
 3. NGO liaison groups.
2. Visit the organizations and collect information needed through the semi-structured questionnaire appended.

3. Submit completed questionnaire to Coordinator in Nairobi

The role of the contact person is to identify existing organization dealing with women health issues in their country. This will be done using directories (where they exist, for eg. the SOMANET directory), and information from organizations such as WHO, UNICEF and the NGO liaison group and others. The contact person would then administer semi-structured questionnaires to the identified women's groups (both governmental and non-governmental organizations). These completed questionnaires would then be submitted to the coordinator.

The coordinator will be based in Kenya. Among the tasks of the coordinator include;

- 1) identification of country contact person,
- 2) design and mail questionnaires;
- 3) collate and analyze information received;
- 4) based on the findings of the needs assessment, decide on the modality of launching of the network;
- 5) disseminate information regarding the needs assessment findings and decision on type of network to participating countries through newsletter, workshops and conferences; prepare to launch the network as soon as feasible.

WOMEN'S HEALTH NETWORK

QUESTIONNAIRE TO BE ADMINISTERED TO ORGANIZATIONS INVOLVED IN
WOMEN'S HEALTH ACTIVITIES:

1. COUNTRY: _____

2. NAME AND ACRONYM OF ORGANIZATION: _____

3. ADDRESS: _____

4. PHONE: _____ FAX: _____

5. NAME AND TITLE OF PERSON INTERVIEWED: _____

6. TYPE OF ORGANIZATION:

6.1 NGO _____

6.2 GOVERNMENTAL _____

6.3 INTERNATIONAL _____

6.4 PROFESSIONAL _____

6.5 OTHER (Specify) _____

7. WHAT IS THE GOAL OF THIS ORGANIZATION?

Attach brochure if any:

8. WHAT ARE THE OBJECTIVES OF THE ORGANIZATION?

9 ELIGIBILITY FOR MEMBERSHIP IN THE ORGANIZATION

9.1 Open to anybody

9.2 Limited membership

If limited membership indicate membership criteria

10. HOW MANY ARE THE MEMBERS ? _____

11. WHAT IS THE COVERAGE OF THE ORGANIZATION

11.1 NATIONAL _____

11.2 REGIONAL _____

11.3 INTERNATIONAL _____

12. WHAT ARE THE AFFILIATED ORGANIZATIONS?

13. ACTIVITIES RELATED TO WOMEN'S HEALTH (Please tick appropriate box and explain activity in the space provided)

13.1 NETWORK _____

13.2 FAMILY PLANNING _____

13.3 CURATIVE CARE _____

13.4 COUNSELLING _____

13.5 WOMEN GROUP _____

13.6 OTHER: _____

14. WHAT ARE THE STRENGTHS OF THIS ORGANIZATION?

A. PERSONNEL:

POSITION	QUALIFICATION
1.	
2.	
3.	
4.	
5.	

B: MATERIALS:

- 1. TRANSPORT.....
 - VEHICLES:.....
 - FUNDS:
- 2. DOCUMENTATION:
 - COMPUTERS
 - TYPEWRITERS
- 3. COMMUNICATIONS
 - TELEPHONE:
 - FACSIMILE
 - E-MAIL
 - OTHER

WHAT AREAS DO YOU THINK ARE DEFICIENT IN YOUR ORGANIZATION?

15. IN YOUR OPINION, DO YOU THINK THERE IS A NEED FOR AN AFRICAN WOMEN'S HEALTH NETWORK?

15.1 YES

15.2 NO

15.3 YES & NO

15.4 NOT SURE

15.6 DON'T KNOW

16. If Yes to # 15 above indicate what role you would perceive this network to perform.

17. If No, please give reasons:

(Please attach your association's brochure detailing activities.)_

BEST AVAILABLE DOCUMENT



Kenya Medical Women's Association

Kabarnet Road
P.O. Box 49877
Tel/Fax: 560813
Nairobi, Kenya

The Kenya Medical Women's Association (KMWA) draws its membership from women medical doctors and dentists registrable in Kenya. KMWA was founded in March 1983.

Our main objectives are:-

1. To provide a means of communication to medical women in different parts of the country and to foster friendship and understanding amongst them.
2. To offer opportunities for medical women to meet, confer and take necessary action on matters relating to the health and well-being of the various communities they serve particularly relating to women and children.
3. To afford opportunities for medical women to have a voice in professional and related bodies.
4. To encourage young women to enter into the medical field and related professions
5. To encourage, commission and conduct research into health problems relating to maternal and child health.

Activities

The major activities of the association fall under three categories:

A. Service to the Community

The members of the Association have taken up the challenge and freely offer their expertise to the needy communities in the country e.g providing maternal and child health care services, health education, and counselling on topical and relevant issues.

Previous activities held include:

1. Medical field days in Korogocho and Kangemi villages, Mukuru and Kibera (urban slums) in Nairobi, Ndeere sub-location and in Machakos.
2. Tubal ligation at Pumwani Maternity Hospital, Nairobi
3. Immunization project at Ndeere Health Centre
4. Pap smear examination in Siaya District and Dagoretti Health Centre, Nairobi

B Continuing Medical Education

KMWA holds annual scientific seminars to promote the advancement of medical knowledge and practical skills not only for medical colleagues but also for other professionals in related fields.

Themes discussed during Scientific Seminars include:-

- 1985 - Women and Health
- 1986 - The Adolescent - Medical and Psycho-social aspects
- 1988 - Your health is your responsibility
- 1989 - Child abuse and neglect - with published proceedings
- 1990 - Women and health awareness workshop
 - National Workshop on World Summit for Children: A Kenyan Perspective
 - Women, Children and AIDS - the occasion of World AIDS Day
- 1991 - Parliamentarian's seminar on AIDS
- 1992 - AIDS orphan survey dissemination workshop
 - Screening for cancer of the uterine cervix for medical professionals, health visitors and family planning workers
- 1993 - Quality of Care (QOC) and Contraceptive Technology Update for medical professionals and family planning managers. KMWA/CEDPA.
 - MWIA Regional Congress on the Health of Women and Safe Motherhood

C Projects and Publications

1. Well Woman Clinic
2. Technical assistance for Quality of Care (QOC) and QOC Assessment for Family Planning Sub-projects of the Centre for Development and Population Activities (CEDPA) in Kenya.
3. Intercountry Study on the Health of Women.
4. Pre-summit workshop - Kenyan perspective (UN World summit for Children)
5. Plan of Action after U.N Summit for Children
6. AIDS orphan survey in Kibera
7. Female circumcision study
8. Review of Child Laws in Kenya

DRAFT

DRAFT OUTLINE OF ACTION PLANS ON WOMEN'S HEALTH

The first Regional Congress of the Medical Women's International Association Near East and Africa region, was held in Nairobi, Kenya from 29 November to 3 December 1993. More than 500 participants attended, from 56 countries. The theme of the Congress was "The Health of Women and Safe Motherhood". Sub-themes included: Socio-Economic and Cultural Factors; Reproductive Health – Sexuality and Fertility; Health of Girls; Maternal Mortality and Morbidity; Reproductive Tract Infections and Related Problems; and Networking and Communication. The Congress was organised by the Kenya Medical Women's Association, with support from international, regional and local agencies, as well as private sponsors. The following statement reflects and summarizes the discussions during the Congress, and outlines the recommendations for action to improve the health of women in Africa and the Near East.

This meeting highlighted, in convincing and sometimes alarming detail, the health problems that afflict females throughout their lives. During infancy and childhood, malnutrition and infectious diseases kill thousands of girls; in some countries social and cultural practices negate the biological advantage of females, leading to higher mortality for females than males in certain age groups (especially 2-5 years). During adolescence, unwanted pregnancy and sexual exploitation can cause physical, emotional and psychological damage, with lifelong consequences.

The pages that follow outline key interventions to prevent unnecessary death and improve the health of females throughout their life span, as discussed and recommended during the Congress presentations, panels, workshops and discussions. We recognise that not all countries can implement all of these interventions at once, and that not all the specific recommendations that were made during the Congress are reflected here; priorities must be identified, national capacities must be taken into account, and different cultural, economic, and social contexts must shape the actions taken by the participating countries. Nevertheless we, the participants of the Congress, hope and expect that all the countries represented here will begin the process of implementing the plan of action immediately, and as delegates to this Congress we commit ourselves to taking the steps necessary to ensure that this will happen. This includes working together, as individuals and through our organisations, to ensure that necessary investments are made in providing adequate health, education and other social services for girls and women.

PLANS OF ACTION ON WOMEN'S HEALTH

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Childhood (0-10 yrs)	All childhood problems	<ul style="list-style-type: none"> ● Mobilise political will and public commitment to ensure compliance with U.N. Convention on the Rights of the Child ● Where appropriate, create task force or other body to monitor implementation of National Plans/Programmes of Action following up on World Summit for Children
	Discrimination in access to food, education, and health care (son preference)	<ul style="list-style-type: none"> ● IEC and gender sensitization of the community ● Outreach by health workers to ensure equal coverage for all children by health services (e.g., for immunisation, ORT, basic curative care) ● School feeding programmes, where feasible ● Compulsory education and/or affirmative action policies in schools (subsidies/preferential admission for female students)
	Excessive workload for girls (household tasks, including care of siblings)	<ul style="list-style-type: none"> ● Promotion of labour-saving devices to reduce workload of women and their daughters ● IEC to modify socialisation and childrearing practices with regard to boys, and increase male involvement in household tasks (including child care)
	Female genital mutilation	<ul style="list-style-type: none"> ● Legislation to prohibit the practice ● Community education on health consequences of FGM ● Culturally appropriate/sensitive IEC to combat the practice ● Promotion of alternative sources of income for practitioners of FGM (e.g., TBAs)
	Child labour and prostitution, and other forms of exploitation	<ul style="list-style-type: none"> ● Legislation to protect children's rights, including laws prohibiting child labour, and enforcement and monitoring of those laws ● IEC for the community ● Promote educational opportunities for girls (as above)
	Child abuse, including sexual abuse	<ul style="list-style-type: none"> ● Enactment of protective legislation, and enforcement and monitoring of laws ● Adequate punishment of perpetrators ● IEC/community mobilisation to recognise and combat the practise ● Education/training for health workers to recognise and respond to signs of abuse ● IEC/education to encourage parents to spend more time with their children

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Adolescence (10-15 yrs)	Early sexual activity	<ul style="list-style-type: none"> • Establish minimum legal age at marriage (where necessary) and enforce/monitor legislation • Compulsory and free schooling for all children • Punish sexual exploitation of young adolescents • IEC for community (incl. men) on health and socio-economic consequences of early pregnancy • IEC for adolescents: <ul style="list-style-type: none"> • Use positive messages, promote alternatives to early sexual activity • Address specific knowledge gaps (based on research findings) • Sex education, starting at appropriate age (before sexual activity is initiated): <ul style="list-style-type: none"> • Train teachers to improve their knowledge and communication skills • Produce educational materials specifically targeted for adolescents • Target out-of-school youth • Integrate with moral/religious teaching • Use traditional channels of information (e.g., aunties, grandmothers, etc.) and revive traditional sanctions against early sexual activity • Education/training for parents to improve communication skills for talking with youth
	Early and unwanted pregnancy	<ul style="list-style-type: none"> • Family life/sex education (see above) • Ensure access to family planning services, humane treatment of abortion complications and, where legal, safe abortion services <ul style="list-style-type: none"> • Eliminate medical and social barriers (e.g., ensure confidentiality at FP clinics, sensitise health/family planning workers to needs of adolescents) • Design and implement service delivery programmes specifically for adolescents • Train health workers in management of unsafe abortion, including clinical management and humane/sympathetic treatment • Establish/strengthen community-level education, training and income-generating opportunities • Rehabilitation for school drop-outs, including continuation of schooling • Establish/expand peer support and counselling programmes
	STDs and RTIs, including AIDS	<ul style="list-style-type: none"> • Family life/sex education (see above), including counselling • Ensure access to services for detection and treatment <ul style="list-style-type: none"> • Eliminate medical and social barriers • Outreach through youth groups, schools, etc. • Provision of preventive methods (condom) for those at risk
	Vesico vaginal & recto vaginal fistulae	<ul style="list-style-type: none"> • Same as for "early and unwanted pregnancy" (see above) • Promote delivery in health institutions for young mothers (under age 18, and esp. under 16) • Provide access to rehabilitative services (surgery)
	Malnutrition (including anaemia)	<ul style="list-style-type: none"> • Target adolescents for food and iron supplementation, to prevent cephalo-pelvic disproportion • Nutrition education, for adolescents and parents/community

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Reproductive Ages (15-49 yrs)	STDs and RTIs	<ul style="list-style-type: none"> ● Educate women on preventive behaviour and recognition of signs of STDs/RTIs ● Train health workers in detection and treatment ● Educate community on dangers of traditional practices that put them at risk ● Develop community guidelines for education and counselling; involve range of health and community leaders, including TBAs and traditional healers ● Encourage cooperation of men regarding prevention of RTIs and STDs ● Screen clients for risk factors before giving contraceptive method, select most appropriate (e.g., no IUCD for women with STD/RTI) ● Establish "well-women clinics" offering comprehensive reproductive health services (antenatal, family planning, post-partum, treatment of infertility, STDs/RTIs) to help avoid the stigmatization of STD clinics
	HIV/AIDS	<ul style="list-style-type: none"> ● Hold special Congress to develop strategies for dealing with HIV/AIDS ● Educate public on dangers of practices that put them at risk of HIV infection ● Sensitise communities on how to support HIV-positive women ● Educate men regarding HIV transmission, and encourage use of condoms ● Use traditional folk media to reach people and elicit feedback ● Continue research (i.e.; why high rate of condom breakage in Africa? new trends of transmission?) ● Encourage community responsibility and involvement; i.e. parents as role models, peer group counselling ● Encourage government to commit to HIV/AIDs control as a priority
	Infertility	<ul style="list-style-type: none"> ● Prevention of STDs and RTIs, as above ● Increase use of post-partum and immunisation clinics to help prevent secondary infertility ● Educate communities regarding causes and treatment of infertility

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Reproductive Ages (15-49 yrs)	STDs and RTIs	<ul style="list-style-type: none"> ● Educate women on preventive behaviour and recognition of signs of STDs/RTIs ● Train health workers in detection and treatment ● Educate community on dangers of traditional practices that put them at risk ● Develop community guidelines for education and counselling; involve range of health and community leaders, including TBAs and traditional healers ● Encourage cooperation of men regarding prevention of RTIs and STDs ● Screen clients for risk factors before giving contraceptive method, select most appropriate (e.g., no IUCD for women with STD/RTI) ● Establish "well-women clinics" offering comprehensive reproductive health services (antenatal, family planning, post-partum, treatment of infertility, STDs/RTIs) to help avoid the stigmatization of STD clinics
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	Infertility	<ul style="list-style-type: none"> ● Prevention of STDs and RTIs, as above ● Increase use of post-partum and immunisation clinics to help prevent secondary infertility ● Educate communities regarding causes and treatment of infertility

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Reproductive Ages (cont.)	Maternal mortality	<ul style="list-style-type: none"> ● Set clear objectives for action; i.e., link research findings with clinical services and activist groups <ul style="list-style-type: none"> ● Change focus of discussion from "causes" of maternal mortality to operational research and active prevention ● Establish task forces/pressure groups at country, regional and international levels to follow-up action ● Design action programmes that respond to regional variations ● Promote greater community involvement using available structures (women's groups) and channels (TBAs) ● Carry out comprehensive Safe Motherhood IEC: <ul style="list-style-type: none"> ● Promote recognition of Safe Motherhood as a human rights issue throughout a woman's lifespan ● Use mass media to create public awareness of importance of Safe Motherhood ● Conduct community-based health education targeting women, families, and communities to promote appropriate health behaviour (especially recognition of signs of pregnancy-related complications) ● Promote community involvement in dealing with obstetric emergencies (e.g., transport and communication, blood donation, etc.) ● Provide comprehensive, high-quality maternal health services: <ul style="list-style-type: none"> ● Training of health workers, especially midwives and TBAs, in clinical and inter-personal skills to improve the quality of existing services ● Ensure linkages between various levels of the health system in terms of monitoring, supervision, reporting (especially for TBAs) ● Develop treatment guidelines or protocols for the management of maternal complications ● Provide adequate equipment and supplies for preventive, diagnostic and curative services ● Incorporate concept of Safe Motherhood into pre-service teaching curricula for health personnel ● Strengthen national and regional training institutions to increase their capacity, establish registers of qualified and accredited trainers, and target women in particular for training in research and clinical services ● Review existing policies regarding distribution/location of health facilities and personnel to ensure adequate coverage and accessibility of maternal health services ● Improve the utilisation of documentation for monitoring and evaluating programmatic progress

LIFE STAGES	RELATED PROBLEMS	STRATEGIES AND ACTIVITIES
Reproductive Ages (cont.)	Unwanted pregnancy and unsafe abortion	<ul style="list-style-type: none"> • Take advantage of "missed opportunities" to provide family planning; i.e. maternity wards, outpatient departments <ul style="list-style-type: none"> • Access to <u>all</u> women, including unmarried women, adolescents, etc. • Identify and remove barriers to family planning; i.e. unnecessary requirements, economic, process hurdles, male consent, etc. • Encourage medical community to acknowledge and address abortion as a health problem, and to take leadership in advocating for legal and programmatic change • Integrate abortion-related care into Safe Motherhood strategies • Consider establishment of multi-disciplinary "safe abortion" task forces • Train medical staff in the use of manual vacuum aspiration (MVA) • Provide post-abortion family planning services in appropriate locations (e.g., gynaecological wards)
	Reproductive health and sexuality	<ul style="list-style-type: none"> • Improve understanding of women's sexuality <ul style="list-style-type: none"> • Train/educate health providers to understand the personal needs and constraints of each client as a means to improve the quality of services • Improve male sensitivity to women's sexual needs; facilitate communication • Carry out research to identify the predominant norms, values and socio-economic determinants affecting sexual decisions, risk perceptions, reproductive health practices and health seeking behaviors • Improve reproductive health technology <ul style="list-style-type: none"> • Conduct research into the causes of infertility, including socio-cultural factors, in concert with contraceptive method research
	Cancers (cervix, breast and uterus)	<ul style="list-style-type: none"> • Educate women on importance of screening and identification of symptoms for early detection and treatment of disease; involve women's groups in promoting compliance with regular screening at appropriate intervals • Train and educate health workers in clinical and interpersonal skills: importance of screening, identification of symptoms, and counselling • Provide drugs for pain control • Develop national screening programmes, including mechanisms for monitoring coverage such as the use of women's health cards and a national database • Make screening available to all sexually active women, but target some groups; i.e., women with multiple sexual partners or who began sexual intercourse at a young age • Develop protocols for recommended age at first screening and frequency • Establish/strengthen capacity for management of early lesions, where feasible • Research the development of lower-cost treatment options • Create regional centres for laboratory diagnosis and/or treatment of cancers

LIFE STAGES	ASSOCIATED PROBLEMS	STRATEGIES AND ACTIVITIES
Menopause (45-59 yrs)	Problems of menopause	<ul style="list-style-type: none"> ● Education/IEC for both women and men on: <ul style="list-style-type: none"> • Symptoms of menopause and explanation of the process • Recognition of danger signs that are not related to menopause (e.g., neoplasms) ● Training of health workers to recognise menopause and counsel women
	Carcinomas (cervix, breast, uterus)	see "Reproductive Ages" above
Elderly (60+)	Cancers Genital prolapses Nutritional deficiencies, incl. osteoporosis Disabilities	<ul style="list-style-type: none"> ● see "Reproductive Ages" above ● Train health workers to recognise and manage health problems of elderly ● Strengthen social support systems, including: <ul style="list-style-type: none"> • Facilities to provide care or accommodation for elderly • Family and community assistance for disabled elderly ● Health education/IEC for elderly on: <ul style="list-style-type: none"> • Adequate nutrition (including calcium) • Maintenance of exercise/mobility

LIFE STAGES	ASSOCIATED PROBLEMS	STRATEGIES AND ACTIVITIES
All Ages	Mental disorders	<ul style="list-style-type: none"> ● Prevention of mental disorders: <ul style="list-style-type: none"> ● Establish and promote women's support groups ● Address causes of mental stress (social discrimination and low status, workload, marital problems, substance abuse, violence, etc.) through counselling and other appropriate means ● Improve existing services: <ul style="list-style-type: none"> ● Decentralise treatment centres ● Recruit/train additional staff ● Subsidise cost of drugs for treatment ● Educate, sensitise and train all health personnel regarding symptoms and treatment of mental disorders, through both pre-service and in-service training programmes ● Develop alternative community-based approaches to treatment ● Coordinate with other professionals (e.g., social workers) ● IEC to destigmatise mental health problems
	Violence	<ul style="list-style-type: none"> ● Enactment of protective legislation, and enforcement and monitoring of laws ● Adequate punishment of perpetrators ● IEC/community mobilisation to recognise and combat violence, including: <ul style="list-style-type: none"> ● Counselling and education for men ● Campaign against substance abuse ● Train health workers to recognise and respond to problems, including: <ul style="list-style-type: none"> ● Referral to STD services, counselling, and legal advice ● Humane and sympathetic treatment of victims of violence ● Collection of evidence, as appropriate ● Establish linkages with legal system and women's groups (for support/counseling)
	Occupational and environmental hazards (indoor and outdoor)	<ul style="list-style-type: none"> ● Develop/define an overall policy ● Detection and management of environmental toxins ● Train health workers to recognise symptoms ● IEC for the community to reduce or eliminate environmental hazards, taking into account traditional practices ● Promote the development and use of appropriate technologies

Appendix G

USAID/TANZANIA STRATEGIC OBJECTIVE 3

"Increased Use of Family Planning and HIV/AIDS Preventive Measures"

Overview

The population of Tanzania has grown from 7.7 million in 1948 to almost 27 million in 1993. The growth rate is estimated at over 3% per year, with a concomitant doubling time of just over 20 years. Population growth rates have increased since independence due to continuing high fertility and rapidly declining mortality. Women have an average of 7 births during their reproductive lives, one of the highest total fertility rates (TFR) in the world. The population is also very young: approximately 54% are less than 15 years of age, implying continued high population growth rates and high dependency ratios.

Although the infant mortality rate (IMR) has fallen since independence, the present IMR of 105 deaths per 1000 live births is still extremely high. Although immunization coverage is good, other trends -- the spread of HIV, persistent malnutrition, malaria, diarrheal diseases, and other health problems -- will continue to keep IMR figures high. Maternal mortality remains high as well, with 200 - 400 maternal deaths per 100,000 women. High maternal mortality implies poor maternal health with negative effects on women's economic productivity as well as their ability to care for their children. Although Tanzanian women are unique in that most of them report for at least one antenatal visit, poor health care facilities, septic abortion, malnutrition and other health problems are contributing factors.

HIV infection rates are increasing rapidly, with national prevalence estimated at about 5% of the population. They are highest among the 15 - 45 year age group and infants, and are increasing among adolescents. Sexually transmitted diseases (STDs) are an important cofactor in HIV transmission; STDs are among the ten most common causes of outpatient attendance in Tanzania. Because of the nature of the HIV/AIDS epidemic and the groups it affects, AIDS will have far-reaching implications for Tanzania over the next several decades. Health and other services will be severely taxed as demands for treatment of opportunistic infections (e.g., tuberculosis, skin diseases) and full-blown AIDS increase. As the ranks of working-age adults decrease, the work force will become younger, less skilled, and less experienced. The numbers of orphans due to deaths of parents from AIDS has already increased rapidly in many areas of the country.

With the myriad of health problems Tanzania faces, USAID has chosen to concentrate its resources in the two areas of reproductive health where it can have the highest impact: population/family planning; and AIDS control and survivor support.

Please see the "Fact Sheet" (next page) for a summary of Tanzania health statistics.

Fact Sheet

1988 Population Data¹

Total population (millions)	23.1
Urban population (percent)	18
Annual natural increase (percent)	3.1
Population doubling time (years)	23
Crude birth rate (per 1,000 population)	46.0
Crude death rate (per 1,000 population)	15.0
Life expectancy at birth male (years)	47
Life expectancy at birth female (years)	50

Tanzania Demographic and Health Survey 1992

Sample Population

Women age 15-49	9,238
Men age 15-60	2,114

Background Characteristics of Women Interviewed

Percent with no education	33.9
Percent attended secondary or higher	4.8

Marriage and Other Fertility Determinants

Percent of women 15-49 currently married	65.4
Percent of women 15-49 ever married	75.6
Median age at first marriage among women age 25-49	17.9
Median duration of breastfeeding (in months) ²	21.6
Median duration of postpartum amenorrhoea (in months) ² ..	13.3
Median duration of postpartum abstinence (in months) ²	6.5

Fertility

Total fertility rate ³	6.3
Mean number of children ever born to women age 40-49	6.9

Desire for Children

Percent of currently married women who:	
Want no more children	16.6
Want to delay their next birth at least 2 years	23.9
Mean ideal number of children among women 15-49 ⁴	6.1
Percent of women giving a non-numeric response to ideal family size	13.7
Percent of births in the last 5 years which were:	
Unwanted	8.1
Mistimed	15.2

Knowledge and Use of Family Planning

Percent of currently married women:	
Knowing any method	80.2
Knowing a modern method	77.6
Knowing a modern method and knowing a source for the method	71.1
Had ever used any method	25.7
Currently using any method	10.4

Percent of currently married women currently using:

Pill	3.4
IUD	0.4
Injection	0.4
Diaphragm, foam, jelly	0.0
Condom	0.7
Female sterilisation	1.6
Male sterilisation	0.0
Periodic abstinence	1.3
Withdrawal	1.9
Other traditional	0.6

Mortality and Health

Infant mortality rate ⁵	91.6
Under-five mortality rate ⁵	141.2
Percent of births ⁶ whose mothers:	
Received antenatal care from medical provider	91.8
Received 2 or more tetanus toxoid injections	71.5
Percent of births ⁶ whose mothers were assisted at delivery by:	
Doctor	6.1
Midwife/trained nurse/MCH aide	47.0
Traditional birth attendant	13.4
Percent of children 0-1 month who are breastfeeding	99.2
Percent of children 4-5 months who are breastfeeding	100.0
Percent of children 10-11 months who are breastfeeding	99.2
Percent of children 12-23 months who received: ⁷	
BCG	95.4
DPT (three doses)	79.8
Polio (three doses)	77.1
Measles	81.2
All vaccinations	71.1

Percent of children under 5 years⁸ who:

Had diarrhoea in the 2 weeks preceding the survey	13.1
Had a cough accompanied by rapid breathing in the 2 weeks preceding the survey	8.2
Had a fever in the 2 weeks preceding the survey	31.0
Are chronically undernourished (stunted) ⁹	46.7
Are acutely undernourished (wasted) ⁹	5.6

¹ Based on 1988 census data

² Current status estimate based on births during the 36 months preceding the survey

³ Based on births to women 15-49 years during the period 0-2 years preceding the survey

⁴ Excludes women who gave a non-numeric response to ideal family size

⁵ Rates are for the period 0-5 years preceding the survey (1987 to 1991)

⁶ Figure includes births in the period 1-59 months preceding the survey

⁷ Based on information from vaccination cards and mothers' reports

⁸ Figures include children born in the period 1-59 months preceding the survey

⁹ Stunted: percentage of children whose height-for-age z-score is below -2SD based on the NCHS/CDC/WHO reference population; wasted: percentage of children whose weight-for-height z-score is below -2SD based on the NCHS/CDC/WHO reference population.

Opportunities

On the family planning side, although availability and utilization of FP services is low (use of modern methods is just under 7%), demand for services is high. The 1991/92 Demographic and Health Survey (DHS) indicate that 40% of reproductive age women would like to space or limit births. The Government of Tanzania has developed a national population policy and a new five year strategy designed to increase accessibility and availability of FP services. It has encouraged donor technical assistance and deployed additional personnel to work in the FP/MCH area. The existence of an already existing integrated FP/MCH infrastructure has facilitated implementation of the National Family Planning Program, and national efforts in training and information are underway.

The Government has also established a National AIDS Control Programme which coordinates national and donor support in a variety of AIDS control areas. It recently developed its second five year Medium Term Plan to map out implementation of activities including condom commodity distribution, information/education (IEC) campaigns, blood supply testing, STD control, and research. The Medium Term Plan recognizes the contribution of non-governmental organizations (NGOs) to the fight against AIDS and has sought to decentralize its programs to the regions and districts.

Although USAID has been the major supplier of condoms to the Government's public sector program, there has been growing Government support for alternative channels of condom distribution. A USAID-funded social marketing program to sell condoms and other health products on a commercial basis is now underway, and initial sales are encouraging.

USAID Support

1. Family Planning Services Support (FPSS)

FPSS is a seven year project, approved by the United States and Tanzania Governments in 1990. It provides up to \$20 million to the National Family Planning Programme (NFPP) to help strengthen family planning/maternal child health (FP/MCH) services in Tanzania. The project purpose is to increase contraceptive awareness, acceptance and use. This will be measured by an increase in the contraceptive prevalence rate over the life of project (LOP).

The strategy of the FPSS is to improve the availability and quality of FP services, so as to enhance their acceptance and use by men and women who choose to space or limit their families. Although use of modern contraceptive methods is low (6.6%) and fertility is high (6.3), both men and women are knowledgeable about at least one modern contraceptive method. More importantly, 30% of currently married women want to use FP to space children or limit births altogether, but are not using any FP method.

To meet this unmet demand, the FPSS provides technical assistance in areas designed to improve availability of contraceptive methods and access to different types of services.

These areas include management, clinical family planning training, logistics, workplace and community-based FP services, and information/education and communication (IEC). The project supports national data collection and surveys, including the Demographic and Health Survey (DHS) and the Tanzania Situation Analysis (TSAS), as well as dissemination of this data to policy makers, health professionals and other groups. FPSS provides commodities in the form of vehicles and clinic equipment and has helped to equip, hire staff and rent office space for the Ministry of Health Family Planning Unit (FPU). FP managers, training teams, service providers and other cadres receive special training through the INTRAH program. Of special note is the support provided (through the Family Planning Association of Tanzania, UMATI) to develop a network of trained personnel and service sites to meet the substantial demand for voluntary surgical contraception (VSC); and assistance to the NFPP to develop a national training strategy and national curricula for service providers. Workplace-based family planning and community-based distribution programs are being supported through Pathfinder International programs with NGOs, specifically, UMATI, the labor union (OTTU) and Tanzania Occupational Health Services (TOHS). FPSS provides almost 60% of the contraceptives required by the NFPP, the balance provided by UNFPA and by ODA.

A variety of cooperating agencies provide implementation assistance. These include the University of North Carolina/INTRAH, Johns Hopkins University, John Snow Inc., the Carolina Population Center, Pathfinder International, and the Association for Voluntary Surgical Contraception.

Donor coordination is already active and encouraged. FPSS has worked closely with UNFPA in areas such as training, logistics and contraceptive commodity support. ODA has provided support in the area of contraceptive supplies, and extending VSC services. GTZ and other implementing agencies have worked closely with the FPU to incorporate national training standards and curricula into their own programs.

Contacts:

Mr. Rogatian Shirima, Principal Secretary, Ministry of Health
Dr. Fatma Mrisho, Assistant Chief Medical Officer/Preventive Services, MOH
Dr. Calista Simbakalia, Programme Manager, National Family Planning Programme
Dr. Naomi Katunzi, Executive Director, UMATI
Dr. Anatole Rukonge, VSC Director, UMATI

2. Tanzania AIDS Project (TAP)

The Tanzania AIDS Project (TAP) is a new USAID effort in the AIDS area. This five year, \$20 million project was signed by the United States and Tanzania Governments in July 1993. The project purpose is to increase the practice of HIV preventive measures and to improve the socio-economic well-being of AIDS orphans. Support for orphans is broadly defined to include families affected by AIDS.

Increased practice of HIV preventive measures is accomplished through encouraging early identification and treatment of STDs; increased availability of and access to condoms; and developing and marketing messages to motivate individual and community behavior change (behavioral change communication or BCC). Activities to improve the well-being of orphans will include home care, counselling, NGO coordination, and policy research.

The primary TAP strategy is to use the non-governmental sector to carry out AIDS prevention and control activities, and to provide support services to AIDS orphans and their families. Networks of NGOs ("clusters") will be formed to provide a range of prevention and support services to communities associated with a worksite or other place where large groups of adults are concentrated. To some extent, project activities will be financed through contributions from participating businesses. The main implementing agent for this USAID project is AIDSCAP, a consortium of agencies, under the prime contractor, Family Health International. Population Services International is responsible for the social marketing component of the TAP.

The TAP is now developing strategies to increase STD treatment coverage and will coordinate with principal donors on this issue. Communication for behavior change will occur primarily through worksite and high transmission area peer education programs and will promote condom use, STD treatment, and individual risk management. At the community level, communication will encourage coordination of NGO efforts to provide services and develop community strategies.

Since condoms are an important means to prevent STDs and HIV, 25% of the TAP budget has been allocated to condoms (private and public sector) and through 1994, USAID remains the only donor of condoms to the NACP and social marketing program. However, other donor support has been successfully sought. Beginning in 1995, UNFPA will meet the entire public sector condom requirement (for both FP and AIDS) for at least three years; and the Dutch Government has committed itself to providing up to 40 million condoms for social marketing over a five year period. Other health products, such as gloves, needles/syringes, bednets, and oral contraceptives will be assessed to determine their feasibility as products which can also be socially marketed.

Orphans and families affected by AIDS will be assisted by NGOs supported through the TAP. The project is providing support for a national family assessment which will look at coping mechanisms and possible interventions NGOs can implement in support of the growing numbers of orphans. Further, the USAID Mission has established a Social Action Trust, projected to total \$40 million by 1997. Proceeds from the Trust will be used to support NGOs working to assist orphans and families affected by AIDS.

Contacts:

TAP Resident Advisor (to be appointed), AIDSCAP, Dar es Salaam
Mr. Tim Manchester, PSI representative, AIDSCAP, Dar es Salaam
Dr. Rowland Swai, Programme Manager, National AIDS Control Programme
M. C. Njimbay, Social Welfare Division, Ministry of Labour and Youth Development.

Other USAID-Supported Health Activities

USAID, through its AID/Washington headquarters, supports the Dodoma Eye Project in collaboration with Helen Keller International. The project's main objective is to reduce blindness prevalence from 7% to 1% by the end of this decade. Because Dodoma region is among the very dry regions of Tanzania, blindness is mainly caused by trachoma which has rates of 60% among children in primary school and 32% for adult women. Interventions are community based and focus mainly on hospital based and outreach cataract operations; mass treatment of trachoma; and increased water supply with emphasis on improving personal hygiene. Project activities are integrated in the other primary health care and community development activities. Generally, the results are encouraging.

The Johns Hopkins University has a research grant from AID/W to work in collaboration with University of Dar es Salaam on Zanzibar to study the effects of helminths on children's nutritional status. This project has just begun.

In addition, an Africa-wide malaria conference to look at the impact of insecticide-impregnated bednets on mosquito control is scheduled to be held in Dar es Salaam in September 1994. This conference will disseminate findings from a three year study in Tanzania which looked at the impact of bednets on malaria prevalence in coastal areas of Tanzania.

Population and Health Office Staff

Dana Vogel has been at post since January 1991, and serves as the P&H Office Chief. She has worked in Sudan, Niger and Bangladesh as a Health/Population Officer, and has been with AID since 1980. Dana has an M.A. in International Affairs from George Washington University.

Michael Mushi is the Assistant Health Officer and is a Clinical Officer by training. Mike has worked for GTZ and other agencies and has many years of experience in health program management.

F. Mburu is the Senior Population Programme Specialist. He has taught at the University of Nairobi and consulted on health projects for UNICEF, WHO, World Bank, Red Cross and other agencies in various parts of Africa. Dr. Mburu holds a PhD. in Health Management from the University of Mississippi and an MPH in Health Planning from the University of Texas. He has just begun his third year in USAID.

Susan Hunter is the AIDS Sector Advisor for the Mission and arrived at post in January 1994. Susan has taught at Makerere University in Uganda as a Rockefeller Foundation Social Sciences Fellow; and consulted with Save the Children Fund (UK) and UNICEF. She has a PhD. in medical anthropology from SUNY Albany.

Suggested Other Reading

The project papers for the FPSS and TAP are available upon request. However, included with this information are several informational documents.

1. Tanzania Demographic and Health Survey 1991/92, summary report, Tanzania Bureau of Statistics.
2. Family Planning Services in Tanzania: An Overview, Bureau of Statistics/FPU/PPU, Tanzania.
3. Family Planning Saves Lives, 2nd edition, Population Reference Bureau, 1991.
4. U.S. Population Assistance: Issues for the 1990s, Population Crisis Committee, 1991.
5. "AIDSCAP in Tanzania," Family Health International.
6. "Tanzania AIDS Project," (descriptive handout), AIDSCAP.
7. U.S. Agency for International Development Responds to AIDS, AID/W.
8. The Impact of HIV/AIDS on Population Growth in Africa, African Population Advisory Committee, May 1993.