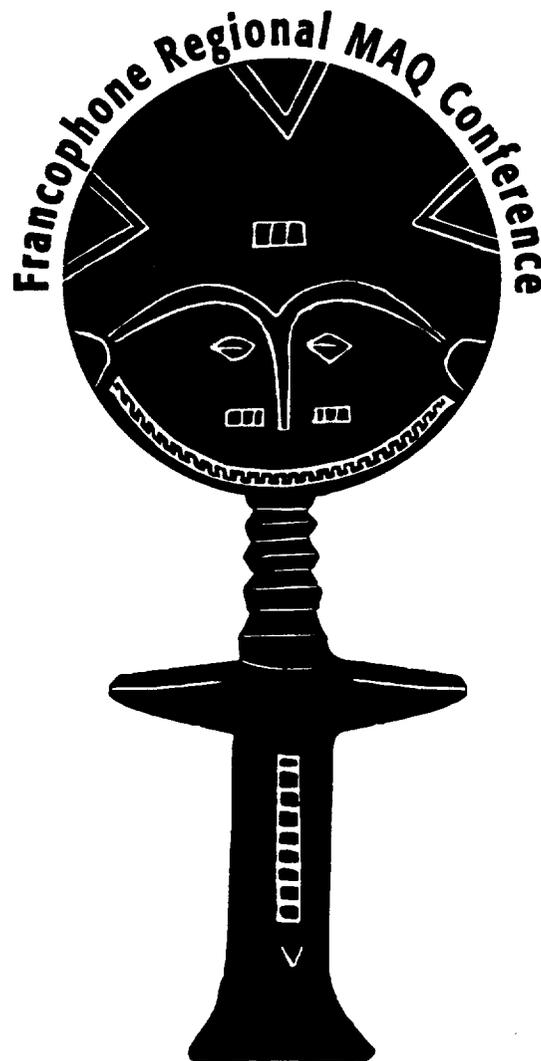


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PROCEEDINGS

Regional Conference
on Increasing Access and Improving the Quality
of Family Planning and Selected Reproductive Health Services
in Francophone Sub-Saharan Africa



Ouagadougou, Burkina Faso
March 12-17, 1995

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Family Health International (FHI) is a non-profit organization dedicated to improving reproductive health around the world, with an emphasis on developing countries. FHI is committed to expanding family planning options; preventing the spread of AIDS and other sexually transmitted diseases; and improving the health of women and children. FHI has provided technical assistance and conducted research for more than 20 years in over 100 countries with ministries of health, universities, clinics, indigenous non-governmental organizations, researchers, physicians and family planning and reproductive health providers.

A Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) is a non-profit organization that works to institutionalize the teaching of reproductive health and family planning in medical and paramedical educational programs and to improve the training capacities of teachers concerning reproductive health. Since its creation in 1973, JHPIEGO has supported the training of more than 87,000 health professionals in more than 120 countries and currently conducts activities in 23 countries worldwide.

INTRAH (The Program for International Training in Health) is a non-profit organization whose mission is to assist countries in various stages of development transition to improve the development and delivery of essential reproductive health services through better preparation and utilization of human resources. Since its inception in 1979, INTRAH has successfully assisted government and non-governmental agencies, educational institutions, USAID missions and other groups in nearly 40 countries worldwide to systematically address human resource development needs, including personnel planning and management, training, supervision and other aspects of organizational support.

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Proceedings

Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa

Ouagadougou, Burkina Faso

March 12-17, 1995

Co-organized by:

Family Health International (FHI)

A Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)

Program for International Training in Health (INTRAH)

In collaboration with:

Access to Voluntary and Safe Contraception (AVSC International)

Cooperative for American Relief Everywhere (CARE)

Centre for Development and Population Activities (CEDPA)

Futures Group

Institute for Reproductive Health (IRH)

International Planned Parenthood Federation (IPPF)

Johns Hopkins University/Population Communication Services (PCS)

Management Sciences for Health (MSH)

Pathfinder International

Population Council

Population Reference Bureau (PRB)

Population Services International (PSI)

Support for Analysis and Research in Africa (SARA)

United Nations Children's Fund (UNICEF)

United Nations Population Fund (UNFPA)

United States Agency for International Development (USAID)

University Research Corporation (URC)

World Health Organization (WHO)

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□ the Burkina Faso Ministry of Health for hosting this conference in Ouagadougou and for its support during the conference.

□ the U.S. Agency for International Development's Office of Population in Washington and the USAID Mission in Ouagadougou for their contributions and financial support to this conference.

□ the 20 members of the Africa-based Technical Committee who developed the conference program after several months of reflection concerning the priority family planning themes for the region. During the conference, these committee members worked tirelessly to assist delegations to prepare their action plans.

□ the U.S. Coordination Committee, which coordinated the technical and financial resources necessary for the successful implementation of the conference. The members of this committee, representing more than a dozen of USAID's Cooperating Agencies and other organizations working in the region, furnished necessary information to their counterparts based in Africa.

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□ the conference delegates from Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Madagascar, Mali, Niger, Senegal and Togo, as well as the non-delegate conference participants,

who functioned as presenters and resource persons. Their participation throughout the week demonstrates the commitment of the region to family planning and reproductive health.

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Note from the Editor:

Proceedings of the Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa presents the voices and concerns of francophone African professionals working across sectors to improve family health today. We attempted in this collection of presentations and other conference materials to preserve the richness of individual presenters' words and the context in which each described his subject. Many of the ideas and observations made in individual presentations surface throughout, demonstrating commonalities among country experiences and growing linkages between issues. We hope the proceedings reflect the richness of the preparatory collaboration among members of the Africa-based Technical Committee and the U.S. Coordination Committee, and the highly participatory nature of the conference itself. We are pleased to offer it as a record of voices from the region in dialogue about emerging issues of the day.

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Executive Summary

The Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa was held from March 12 to March 17, 1995, in Ouagadougou, Burkina Faso. The conference was organized by Family Health International (FHI), INTRAH (The Program for International Training in Health), and A Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), with the collaboration of the Burkina Faso Ministry of Health and financial support from the U.S. Agency for International Development (USAID).

The conference was jointly planned by an Africa-based technical committee and a coordination committee based in the United States. The Africa-based Technical Committee was responsible for the development of all technical aspects of the conference. This 20-member committee, made up of West African leaders in the public and private sectors, NGOs, women's organizations and local representatives of donors and cooperating agencies, brought expertise in FP/RH on the national as well as on the regional level to the conference. The Africa-based Technical Committee also established delegate selection criteria and developed the conference program, with guidance from INTRAH's regional office at Lomé, Togo. The Technical Committee formulated the goal of the conference, identified conference themes, and put together the program based on the results of the needs assessment conducted in the region by the program leaders and FP/RH service providers.

The U.S. Coordination Committee consisted of representatives of USAID's Office of Population and 14 USAID cooperating agencies. Suggestions by members of the U.S. Coordination Committee were incorporated in the program to ensure that the experiences and resources of the Office of Population and its cooperating agencies were applied to conference planning. The U.S. Coordination Committee also mobilized financial and human resources.

The conference's main goal was to increase the accessibility and improve the quality of family planning and selected reproductive health services in francophone sub-Saharan Africa. Its general objectives were:

- To plan the reduction or removal of barriers to the access, quality and utilization of family planning and selected reproductive health services
- To plan the initiation of new approaches to improve the access and assure quality of certain elements of reproductive health and family planning services
- To determine the implications of gender issues on the status of reproductive health and family planning services.

One hundred and twenty-six participants, including health professionals, jurists, government agency representatives, population experts, journalists, religious leaders, representatives of women's groups and sociologists attended the conference (a complete list of participants can be found in Appendix 1). The core group of participants was 54 delegates from ten francophone African countries: Benin, Burkina Faso, Cameroon, Guinea, Côte d'Ivoire, Madagascar, Mali, Niger, Senegal and Togo.

During the six days of the conference, delegates and other participants attended sessions to update knowledge on contraceptive methods, to examine strategies to improve provision of services and to share experiences about the social and cultural factors that influence reproductive health in the region. Based upon the information received in these multi-disciplinary sessions, each delegation developed an action plan for its country. These plans consist of a series of strategies designed to eliminate barriers to family planning and to improve selected reproductive health services.

Over the course of the conference, common experiences among countries and creative solutions to problems emerged from the presentations and discussions. Presenters noted how much progress had been made already toward improving reproductive health and family planning services, and identified several themes common to many countries in the region:

The improvement of both quality of reproductive health services and access to these services is a multi-disciplinary endeavor requiring the participation of many different actors working in the public, private and NGO sectors. Linkages among the various agencies, institutions, ministries, organizations, and key players need to be nurtured to maximize the impact of efforts toward this common goal.

Up-to-date service delivery guidelines are a valuable resource to support efforts to standardize the quality of services offered to clients. Such guidelines should be developed, where absent, and existing guidelines should be further disseminated and applied in the region.

Legal and regulatory reforms to improve the status and the reproductive health rights of women should be pursued throughout the region. Reforms should include efforts to reduce the incidence of female genital mutilation.

Reproductive health and family planning services should be expanded to include youth in culturally sensitive ways. Legal and regulatory reforms should be introduced to reinforce the rights of adolescents to reproductive health information and services.

Additional training of health providers at all levels is needed to enable staff to improve all aspects of reproductive health and family planning service delivery, including management. Reproductive health/contraceptive technology update seminars should involve the participation of decision-makers and key service providers at the country level.

Greater emphasis should be placed on the development, implementation and evaluation of national IEC strategies that harmonize messages across programs and reach out to new, important target groups such as adolescents and men.

Contraceptive methods are still unavailable to many segments of the population, particularly in rural areas. Greater use of community-based distribution and social marketing of contraceptives could increase access to birth-spacing methods among such underserved groups, and these approaches should be considered.

Post-abortion care is an urgent need in the region. Post-abortion family planning, counseling and referral services should be provided to women of reproductive age. Multi-country research is already being planned to determine the most effective ways to provide such services.

Integration of STD/AIDS prevention services with family planning services is an issue of great importance to many service providers, especially where rates of infection are high among clients served by family planning programs.

These points were defined by conference participants as the key practical issues related to reproductive health delivery in francophone West Africa today. USAID's global Maximizing Access

and Quality (MAQ) initiative, a conceptual and practical approach to improving reproductive health services, was promoted as a way to focus efforts to address such needs. The MAQ initiative outlines four areas to address in efforts to improve reproductive health services:

- Client-provider interaction — encouraging accurate, clear, courteous, and empathic exchange between client and providers.
- Management and supervision — strengthening the management and supervision of programs to reinforce quality of care in a gender-sensitive way.
- PACE (Policy, Advocacy, Communication and Education) — encouraging policy- and decision makers to adopt and implement policies that improve quality and access to reproductive health services, and using communication and education to ensure that policies and standards are implemented.
- Technical guidance and competence — improving providers' technical competence through development of appropriate technical guidelines and training.

The Burkina Faso conference is the first regional francophone conference to examine ways to maximize access and quality of selected reproductive health and family planning services, using a participatory process involving the public and private sectors and the NGO community. Similar conferences and workshops related to the MAQ initiative have been held around the world, among them an East and Southern Africa regional workshop in Harare, Zimbabwe, in January and February, 1994; a seminar in Nairobi, Kenya, in July, 1994; a service delivery guides and guidelines conference in Lomé, Togo, in July, 1994; a session at the Third Congress of the Society of African Obstetricians and Gynecologists (SAGO) in Yaoundé, Cameroon in December, 1994; and two regional workshops in Latin America and Asia in November, 1993.

The conference was significant in that it raised once more the issues of laws, practices and protocols that create barriers to access and quality of services. The draft action plans developed by country delegations are an important initial step toward articulating practical strategies to improve selected reproductive health and family planning services in the region.

In addition, participants committed themselves to work actively to change priorities and bring a new perspective to the social, health and cultural issues in their countries that affect service delivery. As effective advocates of services for adolescents, the involvement of men, counseling and integration of services — to name but a few — the participants will undoubtedly implement innovative ways to improve FP/RH service access, quality and use throughout the region.

The collaborative process followed in organizing the conference established a vehicle for coordination throughout the region. Because of this conference, a network of professionals now exists in

francophone sub-Saharan Africa ready to support and promote the MAQ concept. For the Africa-based Technical Committee members, the conference produced an organization and coordination mechanism that will now enable them to launch other FP/RH activities. The members of this group are now fully dedicated to eliminating barriers to access to and quality of selected reproductive health and family planning services in the region.

— The Africa-based Technical Committee

Introduction

The Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa began with an opening ceremony highlighted by addresses from the Minister of Health of Burkina Faso, the U.S. Ambassador to Burkina Faso, and a representative of the Africa-based Technical Committee. They welcomed the participants and emphasized the importance of maximizing access and quality (MAQ) to improve FP/RH services in the region. The USAID/Washington representative also delivered a speech in which she indicated the agency's priorities and described its changing role in the area.

Following the opening ceremony, the work of the conference began. The specific objectives of the conference were:

1. To define the elements and indicators of quality and accessibility to selected reproductive health and family planning services, including how to use the indicators to measure the implementation of programs and the impact of planned interventions
2. To provide an update on selected aspects of reproductive health and contraceptive technology
3. To identify the important barriers to quality and accessibility to selected reproductive health and family planning services
4. To share strategies to improve accessibility, acceptance, and quality of services
5. To prepare country-level action plans to improve accessibility to and quality of certain aspects of reproductive health and family planning services.

Over the course of the conference, presentations were made in the form of panels on the following themes and sub-themes:

- Maximization of Access to and Quality of Reproductive Health and Family Planning Services (MAQ)
- Definition of MAQ concept and of the barriers to accessibility and quality of services
- Statistical profile of francophone Africa
- Update on specific family planning methods and reproductive health services
- Prevention of infections
- Lactational Amenorrhea Method (LAM)
- Natural Family Planning (NFP)

- Permanent contraceptive methods
- Eligibility criteria: new WHO approach
- Hormonal methods: pills, injectables and implants, and their eligibility criteria
- IUD and its eligibility criteria, and postpartum FP
- STD/AIDS and barrier methods
- Emergency contraception
- Post-abortion care
- Client-service provider interaction
- Factors influencing family planning and reproductive health in the region
- Legal aspects, regulations
- Harmful traditional practices
- The responsibility and power of women and men
- Strategies to improve accessibility and quality of FP/RH services
- FP/RH service policies, standards and protocols, and other guidelines and their expected results in service access, quality and use in the region
- Legal clinics
- Motivating men
- Services for adolescents
- COPE
- Community-based distribution
- Social marketing
- Partnership of public, private and non-governmental sectors
- Integration of services for: STD and RH/FP, AIDS and RH/FP, FP and postpartum care
- Communications strategies to increase access to and quality of RH/FP services
- RH/FP counseling.

The intense discussions that followed panel presentations generated fruitful dialogue among participants, who shared information and experiences. Certain topics elicited considerable interest, enthusiasm and debate among the participants:

- Community-based distribution of contraceptive products, particularly the experience of Mali

- The countries' commitment to increase their efforts to include in their programs reproductive health services for young people, for men and for other underserved and marginalized groups
- The realization by several delegates of the importance and magnitude of the task ahead to effect legal reforms permitting better access to reproductive health services.

Work sessions to prepare the country-level action plans were held daily by each delegation. The last day of the conference was dedicated to finalizing the plans, presenting them in plenary session, and to discussions between international donor representatives and delegations.

The conference closed with speeches delivered by the Burkina Faso Minister of Health, a representative of the country delegations and a representative of the Africa-based Technical Committee. The speakers congratulated the participants for the active role they had played and for their efforts to develop country action plans. They also reminded the audience that the work was not finished but had hardly begun, because their commitment to improving access and quality of services would be manifested in the activities carried out upon their return home.

Upon their return to their respective countries, the delegates will pursue efforts to enlist the support of national decision makers and leaders in the acceptance and implementation of their action plans. It is expected that USAID cooperating agencies and other donors will orient their technical assistance to the activities identified by the delegates. FHI, INTRAH and JHPIEGO envision the development of a mechanism to share information about MAQ activities with conference participants and others committed to reproductive health and family planning service improvements in the region. In addition, the Africa-based Technical Committee will perform a short- and long-term evaluation to assess the participants' opinions about the conference and the success of efforts to implement action plans in country. Given the increasingly limited resources and the closing of USAID missions in several of the countries in the region, special efforts will be necessary to ensure that these follow-up measures are implemented.

Opening Remarks and Keynote Speeches

Opening Remarks by the Burkina Faso Minister of Health

His Excellency Christophe Dabiré

On behalf of the government I am privileged to represent, I would like to extend to all participants a cordial welcome to Burkina Faso and express our satisfaction for having been chosen as host to this francophone regional conference. I hope you will find in Ouagadougou an environment conducive to discussion and to the development of your work.

Ladies and gentlemen,

The urgency of this conference's theme is recognized by the international community as well as by African communities.

Health indicators of our different nations are summoning us all — political authorities, scientists, researchers, health providers, and the people of our cities and villages — to action. Life expectancy in our part of the world is indeed poor, infant mortality exceeds 100 deaths per 1,000 live births, and maternal mortality remains high. This situation can be traced to insufficient access to prenatal care, to childbirth attended by poorly qualified personnel, to the low vaccination rate, to malnutrition, and more.

Faced with such a situation, what can the immediate answer be but to work to improve accessibility and quality of reproductive health and family planning services?

I can assure you that the objectives you have established, which were the topic of the Lomé meeting in July 1994, correspond exactly to the different nations' maternal and child health policies.

Reproductive health and family planning are the keystones of the population policies developed by our nations. Beyond the issues of population growth and well-being with which we are concerned, lies the problem of development. Indeed, we need to emphasize that social development, human development, or long-term development have no meaning unless they are linked with population issues. For the past three decades, industrialized nations as well as developing countries have become aware of this close link, which constituted the primary justification for the first International Conference on Popula-

tion and Development in Bucharest in 1974. Since then, two similar conferences have been held: one in Mexico City in 1984, and one in Cairo in 1994.

Ladies and gentlemen, I want to stress the importance of this conference, because it will expand upon the ideas that emerged from the Lomé and Yaoundé meetings and will encourage the sharing of experiences with the use of different strategies designed to improve accessibility and quality of health services. This conference will also contribute to the establishment of an action plan for each country. We look forward to concrete proposals.

Before concluding my remarks, allow me to thank and to congratulate the United States Agency for International Development (USAID), whose involvement with our countries in the areas of population and development is constant and significant, especially in financial and material terms. In Burkina Faso, the 1993 Demographic and Health Survey and the establishment of a large number of Maternal and Child Health and family planning projects were made possible by USAID's involvement. The current conference is also to its credit.

I also take this opportunity to thank the American cooperating agencies and all international organizations for their important contribution to the establishment of our numerous health projects.

I gratefully acknowledge the presence of representatives of other francophone countries at this conference. Burkina is honored by the mark of friendship that their attendance indicates. To all, we wish a pleasant and productive visit in our country.

I am convinced that the objectives you have set for yourselves will be met, and we are looking forward to the outcome of your efforts. I invite participants to remain committed to support the efforts made each day to improve access to quality reproductive health and family planning services for the benefit of our countries' target populations.

I wish you complete success in your work and officially open the Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa.

**Introductory Remarks from the U.S.
Ambassador to Burkina Faso**

His Excellency Donald McConnell

It is my pleasure to participate in the opening ceremony for this regional conference on the improvement of access and quality of reproductive health and family planning in francophone Africa.

On behalf of all those present today, on behalf of the United States Government, and speaking for myself, allow me first to express my sincere thanks to the Government of Burkina for having accepted to host this very important conference. Their hospitality is a further demonstration of Burkina's continuous efforts to improve the health of its population, in particular that of mothers and infants. I would also like to thank the Government of Burkina for its hospitality to the members of the delegations participating in this conference, and extend my appreciation to those responsible for preparing it. To all of you, thank you.

Ladies and gentlemen, this conference will examine the crucial issue of access to and quality of reproductive health services, a question of great urgency and one of the priorities of this country as well as of most countries in Africa. This concern occupies a rightful place among the objectives of the U.S. Government aid program. Indeed, we have supported the health program for the past decade, and specific efforts have been made in the area of family planning, which is one of the most dynamic programs in the sub-region. Its success should be attributed primarily to the Government of Burkina who deserves our congratulations not only for the coordination efforts between parties, but also for the excellence of the help received on the national level towards the proper establishment of programs.

As you know, USAID will be closing its Burkina office this year. However, I can assure you that steps are being taken in order to ensure the continuing support of the national program. Thus, two of our technical cooperation agencies, the Population Council and the SEATS Project, have offices in Ouagadougou and will continue to assist the Ministry of Health on health issues.

I can assure you that this conference responds to a concern that USAID shares with the countries represented here. In one week, delegates of ten francophone African countries present today will examine the "MAQ" concept and will discuss barriers to access, to quality and to utilization of

services. They will review the different strategies that could be developed, and finally they will establish action plans designed to improve access to and quality of services in each of their countries. These action plans must be more than a simple exercise. They must reflect the realities encountered in the field and provide an operational framework for the support of national programs.

Good luck on the completion of your task. Thank you.

**Introductory Remarks from the Africa-based
Technical Committee and Cairo Conference
Perspective**

Presenter: Dandobi Maikibi

On behalf of the Technical Committee members responsible for the preparation of this conference, it is my privilege to welcome you to the Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone sub-Saharan Africa.

Following the 1974 Bucharest Conference and the 1984 Mexico City Conference, the September 1994 International Conference on Population and Development in Cairo brought together the delegates of 182 nations to focus on the issues of population and development. This meeting, which occurs six months after the conference in Cairo, gives the countries represented here the opportunity to support the establishment of action programs recommended at Cairo.

After long and difficult negotiations, the conference adopted an action program based on an international consensus. The Cairo action program set objectives to meet the many fundamental challenges that face humankind. These objectives include:

- Economic growth supported by long-term development
- Education (that of girls in particular)
- Fairness and equality between the sexes
- Greater power for women
- Reduction of maternal, infant and child mortality, and universal access to reproductive health services, including FP and sexual health.

In its chapter regarding reproductive rights and health, the program underscores the reasons that prevent the population from enjoying true reproductive health: the lack of adequate knowledge about sexuality, the poor quality of available reproductive health information and services, discriminatory social practices, negative attitudes towards women and girls and their lack of power over their own sexual life and reproductive functions. Foremost among the measures that the Cairo program calls for to address this situation, is that all countries engage in vigorous efforts to improve as soon as possible — and at the latest by 2015 — access to reproductive health services for all through the use of their primary health care networks. To this end, all the countries were invited to identify and then eliminate the main barriers that continue to undermine the utilization of reproductive health and FP services.

Our conference program, established by the Africa-based Technical Committee that I have the privilege to represent at this opening ceremony, adheres fully to the recommendations that emerged from the Cairo International Conference on Population and Development. Indeed, the Technical Committee, whose members are in charge of RH/FP in our region, collaborated with the U.S. Coordination Committee to identify the different barriers to accessibility and quality of RH services. This inventory enabled us to formulate the following objectives for this conference:

- Reduce or eliminate barriers to access, quality and utilization of RH services including FP
- Find new ways to improve access and ensure the quality of RH services including FP
- Define the implications of gender issues on RH/FP services.

This conference brings together for five days about one hundred delegates and resource persons from the ten following countries: Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Madagascar, Mali, Niger, Senegal and Togo. Representatives of about 20 cooperating agencies and donors are also participating in this conference as observers.

At the conclusion of the conference, we expect to have an action plan for each country and a mechanism to follow up and evaluate implementation of these plans.

Ladies and gentlemen, on behalf of the Technical Committee, allow me to express our thanks to the government of Burkina Faso for hosting our conference in Ouagadougou under the sponsorship of the Minister of Health, and to the USAID Mission in Burkina Faso for its support and contribution to the organization of this conference.

I would also like to take this opportunity to thank all the cooperating agencies who sponsored the Technical Committee members during their two meetings in Lomé, Togo and two meetings in Ouagadougou, Burkina Faso. These same agencies have also sponsored the delegates to this conference and have provided reference documents.

The Africa-based Technical Committee would also like to address its thanks to his excellency the Minister of Health and to his excellency the Ambassador of the United States of America, as well as to all our guests for honoring this ceremony with their presence. I hope that our work will result in concrete action for the improvement of reproductive health in the region.

Keynote Address on Family Planning and Reproductive Health in Francophone Africa

Speaker: Pascaline Sebgo

It is a great privilege for me to speak at this important meeting. I was asked to present a keynote address on reproductive health in sub-Saharan Africa to provide a context in which to place this regional conference's effort to improve access and quality of reproductive health/family planning (RH/FP) services.

My presentation this morning is composed of three parts:

1. A brief review of the family planning situation in our sub-region and a review of international and regional conferences, which have been major turning points in the development of our family planning programs

2. An overview of the progress made in the field of family health, with a focus on the national program in Burkina Faso

3. A short analysis of the problems and challenges that continue to confront RH/FP program leaders and the measures needed to improve accessibility and quality of RH/FP services to benefit our populations.

I. Review of the past fifteen years

In the early 1980s, most of our governments were reluctant to become involved in family planning programs. Indeed, about 60% of sub-Saharan countries estimated the growth rate of their population as satisfactory. In addition, public opinion held that donors in the West were pushing for a reduction in population growth. The legal status of family planning was ambiguous and the French colonial law of 1920 regulating contraception continued to undermine programs.

Most FP services were offered by family planning associations and the phrase "child-spacing" was found to be more acceptable than "family planning." Family planning remained very much under the auspices of the medical profession. Contraceptive prevalence was poor, and in most cases was non-existent. The low status of women and the lack of men's involvement in family planning acted as negative factors and constraints.

Important Meetings and Conferences

A series of international conferences contributed substantially to raising the consciousness of policy makers and to including population and reproductive health in development plans. Accordingly, the early 1990s witnessed in our sub-region an increased awareness of the necessity to consider population and health issues in development.

A great number of representatives of our governments attended the 1974 conference in Bucharest. This representation clearly demonstrated the interest and concern that our leaders now have for population issues. The Bucharest conference adopted a global population plan but saw two schools of thought emerge: some advocated a fertility decrease as a necessary condition to any development, while others called for a new economic order that would eliminate inequalities among nations.

In 1994, the Mexico City conference focused on:

- Links between population issues and development
- National sovereignty in terms of population policies and programs
- Individual freedom of choice in terms of couples' reproductive function.

In Africa, the 1971 Accra conference and the 1984 Arusha conference also addressed economic and population problems.

The 1987 conference in Abidjan, sponsored by USAID, was attended by family planning experts. Discussions focused on problems linked to the practice of requiring clinical examinations before prescribing certain hormonal family planning methods. In 1990, FHI sponsored a meeting in Dakar to discuss the dissemination of study results regarding required laboratory tests.

The 1988 Niamey conference on safe motherhood, as well as the Third African Conference on Population, held in 1992 in Dakar, marked a turning point in terms of family health programs in our sub-region.

Finally, as Dr. Maikibi mentioned in her earlier remarks, the recent Cairo International Conference on Population and Development addressed urgent issues of reproductive health.

II. Progress and current situation

Over the past decade, changes in family planning have taken place in our region. Studies have shown that our countries have made progress in the following areas:

- The definition of FP policies and programs
- The establishment of FP services and IEC activities
- The establishment of supervisory mechanisms
- The creation of service guidelines and standards
- The improvement of skills
- Policies and task preparation
- Service delivery and related activities
- Evaluation activities
- Availability of and access to services.

However, in spite of these improvements, much remains to be done. During the last decade, a noticeable change took place in the attitudes of governments towards family planning. In contrast to the early 1980s, the late 1980s and the beginning of the 1990s saw much greater involvement on the part of governments. For instance, 56% of governments in sub-Saharan Africa now consider their country's birth rate as too high. In addition, populations themselves are more aware of the problem thanks to the greater availability of Demographic and Health Survey data and other research results on contraceptive prevalence as well as on knowledge, attitudes and practices related to contraception.

With the support of USAID, UNFPA, IPPF, the World Bank and international NGOs, we are witnessing the development of national family planning programs. Family planning organizations and other NGOs are increasingly perceived and viewed as partners of government in national FP programs. We are seeing some increase in contraceptive prevalence rates, especially in urban areas. Efforts are being pursued to diversify the ways by which services are offered: integrating FP services into maternal-child health activities, social marketing and community-based distribution.

The Burkina Faso Case

[An overview of the progress accomplished in family health was presented.]

III. Problems and future prospects

Sub-Saharan Africa has the highest population growth rate in the world. Currently, the annual average rate of natural growth in the region is about 3%. For the past thirty years, the fertility index has decreased by only 5%, from 6.7 to 6.4 children per woman.

Most countries appear to attach more importance to the development of policies and programs than to activities crucial to increasing public sector resources, facilitating private sector participation or repealing restrictive laws. Consequently, the availability of and access to services remain at low levels compared to what is needed to decrease fertility rates and slow population growth.

The following examples illustrate the region's current health status:

- High rate of maternal mortality
- High rate of infant mortality
- High fertility rate
- High rate of population growth
- Contraceptive prevalence still below 10%.

The upsurge of STDs and the appearance of AIDS are serious threats to the health of the populations we serve in our programs and must be aggressively fought.

The status of women, the low rate of school attendance among girls, and women's lack of power in couples' decision-making processes limit their access to RH services.

According to a report issued by the Advisory Committee for Population in Africa (APAC): "The rapid increase of the number of young people represents one of the greatest challenges for the region. The United Nations estimates that, in 1960, the region had 69 million youth between the ages of 10 and 24. In 1985, the number had more than doubled, climbing to nearly 141 million. It is anticipated that the number of youth will have increased by yet another 131 million by the year 2000, reaching a total of 272 million.

These figures do not simply represent tomorrow's parents but also today's parents. A large number of young women become mothers for the first time when they reach adolescence. According to a study published by the Population Reference Bureau, in 10 of the 11 countries investigated, at least one woman in five between the ages of 15 and 19 had at least one child or was pregnant at the time of the interview.

In spite of this high rate of pregnancies among adolescents, the data indicate that the median age at the time of the first marriage — legal or common-law marriage — is increasing in Africa. However, sub-Saharan Africa still has the world's lowest median age. DHS data indicate that in nine of the twelve nations investigated, the majority of women aged 20 to 24 at the time of the study were married before reaching the age of 20.

Problems associated with early pregnancies, now complicated by STD/AIDS and other issues, are widely recognized today as program priorities.

Reproductive health, or "health in terms of reproduction," as defined in chapter VII of the Cairo Conference report and adopted by the present conference, gives us the opportunity to expand our future programs to include all the components identified in order to increase access and quality (see Cairo definition).

The programs should focus on the reduction or elimination of barriers to access and to increasing the quality of RH/FP services. A needs assessment conducted for this conference highlights the principal barriers in the sub-region. The following actions are needed:

- Pay greater attention to clients' needs
- Involve men and communities more fully
- Recognize the needs of youth and other special groups

- Improve coordination of activities to ensure rational utilization of human, material, and financial resources
- Diversify the way services are offered (CBD, social marketing)
- Integrate services
- IEC
- Offer long-term methods
- Define service policies and guidelines.

Political engagement and community and NGO involvement are elements essential to increasing access and to improving the quality of family planning and reproductive health services. However, political engagement must not stop at lobbying for the cause at hand. It must be translated into concrete measures to facilitate program expansion, such as repealing laws and regulations that restrict access, and supporting the development of a solid institutional base to address these needs.

Keynote Address on the MAQ Initiative in Francophone Africa

Speaker: Marjorie Horn

It is a special pleasure to participate in this francophone Africa conference devoted to maximizing access to and quality of family planning and reproductive health services. I am delighted to be in Burkina Faso, and I thank you for the warm hospitality you have extended to the corps of regional and international experts who are present for the week. The Ministry of Health, USAID's Burkina Faso Mission and the conference organizers have put forth particular efforts and I thank them for their work.

USAID welcomes this opportunity to work together with all of you to promote change in national and regional policies, programs and procedures by strengthening regional capacity to advocate for improved reproductive health services. Experience and research results have shown that one of the most obvious and effective ways to markedly improve service is to provide clients with quality services and expanded access. We are therefore delighted to join you in forming a partnership to develop a new initiative for improving services: Maximizing Access and Quality, or MAQ. MAQ is an initiative designed to bring to the field the tools and information useful for advancing quality and

access. We are hoping that, during the course of this conference, a number of ideas will emerge for the practical application of MAQ in the region.

It is the intention of this conference to provide you with up-to-date, sound information about contraceptive technology, quality of care and service delivery. More importantly, you will have the opportunity to apply this information to your own country circumstances as you develop action plans later in the week. As the conference continues, we will hear many examples of progressive policies in the francophone Africa region aimed at empowering service providers to improve access and quality. Through highlighting these examples as well as drawing on current scientific information, you will design action plans that will serve your country's health system well. We are optimistic that the strategies and plans of each country delegation will initiate a creative process for overcoming barriers to quality and access.

I am gratified to see before me such a distinguished group of health care providers, advocates and policy makers — all committed to improving reproductive health for women and men in the region. USAID is pleased to collaborate with you in meeting the challenges of providing high quality, accessible services in the region. Moreover, we look to you to take what you learn at this meeting and become champions of improved service quality and access in your own countries. You have been selected as leaders and potential agents of change who can initiate this process and guide it once you return home.

As many of you know, USAID is in the process of closing its missions in several countries in the region. Nevertheless, the Agency will maintain its presence in the region and also will continue to provide support for selected activities in countries where there is no mission. For example, USAID has large bilateral programs in the areas of population and reproductive health in Senegal and Mali, and new projects are being developed in Niger, Benin and Guinea. Further, USAID is pleased to participate as a continuing donor in several organizations active in your countries. Through its support of CERPOD (Centre des Recherches sur la Population et le Développement), critical attention has been directed to the development of population policies for a number of countries in sub-Saharan Africa, as well as the dissemination of information on policy and research results. During the next

few years, attention will be directed increasingly towards the implementation of these policies—an activity that should directly complement the interests of this conference. In addition, last year USAID was able to resume its funding of the International Planned Parenthood Federation. Present in every country represented at this conference, IPPF is an active force in the provision of high quality, accessible reproductive health services.

An important component of USAID's activities throughout the developing world is research: both biomedical and operations research. In countries where USAID has no mission, research will be permitted that is of clear importance to one or more of the Agency's strategic areas (such as population and health), that will have benefits or application beyond the borders of the host country, and that cannot be conducted effectively or efficiently in other countries where USAID does have a presence.

USAID is currently planning the implementation of a regional family health and AIDS project by our regional office in Abidjan. Focused primarily on those countries affected by mission close-outs, this project will address the availability and use of family planning, HIV/AIDS and child survival services, and will do so in concert with other donors and with host country governments. Indeed, the Office of Population in Washington will also be directing attention to encouraging other donors to increase their support for reproductive health and HIV/AIDS activities in the region.

Finally, USAID expects to be able to continue to support conferences such as this one on critical population and health issues that will include participants from countries throughout the region. Our interest and concern for the region remains high.

For U.S. population assistance worldwide, the Clinton administration has provided new leadership and strategic direction to expand our family planning focus into a broader reproductive health agenda. The Agency's new population and health strategy has the following principal objectives:

- Promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children
- Improving individual health, with special attention to the reproductive health needs of women and adolescents and the general health needs of infants and children

- Reducing population growth rates to levels consistent with sustainable development
- Making programs responsive and accountable to the end-user.

Within this strategy, USAID's reproductive health program has three priorities:

- Family planning and related fertility services
- Safe pregnancy services, breastfeeding, and the improvement of women's nutritional status in order to decrease maternal morbidity and mortality
- Prevention and management of sexually transmitted diseases/HIV.

As reflected in these priorities, USAID firmly endorses the value of advancing a broader reproductive health agenda in its programs. While working within this agenda, we are committed to maintaining our strong and critically important family planning program. Our first guiding principle is that family planning will remain the centerpiece and predominant focus of the Office of Population's program.

Family planning has immediate benefits for the health and well-being of women and children and is the most cost-effective intervention for lowering fertility. Because of USAID's 29-year history in this area, our extensive network of specialized cooperating agencies, our technical expertise, and our broad field presence, we have a unique role to play and a strong comparative advantage in family planning. Family planning is the foundation that must be further strengthened and upon which we can build additional activities in reproductive health.

The second guiding principle is that we will focus on family planning and reproductive health interventions that benefit the most women and men at an affordable cost and have the highest public health impact.

In implementing our strategy, the Maximizing Access and Quality Initiative (MAQ) stands out as a critical vehicle for reaching our objectives and focusing on our priorities.

MAQ builds on previous efforts of the Office of Population, our cooperating agencies, and other international organizations over the years to identify the components of quality of care and ensure that they are reflected in service delivery programs. The purpose of the MAQ initiative is to identify and implement practical, cost-effective, focused and actionable interventions aimed at improving both the access to and quality of family planning and

reproductive health services. The overall rationale is that a large unmet demand exists for voluntary contraceptive and reproductive health services. By removing policy and practice barriers to service, promoting access and improving quality, we can focus on specific practical improvements which serve the needs of clients and thereby markedly improve programs.

In the process of developing this access and quality initiative, we have identified four MAQ priorities that are especially pertinent:

First, improving technical competence through appropriate technical guidance and training. Among the technical issues included here are maintaining aseptic conditions, observing protocols, and assuring that appropriate criteria are used to determine clients' eligibility for contraceptive methods. A high level of technical competence protects the safety of clients by improving techniques and practices. Also, sound technical guidelines help avoid inappropriate contraindications that deny certain clients access to services. In many countries, for example, women who can safely use family planning are denied it due to overly-restrictive clinic protocols. Members of MAQ's technical guidance working group have just completed a document entitled "Recommendations for Updating Selected Practices in Contraceptive Use: Volume I." This document is designed to break down medical barriers by providing service providers with guidelines on which clients are appropriate candidates for which contraceptive methods. Members of this working group have also participated in a WHO initiative to revise worldwide guidance on eligibility requirements for contraceptive methods.

Second, improving client-provider interactions. This MAQ priority refers to how the client perceives interaction with providers. It involves such issues as the quality of counseling provided to the client, the degree of empathy in the provider's manner and the amount of time spent with the client. A quality exchange between client and provider is important for many reasons. Clients deserve to be treated with dignity, courtesy and attentiveness. They also deserve to receive quality information on the benefits and disadvantages of different methods of family planning. The client's understanding of how to use a method and the possible side effects can contribute to better use of contraception. In a study in Niger, clients who felt

that they were not well counseled were nearly twice as likely to abandon contraception as were clients who considered themselves to have been adequately counseled about side effects.

Third, strengthening the management and supervision of programs to reinforce quality of care in a gender-sensitive way. Management infrastructures, particularly in large bureaucracies, are often overstretched, and staff may lack access to strong support and guidance from supervisors on a regular basis. This poses a challenge to rewarding staff for new behaviors that focus more on provision of quality services rather than on the number of clients seen that day, or number of clients leaving the clinic with a given method, as often tends to be the case. In addition, many management problems that can be resolved at the local level often await solutions from distant headquarters offices. Numerous management techniques, such as COPE (a clinic self-assessment exercise that you will learn more about this week) have been effective in assisting clinics with resolving their own problems, from logistical and supply issues to client interaction issues. Tools to facilitate local-level problem solving are a priority for effective management in family planning/reproductive health programs.

Fourth, encouraging policy makers to adopt and implement policy norms which aim to improve quality and access. Here, a key issue of concern is the definition and dissemination of policy messages and tools that promote quality and access. Another is advocating MAQ priorities to policy makers and managers. One effective means that the MAQ initiative uses to reach policy makers is regional conferences, much like this one in francophone Africa, that focus on the programmatic advantages to increasing quality and access. As you develop your country plans, we will look to you to include effective approaches to communicating MAQ messages and gaining the support of policy makers.

In Latin America, East Africa and Asia, regional conferences have been held that focus on MAQ as the principal theme. These conferences have already contributed to concrete improvements in access and quality. In February 1994, delegations of policy makers, health care professionals, and reproductive health advocates from six East African countries gathered in Zimbabwe to address the MAQ initiative at the regional and national level. Following this conference, in-depth follow-up interviews were conducted to assess progress made toward country action plan

objectives formulated during the conference. In Botswana, two family planning leadership conferences were held subsequent to the Zimbabwe meeting. At these national-level conferences, delegates (many of whom had attended the regional MAQ meeting) came to consensus on a wide variety of revisions to the Botswana Family Planning General Policy Guidelines and service standards. For example, age and parity restrictions will be removed for all reversible methods. In addition, inappropriate contraindications for specific contraceptive methods will be removed in accordance with the USAID-MAQ technical guidance document.

Through regional activities and other access and quality interventions, MAQ promises to provide in-country specialists, as well as staff of USAID's cooperating agencies, with many useful tools for improving services. In addition, MAQ will help address other program areas identified as priorities by USAID's Office of Population. These areas, all complemented by MAQ's emphasis on access and quality, are as follows:

1. Reducing unmet need and increasing demand
2. Addressing the needs of young adults
3. Reducing unsafe abortion through post-abortion treatment and contraception
4. Adding other selected reproductive health interventions, including STD/HIV prevention; breastfeeding; increasing linkages with safe motherhood and STD management; and reducing harmful practices such as female genital mutilation
5. Strengthening linkages with other related areas, such as child survival, women's employment and status, environment and democracy.

We welcome all of you to join us as partners in addressing these challenges, especially in translating the principles of access and quality into stronger programs and measurable improvements in services. I look forward to the outcome of this and other conferences where delegates take a hard look at the policies and practices in their countries and return home committed to working towards changes in policy and service provision. I am certain that such careful examination, followed by action, will lead to better reproductive health care for men and women in the francophone Africa region.

Thank you. I wish us all a successful and productive week.

Plenary Session Presentation Summaries

Maximizing Access and Quality

Maximizing Access and Quality (MAQ) of Reproductive Health and Family Planning Services

Presenters: Alain Damiba and Manuel Pina

In francophone Africa, as in other developing regions, there exists a significant difference between the demand for family planning services and the actual, continued use of these services. Some of the reasons why family planning isn't used concern the accessibility and quality of FP/RH services. A look at the region's RH/FP services often reveals that:

- Certain categories of professionals are not authorized to offer certain methods
- Unmarried women have difficulty obtaining some methods
- Men are not targeted as FP service users
- Clients are not made to feel welcome and are poorly treated in service centers
- Services are almost exclusively offered in health centers.

By focusing on improving quality and access, programs can take significant steps to ensure that FP/RH services better meet the needs of clients. Access and quality must be priorities in order to build a satisfied clientele and, therefore, to increase clients' use of services.

Elements of quality of care are:

- Choice of appropriate and adequate services
- Giving information to clients on available methods and services
- Providers' technical competence
- Interpersonal relations between provider and client
- Mechanisms ensuring follow-up and continuity.

Several factors determine the quality of each of these components. For instance, a limited choice of contraceptive methods could be due to:

- Prejudice on the part of the provider who prefers certain methods over others
- The absence of trained providers offering certain methods
- Inadequate logistics
- Limited number of methods available in a given country.

Access consists of factors that either encourage or prevent contact between client and RH services. Access may have to do with geographic distance from the clinic, fees too high for clients to pay, administrative obstacles, lack of knowledge about services and psycho-social issues. Efforts at improving access must, therefore, include a variety of management approaches and intervention levels (political, socio-cultural, legal, etc.) to increase the chances of success. Service providers need political and social support to help improve their programs.

Inappropriate and or unnecessary medical barriers with no scientific justification impede access and RH service utilization. These include:

- Inappropriate contraindications
- Inappropriate eligibility criteria
- Provider bias
- Inappropriate management of side-effects
- Regulatory factors.

However, caution must be used in the approach to reduce the medicalization of FP/RH service management so that health services important to women's health, such as pelvic exams, are not lost.

Proposed strategies to improve access to and quality of FP services consist of the integration of RH services (taking into account clients' perspectives), including postpartum, post-abortion, STDs, etc. Also needed is an update of policies, service standards and protocols, and the improvement of communication, training and service supervision. In addition, roles, responsibilities and the authority that women and men exert must be increased and service delivery systems must be diversified.

Maximizing access and quality is what many FP/RH service providers and program managers attempt to do every day. However, the MAQ initiative is designed to highlight the most effective, feasible ways to operationalize access and quality in programs. Many MAQ strategies have been implemented and have shown successful results in terms of increasing quality and access:

- Community-based distribution of contraceptives
- Addition of new methods to increase choice
- Improvement of counseling in FP/RH services
- Revision of service guidelines and protocols.

In reorienting services to maximizing access and quality, it is essential to remain focused on the actual users of services — the clients. By adequately responding to the needs of clients, MAQ offers great potential for increased, sustained use of FP/RH services.

Regional Profile on Access to and Quality of RH/FP Services

Presenter: Diouratié Sanogo

This talk deals with the results of situational analysis studies completed in Benin, Burkina Faso, Madagascar and Senegal between 1991 and 1994. The results are as follows:

Infrastructure: In these four countries, availability and operation of services are considered fairly satisfactory, except in rural areas where they are inadequate.

Supplies/Equipment: Several service delivery points (SDPs) suffer from a shortage of supplies essential to service. Over half of the SDPs have no sterilization equipment.

Contraceptive Availability/Management: A range of contraceptives are available in the SDPs, but all methods are not available at all SDPs. Condoms represent the most available method. Combined oral contraceptives and progestin-only pills are usually available, while injectables are only sometimes available. Contraceptive stocks are adequate in more than half of the SDPs, but improvements are needed everywhere.

Personnel: The majority of service providers are midwives and nurses. Physicians equipped with the required skills rarely intervene (1% to 12%). About 15% to 40% of service providers have received no training. Service providers who are trained have often received only one type of training at the expense of others (FP clinical training versus counseling or IEC training). Refresher courses are rare. Training in voluntary surgical contraception is virtually nonexistent.

IEC Materials/Activities: The absence of IEC materials and activities in the majority of SDPs constitutes one of the greatest weaknesses of FP programs.

Management: In most SDPs, no written guidelines for management of daily FP activities exist. Supervisory visits are rare.

Service Statistics: In general, the quality of available statistics is so poor that it makes it difficult to correctly estimate the annual average number of clients.

Service Quality: The information given to the client is often insufficient, especially in terms of side effects. Only one country currently has a document of service standards and protocols. Most clients come to the SDPs requesting a preferred method that they receive most of the time. They are given information on the method of their choice, but nearly half of them are given no information on the other methods available. In all countries, the service provider greatly influences the client's choice of contraceptives. This is particularly true in countries where the FP program is relatively young. This situation can be partially explained by provider biases and the unjustified application of eligibility criteria.

Organization of Services: In all countries, FP services are generally integrated into MCH services. FP services are offered in most SDPs every day, but often in too short a time slot. In addition, they often open late. Again, in all countries, services are offered in conjunction with other health services, but the level of integration of these services is inadequate. Services are organized in varying ways from one SDP to the next within the same country.

Service Providers' Technical Competency: Most service providers demonstrate good theoretical knowledge and know proper procedures when faced with particular situations, but the kinds of questions that some of them ask during clinical examination leave much to be desired. In addition, procedures to ensure aseptic conditions during pelvic examination are not always followed. Moreover, providers often deal inadequately with clients who indicate problems with the method they use.

Interpersonal Relations: The majority of clients indicated that they had been pleasantly greeted, and had received the information and the services they were seeking. The waiting time was long but reasonable, they said. The satisfaction they expressed could have been, however, a manifestation of culturally accepted politeness.

Methods to encourage service continuity: In general, SDPs have no follow-up system to visit clients at home. This would require additional service providers. All SDPs require the client to come to them. This system seems to function well in all countries.

A Profile of the Region: Demographic Health Surveys

Presenter: Mbaye Seye

This talk is intended to communicate the DHS data collected in all the countries that are represented at this conference, with the exception of Benin. The data reveal the following information about the region studied:

- FP reaches only a small percentage of the target population, while unmet needs remain high
- There exists a lack of FP information
- Rural populations have little access to FP services
- Maternal and infant-child mortality have decreased, even though numbers remain high.

Based on these findings, DHS issued the following recommendations:

- It is urgent that IEC programs be revitalized
- Access to and quality of FP/RH services should be improved
- FP services should be expanded to rural areas, by implementing new and appropriate service delivery approaches
- DHS should be updated and their implementation in countries not yet reached should be encouraged.

Area Profile: Needs Assessment

Presenter: Onanga Bongwele

Six months prior to this conference, a needs assessment questionnaire was sent to key persons in the region, including health professionals, those in charge of training, members of the Africa-based Technical Committee, members of women's organizations, USAID mission personnel and representatives of donor agencies. Fifty-three percent (N=32 people) of those who received the needs assessment questionnaire completed it.

The Africa-based Technical Committee analyzed the data in relation to the conference's objectives and proposed topics. The following conclusions were drawn from the results:

- Current services do not include certain RH key elements (such as services for adolescents, post-abortion FP).
- Gender problems continue to form barriers to the access to and use of services.
- Availability of services (CBD, social marketing, FP/STD integration) fails to match existing needs.
- Data are inadequately applied to decision-making. Operations research, supervisory evaluation, management information systems, and utilization of study results need to be strengthened.
- The political, administrative and legal context of current programs is inadequate and constitutes a major obstacle to access, quality, and utilization of services (policies, standards and protocols, for instance).
- Certain traditional values and practices are not sufficiently taken into account in program and strategy development.

Update on Selected Methods and Services

Infection Prevention

Presenter: Willibrord Shasha

The high rate of maternal mortality testifies to failings of obstetric care in the Third World. Infection is among the three main causes of maternal mortality and is, in certain circumstances, the main cause. In addition to post-surgical infections, postpartum and post-abortion hepatitis B, C, D and AIDS infections have been recorded.

Infection prevention in family planning, health care, and reproductive services has two objectives: to reduce the risk of infection from microorganisms, involving serious infections or sores, intra-abdominal or scrotal abscesses, pelvic inflammatory disease, gangrene, and tetanus; and to prevent serious and deadly disease, such as hepatitis B and AIDS.

Microscopic pathogens causing serious disease are found in blood and other body fluids, such as mucus, vaginal discharge, sperm, and amniotic fluid. All persons who work with blood or body fluids are at risk: persons in charge of cleaning and maintenance, technicians and aides, as well as nurses and physicians. Clients risk infections when instruments or equipment are used repeatedly, before microorganisms are removed or eliminated. The practice of infection prevention minimizes the risk of infection by microorganisms for health personnel and clients.

Infection prevention is an easy and inexpensive practice and consists of handwashing before and after each procedure, and before and after examining each client. Wear disposable gloves each time there is a possibility of touching blood or body fluids, and change gloves before treating another patient. Instruments must be decontaminated, cleaned and sterilized before re-use.

Introduction of Lactational Amenorrhea Method (LAM) To MCH/FP Services in Burkina Faso

Presenter: Meba Kagone

The family planning method known as the Lactational Amenorrhea Method (LAM) relies on the following principle: the woman who continues to breastfeed fully or nearly fully, and whose periods have not returned in the first six months postpartum is protected against pregnancy during that time. Correctly used, the method is 98% effective. In Burkina Faso, LAM was introduced by the Burkina Midwives Association with technical assistance from SEATS and the Institute of Reproduction and Health of Georgetown University in Washington, DC. Two LAM training sessions of three days duration were held in 1993 in Ouagadougou and in Ouahigouya, in the north. The participants were 33 service providers, midwives or nurses from eight health centers. They developed an action plan to introduce LAM in their respective centers, to support current maternal breastfeeding activities, under the direction of the Ministry of Health and UNICEF.

LAM was introduced in four stages:

- Information was given to other service providers, sensitizing them to LAM
- An action plan was finalized with other service providers

- Service providers at centers and in communities informed clients about LAM
- Women were recruited to participate in LAM and follow-up was initiated.

These are the results of the LAM introduction in six centers (two in Ouagadougou and four in Ouahigouya) as of March 1995:

- Total number of LAM users: 257
- Number of women who went on to use another method: 62
- Loss to follow-up: one woman
- Positive effects on infant growth
- Increase in women's interest in contraception.

Barriers to the introduction of LAM were as follows:

- Mothers and their mothers-in-laws' anxiety in terms of fully breastfeeding (afraid of depriving the child other liquid nourishment). However, the growth of babies fully breastfed, as well as sensitization efforts aimed at mothers-in-law, have often been successful in dispelling these anxieties.
- Skepticism of some health professionals. However, observing the growth of fully breastfed babies as well as listening to the testimony of women practicing LAM have rallied a number of skeptic souls to the cause of LAM.
- Difficulties in following up with women in the community.

Service quality was improved in the centers where LAM was introduced, as follows:

- At the centers, members of the staff discuss service problems that might arise, and try to solve them.
- Communication between service providers and mothers who have chosen LAM is increasing and improving.
- LAM supports efforts to integrate all MCH/FP services because the mothers who practice LAM and their babies use all these services.
- LAM helps improve husband and wife dialogue in terms of contraceptive choices, as well as dialogue between husbands and FP service providers.
- LAM increases service providers' interest in breastfeeding, and helps solve mothers' health problems that might be linked to breastfeeding.

The Contribution of Natural Family Planning Methods

Presenter: Claude Lanctôt

Natural Family Planning (NFP) consists of using methods that are based on natural manifestations and symptoms of the menstrual cycle. At the appearance of signs indicating that a woman has entered the fertile period, the couple abstains from sexual intercourse if they wish to prevent pregnancy. On the other hand, if the couple wishes to become pregnant, they will plan to have sexual intercourse during fertile periods.

The Demographic and Health Surveys reveal that, in 1993, 14% of married women who practiced FP used periodic abstinence. Even though periodic abstinence is not the same as NFP (NFP defined by the determination of a woman's fertile period), these statistics indicate that in several countries periodic abstinence and NFP play a crucial role in people's efforts to control fertility.

The reasons couples choose natural family planning methods vary according to social classes and cultures.

NFP hinges on the self-knowledge needed to determine when fertile periods occur. This implies that a man in good health is permanently fertile as soon as he reaches puberty, while a woman in good health is fertile only during cycles or intermittently, between the time her first period appears until menopause. A woman's fertile phase lasts usually seven days: a maximum of five days before ovulation, the ovulation day, and 24 hours after ovulation.

The four major NFP methods that are currently acknowledged and used are based on determining the woman's fertile period:

- The calendar or Ogino-Knaus method
- The temperature method (thermal changes immediately following ovulation)
- The cervical mucus method, based on cervical mucus changes during the menstrual cycle (the reliability is estimated at about 97% if used regularly and correctly)
- The sympto-thermic method (STM), which combines thermal changes and cervical mucus changes with other changes or physical signs of ovulation (reliability estimated at about 98% if used regularly and correctly).

Over the past 20 years, several countries have promoted modern NFP methods through small local or national NGOs. For instance, in Africa, in six of the 10 countries represented here, more than 20 new programs are in operation.

A recent brochure published by WHO describes the major elements of NFP service delivery. Since NFP is essentially an educational approach based on the knowledge of human fertility and of sexual behavioral changes, service delivery depends mainly on training health educators, both male and female, recruited from among the people, and ensuring that they are supervised by appropriate individuals so that quality control and training are maintained.

Field observations made over the last four or five years have made it possible to identify the major elements that determine NFP service quality, through operation and performance indicators developed by educators and supervisors. In 1992 in Yaoundé, NFP program participants from French- and English-speaking African countries agreed on a simple service evaluation form, to be regularly completed. With the help of an "integrated management system," NFP services can be easily examined, analyzed and implemented. This can be done by pursuing public awareness campaigns, and by identifying and correcting the main elements that contribute to clients discontinuing a method or having unwanted pregnancies.

Update on Permanent Contraceptive Methods

Speaker: Robert J. I. Leke

This presentation addresses the following issues:

- The importance of voluntary permanent contraception
- A description of permanent, non-surgical contraceptive methods for men and women
- The side effects, contraindications, and long-term consequences of these methods
- The programmatic implications of permanent contraception.

In order to deal with the issue of sterilization the following measures must be considered:

- Disseminate clear and accurate information, using all means of communication
- Provide objective and empathetic counseling

- Opt for local anesthesia
- Increase centers where sterilization is available
- Train, supervise, and evaluate personnel continuously.

In order to improve access to permanent methods, the following measures must be addressed at the level of decision-makers:

- Eliminate constraints having to do with age, parity and partner's consent
- Make these methods more affordable
- Organize provider training programs on permanent methods.

At the level of service providers it is necessary to:

- Include permanent methods as a desirable FP option
- Expand services providing permanent methods
- Provide objective and empathetic counseling
- Broaden the use of local anesthesia
- Supervise and evaluate service providers.

At the level of trainers it is necessary to:

- Focus on technical competence as well as counseling
- Teach interpersonal communication skills
- Insist on practical rather than theoretical knowledge.

At the level of communicators:

- Help popularize these methods as a contraceptive option
- Disseminate information on permanent methods through mass media.

Medical Eligibility Criteria for Certain Contraceptive Methods (Hormonal Methods and IUD) According to WHO

Presenter: Robert J. I. Leke

Progress and the scientific application of hormonal contraceptives and the IUD are not uniform everywhere, and certain contraceptive methods remain subjective. Consequently, WHO and other organizations are focusing on the

improvement of access and quality of FP services. One of the strategies that has been suggested is to update the medical eligibility criteria for contraceptive methods.

The following factors warranted an update of the current eligibility criteria for contraceptive methods:

- Lack of current scientific information in protocols and policies
- Individual sensitivity and theoretical concerns with no scientific basis
- Service providers' personal biases and preferences
- The absence of standardization and uniformity of procedures
- The need to take into account field realities.

WHO has developed new eligibility criteria for the following contraceptive methods:

- Low-dose combined oral contraceptives
- Progestin-only oral contraceptives
- Depot-medroxyprogesterone acetate (DMPA)
- Implants (Norplant)
- Copper IUDs.

Conditions affecting eligibility for the use of each contraceptive method fall into the following categories:

1. A condition for which there is no restriction for the use of the contraceptive method
2. A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3. A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4. A condition which represents an unacceptable health risk if the contraceptive method is used.

Thus, in terms of community-based distribution, the last two categories limit the utilization of contraceptive method, while categories 1 and 2 permit the utilization of the method.

The benefits of new medical eligibility criteria are as follows:

- Distinctions are made between restrictions for high-dose estrogen oral contraceptives and low-dose estrogen oral contraceptives.

- Eligibility criteria for progestin-only contraceptives differ considerably from those for combined estrogen and progestin contraceptives
- There is a new definition for eligibility criteria related to age
- Better definition can be applied for certain criteria, for example: vaginal bleeding
- Medical conditions are specified for which there are no restrictions on contraceptive choice
- Suitability of IUD use is specified for a variety of conditions; for instance, there is no restriction on IUD use for breastfeeding or diabetic women.

The following measures are under consideration:

- Revise eligibility criteria for all other contraceptive methods
- Examine programmatic implications of these criteria
- Disseminate results
- Integrate other strategies aimed at improving FP service access and quality.

Update on Certain Hormonal Contraceptive Methods (Pills, Injectables, Implants) and Their Medical Eligibility Criteria

Presenter: Robert J. I. Leke

1. Combined Oral Contraceptives (COC)

Contraceptives containing estrogen affect ovulation, implantation and transport of the ovum. Progestins act upon the cervical mucus, ovum transport, implantation and ovulation.

Clinical factors indicating that the combined pill may not be an appropriate method choice are:

- Pregnancy
- Migraine headaches with focal neurologic symptoms
- Women over 35 years of age who smoke heavily (more than 20 cigarettes per day)
- Active viral hepatitis
- During first six months of breastfeeding
- Moderate or severe hypertension
- Sickle cell anemia

- Unexplained vaginal bleeding before medical evaluation.

The pill can be distributed by various trained health care personnel at different levels of the system as follows:

- In the village: the distribution can be done by traditional birth attendants, health agents, (community distribution), opinion leaders, health educators serving youth.
- At the health center: nurses, midwives, physicians/specialists, researchers/professors.

2. Progestin-only Pill (POP)

The benefits of this pill are:

- Reliable and acceptable method
- Contains no estrogen
- Reduced cardiovascular complication risk
- Minimal side effects
- More rapid return to fertility than COCs
- Does not jeopardize breastfeeding
- Little effect on hematologic factors.

POP disadvantages are:

- Slightly less effective than COCs
- Systemic maternal diseases affect its effectiveness
- Less effective in preventing unwanted pregnancies
- Greater risk of ectopic pregnancy compared to COCs, Norplant, and DMPA
- More frequent menstrual disturbances (short cycles, amenorrhea, spotting)
- Less used than COC
- Higher incidence of functional ovarian cysts
- Must be taken at the exact time of the day prescribed.

Non-contraceptive effects of oral contraceptives are:

- Reduction of the menstrual flow
- Prevention of premenstrual syndrome
- Treatment for dysmenorrhea
- Reduced risk of endometrial and ovarian cancer and PID
- Fibrocyst and fibroadenoma reduction.

3. Injectable contraceptives

There are several types:

- Depo-Provera (DMPA) — Injectable every three months
- Noristerat (NET-EN) — Injectable every two months
- Cyclofem (DMPA + estradiol cypionate) — Injectable once a month
- Mesigyna (NET-EN + estradiol valerate) — Injectable once a month.

Some of the benefits of this method are:

- Convenience in terms of timing
- Reliability and acceptability
- Does not suppress lactation (Depo-Provera and Noristerat only)
- No constraints on sexual relations
- Amenorrhea improves condition of clients with anemia.

Possible disadvantages are:

- Delay in return to fertility
- Amenorrhea, abnormal bleeding or irregular menstruation
- Injections must be administered by medical personnel.

Several improvements to hormonal contraception are under study, such as dose reduction and new devices (vaginal rings, microspheres, self-injections). A progestin-releasing IUD is already on the market in several countries.

The hormonal method eligibility criteria issued by WHO should be applied.

IUD Use among Women in Urban Ouagadougou

Presenter: Bibiane Koné

This is a prospective and retrospective study conducted in five family planning centers in Ouagadougou, with the aim to assess intrauterine contraception over a five-year period (1987-1991.) Among women using a contraceptive method at FP centers, 25.6% used the IUD (second most popular method).

Among 5,379 IUD users in the retrospective study:

- 1,183 cases had complications (22%)
- 1,455 women discontinued the method (27%)
- 566 were lost to follow-up (11%).

In the prospective study, which included 186 IUD users and 188 non-users, obstacles to IUD acceptance were linked to:

- Rumors and misinformation about IUD complications and risks
- Moral objectives to its mode of action
- Psychological considerations in relation to the low level of education of users.

The IUD and Postpartum Contraception

Presenter: Fatimata Diabaté

The following are some of the many benefits of postpartum contraception, notably:

- Integration of prenatal and postnatal consultations with infant care
- Dissemination of FP and child-care information to couples.

The best time to counsel the client is before delivery. Whatever method is chosen, it must not interfere with breastfeeding. The different methods appropriate for use during the postpartum period are:

- Lactational amenorrhea method (LAM)
- The intrauterine device (IUD)
- Natural family planning
- Permanent contraceptive methods (male and female sterilization)
- Progestin-only methods
- Combined oral contraceptives (only if woman isn't breastfeeding).

Coverage, quality, and service availability are basic issues in postpartum care. Meeting women's postpartum contraceptive needs is an important component of infant and maternal health.

As demonstrated by scientific research, the IUD prevents the sperm from penetrating the fallopian tubes, and thus decreases the sperm's capacity to fertilize the ovum. The IUD can be used effectively for up to 10 years. Shelf-life is good for up to seven years in sterile packaging. The IUD can be inserted at any time in the cycle, in the immediate postpartum and post-abortion if there is no sign of uterine infection.

STD/AIDS and Barrier Methods

Presenter: Willibrord Shasha

STDs pose problems throughout the world. Third World countries lack resources to manage STD cases. The WHO has developed a symptomatic approach to maximize accessibility and quality of care. Through this approach, all STDs with manifest symptoms are treated.

The main symptoms are vaginal discharge, urethral discharge, genital ulcers, lower abdominal pain, and ano-genital dermato-venereal symptoms. The symptomatic approach is easy for health providers to learn and allows treatment of the client during the first visit. Unfortunately, asymptomatic clients are not identified or treated. Also, clients are treated with drugs that can cause side-effects. In addition, treatment with expensive, broad-spectrum drugs that are not specific to a particular pathogen leads to wastage and may contribute to the problem of drug resistance.

Treatments should be based on the results of sensitivity tests and the availability of drugs in the country. STD treatment also requires the treatment of sexual partners.

Certain barrier methods are effective in preventing STDs. It is important to use them systematically and correctly, to have cooperation between partners, and have a regular supply available. Barrier methods that are very effective against STDs are less effective against pregnancy, and vice-versa. Clients at risk of infection could benefit from double protection.

The male latex condom protects against STDs and HIV. The spermicide (nonoxynol-9) and the sponge with N-9 protect against bacterial STDs and their effect on HIV is under study. The diaphragm with spermicide (N-9) and cervical cap with spermicide (N-9) are barrier methods that offer possible protection against bacterial STDs but their effect on HIV and other viral STDs is not known.

Emergency Contraception

Presenter: Manuel Pina

Emergency contraception (EC) is a "time-sensitive" contraceptive method used by a woman in the first hours following unprotected sexual intercourse, during ovulation and when a woman may be fertile. According to WHO, 450,000 unwanted pregnancies per day result in 150,000 induced

abortions per day. Of these, one-third are performed under dangerous conditions. More than 60,000 women die each year as a result of induced abortion.

The benefits of EC are:

- A 50% decrease in the number of unwanted pregnancies
- A 30% decrease in the number of induced abortions
- Access to FP services for a newly targeted group at risk: women who do not want to become pregnant but are not yet users of a contraceptive method.

EC methods used are:

- Combined oral contraceptives (estrogen-progestin pills)
- The copper IUD
- RU-486 (anti-progestin)
- Others: strong doses of estrogen (not recommended).

EC prevents fertilization or the implantation of the fertilized ovum (nidation).

Correct use of EC (pills) decreases the risk of pregnancy by 75%.

With rare exceptions, all women who have engaged in unprotected sexual intercourse are eligible for EC (pills) within 72 hours, or eligible to be fitted with a copper IUD during the five days following intercourse. Potential clients are:

- Women who are rape victims or who are exposed to a teratogenic agent
- Women who have used a method that failed
- Women who do not use a regular or planned contraceptive method.

The dosage for hormonal methods and protocol for copper IUD insertion for emergency contraception are well established. The IUD is not recommended for women at risk of STDs or who have a history of pelvic infection or ectopic pregnancy. EC methods should not be prescribed for women whose medical history makes them at-risk cases. Regarding pills used in EC:

- The doses are too small to result in long-term effects.
- There is no evidence of blood clotting problems, nor is the fetus affected (should EC fail).
- Immediate side-effects (nausea, vomiting, breast tenderness) are the most common.

- The menstrual cycle may be disturbed, with periods appearing early or late (3-week delay).

The potential client should be aware that:

- EC using COC is 75% reliable if used within the first 72 hours.
- Contraceptive protection is of short duration (except for the IUD).
- EC is safe for most women.
- The major side effects, nausea and vomiting (pills), are experienced by one-third of clients.

In terms of programs, the following measures should be adopted:

- Inform clients and train service providers on EC methods and their use.
- Integrate EC in current FP, STD and other women's health services.
- Initiate or make necessary changes to existing policies, service standards and protocols, IEC programs, service supervision and management.

Post-Abortion Care

Presenter: Christiane Wellfens-Ekra

Throughout the world, about two of every five abortions are at risk of complications. The post-abortion period is an opportune time to consider increasing family planning service accessibility and quality.

The key elements of care during this period can be categorized into three levels:

- Emergency care concerning an incomplete abortion and complications
- Adapted counseling and family planning services
- Integration of emergency services with other reproductive health services.

Above all, it is the quality of listening (counseling) at this particular time that will influence a woman's decision to continue contraception and will allow avoiding a relapse, which is not without consequences to a woman's health.

Client and Service Provider Interaction

Presenter: Justine Belem

Good interaction between client and service provider is essential to the quality of care. However, several factors make this interaction difficult. For many FP/RH service clients, daily life poses a series of major problems. Women are responsible for accomplishing basic tasks such as providing water, food, etc., especially difficult in Africa. Typically, the client faces an unknown provider.

At the level of personnel, service providers often lack motivation. They typically face a heavy client-load and they are overworked and have little time to spend with each client. There is a severe shortage of essential supplies. In addition, service providers have basic needs of their own which must be taken into account.

To improve the situation, service providers must be aware of these constraints and try to overcome them. They must treat clients with respect, and not as if they were children. They must respect the clients' privacy and their choices. They must refrain from judging them. To break these rules damages the client-service provider interaction.

Client and Service Provider Interaction

Presenter: Cynthia Steele Verme

Good interaction is not only a matter of ethics, it is also crucial in improving a client's reproductive health. A study implemented at 10 sites in Nigeria, Ghana and Sierra Leone illustrates this point. By their attitudes, service providers prevented the treatment of obstetric complications. The barriers that they created were as damaging as the shortage of blood, medicines or supplies.

To improve client and service provider interaction, I address my recommendations to decision makers and international donors, as well as to service providers.

Decision makers should not expect the impossible from service providers who are entrusted with an important task and who often demonstrate courage in difficult situations. They too have needs and rights.

Decision makers must define their expectations and set norms for client and service provider interaction, to serve as a basis for services, training and supervision. In order to determine appropriate norms, it is important to find out how the clients view the services, what they expect of them, and then take their opinions into account.

All aspects of middle- and long-term objectives must be considered, not just the impact they will have. In program evaluation, international donors should include qualitative indicators as well as results, such as couple-years of protection or the number of methods distributed.

Even though this task will be more difficult to accomplish if the available funds decrease, decision makers must resist the temptation to finance only those components that can be seen and counted, such as equipment and supplies. Programs will not improve unless we invest in training, supervision and evaluation, all of which are crucial but intangible.

Clinical training should include modules on client relations, in addition to training in technical skills. Alternatives to traditional training must be found. Training must serve as a model for how clients should be treated, rather than the opposite.

Other staff members who come in contact with clients must also be included, supervisors in particular. Interpersonal relations include counseling, but should not be limited to counselors. Even if the counselors do a fantastic job, much of its value is lost if someone at the reception desk makes fun of the client, or if a clinical staff member is rude. Every member of the staff is responsible for creating a positive climate of interaction. Supervisors should support measures promoting good interaction, and recognize service providers who perform their task well.

Service providers should not pass judgment on clients who come with reproductive health problems, or decide who should or should not receive services, such as adolescents. It is important to be honest and open with clients, and not to focus only on positive information.

Even if funding for services does not improve, many inexpensive changes could be made to improve interaction: service providers can introduce themselves to the clients, respect privacy during consultations, cover the client with a sheet while she is being examined or hold hands with an anxious client.

General recommendations should be that service providers recognize and respect two major principles that may appear contradictory at first sight: (1) each client is unique; and (2) human experience is universal. Each client comes from a different background, has a different temperament, health status and expectation, all of which influence her preferences. Service providers must not apply generalizations without first finding out from the clients themselves who they are, what they want and what their needs are.

Different from one another as they may be, all clients have in common that they want to be treated with respect, courtesy and kindness. An understanding of the universality of human experience is fundamental in showing compassion, which is the very basis of good relations.

This poem, written by a 16-year-old girl (Amy Maddox of Franklin Community High School in Bargersville, Indiana, USA), describes better than I could how clients, service providers and all of us can re-examine and fill the social distance that separates us. The poem is titled "Underneath we're all the same."*

*He prayed — it wasn't my religion.
He ate — it wasn't what I ate.
He spoke — it wasn't my language.
He dressed — it wasn't what I wore.
He took my hand — it wasn't the color of mine.
But when he laughed — it was how I laughed,
And when he cried — it was how I cried.*

* *Teaching Tolerance*. Spring 1995. Ed. Sara Bullard. Southern Poverty Law Center, Montgomery, Alabama.

Legal and Regulatory Issues

Legal, Regulatory and other Barriers

Presenter: Awa Nana

In the 1980s, new national programs were started, mostly supported by either private organizations, or parastatal controlled FP services. As a result, contraceptive use increased, and it was believed that certain institutional and legal obstacles had been overcome since no one mentioned them.

Today and after examining the issue, it is clear that such is not the case. Of the 10 countries studied, at least six — Burkina Faso, Niger, Mali, Senegal, Cameroon and Togo — are governed by regulations contained in documents on "FP service policies and standards." One could argue that these documents are purely technical and don't carry legal authority, or have regulatory decree status. The Togo document, for instance, is simply signed by a Ministry of Health bureau employee. Why then has it not been turned into a legal order? What are we waiting for to integrate these policy documents into the existing battery of documents?

This clearly indicates that real constraints persist. They range from socio-cultural to institutional, structural, organizational and programmatic, and their presence permeates this conference. This issue must be addressed in our programs and action plans.

We have agreed upon a common RH definition which implies individual freedom to practice contraception and lead a satisfying sexual life. We have achieved progress in terms of population policies, service delivery and protocol development, but this is not enough. If we consider the case of Burkina Faso or Niger, a decree was adopted for a partial repeal of the 1920 law regarding contraceptives. But does the decree authorize FP/RH as currently defined? Our legal documents do not mention this universal principle of the human right to procreate or not to procreate. On the contrary, most of the current legal texts and regulations in our region contain RH/FP constraints.

Legal aspects forming barriers to RH/FP: Most of our legal texts recognize traditional practices which themselves constitute an obstacle to access to RH/FP. Many of our countries have laws that support a rising birthrate. They deal with polygamy, inheritance, marital age, sterility as justification for divorce, the affirmation of men's prerogatives, etc.

How can we promote a review of legal and institutional frameworks?

- by developing or updating policy documents, service guides and standards
- by developing associations and NGO actions and activities to inform and educate in the field of rights and liberties, and

- by influencing leaders to endorse reforms and laws to improve access to RH/FP. These laws should not impede, nor should they repress, but should instead promote or discourage as the case may be.

In conclusion, what strategies should MAQ adopt?

- inform individuals of their current rights and those that should be promoted
- integrate legal components into action plans
- examine laws and regulations which have a negative effect on service delivery and women's status
- study legal documents on RH/FP
- promote new institutional framework designed to change social and legal practices (such as marital age and treatment of infertility).

CERPOD's Contribution Regarding Legislative and Regulatory Documents Related to Policy and Population

Presenter: Mouhamadou Gueye

Ever since its establishment in 1988, CERPOD has contributed to the organization and the implementation of population policies in the Sahel. That same year, CERPOD organized the first conference on population policies in the Sahel in N'Djamena on December 5-19. That conference resulted in the N'Djamena Action Plan (NAP) on population and development in the Sahel, which was adopted by the nine CILSS member states in Praia in January 1989.

The NAP recommends that the nine states adopt national population policies. It also recommends that a legislative and legal framework be developed in keeping with the objectives of their population policies.

When the action program was adopted, Senegal stood as the only country to issue a declaration of population policies. Today, six of the nine nations have made a similar statement. The other countries are now engaged in formulating and adopting such a document. All francophone CILSS member states have endorsed a national population policy.

The importance of legislative, regulatory and organic documents has not gone unnoticed by NAP. In fact, NAP has made recommendations concerning regulatory reform.

Regarding fertility and family planning, NAP suggests that all Sahelian countries take steps to ensure the right of each individual to freely decide on child-spacing and the number of children to have.

Acknowledging the central role of women in terms of RH/FP, NAP asks that the countries adopt family codes to recognize and protect women's rights as well as legal equality between women and men, ensuring that rights and legal equality are applied.

NAP urges that the states adopt measures to raise the age of first marriage, citing the risks that accompany early pregnancies.

In order to support the Sahel region member states in their efforts to formulate and implement population policies, CERPOD analyzed legislative, regulatory and organic texts in terms of population and development. The resulting studies were submitted at the second conference on population policies in the Sahel, held in Dakar in July 1992. The interest shown in these studies led to inclusion in the Dakar Declaration of the necessity to re-activate the organic, legislative and regulatory documents regarding policies and populations, in the context of international constitutions and conventions, and to also develop strategies towards the application of these texts.

As a result, CERPOD initiated a research project designed to identify socio-cultural barriers to the implementation of population policies in the Sahel.

Legal and Regulatory Issues: the Case of Togo

Presenter: Nagbandja Kambatibé

In Togo, FP efforts were launched by the ATBEF and supported by women's associations as early as 1974. In 1975, the first ATBEF family planning center was opened in Lomé. Between 1984 and 1987, FP centers were started in all the district (prefecture) capitals: 27 by the end of 1987. In late 1994, 190 centers were functioning in rural as well as urban areas. Togo has clearly demonstrated its commitment to FP, as confirmed by its written statement to international institutions (World Bank, UNICEF, WHO, UNFPA, etc.). Togo's commitment earned it the

annual UNFPA Population Activities Award for 1989. Its government endorsed national health and population policies and standards. These documents inspire confidence among service providers and contribute to FP program development, even though the French colonial law of 1920 has not been repealed, and no law actually authorizes FP.

In the future, legislation should be enacted that will help improve what is now a deplorable FP situation. However, efforts in that direction should proceed with caution. Indeed, sub-Saharan parliamentary figures are young and could easily succumb to lobbying groups opposed to family planning. Attempts to go too fast could have the opposite effect of enacting laws limiting family planning rather than promoting it. Before bills are proposed, the first step is to accelerate the sensitization of parliamentarians.

Harmful Traditional Practices

Introduction to Traditional Practices Harmful to Reproductive Health

Speaker: Pagomdzanga A. Nitiema

Given that there can be no development without health, and that reproductive health is at the core of basic health, it is crucial to encourage use of methods, be they modern or traditional, if we are to promote improvements in health in general, and more particularly the health of mother and child (breastfeeding, carrying babies on one's back, etc.).

On the other hand, all practices that are harmful to reproductive health must be eliminated. What are these harmful practices? Essentially, they include:

- Mutilations: female circumcision or excision (in 1986, 75,000,000 women are believed to have been "excised" in more than 30 African countries) and other mutilations (scarification, removal of the uvula)
- Nutritional taboos: foods that are forbidden, but are of great nutritional value, especially for pregnant women, women who breastfeed, and for young children
- Force-feeding of women

- Traditional delivery methods (Gishiri, Zur-Zur, abusive use of oxytocic substances, manual expressions)
- Forced marriage, high dowry
- Early pregnancies, early marriages
- Widowhood, levirate, witchcraft.

The issue of practices harmful to reproductive health is raised in an attempt to respond to the following questions:

- How common are these practices and how do they affect RH?
- What experiences have been reported, what lessons can be drawn from measures used until now to fight such practices?
- What legal and social measures are we currently applying or could we consider applying to counter these practices?

In conclusion, we must promote those traditional practices that are beneficial. But all methods that are harmful to RH must be eliminated. Given the fact that these practices stem from social and cultural factors, they cannot be suppressed unless we succeed in changing innate attitudes. It is evident that legal measures will have to be applied, but in so doing, we must be careful to take these social and cultural factors into account. For this reason, communication efforts to spread information and education must be given priority.

Harmful Traditional Practices

Presenter: Miriam Lamizana

Excision persists and is common in Burkina Faso. Between 70% and 90% of Burkina women are excised. The National Committee Against Excision was created in order to confront this serious problem. A decentralized body, it is divided into 30 regional committees whose task includes the development of education and sensitization programs such as training, discussions and film-debates. Target recipients are health professionals such as midwives, as well as the general public. The committee is engaged in efforts to introduce the topic of harmful traditional practices in the national curricula and in literacy programs. It is also involved in proposing bills to make these practices a criminal offense.

Summary of ASDAP/CEDPA's Intervention in Mali

Presenter: Fatoumata Traoré

Mali has been involved in a continuing consciousness-raising campaign on practices that are harmful to the health of mother and child: sexual mutilations and early marriages.

This effort has focused on opinion leaders, including religious leaders, villages chiefs, administrators, social or health workers, those involved in practicing excisions, press correspondents, those working with young people and women.

We propose the following strategies:

- Create income-generating activities for those who practice excisions as a way to involve them positively in a community program designed to raise consciousness.
- Involve traditional midwives and mothers-in-law (who carry great influence) in the program.
- Persuade men to refuse early marriages, enlisting their help in the battle to eliminate harmful practices such as sexual mutilation.
- Enact laws to defend women's physical integrity, and to abolish such practices.
- Involve training centers (organize a major information campaign in the schools aimed at young people).
- Launch a major campaign using mini-workshops to reach all levels of society.

A study completed in Mali revealed that 40% of the population wanted the elimination of these practices, and over 77% cited hemorrhage and infection as causes of mortality following such practices.

Traditional Practices Harmful to Women and Children's Health

Presenter: Caroline Koroma

In accepting the invitation to this conference, the Inter-African Committee on Traditional Practices (CIAF) perceived this meeting as an opportunity to go beyond the issues of improvement of access to and quality of family planning and RH services.

Over the past two days, I have heard it said that:

- Family planning reduces maternal mortality

- A reduction in the number of pregnancies improves maternal and child health
- AIDS prevalence in Africa is increasing at an alarming rate among women and adolescents.

Major health problems — including hemorrhages, infections, high-blood pressure, etc.— can be prevented or treated but often are not because a variety of obstacles delay interventions, resulting in the deaths of millions of women.

The list is long, but I would like to address some salient points.

According to one of the issues of the journal *Network* distributed at the conference, “you cannot talk about family planning to a woman who is hungry.” The same rationale applies to a woman or a girl who is a victim of harmful traditional practices.

Let me illustrate:

- A girl between the ages of 12 and 13 who is forced to become a wife and mother. Her husband is often 30, 40 or even 50 years old.
- A woman with a fistula who has become a social outcast because of her condition.
- A woman infibulated when she was 4 to 8 years old. How can we talk to her about an IUD when we know that she will be infibulated after each delivery? How can we perform a vaginal examination on an infibulated woman to detect and treat an infection?
- How can we talk about FP and RH with a woman who has lost two or three children because of culturally condoned infanticide?

These exemplify CIAF concerns, and reveal areas of possible collaboration with FP providers.

Through its national affiliates, the CIAF has fought against harmful traditional practices for 10 years. Its main objective is to reduce morbidity and mortality rates among women and children by eliminating harmful practices and encouraging beneficial ones.

The following activities can help attain these objectives:

- Develop training programs, launch information and awareness campaigns on the regional, national and international levels
- Initiate research using films and other such media (to document practices).

The CIAF receives assistance from governments, UN affiliates, non-governmental humanitarian organizations, private sources and local contributions. The CIAF is an observer to the Organization of African Unity and is an affiliate of UNESCO. WHO has also granted CIAF official status to pursue its lobbying efforts against harmful traditional practices on the international level.

There is not enough time to discuss the full range of our activities, but I would like to conclude by mentioning the fact that people now dare to talk openly about excision and other harmful practices. These topics were once taboo.

Finally, I am pleased to see the importance that conference organizers have accorded to harmful traditional practices by including this topic in the program. Dr. Nitiema's talk, the film and the panel discussion by representatives of three national committees — Burkina, Mali and Niger — will provide further information on the work of the CIAF.

Factors Influencing Family Planning and Reproductive Health in the Region: Harmful Traditional Practices

Presenter: Ouassa Djataou

This presentation is about the situation in Niger regarding traditional practices. It also addresses the activities of the Niger Committee on Traditional Practices which affect the Health of Women and Children (CONIPRAT).

How these methods negatively affect maternal and infant health is well known. Two doctoral theses in medicine were published in Niamey: the first one in 1986 dealt with the issue of excision, the other, in 1992, on removal of the uvula. The following conclusions can be drawn from these documents:

- Of 540 cases of excised women identified during deliveries in Niamey maternity clinics, 388 (71.85%) were from Niger. These figures are important because government authorities tend to deny that excision is practiced in Niger.
- According to the 1992 study, 50 to 70 children under the age of five are admitted with complications from removal of the uvula each year at the National Hospital in Niamey. Nearly one-fifth of them die in the hospital.

The same study estimates the prevalence of removal of the uvula in Niamey is 20% among children between birth and the age of five.

An assessment of frequently applied traditional practices in Niger (1992 CONIPRAT baseline survey) focuses on methods that must be eliminated and those that should be encouraged. The following is a list of harmful practices:

- Removal of the uvula
- Excision
- Early marriage and pregnancy
- Food taboos and dietary restrictions
- Force-feeding
- Scarification and tatoos
- Touching the skin with a burning stick
- Blood-letting

Some traditional methods have positive effects, and should be encouraged:

- Breastfeeding
- Prescription of 40 days' sexual abstinence after delivery
- Carrying babies on one's back
- Growing certain crops off-season
- Birth-spacing through traditional, effective FP methods
- Non-consummation of marriage until the bride reaches a certain maturity (an ancient practice which should be revived).

CONIPRAT is affiliated with CIAF (Inter-African Committee on Traditional Practices). For the time being, the committee's objectives are to:

- Increase awareness among political, traditional and religious leaders, couples, opinion-makers, rural midwives, emergency medical personnel and health aides of the negative consequences of traditional practices and make their elimination a priority.
- Increase awareness of the consequences of specific traditional practices on women's and children's health.
- Explore ways to promote women's and children's health.
- Distribute all information, documentation or research on traditional practices harmful to women and children.

To meet its objectives, CONIPRAT will focus on consciousness raising, training and education, research, and mobilization of financial resources.

Report on Burkina's Fight Against Practices Harmful to Women's and Children's Health

Presenter: Félicité Bassolé

The major harmful consequences of certain practices on the health of women and children have prompted the government of Burkina Faso to establish, in collaboration with a number of NGOs, an organization known as the "National Committee for the Elimination of Excision."

Its mandate is as follows:

- To establish programs, and coordinate, evaluate and supervise activities
- To establish and implement an effective IEC program
- To conduct research on the practice of female excision.

The committee is made up of representatives from several government agencies, NGO representatives and traditional and religious leaders, and will be presided over by the honorable First Lady of Burkina Faso.

The committee collaborates with individuals (midwives, members of women's groups, leaders of rural midwives) responsible for publicizing information to the different target groups. Efforts are made to integrate the subject of harmful traditional practices into the curricula of primary and secondary schools.

There are laws in effect to suppress harmful practices regarding excision. One of these laws was enacted during the colonial regime, banning excision under the rubric "involuntary physical injuries." With the collaboration of the Ministry of Social Action, the Committee was able to insert clear provisions regarding excision in the new penal code which is being drafted.

The problem of harmful practices is rooted in socio-cultural beliefs. Efforts to eliminate such practices must take these into account. Tact and a sensitivity to ethno-geographic differences are essential.

Gender Issues

The Responsibility and Power of Women and Men

Presenter: El Hadj Mamadou Bella Doumbouya

Culture determines the responsibilities and powers of the members of a given society. Thus, culture evolves by borrowing from other progressive elements to modify habits positively. African society does not escape from this rule. This is why I was very pleased to hear Professor Leke suggest the importance of taking into account local and socio-cultural realities, during his impressive exposé on scientific discoveries in RH/FP.

This recommendation seems to be very important in view of our setbacks in other domains that seem to result from the fact that principles are applied to us, such as structural adjustment, intended to match the pace of the State to the contributions of economic actors in the country, but without considering local realities. We know the results.

We must therefore insist that socio-cultural realities be taken into account in the application of scientific discoveries related to RH/FP. In considering RH/FP as a way to reduce the size of families to suit parents' financial means, we find responsibilities and obligations in the socio-cultural principles of Muslim communities, that if properly carried out by parents, could become the bases to apply scientific discoveries, with the agreement of the population at all levels.

Responsibilities and obligations of women: they take responsibility to fulfill all of their obligations related to their husband and children. The woman is the first to rise and the last to go to bed.

Activities of men: they are often ignorant of basic principles of Islam. They exploit women and neglect the most basic obligations toward their wives and their children.

Their duties to their wives include the provision of housing, clothing, care, and nourishment, under decent conditions.

Their obligations to their children include the provision of housing, clothing, care, and nourishment, as well as education until the children are of legal age.

In reality, and in addition to their own duties, women take on a large part of men's obligations. Each woman takes care of her children. During a postpartum period of several weeks, the woman takes all her young children to her parents. Under these conditions, men have no interest whatsoever in FP. To the contrary, if these duties were imposed upon the men, a man with a wife and three children whom he must house, nourish, clothe, care for, would not have any desire to take a second wife who would bear him additional children.

Proposed measures: Information for all players. Literacy is imperative: it would allow one to inform large groups of peasants in writing, in their language, about mutual rights and obligations, the need to limit the number of children to parents' financial means, and within this context, to apply the results of new scientific discoveries.

In 1990, the Organization of Volunteers for Economic and Cultural Development (OVODEC) launched a literacy campaign in Foutah Djallon. This was done through the use of Arab script, emphasized by UNESCO and ISESCO, because 60 to 70% of adults in Foutah could read the Koran, and thus knew the Arab alphabet. Consequently, they only had to learn the letters, to transcribe the Pulaar sounds that do not exist in Arabic, to write their language correctly. This campaign has had such good results that we edit a monthly bulletin to serve as post-literacy and information material. This bulletin has been used to fight social problems, beginning with the publication of a poem I wrote to encourage mothers to send their daughters to school, and not let them marry before the age of 18, as set by law in Guinea.

Women's and Men's Responsibility and Power

Presenter: Monique Ilboudo

Just because women give birth to children does not necessarily imply that they alone should be responsible for their care while they are growing up. Motherhood has for a long time been a symbol of female submission to nature and to man. For many women, motherhood has been a source of problems and even enslavement; it still is for a great number of women.

Birth control as well as all discoveries regarding women's health have all combined to greatly improve women's living conditions. Unfortunately, many women continue to have no access, or difficult access, to FP services. This is true not only in practical terms (distance to travel or cost of FP/RH services), but also because of socio-cultural, political, historical barriers:

- Women identified only as reproductive machines
- The deification of the mother in society: only by becoming a mother does she become a woman
- Procreation as a social duty: to take up the rightful place of spouse, the young bride will rush to demonstrate her fertility
- Conjugal relations do not entail sexual pleasure: the man is therefore free to seek his pleasure elsewhere
- The patriarchal system gives exclusive decision-making power over all issues, including family finances, to men, who suffer the least in procreation. If the men were the ones who had to suffer delivery pains and sometimes even death, they would have been quick to adopt family planning and see to it that the risks of mortality were limited
- Children perceived as work force: the greater their number the better
- The gap between law and reality: in spite of the law, traditional practices continue
- The law impedes the development of rational RH policies. Legal texts reflect radical positions on abortion, linked to taboos, and impede efforts at preventing abortions through rational means; nor is the health of women who undergo abortions considered.

Barriers involving men's and women's responsibility and power can be eliminated only by re-examining male-female relations all over the world, and by giving women's demands serious consideration. It is essential that:

- Women's right to their physical integrity be recognized, and that their views on issues regarding their health, procreation, and sexual relations be acknowledged. Rape by husbands must be treated as a crime.

- The education of girls must become a priority issue if we are to remove the perception that they are nothing but reproductive machines.
- We must sensitize populations to the fact that children have rights too, that they are more than old-age insurance. We have no right to produce children unless we are able to take proper care of them.
- We must make men understand that they need to assume an important share in the responsibility to produce and care for children.
- Legal documents dealing specifically with FP/RH must be added. For instance, the Burkina Faso Penal Code bill proposes to impose sanctions on sexual mutilations.
- Documents and sections of current laws dealing with FP/RH are too scattered and need to be listed and itemized, so that they can be used by women and service providers.
- Women and children have to be recognized as human beings whose rights must be respected.
- Men's sexual and procreating activities occur outside as well as inside the family.
- Economic and social crises, migrations, family upheavals (divorce, widowhood, out-of-wedlock pregnancies) have resulted in men's gradual disengagement from caring for their families and in the increase of women's economic responsibilities regardless of the type of family involved.

It is essential that MAQ strategies consider men's involvement a major issue. Not only must men be persuaded to "authorize" their wives and daughters to practice FP and make use of health care services, they too must be viewed as procreators. Consequently, effective strategies must aim at increasing men's awareness regarding their responsibilities as sexual partners, procreators and fathers.

Scientists should focus their efforts more towards promoting contraceptive methods among men. IEC program managers need to address their messages to men as well, translating medical terms in the national languages. If the results are to be permanent, our efforts at making men assume responsibility must be accompanied by a new definition of masculinity, virility and sexuality. Greater respect for their sexual partner, shared responsibilities in the upbringing and care of children, and more equality between men and women should be the result.

At the same time, efforts should be focused on women in two areas:

- Respond to women's needs in terms of contraceptives, medical supplies, medicines, etc
- Help women gain control of their sexuality and fertility.

These objectives can be achieved on several levels. On the government level, help can be provided in the implementation of affirmative educational policies, access to work and other resources, the repeal of laws limiting women's autonomy and their access to resources, and the development and respect of agreements aiming at women's liberties (such as reproductive rights).

At the level of agencies/service providers:

- Accept the concept that women's bodies are their own, and help women to assert control over their physical integrity

Women's and Men's Responsibilities and Power in Terms of FP/RH

Presenter: Codou Bop

One of the most important challenges that Africa faces in the 21st century is achieving equality of women and men, a process that necessarily implies increasing the authority that women exert. A similar challenge confronts those who are involved in the field of FP/RH. It is crucial that they find ways to increase men's awareness regarding their responsibilities as sexual partners and procreators.

Clearly, agencies, public authorities, service providers and scientists are all accountable for the minor role that men have assumed in this area.

Indeed, their efforts have focused on the women who are seen as the major fertility control instrument, making them alone responsible for population explosion. However, research results reveal a different story:

- Men want a greater number of children than do women and, on average, more children are fathered by individual men than are born to individual women.

- Provide women with all necessary information and services on all aspects of health and reproduction, regardless of their age and economic situation
- Respect the client and the choice she makes
- Develop a partnership between women's groups and NGOs.

At the level of financial donors:

- Strengthen their collaboration with women's groups and NGOs to help them be heard in decisions affecting women's health, fertility, and sexuality. Such collaboration should also increase their authority at the national and international levels. Financial support and training will be needed to accomplish this task.

Strategies to Improve Services

FP/RH Service Policies, Standards, and Service Delivery Guidelines

Presenters: Pape Gaye and Manuel Pina

Policies, standards and protocols are essential to any family planning and reproductive health (FP/RH) program that aims to maximize access to and quality of services. Without guidelines to specify and standardize the services offered by a program, providers and administrators lack both a common vision and modus operandi for delivering high-quality care. For example, when developed and implemented in a participatory fashion, national clinical protocols improve services by assuring that:

- There is agreement between what is taught and what is practiced
- Providers agree on common approaches to offering services
- Service is guided by the latest technical evidence as well as careful consideration of local realities
- Providers are better supervised and evaluated.

What are the differences among service policies, protocols and standards? Service policy outlines the overall conception of programs and defines the rationale of service, types of services offered, beneficiaries of service, providers of services, as well as the service delivery points, the organization of services and the resources to be

used. Service standards cover the acceptable performance level of the program, provider or service. For example, standards could describe the services that must be provided and the improvements that must be made to meet minimum quality standards. Standards could also specify the qualifications required for each health provider position. More procedural in nature, service protocols address such issues as clinical steps necessary for the delivery of specific services offered. Protocols also provide direction on the coordination of tasks (such as referral, supervision, follow-up, etc.) carried out at service delivery points.

A lengthy participatory process is needed to prepare accurate, well-accepted policies, protocols and standards. First, to ensure that those developing and endorsing the documents have the most accurate scientific information at their disposal, a technology update should be held for them. All sectors involved in developing, accepting, or implementing the document must be involved in both technical updates and the planning processes. From the beginning of the process, key players must be identified and involved. Although the principal actors will vary by country, important sectors to involve are public sector, non-governmental organizations, private sector and basic training organizations.

To implement new protocols or standards necessitates not only an attitudinal change on the part of policy-makers, but also a behavior change on the part of providers and supervisors. Merely disseminating a new set of protocols will not change practices. Protocols must be tightly integrated into both preservice and service training curricula. Providers and supervisors must be oriented to the new standards and trained to apply them.

Finally, a policy, protocol or standard is never "finalized." Guidelines for practices must be continually updated to reflect new medical or service delivery findings or changes in the population served.

The recent experience of Uganda highlights the benefits of revising FP service standards and protocols. For example, the new practice and protocol documents have expanded the role of the "aides-soignants" or health aides, resulting in more effective use of this staff position: after a review and revision of service protocols, health aides were allowed to provide oral contraceptives to women. When the Minister of Public Health

saw that this policy change was working, he authorized health aides to deliver DMPA as well. The success of Uganda's revision process is attributed to the commitment to having the most up-to-date protocols and standards, the high degree of participation, and their comprehensive approach to dissemination and training.

Legal Clinics

Presenter: Awa Nana

Senegal, Mali, Cameroon, Benin and Togo are the site of experimental "legal clinics," where women can learn what their rights are, and how to defend and protect them. These information centers were developed under the sponsorship of Canadian international donors. The ACCT and USAID are also interested in supporting them. In Togo, there are three centers, two of which are operational:

- The CRIFF (Information Research and Women's Training Center) in Lomé
- The ATEFF (Togo Association for Women and Young Girls' Training) in Sokodé
- The "legal clinics" are staffed by men and women who are professionals in the field of law or education, but who are primarily involved in research, information (to women) and legal assistance.

These professionals, most of whom are magistrates, lawyers and university professors, are present at the center every day, Monday through Friday, from 5 pm to 7 pm, to help individuals who are "victimized" either physically or mentally. The clients receive assistance in finding solutions to legal problems that frighten them and with which they don't know how to cope. These situations may have to do with civil status, pensions (from food distribution to survivor benefits), inheritance, sale or loss of property, bail, commercial contracts and social security, work, layoffs, harassment, expulsion from conjugal home, relations with in-laws, legal recognition of a child, paternity search, family desertion, etc. The center offers free legal assistance as well as counseling services. It serves as guide and contact, mediates discussions with partners, helps couples in matters of conciliation and reconciliation, etc.

Legal clinics see their role as that of lobbying organizations committed to informing and training women in assuming their civic responsibility to vote, teaching them how to vote, why they should vote, and persuading them to run for election. The clinics aim at inculcating self-confidence in women of all walks of life.

Meetings with government and parliamentary leaders and local and political leaders serve as forums to promote women's rights. The clinics intend to supplement their educational mission by training "paralegals" in rural areas. In terms of strategy, the clinics would like to be integrated with RH/FP services, and be recognized or incorporated with village health units. They would also like to participate in CBD activities, in social marketing, etc.

Finally, clinics' research activities can contribute to efforts at eliminating harmful practices and STDs/AIDS, repealing reactionary laws and regulations, and reviewing legal texts for the purpose of improving the integration of all RH/FP components.

Role of Opinion Leaders in the Promotion and Distribution of Health and FP Services in Rural Cameroon

Presenter: Diouratié Sanogo

As in other sub-Saharan countries in Africa, the contraceptive prevalence rate in Cameroon is low. Family planning is hardly known, particularly among men. Consequently, in 1991, the Ministry of Health, through its Department of Family and Mental Health and with the technical assistance of the Population Council, developed and tested an IEC strategy specifically designed for men.

This presentation aims at showing the results of operations research that combines IEC with FP service delivery, integrated into a primary health care program being carried out in a rural area. This approach enabled men who were influential in their communities to gain a better knowledge of FP and assume the role of community-based distributors of contraceptive methods in their respective villages. The objectives of the research were as follows:

- To demonstrate the feasibility and acceptability of using male opinion leaders in the community as a communication network to reach the target population

- To assess how these opinion leaders' IEC activities had changed FP knowledge, attitudes and practices among the target population
- To determine how satisfied the target population was with opinion leaders' involvement in FP activities.

The methodology applied is quasi-experimental: a pre-test and post-test study method, without a control group, combined with time series analyses. The first step was to select opinion leaders based on their status in their communities. A democratic process was used, involving both the health personnel and village health committee members. The opinion leaders developed family planning IEC activities and assumed responsibility for distribution of condoms, spermicides and oral rehydration packets. Activities included home visits, educational meetings in the villages, and referrals to health centers participating in the project for prescription contraceptives. Both opinion leaders and health professionals were trained to implement the study.

The intervention had a remarkable influence on FP knowledge, attitudes and practice of the target population. The proportion of women and men now capable of naming at least one modern contraceptive method increased from 46% (pre-test) to 62% (post-test) among women and from 56% to 86% among men. However, attitude changes remained minimal. Yet, the level of communication between couples appears to have increased dramatically. The number of men and women who indicated that they had already discussed modern contraceptive methods with their partners had nearly doubled among both genders.

This study revealed that it was possible to employ opinion leaders as CBD agents. It also showed that opinion leaders were capable of counseling women on a proper contraceptive method. These results suggest a measure of hope for the promotion of FP in rural areas.

Dakar Adolescents' Viewpoint on Barriers to the Use of FP Services

Presenters: Christine Naré and Penda N'Diaye

This 1994 study was conducted with adolescents from the Medina and Rebeuss neighborhoods in Dakar. Group discussions were used to collect data from 73 adolescents, from 15 to 20 years old (50 females and 23 males).

Results show that for the most part, young adolescents required information on sexuality, reproductive health, and contraceptive methods. In fact, results show that young people recognize that many factors contribute to adolescent sexual practices. Adolescents, however, have problems in managing sexuality because they cannot communicate with parents, are rejected by FP services because of their age, and the family life education courses in school do not provide them with enough information. They have little knowledge of contraceptive methods. They are aware of STD/AIDS prevention but because of the above mentioned barriers and the cost of condoms, adolescents practice high-risk behavior (multiple use of a single condom).

Undesired pregnancy is scorned by families and adolescents. The first reaction is abortion, which is induced at great risk considering the meager financial resources of adolescents.

In view of these barriers and risks taken by adolescents, innovative strategies must be identified and implemented to safeguard the lives and the reproductive health of young people.

Summary of ABBEF Experience in Adolescent Counseling in Burkina Faso (Youth for Youth Project)

Presenter: Oscar Koalga

The "Youth for Youth" Project provided an opportunity to launch a pilot RH information and service-distribution program for young people. It also demonstrated to the government that aiming RH at young people was a feasible task.

Project objectives:

- To develop a structure for the expansion of family education/FP information and education activities
- Provide RH services to adolescents.

Strategies employed:

- Promotion of awareness and involvement of parents, educators, professionals, traditional leaders, religious and political leaders
- Training of young health educators (in and out of schools)
- Developing RH service distribution centers
- Developing education activities for young health educators
- Having young educators refer youth to health centers
- Using teaching materials developed by young people
- Using information and communication networks established by young people
- Developing an adequate information system to document project results.

Operational results:

- Two functioning centers for young people
- 1,877 KAP results collected
- 77,304 young people between the ages of 14 and 25 reached by young health educators
- 126 area health educators and 77 academic club health educators recruited, trained and working in the field
- Counseling services provided to deal with specific problems of motivated young people
- Contraceptive and gynecologic consultation services provided to young people
- STD screening and treatment for young people.
- Gynecological disease treatment.

Lessons learned from the project:

- In most of the activities, involving adolescents has motivated a large number of young health educators to volunteer their help. They provide regular services without expecting any financial payment
- Young health educators' status has risen within their families, who now solicit their opinions in matters of family decision-making.

Improvements needed:

- Increase contraceptive distribution by young health educators in the field
- Assume responsibility for STD treatment of young people in the health centers

- Develop a global IEC project strategy to include the use of other messages and mobilization networks
- Increase the quantity and improve the quality of IEC materials
- Standardize training/refresher courses of young health educators, and create teaching materials for training/refresher courses
- Design documentation in accordance with young people's needs
- Research/analyze young people's needs
- Improve project data collection, processing and analysis
- Provide necessary tools to improve follow-up
- Balance the number of young female and male health educators
- Maintain a high level of awareness of parents and educators to the information needs of young people over the age of 17
- Improve motivational methods
- Establish a more effective supply system.

The Prevention of Early Motherhood in Cameroon

Presenter: Damaris Mounlon

In the context of improving women's health, which in turn allows women to better face the complexity of problems caused by development, the Women, Health, and Development organization (FESADE) has taken on the phenomenon of early motherhood among 12- to 19-year-old adolescents. A national study, performed by FESADE in 1993, revealed that 14.72% of pregnancies occur in adolescents under the age of 18. Consequences are: school drop-outs, induced abortions, and death.

Therefore, the participation of these young women in the development process is affected. FESADE, which works in the prevention of early pregnancy, has two goals:

- To eradicate, or at least reduce, the consequences of early pregnancies
- To empower adolescents against the harmful effects of unprotected sex (early pregnancy, STD/AIDS).

For this, the organization produced an educational booklet on the prevention of early pregnancy and organized workshops with target populations using this tool.

FESADE supports its activities by radio broadcasts conducted by journalists trained in FESADE objectives and approaches.

FESADE is preparing an adolescent sexual education program with two components:

- One through the formal educational system
- The other, for pre-adolescents, families, and the community.

This task, which is under way, associates the different actors in adolescent education: official Cameroonian government services, NGOs, and private services.

If funding is obtained, FESADE expects to accomplish the following in the short-term:

- Completion, printing of booklets, and dissemination of the program
- Training of trainers, teachers, parents, and adolescent groups.

This project will be part of the draft action plan produced during the current conference.

Adolescent Reproductive Health

Presenter: Robert J. I. Leke

The following statistics highlight the situation of adolescent sexuality in Africa:

Fewer than 30% of adolescents know anything about the fertile period, yet adolescents are responsible for more than 20% of Africa's annual birthrate. Vaginal heterosexual sex is the most common (78%) among adolescents. Heterosexual oral sex is reported by young people at 1.58%, and masturbation at 4.8%. A 1992 study conducted in Cameroon showed that 74% of adolescents reported that their parents refused to discuss sexuality, under the pretense that there is already too much sex among adolescents; 69% reported being pressured into having sex; 60% indicated ignorance of the consequences; and 45% said they had sex in exchange for favors or money.

Family planning methods are fairly well known, and a positive attitude towards FP is apparent, but fewer than 34% practice it. School teachers represent an important source of information among adolescents (34%), followed by medical personnel (19%) and sexual partners (20%).

FP information aimed at adolescents must reach its target before the beginning of sexual activity because 50% of pregnancies occur within the first six months of initiation of sexual activity, while only 6% want to become pregnant during that period.

About 30% to 40% of adolescents indicate that an unmet need for FP exists.

Among contraceptive methods suitable for adolescents, natural methods, with the exception of LAM, are not appropriate. Condoms are however very much in use. Pills and spermicides are accepted and used. The IUD is infrequently used, and the rate of complications that result from its use may be higher among adolescents. Injectables and Norplant implants are effective but are not always a first choice for adolescents. Permanent methods are rarely indicated.

Strategies aimed at improving the health of adolescents should have the following objectives:

- Correspond to wishes and priorities of young people
- Involve young people
- Offer services that are acceptable and accessible to young people
- Appeal to both genders
- Offer a variety of services.

The following strategies/programs are suggested:

- General education and sex education
- Training of personnel (service providers)
- Efforts to eliminate harmful traditional practices
- Promotion of good traditional practices
- Effort to eliminate other high-risk behaviors among young people (alcohol, drugs, tobacco)
- Establishment of social structures
- Extension of FP to adolescents

- Make services accessible to young people
- Enlist young people's participation as partners
- Communicate clear, non-contradictory messages.

The COPE Experience in Africa

Presenter: Yatshita Mutombo

The organization Access to Voluntary and Safe Contraception (AVSC) International evaluated the impact of the "Client-Oriented and Provider-Efficient" (COPE) technique on the quality of family planning service provision. This technique hinges on the client as well as the effectiveness of health care personnel. Having introduced COPE in more than 11 African countries and in several other countries around the world, AVSC returned 3 to 15 months later to evaluate the impact. COPE is based upon several "key" principles: that clients have the right to expect high quality service, and that service providers have needs that must be met to provide such services. COPE benefits from the fact that those who implement it, namely service providers, are the persons most familiar with the problems and their solutions. COPE includes all personnel involved with service delivery, from the office clerk to the physician, giving each one an equal opportunity to participate, contribute and take responsibility.

The technique is a tool to evaluate and improve quality at the service delivery sites. COPE involves three main components:

Self-evaluation using a verification sheet and client interview forms; the personnel evaluate medical services, nursing care quality, administrative functions, community participation, space, supplies, counseling, and information and education sessions.

Examination of client flow, following clients from the time they arrive at the service site until they leave, calculating how long clients wait and where the delays occur.

An action plan that reviews the results of the above analysis, lists the measures that should be taken to resolve the problems identified and the individuals who are responsible, and establishes a timetable for implementing the action plan.

The evaluation showed that about 75% of "solvable problems" identified by COPE were solved without external resources. In most cases, the personnel came up with simple and creative solutions. In five clinics where client waiting time was found to be relatively long, the personnel decreased the average waiting time by 42%. The evaluation revealed numerous improvements in service quality, as well as greater personnel participation in problem solving. "Unsolvable problems" — problems that could not be solved without external intervention — were lack of equipment, supplies, insufficient personnel, and inadequate training funds.

AVSC drew several conclusions from evaluating the use of COPE:

- COPE succeeds when personnel are enthusiastic and ready to perform honest self-evaluation
- COPE succeeds more often in non-governmental organizations than in public sector services
- Once introduced, COPE can be easily transferred to other sites and does not require specialized personnel.

Changes in clients' satisfaction following the introduction of COPE were not examined, but a study in this area is planned.

COPE does have its limits: it is difficult to measure COPE's global impact and to compare results from one country to another. However, the technique is effective, simple, and inexpensive. It was well received by service personnel given full authority to solve problems on their own, and it helped improve the quality of FP services.

Social Marketing

Presenter: Carol Squire-Diomandé

Social marketing is a tool that should and can be used in every program that attempts to change the attitude or behavior of a given population. Definitions of social marketing are often limited to the idea of selling health products at low prices, at outlets where widely-purchased products like soap are sold. A better definition would be: "the technology to manage social change by increasing the acceptability of a new attitude and/or practice."

Social marketing is a precision tool involving the use of private marketing techniques to target a population or, more accurately, to position the "product" (the idea or behavior to be adopted), and develop communication, distribution, and promotion strategies.

The essential features of every social marketing program follow:

1. One "sells" a "social product." One sells a behavioral change. One tries to change beliefs, attitudes, and even values so that the population changes its practices. To make this more tangible, we offer services or products.

2. The product (that is sold) must be the best solution for the problem as perceived by the target population. If the target population does not perceive the problem, it will not adopt new behavior. We must establish demand, and to do so we must listen to the population. In addition, "the product" must satisfy the need better than "the competition," which isn't another concrete product but other behaviors or the non-adoption of the desired behavior.

3. Each program element must reinforce the message that the product solves the problem, which creates the product image. Social marketing allows us to coordinate all components of a national program so that the population receives consistent messages from all the program activities.

4. Social marketing requires very active management. We not only need baseline population data but also continuous evaluation of activities. If attitudes change, our objectives, strategies, and activities must be modified accordingly.

In conclusion, I would like to emphasize that public health programs require a concerted effort. There is need for a real integration of public programs with NGOs and the private sector. Well-managed, well-executed social marketing is the glue that holds our programs together.

Social Marketing in Mali

Presenter: Mamadou Moussa Traoré

The low rate of contraceptive prevalence (1.3% in 1987), and the fact that 49% of women wish to space births, make contraceptive social marketing (CSM) one of the most important links in the chain of action of the Rural Population Hydrologic Health Project. CSM is also one-half

of the social marketing/community based distribution (CSM/CBD) system established to distribute contraceptives. The Pharmacie Populaire in Mali manages the CSM component with SOMARC's technical assistance. CBD is implemented by the Directorate of Family Health with the technical assistance of The Population Council. Both components are attached to the Ministry of Public Health. CSM/CBD operates in collaboration with the National AIDS Control Program and with several NGOs.

Project development took six months and included signing of protocols; defining tasks, target areas, and responsibilities; and building contacts with public/private organizations-NGOs. In addition, two committees were established: The Advisory Committee manages the program, smooths out any administrative difficulties, especially with customs, and modifies project activities in accordance with current governmental policy. The Support Committee includes neighborhood leaders, imams, preachers and other influential persons. Its task is to ensure that the public receives correct information to counter socio-cultural or religious opposition.

The sale of Protector condoms was launched on April 1992, and that of the Pilplan pill in March 1993. The distribution system operates on three levels: pharmaceutical, CBD (during the first year) and private outlets (shops, grocery stores, bars, hotels). The project uses mobile teams (six young people with motorcycles in Bamako; three teams of two promoters and one physician per team travelling by car in rural areas) to promote and sell condoms during weekly visits to commercial areas and monthly visits to social service or health centers. Mobile teams selling Pilplan pills consist of midwives and physicians. Teams use vehicles decorated with advertising and equipped with sound and video equipment. In addition to per diem, the teams receive bonuses based on the attainment of program objectives.

The project advertises through mass media (television, national and regional radio stations, publicly and privately funded). Advertising is conducted in the two most commonly spoken languages of each region. Promotional activities include contests, sponsorships, newspapers, student conferences, advertising panels in stadia and on buses, and TV and radio debates on the theme of Islam and condom use.

Project activities have resulted in the sale of 3,350,000 condoms between 1992 and 1994, and of 300,605 Pilplan cycles between 1993 and 1994.

The project has encountered a few problems: pharmacies' reluctance to promote Pilplan; the co-existence of social marketing and free condom distribution; anxiety of some Muslims over large scale distribution of contraceptives. To address these problems, the project has modified as necessary program components that authorities opposed and has worked to decrease the free distribution of condoms. In addition, the project is continuously involved in increasing religious leaders' awareness of the need for FP.

The following lessons have been learned:

- Private sector involvement must increase to ensure CSM/CBD continuity.
- Consumers' needs and demands must be continuously reviewed.

For future project expansion, it will be necessary to increase CBD supplies, involve the private sector, develop improved communications strategies, and multiply the number of teams.

Summary of the Community-Based Distribution (CBD) Project in Mali

Presenter: Seydou Doumbia

Our study, conducted after three years of project development and implementation, has shown that CBD is culturally acceptable and technically feasible in the Malian social context. A proper phase of educational outreach prepared the population for activities. The study has also revealed the technical competence of distribution agents selected by members of their community. If CBD agents receive proper basic training and are regularly supervised by competent medical personnel, they provide quality information on FP services, assure the sale of condoms, spermicides and pills, and refer clients to health centers or other FP services.

In particular, the results of the KAP surveys have shown that this type of intervention contributes significantly to an increase in the target population's level of knowledge of modern FP methods. However, this increased knowledge about FP contrasts with low utilization of modern contraceptive methods. The positive changes in attitudes observed during this experimental phase

of project implementation are not reflected in actual behavioral change in the population, perhaps because of the short duration of the intervention.

Despite this incongruity between knowledge and behavior, the main results obtained during this experimental phase so far have surpassed all our expectations:

- Establishment of over 120 community distribution points in the project area
- Strengthening of MCH/FP service delivery in the project area
- Increase of the level of knowledge about modern FP methods
- Increase in contraceptive prevalence from 1% to 31%
- Change in favorable attitudes toward FP.

Given the current state of health coverage in Mali, these results affirm that CBD is one of the surest ways to arrive at a rapid, significant increase in contraceptive prevalence nationwide.

After consideration of the positive results observed, the Government of the Republic of Mali decided in 1994 to expand CBD over the entire country with technical assistance from the Population Council. Financing for this five-year expansion phase has been assured by USAID. In addition to opening 3,000 distribution sites, the expansion project will explore new ways to increase agent mobility, strengthen the image of CBD agents as agents of family well-being by adding essential drugs to the contraceptives they distribute, and identify strategies to make men more aware of reproductive health issues.

Strengthening Private and Public Sector Collaboration Through Strategic Planning and Organizational Development

Presenter: Agma Prins

As in the majority of African countries, where access to services remains limited and localized, the coordination of the efforts of the many organizations involved can contribute to increased access to quality services. The strengthening of the public and private sectors can happen only if the unique strengths of each are used to complement each other.

The private sector has certain advantages over the Ministry of Health:

- It can reach more easily certain segments of the population such as more affluent groups, more remotely located groups, and groups with special needs
- It can afford to take risks in introducing new initiatives
- It can serve as a laboratory (for example, introducing FP in environmental projects)
- It often has more experience in community mobilization than does the public sector.

Management Sciences for Health (MSH) has been involved for several years now in efforts to support private sector FP activities in several countries and to make them complement public sector activities. MSH has worked with NGOs to improve their capacity to plan and manage activities, enabling NGOs to assume their proper role and fulfill the demands made of them. In addition, MSH has helped NGOs to coordinate their efforts in order to maximize each organization's particular strengths. Finally, MSH has worked to facilitate coordination between the public and the private sectors, in order to encourage a rational, effective expansion of quality services.

The USAID-sponsored APPROPOP/FP Project in Madagascar initiated its activities in September 1993. The project's objectives are to reduce the fertility rate and to increase the contraceptive prevalence rate. From the beginning, the project has aimed at achieving harmonious development of FP activities between the public and the private sectors. In addition, the project activities complement the contributions of other donors such as UNFPA, GTZ, the World Bank, ODA and WHO in the public sector, as well as FISA (IPPF) and other NGOs in the private sector.

The APPROPOP/FP Project has two major components:

- Strengthening of local institutions capable of providing technical and material assistance to FP organizations
- Conducting "Service Provision Support Activities" (SPSA), a mechanism to transfer resources to local organizations to help them develop their FP services.

For the past year, the project has focused on three approaches to encourage the effective development and complementarity of FP activities in these two areas:

- Strengthening program planning and management capabilities of each organization that might benefit from SPSA
- Strategic planning in each main geographic region of the project (the two provinces and the capital). Once the region's strategic plan was defined, an action plan was developed for each of the organizations concerned.

The creation of "working groups" at the national level to develop strategies and national work plans in specific technical areas.

The combination of these approaches constitutes a powerful strategy to ensure greater effectiveness of a variety of public and private sector organizations. These approaches also improve coordination among donors and ministry agencies. Appreciating the particular strengths of each organization can help speed up the process to increase access to quality FP services. However, these methods are more difficult to apply and less effective under unstable or uncertain conditions.

Integration of STD/AIDS and RH/FP Services

Presenter: Willibrord Shasha

The high prevalence of sexually transmitted disease (STD) and the rampant increase in HIV/AIDS prevalence rates do not spare clients of FP services. For example, STD prevalence among women seen during prenatal gynecologic and FP consultations in Cameroon are reported as follows: trichomonas 30%, gonorrhoea 18%, and syphilis 17%. Unfortunately, actual prevalence rates may be even higher because many cases are asymptomatic.

FP service providers can offer different kinds of STD care according to the capability of the clinic: STD testing, counseling and referral, condom distribution, partner notification, and community intervention among high-risk groups.

The reason for integrating STD services with FP services is to satisfy the demand of many FP clients, fight high STD rates, avoid unnecessary travel by clients to different clinics, reduce HIV transmission, etc.

This integration, nevertheless, presents problems. It could reduce FP activities because FP providers are already often overworked. It could also increase expenses without completely assuring proper diagnoses.

Certain programs have succeeded in reducing STD prevalence and incidence. The JHPIEGO experience shows that the success of such programs depends on the ratio of the number of providers to clients, the number of IUD acceptors, administrative support, supervision and retraining.

Appropriate Contraceptive Services for Women at Risk of STD/HIV

Presenter: JoAnn Lewis

At present, there is little experience with the integration of STD services with FP services, but increasing numbers of FP clients ask questions about STD, and many request diagnosis or treatment. While there is often a lack of resources for STD clinical services, FP services must respond to this need effectively, especially for the typical client: a woman of reproductive age, who could be exposed to the risk of infection, but who is unable to go anywhere else but a MCH/FP service for her reproductive health concerns.

As an initial strategy for integration, I propose an improvement in the counseling provided to clients. This action is not costly and can be implemented by all FP services. One goal of this counseling would be to help a client estimate her risk of contracting an STD. If she is already infected with an STD, she is at high risk for HIV and other STDs. Unfortunately, the asymptomatic nature of STD in women makes risk assessment more difficult. A procedure must be established to evaluate this risk by asking certain key questions to the client during counseling. Her answers to these questions indicate the risk. The ability to make a valid risk assessment requires service personnel who, at minimum, can recognize STD symptoms and refer clients to appropriate services. This might require stronger training in STDs.

Based on the risk assessment, personnel should help the client choose a contraceptive method, or methods, most appropriate for the client. We must note that the most effective methods to prevent pregnancy are the least effective for protection against STD/HIV. Barrier methods (male condoms, female condoms, spermicides, diaphragms) are most effective in protecting against infection, but their contraceptive effectiveness ranges from 75 to 95%. These methods must be

used correctly during each risky sexual act and, therefore, require strong motivation by the client as well as her partner. This point must be discussed in detail during counseling.

Currently, FHI and our colleagues in Cameroon are evaluating the prophylactic efficacy of vaginal contraceptive film, a product that is very inexpensive and whose use can be controlled by the woman even without the knowledge of her partner.

Hormonal methods, the IUD and surgical sterilization are very effective contraceptive methods, with an effectiveness of 97 to 100%, but they offer no protection against STDs. Some studies have suggested that these methods could predispose a user to HIV infection, and FHI and other organizations are attempting to answer a number of questions concerning the use of these methods and STD/HIV. Natural family planning methods, with the exception of abstinence, do not protect against STD/HIV.

Clients who choose sterilization, a hormonal method, or a natural method, and who are at risk of STD, should also use a barrier method to prevent infection. The double method requires very strong motivation by the client and her partner, and therefore requires good counseling. The double method approach presents an increase in cost, however, which is difficult for many FP services and clients to meet. There may also be repercussions for clients who suddenly ask their spouse or partner to use a condom. Counseling of the couple, whether together or separately, must be encouraged in situations where a risk of STD/HIV infection is present.

The Necessary Contribution of Donor Agencies to the Integration of Health and Family Planning Services

Presenter: Souleymane Barry

There are real possibilities to integrate (1) child survival and STD/AIDS prevention services and (2) family planning and STD/AIDS prevention services. However, donor agencies have an important role to play. The first priority consists of establishing real lines of communication between donors and the different health programs. Donor agencies face challenges to their integration efforts. However, the experience in Ghana shows the interest and efforts by USAID, for example, to facilitate program integration

through direct financial support for the promotion of FP and the fight against AIDS. In effect, at the country level and in Ghana in particular, USAID decided to eliminate parallel mechanisms to finance programs, while simultaneously making future funding contingent upon attainment of expected results by the government. In the opinion of this presenter, it is necessary that USAID redefine its central funding mechanism for its cooperating agencies in order to eliminate duplicative efforts and to facilitate as much as possible program and service integration.

STD/AIDS and RH/FP Programs: Integration Problems

Presenter: Jean Gabriel Ouango

The frightful expansion of AIDS in the world, and especially in Africa, has required emergency measures, including the establishment of the Global Programme on AIDS, establishment of national AIDS committees and the elaboration of vertical programs. The objective of these programs was to act quickly to stop propagation of the virus. Financial, material, and human resources were provided to countries. A public health priority in most African countries, the fight against AIDS was organized independently in each country, and the responsible agencies were integrated into the organizational structure of health ministries as units specifically designated to perform specific tasks.

In African countries, the specialized nature of health ministry directorates creates problems in the integration of their activities. Thus, the AIDS/STD and RH/FP programs are implemented in parallel, often resulting in conflicting messages to the same target populations. Donor agencies favor this vertical structure because of their tendency to finance specific agencies for specific results. To solve this problem, it would be desirable that coordination and management committees be placed in the health organizational structure to:

- Identify activities of the two programs whose implementation could be realized in an integrated manner (e.g., condom promotion, IEC, personnel training based on an integrated module)
- Maximize the impact of educational messages to change behavior by eliminating competing and contradictory messages

- Manage human, material, and financial resources provided to these integrated projects.

Integration of Family Planning Services with Post-Abortion Care

Presenter: Christiane Welffens-Ekra

The post-abortion period is a delicate time for women and generally represents an unmet need in family planning services. The integration of these services is not simple and requires that service providers listen attentively to clients, who are often the objects of scorn and may be depressed. Integration of services should be accomplished by adapting current services to suit the needs of these women. This would require:

- The identification of specific groups' needs (e.g., women seropositive for HIV)
- Improvement in the attitude of providers towards clients and updating their knowledge of post-abortion contraceptive methods and the needs of post-abortion clients
- Elimination of institutional and administrative barriers
- Improvement in the quality of services in post-abortion follow-up, to fill the gaps in the links between FP and abortion services, and to avoid the risk of recidivism and complications.

Communication Strategies to Maximize Service Access and Quality

Presenter: Claudia Vondrasek

The importance of communication in the success of reproductive health programs has become increasingly more evident. Communication helps improve the quality of services and helps increase the acceptability and adoption of family planning and other reproductive health services. It serves to inform, motivate and persuade the population to improve its reproductive health.

Efforts at improving service access and quality, inside or outside the clinics, must begin with targeting the groups we wish to reach. The results of baseline studies help us decide who these groups are.

Communication strategies begin with the mass media, which include television, radio, movies, and newspapers. Mass media can exert a major influence on access: according to the glossary distributed to the participants of this conference, cognitive access, psycho-social access, and even cultural access are all components of service access. Mass media are able to inform a large number of people and to motivate them to action.

A second communication strategy consists of community participation, in which satisfied clients and service providers go into communities lacking health centers or FP services to promote RH/FP. In one particular region in Egypt, the regional rate of contraceptive prevalence was increased by 8%. This was accomplished through a community participation project, which included consciousness raising among staff of regional institutions (FPAs, the religious centers, Ministry of Health agencies, etc.), training of religious leaders to hold meetings to discuss Islam's support of FP, and training of service providers in interpersonal communications.

Lobbying influential persons is the third strategy. It encourages leaders' involvement in promoting a program. If we can enlist the cooperation of the village chiefs, the marabouts, or even a country's First Lady, half of the battle of reaching the rest of the population is won.

The next communication strategy is designated as Service Providers Promotion (SPP). This approach consists of six steps: identify the main service providers, improve their clinical techniques through training, improve their interpersonal communication and counseling skills, use IEC materials (brochures, posters, videos, cassettes), promote and improve the public image of providers through mass media, and recruit and train advocates for RH/FP services. In Ghana, this strategy was responsible for increasing the CYP (couple-year protection) by 90% in three regions.

The fifth strategy focuses on the interaction between client and service provider — the verbal and non-verbal exchange between client and provider, which is the key to improving service quality. IEC materials can provide both providers and clients with reliable information that clients can take home for further study (with their sexual partners). The IEC materials help the provider ensure that all necessary information is communicated to the client.

The last communication strategy is counseling. The BERCER technique is used in counseling training. Several studies have shown the importance of counseling training. It is credited with increasing the number of clients who make their follow-up visits and with increasing method continuation rates.

All these communication strategies have a synergistic effect. The combination of all or several of these strategies guarantees that the target population will receive the information and motivation to adopt behaviors and use services that promote better reproductive health.

RH/FP Counseling

Presenters: Cynthia Steele Verme and Justine Belem

The word "counseling" is difficult to define. Four key elements help define it:

- It is two-way communication (the client and the service provider both talk).
- It is sensitive to the needs and values of each individual.
- It helps clients make choices concerning reproductive health.
- It enables clients to use methods and services confidently.

Reproductive health counseling and giving medical advice are two different things. Medicine is specialized, while reproductive health (RH) entails a comprehensive view of the client. Medicine addresses physiological problems, while RH deals with the way we see ourselves, our identity. Nearly everything related to RH has not only medical consequences, but also personal and social consequences. Counseling not only facilitates the exchange of information, but it also addresses clients' concerns and feelings, which play an important part in a client's decision making process.

Given the fact that counseling and giving medical advice are not the same thing, service providers must apply different skills. For instance, medical terminology that the client does not understand should not be used. The service provider may have to "unlearn" some of the skills that he or she was taught. For instance, physicians receive training in curative medicine. They diagnose and treat diseases, and for each disease there exists a recommended treatment. However, most RH

clients are in good health, and there are no medical reasons for recommending one contraceptive over another. The choice and preference are the client's prerogative, not the physician's.

[At this point, the presenters engaged in role-plays to show the difference between good counseling and bad counseling.]

The four major keys to improving counseling are as follows:

1. Inform the client of side-effects. This will help her choose acceptable methods, manage side-effects, recognize complications and know what to do. Switching methods is perfectly acceptable if the client cannot tolerate side effects of the method currently used.

2. Improve two-way communication. Dialogue is one of the major principles of counseling, but in practice only the service provider's voice is heard. A general rule to improving interpersonal relations is to do less talking and more listening.

3. Recognize individual preferences and needs before overwhelming the client with information.

4. Include a tactful discussion of sexuality during counseling. Sexuality is at the heart of RH and is central to clients' decisions and satisfaction. The issue is even more important when counseling men and young people.

Recommendations for counseling training are:

- Train several providers and include supervisors
- Allow plenty of time
- Focus on strengthening weaknesses (mentioned above).

To support the program, we need to:

- Promote policies that ensure informed choices
- Make available a variety of contraceptive options and services
- Support additional educational activities.

It is also important to adapt counseling to local needs through appropriate methods:

- Develop a glossary of local expressions for medical terms
- Address women's and men's perspectives
- Use tact when discussing sexuality.

Optional Session Presentation Summaries

Social Marketing Techniques

Presenter: Carol Squire-Diomandé

Population Services International (PSI) is a non-profit international organization. PSI is the largest social marketing organization in the world, currently acting in 28 countries of Africa, in Asia and Latin America, and specializes in the context of family planning, AIDS prevention, and child survival.

Social marketing uses commercial marketing techniques to encourage the population to adopt changes of behavior that benefit its health: use of modern contraceptive methods, the use of condoms or a reduction in the number of sexual partners, and the administration of oral rehydration solutions to children with diarrhea.

These techniques are summarized by "the seven P's" of a social marketing plan. It is important to note that in each case, seven elements should be studied, tested, and evaluated for each country. In addition, each step and element should strengthen the message and image of the "product," which is the new behavior desired by the sensitization campaign.

1. Product: The solution to the problem experienced by the target population. What is the image that is to be given to family planning? We have to choose the methods and services to be offered, the brand name, packaging, logo, etc.

2. Price: The purchase price for the consumer is not only financial. We must also consider time, effort, and the potential psychological strain and reduce these as much as possible.

3. Placement: The product must be accessible to everyone. Which distribution system can ensure large coverage at the least cost? If related to service-delivery points, these should respond to clients' needs and not those of suppliers.

4. Promotion: We must establish consumer demand but also motivate decision-makers and intermediaries (the distributors and product retailers), journalists and health personnel. Which combination of mass media communication, selective communication, interpersonal communication should be chosen?

5. Personnel: Everyone associated with the product or services should strengthen the campaign image.

6. Presentation: The physical presentation of the product at distribution points should, above all, strengthen the campaign image.

7. Process: The process to acquire the product or service should be as simple as possible.

Barriers to the Use of FP Services from the Perspective of Women in the Dakar Region

Presenters: Penda N'Diaye and Christine Naré

The results of the 1993 Demographic and Health Survey (DHS) in Senegal revealed the presence of FP barriers and the need to develop further studies to obtain data on the non-utilization of contraceptive methods, and on the difficulties that a great number of women face when they try to obtain a method. The "Expanding Contraceptive Choice" program has therefore completed a study aimed at identifying the constraints and barriers that prevent women from becoming faithful clients of FP services.

Data were collected at semi-structured interviews, using open-ended questions, in two health centers and at home with three target groups: non-users of contraceptive methods, current users and potential users (women who have made the first steps to obtain a method but are not yet users).

The results revealed four types of barriers that prevent women from starting and continuing to use contraceptive methods:

Socio-cultural barriers: The power to make decisions on child-bearing rests with the husband, and nearly 25% of the non-users explained that they were not using contraceptive methods because their husband forbade them to do so.

The image of contraception in society at large shows that it is part and parcel of a struggle between pronatalist ideology and the concept of socially authorized sexual relations (contraception is accepted only within marriage). This notion is restrictive and encourages late initiation of contraceptive use, when a couple has already produced a large number of children or it has just about had the desired number of children. Thus, about 31% of users started to use a contraceptive method for the first time between the ages of 25-29, and 20% between the ages of 30-34. In

addition, delayed use of contraception ignores the risks of early pregnancies since "age does not matter." The eligibility criteria that must be met before use are parity and marital status.

Barriers encountered at medical centers: nearly 50% of the clients believe that they are not allowed to pose questions to service providers.

Medical barriers: the prospective client must make an average of four visits before obtaining a method because 60% of women are asked by the medical personnel to submit to laboratory exams (blood test, Pap smear) and to bring the results before they can obtain a method. For 31% of the women, this requirement is financially difficult to fulfill and results in method use being delayed, in women giving up, or having unwanted pregnancies (7%). Temporary contraceptive methods (such as condoms) aren't consistently provided or available in sufficient quantities, given the delays a woman might experience before completing the required exam or laboratory test.

Barriers related to information: in general, the women can recite the names of the methods but not their advantages, disadvantages, or side effects. Their knowledge is not only limited but is above all incorrect, stemming as it does from rumors because such information comes from town (the principal source of information) and from FP centers (conversations between clients).

These findings show that husbands play an important role in the women's use of methods. Research activities and strategies should be aimed at this target group. The women must pay several visits to the centers before obtaining a contraceptive method, and a majority of women must still submit to laboratory exams. Contraception is perceived mostly as a way to limit births. Other advantages are either unknown or misunderstood. More complete information could help create a better image of contraception and lead to contraceptive practice among young mothers.

How to Use Situational Analysis Results

Presenter: Placide Tapsoba

A situational analysis (SA) serves to identify the weaknesses and strengths of a FP/RH program. It includes a review of the time program components take to provide quality service, and the quality of the care received by clients. This is done by sampling service management measures.

Context of four SA studies: This summary covers a study conducted in four countries which used the same method to maximize utilization of SA results: Burkina Faso (1991), Madagascar (1993), Benin (1994) and Senegal (1994).

What does "utilization of results" mean?: The utilization of results constitutes the objective of all operations research. The results obtained are applied to measures aimed at program improvement.

Application and utilization of SA results in FP programs: These two factors apply to logistics in contraceptive distribution, equipment, personnel, their training and experience, supervision, management, IEC, file keeping and archive maintenance, as well as other aspects of service quality.

Utilization of SA results, preparations for more efficient pre- and post-research utilization of results: The researcher must plan distribution and utilization of results during each phase of the project. He or she must work hand in hand with the first users to develop a research protocol and its implementation. Data collection instruments are subject to change, due to the incorporation of users' comments based on what they expect from the study. To ensure good coordination, a scientific committee involved in SA follow-up is set up and activity reports are prepared at regular intervals.

After the research: A workshop on preliminary results is organized. The operational objectives of the workshop are to encourage utilization, include the discussion of preliminary results, formulate recommendations, develop action plans to implement recommendations, establish a follow-up committee and a schedule and plan for the distribution of results. The Burkina Faso workshop serves as an example of who to invite: directorates of the Ministry of Health, national and regional health services, national and international organizations (USAID, UNFPA, GTZ), the University of Ouagadougou (Schools of Science, Health and Sociology), and research institutions (ORSTOM, CNRST, INSD).

Post-meeting action: Research institution personnel must be encouraged to use the SA data base and should be assisted in implementing recommendations. In addition, users must be helped to develop an intervention program. It is also necessary to build upon users' enthusiasm and distribute results widely.

SA result distribution: The researcher must plan the dissemination of results as soon as the study is under way. This should be done through round-table discussions, seminars, work and information sessions with users and publishers.

Why research results are not always utilized: The individuals who develop and implement the study are not the ones who will use the results. In addition, researchers view their study as completed once the final report is submitted and distributed. It is clear that users do not know how to make use of research reports and are not always associated with the various critical phases of the project.

How to Use the EASEVAL Program to Analyze Demographic and Health Survey Data

Presenter: Don Dickerson

Demographic and Health Surveys (DHS) provide a wealth of information about population and family planning for a large number of developing countries. Most people in the population field read and use the final reports that are produced for each survey. However, each survey contains much more information than is described in the final report. The data sets contain many additional questions. The number of different views of DHS data that are potentially interesting is far too great to include in the final report. Fortunately, most DHS sets are available for further study. However, to access these data sets the researcher needs to use a sophisticated statistical analysis program, typically either ISSA or SPSS. The data sets can be difficult to use, even for someone familiar with these statistical programs. As a result many people who could benefit from further exploration of these data do not have the opportunity to do so.

EASEVAL (Easy Analysis of Survey data for Evaluation) is a computer program designed to provide easy access to DHS data sets to anyone with a computer. The program uses a user-friendly menu system that allows the user to investigate DHS data sets beyond the information available in the final reports. For example, to produce frequencies or cross-tabs, the user simply selects "Frequency" or "Cross-tab" from an EASEVAL menu, then selects the desired variables from a list presented on the screen. The program carries out the necessary procedures and displays the results on the screen or printer as tables or graphs. EASEVAL also includes procedures to calculate

special indicators simply by selecting them from a menu. These indicators include fertility rates, unmet need, parity-based birth rates, etc. EASEVAL can also be used to select subsets of the data file, such as adolescents, for detailed analysis. New variables can be defined by the user and included in the analyses.

EASEVAL works with any standard recode file for DHS data. EASEVAL is primarily a user-friendly interface that guides the user through the process of selecting analyses and variables and displays the results. Data manipulation is actually conducted by a subset of ISSA (Integrated System for Survey Analysis), a program developed by Macro International under the DHS project.

EASEVAL has been developed under The EVALUATION Project (Evaluating Family Planning Program Impact). This project is funded by USAID's Office of Population. The project is implemented by the Carolina Population Center of the University of North Carolina and its subcontractors, The Futures Group International and Tulane University.

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For technical support contact the EASEVAL hotline by facsimile (203) 657-9701, internet RMCKINNON-TFGI@CGNET.COM or telephone (203) 633-3501.

Presentation of Videos on Breastfeeding, FP and LAM

Presenter: Kristin Cooney

Three video-cassettes were shown:

"Breastfeeding: Preserving a Natural Resource"

This 15-minute video shows that breastfeeding is a natural resource that can help attain FP and health objectives. The video illustrates the many benefits of breastfeeding as well as the advantage of promoting programs that support it.

"Breastfeeding, Family Planning and the Lactational Amenorrhea Method (LAM): Directions"

This 15-minute video is designed to help train FP/RH service providers. It teaches how to encourage and support breastfeeding, family planning, and LAM. For the mother who breastfeeds, LAM is a contraceptive method that is safe, reliable and affordable for a period of up to six months after delivery. Benefits of LAM and the eligibility criteria for this method are clearly explained.

"Breastfeeding and Family Planning: Common Goals, Crucial Decisions"

This 8-minute video illustrates how breastfeeding and FP work hand in hand to better manage the family's health. In the context of FP, breastfeeding's benefits to the individual as well as to society as a whole are clearly shown. How breastfeeding and FP complement each other is discussed, as is the concept of LAM.

Each video-cassette and the brochure that accompanies it can be obtained from the Institute for Reproductive Health, Georgetown University Medical Center, 2115 Wisconsin Avenue, NW, Suite 602, Washington, DC 20007, USA.

The Institute of Reproductive Health, established in 1985 at the medical center of Georgetown University, is attached to the Department of Obstetrics and Gynecology. The Institute is sponsored primarily by USAID and is a non-profit, non-sectarian and non-governmental organization. It is divided into two separate divisions: Breastfeeding and Maternal-Child Health (MCH), and Fertility Awareness and Natural Family Planning.

The Breastfeeding and MCH branch encourages optimal breastfeeding, as a way to protect the health of mother and child. It also tries to introduce in a timely manner family planning methods that do not jeopardize breastfeeding. LAM, a method that serves as an introduction to other family planning methods, is an important element of this effort. This method complements other family planning and child survival programs. In collaboration with MCH, FP and child survival programs, as well as with community support groups, the objective of this division is to improve breastfeeding methods and the support given to women who choose to breastfeed. The division supports programs and projects on breastfeeding and fertility: breastfeeding and maternal-child health and other related subjects, research, training, policy change, training-materials development, and technical assistance. The division was recognized in 1991 as the first WHO Collaborating Center on breastfeeding.

Two Videos Showing Two Communication Strategies to Address the MAQ Principle

Presenter: Claudia Vondrasek

Two videos were shown regarding two different strategies to improve the access and quality of FP/RH services:

“Competent Women, Attentive Men: Inspiring Images”

This video’s objectives are to:

- Promote changes in the conception of the different roles and characteristics traditionally assigned to men and women
- Encourage the media to promote FP/RH.

This video, developed for the ICPD, describes the role of the media in promoting the images of skilled, competent, educated, qualified women, and of men who support these women and share responsibility for RH. The video is 17 minutes long.

“BERCER: Video on FP Counseling”

This video’s objective is to provide a tool for training FP service providers in counseling.

This video was developed by the National Family Planning Council of Zimbabwe, with the help of JHU/PCS, and presents six suggested steps for improving the quality of counseling offered to FP clients. These steps are designated under the [French] acronym of BERCER, which stands for “welcome, questions during the session, FP information, choice of FP method, explain the chosen method and schedule the client’s return.” This video is 19 minutes long.

The two videos can be obtained from Population Communication Services, Johns Hopkins University, Baltimore, MD, USA.

Population Communication Services (PCS) extends technical and financial assistance to IEC projects to promote family planning and reproductive health in more than 60 developing countries. PCS was established in 1982 under the sponsorship of USAID. PCS particularly values studies of the public, pre-tests, the use of creative communication by professionals, and regularly performed follow-up and evaluations to link communication activities to service delivery. PCS has pioneered the combined use of entertainment and education to promote health and social messages. In addition, PCS personnel assess communication needs, plan national communication strategies, produce radio and television programs, publish printed and traditional materials, and conduct workshops. PCS also provides training in the areas of project planning, materials development, interpersonal communication and program administration. PCS has published over 10,000 articles and prepares information packages for professionals all over the world.

Introduction to Action Plans

Country delegations' preparation of action plans to increase the accessibility and improve the quality of family planning was a key feature of the conference. During conference planning stages, the Africa-based Technical Committee, the U.S. Coordination Committee and USAID/Washington agreed that the action plans would be the vehicle for implementing recommendations and assessing the conference's impact on national reproductive health and family planning programs.

To facilitate the preparation of the action plans, the Africa-based Technical Committee developed an action-plan format and a country-profile questionnaire to elicit information on the status of family planning and reproductive health in each participating country. Both documents were sent to each delegate prior to the conference. Members of the technical committee provided assistance to the country delegations in completing the questionnaire and, in some cases, preparation of a first draft of the action plans before arriving in Ouagadougou. Responses to the country profile questionnaire provided baseline information on the status of reproductive health and family planning. Whenever possible, pre-conference preparation of delegates and of action plans was coordinated with local authorities to ensure their adherence to the proposed activities.

During the conference, a member of the Africa-based Technical Committee served as a resource person for each delegation to help synthesize the conference presentations, to facilitate discussion during development of the plan, and to assist in use of the action plan format

provided to delegations. Delegations met each day to discuss and, when desired, to incorporate salient portions of the day's plenary sessions into their plans.

In general, the action plans developed reflect delegates' commitment to MAQ. The plans also reflect the multidisciplinary and multisectoral composition of delegations. At the end of the conference, many delegates stated that the preparation of the plans allowed them to appreciate the importance of involving all sectors in reproductive health and family planning programs.

Delegations recommended that the action plans developed at the conference be considered drafts to be finalized upon their return home when additional input is provided by colleagues and partners.

The draft action plans presented in this section also served as a starting point for discussions among country delegations, international donor agencies, USAID missions, and cooperating agencies to identify potential areas of future collaboration.

BENIN ACTION PLAN
(Overview not submitted)

PROBLEM I : Inadequate service provider performance

FACTORS/ PRIMARY CAUSES	OBJECTIVES	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	POSSIBLE PARTNERS
1. % providers untrained in FP	Develop a basic FP curriculum for nurse's aides	Existence of a curriculum for auxiliary health workers	With in-country trainers and technical assistance	DSF	USAID UNFPA UNICEF World Bank WHO
2. Significant % providers untrained in IEC	Train and retrain qualified personnel (2,3,4,5)	Number of personnel trained	"		
3. Significant % providers lacking hands-on training	Assure hands-on training-of-trainers for trainers and instructors	Number of personnel retrained	Decentralize with technical assistance		
4. Unsuitable training facilities in departments	Improve equipment at training facilities (4,9)	Existence of at least one adequate training facility for each department	"		

DSF: Directorate of Family Health

PROBLEM I (CONTINUED)

FACTORS/ PRIMARY CAUSES	OBJECTIVES	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	POSSIBLE PARTNERS
<p>5. Inadequate performance of trainers and instructors</p> <p>6. Unsuitable training of trainers and instructors</p> <p>7. Insufficient supervision according to the qualitative and quantitative plan</p> <p>8. Absence of service protocols</p> <p>9. Lack of equipment</p>	<p>Assure adequate training of trainers and instructors</p> <p>Develop a supervision techniques guide and instrument</p> <p>Elaborate and disseminate the protocols</p> <p>Identify the needs: conduct detailed inventory of equipment</p>	<p>% of sites equipped according to established standards</p> <p>"</p> <p>Existence of the supervision guide to disseminate</p> <p>RH/FP protocols to develop and disseminate</p> <p>Established inventory and identification of equipment needs in all sites</p>	<p>According to established objectives and priorities</p> <p>With in-country trainers and technical assistance</p> <p>With in-country trainers and technical assistance</p> <p>Workshops for trainers and service providers</p> <p>Use of needs assessment forms</p>	<p>DSF</p>	<p>USAID UNFPA UNICEF World Bank WHO</p>

PROBLEM II : Lack of qualified personnel

FACTORS	OBJECTIVES	INDICATORS	STRATEGY	RESPONSIBILITY
1. Hiring freeze	Determine human resource needs according to the established standards	Needs assessed (A)	Involvement of the national assembly	DSF and DSAF
2. Voluntary resignations			<ul style="list-style-type: none"> - Donor agencies - Ministry of Planning - Ministry of Finance - PAS Supervisory Committee (1)(2)(3) 	"
3. Departure due to retirement and death	Search for funding sources for identified positions (1)(2)(3)	Financial needs identified and met (B)		"
4. Structuring of RH/FP training in the faculty and in the training schools	Integration of RH/FP modules into curricula	Completed curriculum FAC INMES INIAB	Dialogue between <ul style="list-style-type: none"> - Ministry of Health and the Ministry of National Education -heads of schools, faculties and DSF 	
	Assure implementation of a pilot social marketing/CBD project	Social marketing/CBD project developed (B) Project implemented	Development of social marketing/CBD project with participants from private and public sectors	"

PROBLEM III: Deficiency of IEC services offered compared to demand

FACTORS/ PRIMARY CAUSES	OBJECTIVES	INDICATOR	STRATEGY	RESPONSIBILITY	DONOR AGENCY
<p>Involvement of decision makers still insufficient</p> <p>Level of target population's knowledge still limited</p> <p>Ineffective IEC intervention</p> <p>Persistence of limiting socio-cultural factors</p> <p>Outdated legislative law</p>	<p>Revitalize the national unit</p> <p>Develop and implement the RH/FP IEC program</p> <p>Assure follow-up of project to amend the law through legislative process</p>	<p>- Functional RH/FP IEC technical committee (A)</p> <p>- RH/FP IEC program timetable (A)</p> <p>- Amendment of the 1920 law introduced (B)</p>	<p>Establishment of a RH/FP IEC national committee consisting of 9 members</p>	<p>DSF</p>	<p>UNFPA</p>

BURKINA FASO ACTION PLAN OVERVIEW

GOAL

Elaborate strategies to improve the accessibility and the quality of reproductive health and family planning services in Burkina Faso.

Propose a package of activities that can serve as a guide to improve the accessibility and the quality of reproductive health and family planning services in Burkina Faso.

THE BURKINA CONTEXT

1. Burkina Faso's Socio-health Profile

A - Demographic data:

- Total population: 10,465,823 (1995 INSD projection)
- Population's annual rate of increase: 2.68% (INSD 1992)
- Women of child-bearing age: 2,302,308 (1995 INSD projection)

B - Health data:

- Maternal mortality rate: 592 per 100,000 live births (INSD 1991)
- Contraceptive prevalence rate (total): 23% INSD (ED 1991)
- Total fertility rate: 6.9 children per woman
- Number of health centers in the country: 931 (DEP 1994)
- Number of health centers offering RH/FP services: >300 in 1994 (DSF)

2. RH/FP Problems

- Political component: much room for improvement
- Institutional component: cumbersome administrative structure
- Socio-cultural and economic components: socio-cultural obstacles and low household economic power
- Coordination component: the mechanisms that coordinate RH/FP projects must be re-examined.
- Operational component: Must take into account the needs of communities.
- Others: Legal aspects of RH/FP must be re-examined.

OUTLINE OF THE ACTION PLAN

1. PRIORITY PROBLEMS

2. OBJECTIVES

3. INDICATORS

4. STRATEGIES/ACTIONS

IDENTIFICATION OF PROBLEMS

1. IN THE LAW

The law does not permit minors (younger than 17) to use reproductive health services; this law does not correspond to the real needs of youth.

Desired change: modify the law (Create specialized jurisdictions for youth with accompanying legal measures)

2. CONTRACEPTIVE TECHNOLOGY

LAM/NFP: methods to promote further.

- WHO eligibility criteria: still poorly understood in their practical application; must wait for other explanatory documents for a better comprehension.
- Hormonal methods, IUDs, permanent methods, barrier methods: improve follow-up, supervision, and management of side effects.
- Emergency contraception.
- Management of contraceptive supplies.
- Miscomprehension and non-application of national standards.

3. POST-ABORTION CARE

Problem: Post-abortion services are not integrated into FP services.

- Inadequate care, case management, counseling.
- Insufficient provider training.

Solution: Expand reproductive health services according to the Cairo conference action plan. Organize post-abortion services and provide necessary equipment.

4. STDs/AIDS

- Principal problem: Integration with family planning and integration into the system to reinvigorate primary health care.
- Functioning of blood banks and quality control at the CMA laboratories.
- Harmonizing/coordinating communication messages and media.
- Insufficient psycho-social services and equipment.

5. TRADITIONAL PRACTICES HARMFUL TO MOTHERS AND CHILDREN

- IEC campaign.

6. ROLES AND RESPONSIBILITIES OF MEN AND WOMEN IN RH/FP

- Weak decision-making power of women.
- Difficulties in involving men.
- Insufficient application of socio-anthropological research results concerning RH/FP.

7. NEW RH/FP CONCEPTS

- Require additional resources.
- Should be specified in the operational plan.

PRIORITY PROBLEMS

1. Misunderstanding and/or non-application of RH/FP policies, standards, and service protocols at various provider levels
2. Inappropriate case management of complicated abortions.
3. Misunderstanding of socio-cultural foundation of traditional practices harmful to the health of mothers and children.

BURKINA FASO ACTION PLAN

PROBLEM: Misunderstanding and lack of implementation of RH/FP policies, standards and service protocols at different levels

FACTORS/ CAUSES	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	POSSIBLE PARTNERS	CALENDAR (including evaluation activities)
<p>1. No implementation of distribution plan: - leaders - training - dissemination of documents</p> <p>2. No updating of documents</p>	<p>SHORT TERM:</p> <p>Create a supervisory technical committee</p> <p>Ensure the dissemination of documents</p>	<p>Existence of the text creating the supervisory technical committee</p> <p>Existence of at least one agent per service delivery point trained in the use of the documents</p>	<p>Identification of the technical committee members</p> <p>Proposals of the text creating the committee</p> <p>Organization of awareness seminars for leaders</p> <p>Training of service providers in use of the documents</p>	<p>DSF</p> <p>DSF</p> <p>MS NGOs Private sector</p>	<p>INTRAH NGOs</p> <p>MS</p> <p>INTRAH PCS</p> <p>Health districts UNFPA GTZ</p>	<p>July 1995</p> <p>August 1995</p> <p>September 1995</p> <p>October 1995 - March 1996</p>
	<p>MEDIUM AND LONG TERM:</p> <p>Periodically update documents</p> <p>Evaluate the application of these documents</p>	<p>Documents are revised at least one time during the duration of the plan</p> <p>Existence of an evaluation report</p>	<p>Organization of a workshop to revise the documents</p> <p>Mid-term and final evaluation of the application of the documents</p>	<p>DSF</p> <p>DSF INTRAH</p>	<p>INTRAH</p> <p>INTRAH Health districts</p>	<p>July 1997</p> <p>December 1996 July 1998</p>

PROBLEM: Inappropriate management of complications arising from abortion

FACTORS/ CAUSES	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
<p>1. Insufficient training of health professionals in care and counseling techniques</p> <p>2. Lack of appropriate equipment and facilities</p> <p>3. Ignorance of risks linked to abortion</p>	<p>Intensify IEC on abortion at all levels</p> <p>Provide health facilities with appropriate equipment</p> <p>Train personnel in counseling</p>	<p>At least one health agent trained in counseling at each health care center providing post-abortion services</p> <p>% of persons asked who know the risks of abortion</p> <p>% of persons using post-abortion services</p> <p>Number of deaths per abortion</p>	<p>Training of health professionals in IEC/counseling</p> <p>Increase public awareness and support for post-abortion services</p> <p>Provide service delivery centers with appropriate equipment</p> <p>Emergency treatment and provision of counseling and FP services</p>	<p>DSF/CHN</p> <p>DSF</p> <p>CHN</p> <p>CHN</p>	<p>CN IEC/Health</p> <p>CN IEC/Health CNLS PCS</p> <p>Population Council FHI Rockefeller Foundation UNFPA GTZ</p> <p>DSF FHI Rockefeller Foundation</p>	<p>September - December 1995</p> <p>July '95 - July '98</p> <p>January - June 1996</p> <p>Continual</p>

PROBLEM: Persistence of practices harmful to the health of women and children

FACTORS/ CAUSES	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTION	RESPONSIBILITY	POSSIBLE PARTNERS	CALENDAR (including evaluation activities)
<p>1. Ignorance of the sociocultural foundation of harmful practices:</p> <ul style="list-style-type: none"> - Insufficient exploitation of existing sociocultural data - Lack of coordination of research <p>3. Failure to adapt current IEC strategies to fight against these practices</p>	<p>SHORT/MEDIUM TERM</p> <p>Improve the level of knowledge about the sociocultural foundation of harmful practices</p> <p>MEDIUM/LONG TERM</p> <p>Reduce the importance of harmful practices</p>	<p>The sociocultural foundations of harmful practices are recognized by key actors</p> <p>Existence of culturally acceptable messages</p> <p>% of women victims of harmful practices</p>	<p>Adapt the content of IEC messages to the sociocultural context</p> <p>Conduct/exploit socio-anthropological research on harmful practices</p> <p>Adapt strategies to fight against harmful practices</p>			

CAMEROON ACTION PLAN
(Overview not submitted)

PROBLEMS: Men are not really involved in FP activities

PRINCIPAL OBJECTIVE: Motivate men to become more involved in FP activities

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
1. Exclusion of men as targets at initiation of FP programme	Get men to feel affected by FP services	Number/percentage of providers that have mastered pertinent knowledge	Provider training concerning FP service provision to men	Government	GTZ WHO PCS INTRAH SEATS USAID AVSC Intl.	During the first 3 months of the plan
	Encourage service providers to be concerned about men in the course of their FP activities	Number/percentage of competent trainees to assure FP service provision to men	Training of village teams to increase awareness of FP (opinion leaders)	NGOs: - FESAGE - CAMNAFAW - AD LUCEN		From the 4th to 7th months of the plan
			Training of mass media agents			From the 3rd to 4th months of the plan
2. Negative influence of parents and friends (want many children)	Make the community understand the obvious advantages of FP	Number of men using FP services as beneficiaries or the number accompanying their spouse	Increase awareness of men about FP activities through mass media and interpersonal communication			Beginning in the 4th month of the plan
3. Limited choice of contraceptive methods for men	Promote barrier methods and natural FP methods Promote vasectomy		Conference-debates			

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDER
<p>4. Current FP services unappealing to men</p> <p>5. Men unaware of how FP directly benefits their health</p>	<p>Reorganize FP services to make them more appealing to men</p> <p>Guarantee confidentiality of services</p> <p>Get men to grasp the importance of FP in the survival and education of their children</p> <p>Get men to understand better the positive effects of FP on the health of their wives and the management of family resources</p>	<p>% of the target audience exposed to a specific message that indicates that the message reached them</p> <p>Number of contraceptive methods known</p> <p>% of target audience that recommends practicing FP</p> <p>Number of available methods</p> <p>Suitable service delivery centers</p> <p>Quality of reception at clinics</p> <p>Duration of client's visit</p> <p>% of men with a favorable opinion of FP</p>	<p>Meeting of village teams with development committees</p> <p>IEC</p> <p>Restructuring of FP services to make them more accessible to men</p> <p>Acquisition of material for vasectomy</p> <p>Training of service providers in vasectomy techniques</p> <p>Supervisory visits to oversee implementation of plan in first 4 months</p> <p>Introduction of COPE into services</p> <p>Quarterly activity reports</p> <p>Impact evaluation</p>			<p>Beginning at 4th month of plan</p> <p>6 months after initiation of plan</p> <p>15 months after initiation of plan</p> <p>3 years (end of plan)</p>

PROBLEM: Elevated rate of early pregnancies (15% - 22%) in Cameroon

GENERAL OBJECTIVE: Reduce the current rate of early pregnancies by 30% in 3 years

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
<p>6. Absence of sex education for:</p> <ul style="list-style-type: none"> - adolescents - parents - teachers 	<p>Elaborate an educational program targeting:</p> <ul style="list-style-type: none"> - adolescents - parents - teachers 	<p>Existence of a sex education program for:</p> <ul style="list-style-type: none"> - adolescents - parents - teachers <p>List of selected schools and communities</p> <p>Legislation in favor of contraception for adolescents</p>	<p>Workshop to develop and review program and associated materials</p> <p>Print program materials</p> <p>Selection of pilot-testing zones:</p> <ul style="list-style-type: none"> - 5 high schools - 10 primary schools - 5 surrounding communities <p>Review of legislation in force concerning contraception</p>		<p>USAID SEATS FHI UNFPA PCS WHO UNICEF GTZ PSI</p>	<p>First 2 months 19th month</p> <p>3rd month</p> <p>3rd month</p> <p>First 2 months</p>

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
	<p>Introduce the FP program into the formal and non-formal educational system.</p>	<p>Number or % of trained persons mastering the objectives, content, methodology and use of materials</p> <p>Number or % of journalists who demonstrate mastering of project objectives on radio programs and the number of messages broadcast</p> <p>Inter-ministry decision to integrate program into formal and non-formal educational system</p> <p>Number or % of persons reached by training that understand correctly the information and messages given</p>	<p>Training of 3 teams composed of 25 trainers each</p> <p>Training of:</p> <ul style="list-style-type: none"> - 75 secondary-school teachers - 100 primary-school teachers - 600 parents of both sexes - 30 radio journalists (national languages + French + English) <p>Inter-ministry meeting to adopt program</p> <p>Implementation of program on the various approved levels:</p> <ul style="list-style-type: none"> - in schools - in communities 			<p>4th and 5th months</p> <p>- 5th and 6th months</p> <p>- 5th, 6th and 7th months</p> <p>- From 5th to 15th month</p> <p>- 6th month</p> <p>Beginning of 4th month</p> <p>From 5th to 36th month</p>

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
7. Inadequate use of contraceptive methods by youth	Improve the knowledge of youth concerning contraceptive methods	<p>Number of disseminated messages by type of medium</p> <p>% of target audience exposed to messages according to persons surveyed</p> <p>Number of health clubs</p> <p>Number of community women's clubs</p> <p>Number or % of youth correctly using at least one contraceptive method</p> <p>Number or % of youth that discuss correct contraceptive use with others</p>	<p>Workshop to develop, print and disseminate information materials</p> <p>Create health clubs in schools</p> <p>Organize community women's clubs</p> <p>Organize information sessions for youth on contraception: - natural - modern</p> <p>Organize information/training sessions for parents on natural and modern contraceptive methods</p>			<p>3rd and 4th months</p> <p>From 5th to 36th month</p> <p>From 5th to 36th month</p> <p>From 5th to 36th month</p>

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
8. Poor instruction of children by family	<p>Increase/improve the knowledge of families about instructing youth</p> <p>Assure impact evaluation of activities described in this action plan</p>	<p>Family harmony</p> <p>Responsible behavior of children</p> <p>Trusting relationships between parents and children</p> <p>Number or % of youth of both sexes not yet sexually active</p> <p>Number or % of youth using contraception</p> <p>% reduction of early pregnancies in intervention zones</p>	<p>Educational sessions with parents on:</p> <ul style="list-style-type: none"> - educational needs of children in the family milieu - healthy leisure activities for youth - child personality development and requirements - biological needs of children at different ages <p>Efficiency and impact evaluation:</p> <ul style="list-style-type: none"> - number or % persons reached in the year - degree of attainment of objectives - identification of strong points and weak points <p>Decide how to improve the situation</p>			<p>From 5th to 36th month</p> <p>From 18th to 36th month</p>

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	PARTNER	CALENDAR
	Assure the supervision of activities implemented under current action plan	<p>Satisfactory provision of services to persons followed</p> <p>Number of youth discussing contraception</p> <p>Provision of services to adolescents</p>	<p>Supervisory mission every 4 months to see:</p> <ul style="list-style-type: none"> - how do targeted populations use the program? - what are the difficulties encountered? - how do targeted audiences receive the messages? - Do they accept them or not? - What difficulties do they encounter? - What are the re-training needs? 			Every 4 months

COTE D'IVOIRE ACTION PLAN OVERVIEW

I. Country Profile

The Republic of Côte d'Ivoire, West Africa, covers an area of 322,500 square kilometers. According to the 1988 General Census of Population and Housing, Côte d'Ivoire had a population of 10,815,694 persons and a growth rate of 3.8%. At present, the population is estimated to be 13.2 million, with 2.9 million women of reproductive age. The overall birth rate is 209 per 1,000, the total fertility rate is 6.3 infants, and the mortality rate is about 594 deaths per 100,000.

The country has 1,284 health-care facilities, of which 72 are family planning centers (43 private centers and 29 public centers). The Côte d'Ivoire Association for Family Well-being (AIBEF) initiated family planning clinical services in 1986 and offered the first non-clinical services in 1992.

The contraceptive prevalence rate is estimated to be 3.3%. The proportion of use by method is as follows:

- Pill 50%
- Injectables 30%
- IUD 10%
- Condom 5%
- Spermicide 5%

Norplant has not yet been introduced into the FP program, and voluntary surgical contraception is illegal. The NGO "PROVIFA" promotes natural family planning methods.

A document of service policies and standards has just been adopted but has not yet been disseminated.

II. RH/FP Problems

Numerous problems influence the maximization of accessibility and quality of services. They include:

- Geographic factors

National coverage of FP services is insufficient and unequally partitioned.

- Political and legislative factors

Article 342-343 of the penal code forbids castration or sterilization. No clearly defined national population policy exists.

- Psycho-socio-cultural factors

Traditional practices harmful to reproductive health exist. The natural "pronatalist" tendency of Ivoirian society is reinforced by religious beliefs.

- Economic factors

The state budgeted 2,000,000 FCFA to family planning in 1994 and 690,000 in 1995. Household purchasing power diminished 20% from 1986 to 1990, and the current situation has been aggravated by the devaluation of the FCFA.

- Factors tied to service delivery

Client waiting time is long in the centers. Clients receive insufficient information about contraceptive methods. Shortages of contraceptive supplies occur.

- Institutional factors

Staff transfers. Poor coordination among the Ministry's health programs (STD/AIDS).

III. Priority Problems

In assigning priority to problems, we have taken into account conference themes and a three-year timetable for the action plan.

The priority problems are:

1. Insufficient family planning services
2. Insufficient IEC
3. Incongruity between the actual services provided and the services called for in the existing service guidelines.

COTE D'IVOIRE ACTION PLAN

PROBLEM 1: Insufficient number of RH/FP service delivery sites

FACTORS	OBJECTIVES	INDICATORS	ACTIONS	CALENDAR	RESPONSIBILITY	PARTNER
<p>1. Inadequate deployment of personnel trained in FP</p> <p>2. Insufficient number of personnel trained</p> <p>3. Insufficient number of RH/FP service delivery sites</p> <p>4. Insufficient supply of contraceptives</p>	<p>From now until end 1997, integrate FP into 110 centers in the country</p> <p>That is, 11 sites per health region: 1 reference center and 10 service delivery centers</p>	Number of new RH/FP centers functioning	1. Conduct FP needs assessment in health centers	Now to end 1995	DPDS or AIBEF	Min. of Constr.
		Existence of at least 1 agent trained in each service delivery site	2. Renovate the sites if necessary	Now to end 1997	DPDS or AIBEF	Min. of Constr.
		Availability of product in each center	3. Redeploy in an adequate fashion personnel already trained	Beginning of 1996 to end 1997	DPDS	Dir. of Pers. of MSPAS
			4. Organize contraceptive technology training sessions	Now to end 1995	MSPAS + AIBEF	MSPAS + AIBEF + INFAS
			5. Supply centers with equipment, material, and contraceptives	Now to end 1995	PSP + PSI + AIBEF	

PROBLEM 2: Absence of a national RH/FP IEC program

FACTORS	OBJECTIVES	INDICATORS	ACTIONS	CALENDAR	RESPONSIBILITY	PARTNER
1. Lack of collaboration among the different organizations involved	To have created by the end of 1995 a national IEC committee	Existence of a national committee	1. Identify contributors	Now to end of 1995	S/D IEC	S/D PF
			2. Organize a meeting with contributors		S/D IEC	
2. Lack of a national RH/FP IEC strategy	To have reinforced by the end of March 1997 the IEC capacity of the DPDS	Existence of IEC study data Presence of RH/FP IEC material	3. Establish the national RH/FP IEC committee	*	S/D IEC	MSPAS + AIBEF + PSI + NGO + other Minis. + Private sector
			1. Collect information about the different IEC programs	Now to end May 1995	S/D IEC	*
			2. Organize workshop to develop a national RH/FP IEC strategy	June '95 to Sept. '95	S/D IEC	*
			3. Organize national seminar to disseminate the strategy	March 1996	S/D IEC	*
			4. Conduct KAP study	Now to end March 1996	ENSEA + S/D IEC	Minis. Inter.
			5. Organize seminar to develop RH/FP messages	Now to end March 1996	IEC Committee	MSPAS + AIBEF + PSI + NGOs + Other minis. + Private sect.
			6. Produce RH/FP IEC materials	Now to end June 1996	*	
7. Distribute IEC material to potential users	Now to December 1996	*				

PROBLEM 3: Incongruity between services provided and the provisions of existing legal and regulatory texts

FACTORS	OBJECTIVES	INDICATORS	ACTIONS	CALENDAR	RESPONSIBILITY	PARTNER
<p>1. Inadequate dissemination of policy and service standards documents</p> <p>2. Lack of RH/FP service protocols</p> <p>3. No updating of service providers</p>	<p>From now through March 1997, get all service providers of the existing 72 FP centers to offer services as described in the policies, standards and protocols</p>	1. Number of personnel retrained in the 72 existing centers	1. Organize a workshop to develop RH/FP protocols	Now to end June 1996	S/D PF	MSPAS + NGOS + Training schools + CNLS
		2. Existence of RH/FP service protocols	2. Organize seminars to disseminate nationally and regionally the national guides and directives	Now to end June 1996	S/D PF	MSPAS + AIBEF
		3. Discontinuation rate	3. Organize contraceptive technology update seminars	Now to March 1997	S/D PF + AIBEF	MSPAS + AIBEF
		4. Contraceptive prevalence rate	4. Carry out regular supervision in the field	Beginning June 1996	S/D PF	MSPAS + AIBEF
			Carry out action plan follow-up activities	4 months and 10 months after initiation of activities	DPDS	Donor agencies
	Conduct an impact evaluation of the action plan	Last quarter 1997				

GUINEA ACTION PLAN OVERVIEW

COUNTRY PROFILE

Total population:	6,500,000
- Women:	51.8%
- Urban population:	26%
- Rate of increase:	2.8%
- Population doubling time:	25 years
- Infant mortality rate:	136 per 1,000 live births
- Maternal mortality rate:	660 per 100,000 live births
- Life expectancy at birth:	47 years
- Total number of primary health care centers:	445
- Number of RH/FP centers:	134 (57% of primary health care centers)
- Number of RH/FP centers in rural areas:	0
- Births occurring in health centers:	25%
- Deliveries assisted by:	
*health professional	31%
*traditional birth attendant	29%
- Women in a stable relationship who want no more children:	14%
- Men in a stable relationship who want no more children:	7%

CONTRACEPTIVE KNOWLEDGE AND USE

- % Women/men who know at least one modern method:	27/53
- % Women/men who currently use at least one modern method:	1/3

PRIORITY PROBLEMS/FACTORS

1. Inadequate provision of reproductive health services

- 1.1 Insufficient number of RH/FP service delivery sites
- 1.2 Insufficient number of trained personnel
- 1.3 Insufficient training
- 1.4 Incomplete range of contraceptive methods offered
- 1.5 Poor functioning of the contraceptive supply system
- 1.6 Failure to apply service delivery and prescription norms and guidelines

2. Inadequate level of RH/FP knowledge in population

- 2.1 Lack of harmony of RH/FP messages**
- 2.2 Absence of a national IEC strategy for RH/FP**
- 2.3 Lack of personnel trained in the elaboration of RH/FP IEC messages and materials**
- 2.4 Insufficient number of RH/FP IEC activities oriented to adolescents and men**

Problems/ Factors	Objectives	Indicators	Strategies/ Actions	Responsibility	Possible Partners	Calendar
	1.1 Introduce CBD into 50 districts of the country between now and the end of 1996	Number of districts benefitting from CBD	1. Elaboration/ approval of the plan to introduce CBD 2. Selection of villages/districts to benefit from CBD 3. Increase awareness of populations on importance of CBD 4. Selection of CBD agents 5. Training of CBD agents 6. Implementation of activities 7. Supervision/ follow-up	MS MI MI/MS Management MS MS MS	USAID AGBEF AGBEF PSI DPS NGOs AGBEF UNFPA USAID IPPF AGBEF AGBEF	End 1996

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Possible Partners	Calendar
2. Insufficient qualitative and quantitative training	2.1 Assure the training/ retraining of at least 3 service providers per center	Number of trained agents offering quality services in the CSI	Assure cascade-effect training of personnel and community agents		USAID AGBEF	End 1996
			Review RH/FP policies and service standards	MS	AGBEF PSI INTRAH UNFPA USAID INTRAH, AVSC	
			Elaborate a training plan	MS		
			Training of trainers	MS	AGBEF, INTRAH	
			Training of agents and providers	MS	UNFPA, USAID UNICEF JHPIEGO	
			Training of A.V.	MS	" "	
			Training of distribution agents	MS/MI	AGBEF PSI	
Follow-up/ supervision	MS					

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Possible Partners	Calendar
3. Incomplete range of contraceptive method options	3. Offer the complete range of RH/FP services in health centers and in hospitals	Number of available methods offered through integrated health services	Introduction of NORPLANT	MS	AVSC, USAID UNFPA, IPPF World Bank	End 1996
			Introduction of LAM to the program	MS	UNICEF USAID	
			Extension of the CCV into reference health centers	MS	AVSC USAID UNFPA	
			Introduction of post-abortion services	MS	JHPIEGO FHI IPAS	
			Creation of specialized services for adolescents	MS	MJS IPPF UNFPA USAID	

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Possible Partners	Calendar
4. Weaknesses in the RH/FP information system and service management	4.1 Improve the CSI contraceptive supply system	Availability of contraceptives in the CSI	Train managers of regional pharmacies	MS	AGBEF PSI	End 1996
	4.2 Improve data collection and analysis	Availability of baseline data at all health care system levels	Train agents in management of supplies	MS	AGBEF PSI UNFPA USAID	
	4.3 Improve the health system, supervision and evaluation of data	Quality of improved services	Regular supervision of M.E. supply management	MS	"	
	Conduct a situational analysis		MS	"		
	Harmonize methods of baseline data collection and analysis		MS	"		
	Follow-up/ Supervision			"		
	Prepare supervision guide			"		

MADAGASCAR ACTION PLAN
(Overview not submitted)

PROBLEM: The challenge for Madagascar is to extend FP services throughout the country and to make these services accessible to youth (adolescents)

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	CALENDAR	PARTNER
Lack of political support Micro-diversity of the population in the sociocultural plan	Form a group of legislators in support of the FP cause	1. Existence of a working group of legislators 2. Commitment of legislators	1. Form a working group	Manitra	Second half April '95	APPROPOP UNFPA GTZ ASSONG Ministry of Population Ministry of Culture Ministry of Health National Assembly
			2. Identify members of the social commission and other influential persons	Gilbart Chantal	April '95 - May '95	
			3. Make a list of essential documents	Zoé APPROPOP	April '95 - May '95	
			4. Make informal contact with key persons	The group	April '95 - May '95	
			5. Formal contact	The group	May '95	

FACTORS/ UNDERLYING PROBLEMS	OPERATIONAL OBJECTIVES	INDICATORS	ACTIONS	RESPONSIBILITY	CALENDAR	PARTNER
			<p>6. Conduct CTU for members of parliament's social commission</p> <p>7. Set up the parliamentary group</p> <p>8. Conduct mass media information campaigns</p>	The group	<p>End of ordinary session</p> <p>Beginning July '95</p> <p>Beginning May '95</p>	<p>RNM-RTM Center of IEC excellence Regional radio stations</p>
	<p>By the end of the year, develop an approach to provide reproductive health services to youth</p>	<p>1. Existence and use of the action plan</p> <p>2. Innovative activities in the reproductive health/FP domain targeting youth</p>	<p>1. Identify the personnel or organizational resources that can lead the process to develop approaches to provide RH services for youth</p> <p>2. Organize orientation sessions</p> <p>3. Organize field trip to Burkina to study the "Youth for youth" project</p> <p>4. Develop action plan based on data gathered</p> <p>5. Follow-up and final evaluation</p>	<p>Manitra Gil</p> <p>Group</p> <p>APPROPOP Manitra</p> <p>Group</p>	<p>July '95</p> <p>October '95</p> <p>November '95</p> <p>Beginning in December</p>	

MALI ACTION PLAN
(Overview not submitted)

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Absence of a national IEC strategy	Raise population's awareness of RH/FP	Increase the utilization rate of RH/FP centers	Recruitment of a national consultant Production of IEC material Identification of appropriate techniques and media Wide diffusion of messages	C.M.I.E.C.S.	P.S.P.H.R.	End 1996

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Under-utilization of FP by adolescents	Increase the utilization of FP by adolescents	Increase in contraceptive prevalence among adolescents	<p>KAP study of adolescents</p> <p>KAP study of parents</p> <p>Dissemination of the results of the different studies</p> <p>Development and implementation of a health project with activities targeting adolescents (information, mobilization, and provision of FP services)</p>	<p>DSFC</p> <p>DNAS</p> <p>ENMP</p> <p>CERPOD</p> <p>NGOs</p> <p>Ministry of Education</p>	<p>USAID</p> <p>UNFPA</p>	1995-1998

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Non-integration of STD services in the RH/FP program	Integrate STD services into the RH/FP program	Number of centers with integrated STD services	Development of STD projects Organization of counseling, diagnosis and treatment of STDs in the centers	DSFC NGOs	UNFPA USAID	1995-1997
Insufficient number of CBD sites	Increase the number of CBD sites	Number of CBD sites created	KAP study Educational outreach Execution of CBD and SOMARC activities Supply of contraceptives Evaluation of the contraceptive prevalence in the different sites Coordination of NGOs	DSFC NGOs Pop. Council PPM/SOMARC	USAID IPPF	1995-1998

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Deficiencies in the performance of service providers	Improve the working conditions and the performance levels of service providers	<p>Number of revised service norms</p> <p>Number of centers adopting COPE</p> <p>Number of providers trained in infection prevention</p> <p>Number of supervisory visits conducted</p>	<p>Revision of norms and procedures</p> <p>Introduction of COPE in the centers</p> <p>Training of providers in infection prevention</p> <p>Continual supervision</p>	DSFC	<p>INTRAH</p> <p>AVSC</p> <p>JHPIEGO</p> <p>PSPHR/USAID</p>	1995-1996
Absence of long-term contraceptives and permanent methods in all PF centers	Broaden the range of available methods	<p>Number of new methods introduced</p> <p>Number of centers offering the newly-introduced methods</p>	<p>Training of providers</p> <p>Provision of appropriate equipment to the centers</p> <p>Supply of contraceptives</p>	DSFC	<p>AVSC</p> <p>JHPIEGO</p> <p>USAID</p>	1995-1997

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Existence of traditional practices including genital mutilation and early marriage	Abolish genital mutilations Increase the age at first marriage	Rate of non-excised women Age at first marriage	Accelerate the introduction of the EVF and EMP in schools Raise awareness of problem among decision makers and opinion leaders	CMIECS DSF NGOs: - Association of Women - Commissariat of the Promotion of Women	USAID	Medium term
Certain sections of the marriage code limit women's access to RH/FP services	Improve women's access to RH/FP services	Utilization rate Rate of knowledge of legal provisions among women	Revision of the Mali Code Elaborate legal texts Popularize the code and other legal texts	Commissariat of the Promotion of Women Women's associations and NGOs Legal services Ministry of Justice DSFC	USAID ACDI UNFPA Netherlands	End 1997

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Lack of qualified service providers	Improve the competence of practicing paramedical personnel and those in training in Health Schools	Number of trained agents Number of retrained agents Number of schools introducing RH in their training program	Introduction of RH in curricula Organization of retraining sessions Organization of personnel training in counseling, contraceptive technology, management of contraceptives, CBD and minilap Follow-up and evaluation of agents	ENMP ESS EPIC CMDC CSTC DSFC CEFA/CAFS JSI	JHPIEGO UNFPA AVSC USAID/PSPHR	1995-1997

Priority Problems	Objectives	Indicators	Strategies/ Actions	Responsibility	Partners	Calendar
Insufficient research on excision and traditional FP methods	Improve the population's level of knowledge about the consequences of excision and on traditional FP methods	Number of studies conducted	Execution of studies Dissemination of results Educational outreach to the population Application of selected methods	DSFC ENMP Institute of traditional medicine	UNFPA WHO	1995-1996
Lack of adequate RH/FP indicators	Define appropriate indicators	List of selected indicators	Situational analysis Workshop to define indicators Dissemination of the indicator list Evaluation of the use of the indicators	DSFC CERPOD Epidemic Division PSPHRE	SARA USAID	1995-1996

NIGER ACTION PLAN
(Overview not submitted)

PROBLEM: Highly elevated maternal and infant-child mortality rates (7 per 1,000; 318 per 1,000)

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	POSSIBLE PARTNERS	CALENDAR (including evaluation activities)
1. Poor accessibility of RH/FP services	<p>Increase access to RH/FP services</p> <p>Increase contraceptive prevalence from 3.2% to 7%</p>	<p>Number of distribution centers open</p> <p>Number of CBD agents trained</p> <p>Number of leaders trained</p> <p>Meetings/sessions to increase awareness</p> <p>Number of contraceptives by method</p> <p>Number of years of couple protection</p> <p>Contraceptive prevalence by method, by sex, by socio-ethnic group</p>	<p>Community based distribution (CBD)</p> <p>Subsidize contraceptive methods</p> <p>Social marketing adapted to the social context</p> <p>Involvement of political and religious leaders in decision making</p> <p>IEC to target groups (adolescents, men, women)</p> <p>Creation of sites adapted to provision of RH/FP services</p> <p>Mobile exam and other services</p>	<p>MSF</p> <p>MDS/PF</p>	<p>CAs</p> <p>NGOs</p> <p>Communities</p>	<p>Now to end April</p> <p>Creation of a committee to finalize the implementation of the action plan developed during the conference</p> <p>Beginning May</p> <p>Initiation of activities</p> <p>1st mid-term evaluation at mid-1996</p> <p>Final evaluation end 1997</p>

PROBLEM

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	POSSIBLE PARTNERS	CALENDAR (including evaluation activities)
<p>2. Poor quality of RH/FP care in the service delivery and distribution centers</p>	<p>2.1 Improve the quality of care in public and private service delivery centers</p> <p>2.2 Increase effectiveness of service providers</p> <p>2.3 Equip the service delivery centers with appropriate materials and products</p>	<p>Number of agents trained</p> <p>Number of IEC and counseling sessions conducted</p> <p>Number of contraceptives distributed by method</p> <p>Rate and number of products used</p> <p>Guides</p> <p>Number of women with good knowledge about RH/FP</p> <p>Number of service providers capable of providing good counseling</p> <p>% service providers with good knowledge of RH/FP</p>	<p>Elaboration of RH/FP service norms and standards</p> <p>Training of service providers</p> <p>Reorganization of services through the use of COPE</p> <p>Regular follow-up, supervision and evaluation of activities</p> <p>Regular supply of service delivery points</p> <p>IEC to target groups</p> <p>Counseling</p>	<p>MDS/FP</p> <p>MSP</p> <p>(Other public institutions of similar rank)</p>	<p>CAs</p> <p>Groups</p> <p>Communities</p> <p>NGOs</p>	

PROBLEM

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTION	RESPONSIBILITY	POSSIBLE PARTNERS	CALENDAR (including evaluation activities)
<p>3. Integration of RH/FP and STD/AIDS services</p>	<p>Bring all the CIS to apply the basic package of services</p> <p>Bring communities (representative) to participate in service delivery and management activities</p> <p>Test and treat all of a FP client's infections</p> <p>Train all CSI agents in use of the basic package of services</p>	<p>PMA/center score</p> <p>Number of agents mastering the PMA</p> <p>Number of RH/FP clients with other needs</p> <p>Number of referred cases</p> <p>Number of STD/AIDS cases tested, treated and cured</p> <p>Number of IEC sessions</p> <p>Number of condoms distributed</p>	<p>Application of a national health policy, notably the PMA</p> <p>Provision of services for all cases and consultations at service delivery points</p> <p>Referral of complex cases to more competent levels</p> <p>STD/AIDS testing using the syndromic approach</p> <p>IEC</p> <p>Condom distribution</p>	<p>MDS/FP</p> <p>MSP</p> <p>M.I/RT</p>	<p>CAs</p> <p>NGOs</p> <p>Associations</p> <p>Community</p> <p>Professional groups</p>	<p>Now to end April</p> <p>Creation of a committee to finalize the implementation of the action plan developed during the conference</p> <p>Beginning May</p> <p>Initiation of activities</p> <p>1st mid-term evaluation at mid-1996</p> <p>Final evaluation end 1997</p>

SENEGAL ACTION PLAN
(Overview not submitted)

MANAGEMENT OF PREGNANCY, CHILDBIRTH, AND POST-PARTUM

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
Shortage of competent services in rural areas	Improve service coverage of rural areas	% of target at least 5 km from a center offering services and equipped with a competent staff	Integration of these activities with those of health posts and adoption of a progressive strategy	MCD and MCR	USAID UNICEF World Bank	To intensify actions already on-going in some regions
Low CPN/CPN1 achievement rate	Raise from 2% to 80% the achievement rate of CPN3/CPN1	CPN achievement rate	Reinforcement of interpersonal communication skills of personnel. - Integrate CPN in the IB at the health post level - Develop IEC	MCD and MCR	UNICEF USAID	
Lack of post-partum follow-up	Assure the follow-up of 80% of assisted deliveries	% of assisted seen in post-partum	- Integration of post-partum follow-up into MCH/FP and the PEV - Develop IEC for providers and clients	MCD and MCR	World Bank UNICEF UNFPA USAID	1995-1998

CPN: Prenatal checkup
SMI/PF: Maternal Child Health/Family Planning
PEV: Expanded Vaccination Program

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
<p>Poor testing for and management of pregnancy risk factors</p>	<p>Test and treat 50% of pregnant women at risk</p> <p>Cover 3 % of need for cesarians</p>	<p>% of pregnant women at risk who are tested and treated correctly</p> <p>% coverage of cesarians</p>	<p>Train personnel in practical aspects of pregnancy, childbirth (partogram) and post-partum management</p> <p>Testing and treatment for the most common RF</p> <p>Integration of the RH module in the basic training schools (ENDSS)</p>	<p>MCD MR DSMI</p> <p>Director of ENDSS DHSP</p>	<p>JHPIEGO SE/PF Project</p>	<p>1995-1998</p>
<p>Low rate of assisted deliveries</p>	<p>Increase to 60% the rate of assisted deliveries by 1998</p>	<p>Rate of assisted deliveries</p>	<p>IEC</p> <p>Improvement and reinforcement of traditional birth attendants' training and equipment</p> <p>Increase in the technical competence of district maternities</p>	<p>MDC and MCR</p>	<p>UNICEF USAID UNFPA NGOs</p>	<p>1995-1998</p>

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTION	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
Lack of service provider supervision	Ensure monthly supervision of all health care facilities	Number of supervisory visits conducted during the year by site	<p>Involve all the district and regional staff</p> <p>Develop supervision visit forms</p> <p>Make the supervision more practical by centering on continuing training and the effective resolution of problems</p>	MCD MCR SDMI	USAID UNFPA UNICEF World Bank	1995-1998
Elevated infant malnutrition rate and low birth weight	<p>Reduce by 50% malnutrition among children aged 0-5</p> <p>Reduce by 50% low birth weight</p>	<p>Malnutrition rate</p> <p>Low birth weight rate</p>	<p>Nutrition education and follow-up</p> <p>Struggle against malnutrition/diarrhea (IEC campaign on ORT)</p> <p>Supplementary CPN to women</p> <p>IEC</p>	SANAS MCD/MCR	USAID UNICEF NGOs	1995-1998

PRIORITY PROBLEMS	OBJECTIVES (short, medium and long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
Inadequate and insufficient IEC activities	<p>Identify and ensure the availability of appropriate IEC materials in 100% of care facilities</p> <p>Increase from 6 to 60% the care facilities that organize targeted IEC activities</p>	<p>% of facilities having appropriate IEC material</p> <p>% of facilities that conduct targeted IEC activities</p>	<p>Operations research on adapted messages and materials</p> <p>Elaborate a list of IEC material/level</p> <p>Provide all facilities with IEC materials</p> <p>Harmonize IEC messages</p> <p>Involve dissemination channels (women, youth, leaders...)</p> <p>Integration of IEC into all service activities</p> <p>Improve client reception and reinforce all interpersonal communication</p>	<p>SANFAM ASBEF EPS/Health Committee DSM/PNPF</p>	<p>USAID UNFPA PPF</p>	<p>1995-1998</p>
Insufficient management information system (MIS)	<p>Train all personnel in utilization of the MIS</p>	<p>% of personnel trained in MIS</p> <p>% of activity reports that are used</p>	<p>Hold a national workshop for cord./MCH and regional workshop for providers</p> <p>Include SIG in all basic training</p>	<p>Statistics MCD/MCR ENDSS ASBEF SANFAM</p>	<p>Donor agencies</p>	

PRIORITY PROBLEMS	OBJECTIVES (short, medium, long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
Insufficient supervision	Assure bi-monthly supervisory visits to all FP centers	% of planned visits actually made, by center	Retraining of supervisors Prepare supervision guides	DSMI/PNPF DSSP MCD/MRD ASBEF SANFAM	USAID UNICEF UNFPA World Bank	1995-1998
Low FP clients' continuation rate	Increase by 50% the continuation rate	% of women practicing an appropriate method (according to their profile) for at least 2 years	Practice the BERGER method Integrate activities in order to furnish a RH/FP service package Household follow-ups Improve service management	MCD MCR DSMI/PNPF SANFAM ASBEF Others	USAID UNICEF UNFPA World Bank	1995-1998

PRIORITY PROBLEMS	OBJECTIVES (short, medium, long term)	INDICATORS	STRATEGIES/ ACTIONS	RESPONSIBILITY	PARTNERS	CALENDAR (including evaluation activities)
Barriers connected to service provision	Offer to all women the methods of their choice according to criteria defined by the established norms	% of women who receive the method of their choice	Finalize the service norms and protocols documents Train service providers Apply the norms and protocols	DSMI/PNPF	ISED ENDSS	1995
Absence of needed RH/FP legal measures and regulations	Adopt legislative measures and regulations on RH/FP	Texts adopted	Revision of texts Improve awareness of decision makers Documentation, text research Study trips Group reflection/ elaboration of texts	MSAS-MJ-MJS MEFP-MFEF	Economic advisors NGOs/Assoc. Religious leaders	1995-1998
Insufficient integration of infertility care and STD/AIDS	Offer a basic RH/FP care package including STD/AIDS and sterility	% of centers offering the basic package	Definition of the basic package Application of the norms and protocols Training of providers IEC targeting the public	PNLS PNPF/DSMI ASBEF SANFAM	USAID World Bank WHO UNFPA	1995-1998

TOGO ACTION PLAN
(Overview not submitted)

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Organization(s) Responsible	Partner	Calendar
Incomplete RH/FP reference documents	<p>Include in the policy, standards, and protocol documents the missing RH/FP documents</p> <p>Produce a national IEC in RH/FP strategy document</p>	Number of meetings of RH/FP committee	<p>Actualization of the national MCH/FP (SR/FP) committee</p> <p>Drafting of the missing RH/FP components</p>	<p>DGS/DSF</p> <p>RH/FP committee</p>	<p>INTRAH UNICEF WHO CARE SEATS</p> <p>INTRAH WHO UNFPA SEATS CARE GTZ</p>	<p>March - December 1995</p> <p>1995 - 1997</p>
		<p>New documents available</p> <p>National commission appointed</p> <p>Collected data</p> <p>Available research results</p>	<p>Adoption of new documents</p> <p>Dissemination of the new RH/FP documents</p> <p>Implementation of a national IEC/RH commission</p> <p>Collection of all existing data on IEC/RH</p> <p>Complement these data by 3 operations research studies on adolescents, men and harmful traditional practices</p>	<p>DGS/DSF</p> <p>DSF</p> <p>DGS/DSF</p> <p>National commission</p> <p>DSF ATBEF Faculty of Medicine</p>		

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Responsible Organization(s)	Partner	Calendar
Reluctance of men concerning FP	Update the national policy document on Population	Drafted document	Preparation of the IEC/RH/FP document	National commission	UNFPA INTRAH GTZ SEATS WHO	1995 - 1997
		Adopted document	Seminar to adopt the IEC document	DGS/DSF		
		Revised document	Revision of the existing document in collaboration with the Ministry of Plan's Population Unit	MSPSN MPAT		
		Finalized document	Finalization of the document during a national seminar	MSPSN MPAT		
	Intensify the ATBEF IEC program targeting men	Adopted policy	Adoption of the document by the government	MSPSN MPAT	UNFPA IPPF CARE	May-December 1995
		Available KAP study data	KAP study on men regarding FP	ATBEF Faculty of Medicine		
		Available IEC material	Production of IEC materials targeting men	ATBEF		
		Number or % of men reached	Educational/ awareness activities for men by socio-professional category through appropriate media	ATBEF		1995 - 1998

MSPSN: Ministry of Health and National Solidarity
 MPAT: Ministry of Plan and Territorial Management

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Organization(s) Responsible	Partner	Calendar
Insufficient RH/FP services to adolescents and to youth	Pursue the implementation of IEC strategies for youth initiated by the ATBEF and Youth Associations	Number or % of youth reached by the program	KAP study to evaluate impact	ATBEF Youth Associations	INTRAH UNFPA	January 1996
			Educational outreach to youth by youth			1995 - 1998
	Introduce EMP and FLE in the formal curricula	Number of hours of FLE in the schools	Revitalization of the EMP/FLE Directorate	DSF	INTRAH UNFPA	May 1995
			Finalization of the EMP/FLE modules	DSF EMP/FLE	INTRAH UNFPA	June - Sept. 1995
	Involve parents in the FLE of their children	Number or % of parents informed about FLE.	Seminar with inspectors to adopt the modules	"		October 1995
			Elaboration of an "information for parents" strategy	DSF/ATBEF EMP/FLE	INTRAH UNFPA	Oct. - Dec.
	Provide RH/FP services adapted to youth	Operations research results available	Implementation of the strategy	"	INTRAH UNFPA SEATS	1996 - 1998
			Operations research on the RH/FP needs of youth in Togo	Faculty of Medicine DSF	INTRAH UNFPA WHO	June - Dec.

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Organization(s) Responsible	Partner	Calendar
Qualitative and quantitative insufficiency of RH/FP services offered	Improve the quality of services offered in the 190 existing RH/FP centers	Number of functioning specialized centers	Open 6 centers specialized in RH/FP for youth (1 per health region)	ATBEF/DSF	UNFPA SEATS GTZ	1996 - 1998
		Number of centers welcoming youth	Restructure the schedule of other centers to make it more amenable to youth	DSF	UNFPA SEATS GTZ	
		Number of youth accepting services				
		Number of centers using COPE	Extension of COPE in the management of all FP centers	DSF/ATBEF	SEATS UNFPA CARE	July 1995 - July 1998
		Number of centers providing RH/FP services according to the established norms	Widen the range of services offered in all centers according to established country standards		SEATS UNFPA Pop Council CARE	1995 - 1998
		Number of service providers trained or retrained	Training and retraining of personnel to increase clinical competence	DSF/ATBEF School of Basic Training	INTRAH UNFPA SEATS CARE Pop Council	1995 - 1998
		Number of functioning legal clinics	Experimental legal assistance in 3 RH/FP centers	DSF/GF2D		

GF2D: Women's Group for Democracy and Development

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Organization(s) Responsible	Partners	Calendar
	Increase from 47 % to 100 % the coverage of the state primary health units in RH/FP	Results from needs assessments available	Annual needs assessment	DSF	SEATS UNFPA CARE INTRAH	1995 - 1998
		Number of primary health care units offering RH/FP services	Progressive introduction of RH/FP services in 211 primary health care units currently lacking these services, according to the Standards	DSF/ATBEF	IPPF	
		Number of service providers trained	Training of personnel in clinical methods	DSF Training Schools	IPPF	
	Open an ATBEF RH/FP clinic in each of the 6 large urban areas of Togo	Number of ATBEF clinics opened	Needs assessment	ATBEF	IPPF	
			Opening of clinics	ATBEF	IPPF	
	Introduce CBD of contraceptives in the 3 other regions of Togo	Geographic coverage rate of contraceptives through DBC	Recruitment of VSR	ATBEF/DSF	CARE SOMARC UNFPA GTZ	1995 - 1998
			Training of VSR	"		
			Implementation of CBD of contraceptives	"		

VSR: RH Volunteer

Factors/Underlying Problems	Operational Objectives	Indicators	Actions	Organization(s) Responsible	Partner	Calendar
Weakness in the follow-up, supervision, and evaluation system	Continue the on-going development of an integrated system of primary health care /RH/FP follow-up, supervision, and evaluation	Number and regularity of follow-up visits by supervisors and evaluators	Update and production of instruments	DSSP/DSF	INTRAH UNICEF CARE GTZ	1995 - 1998
			Training of supervision/follow-up/evaluation teams	DSSP/DSF		
	Implementation of the system	DSSP/DSF				
	Revision of the MIS/RH	DSSP/DSF	UNFPA GTZ SEATS			
	Integrate CBD and social marketing in the MIS	Degree of CBD and social marketing in the MIS/RH				

DSS: Division of Health Statistics

Evaluation of Action Plan

Implementation

The real effects of the conference will be the results in the field and the extent to which MAQ activities in the country-level action plans are applied in country. JHPIEGO, INTRAH and FHI are preparing a conference follow-on plan for evaluating the country-level results of the conference, which will include several components. Among the components are a follow-up questionnaire for delegates, representatives of USAID Missions and members of the Africa-based Technical Committee (ATC) to find out:

With whom/which organizations did delegates share and discuss country-level action plans?

To what extent did country delegations receive official approval for actions from national institutions responsible for developing, implementing and managing the national FP/RH program?

Which actions have been included/integrated into national plans?

To what extent did the MAQ action plan contribute to strengthening the national MCH/RH/FP plans? What concrete examples can be cited to illustrate this contribution?

Which actions have confirmed funding?

Which actions have been implemented?

What factors have contributed to or hindered accomplishments?

To what extent are different sectors/constituencies represented in the delegations working together more effectively or more frequently than before the conference?

To what extent have the country delegations become real constituencies for advocating changes in FP/RH policies and practices?

Where are the reference materials? Who has used them and for what purposes have they been used?

Information collected via these questionnaires will be complemented by information collected via in-depth interviews with delegates, ATC members and USAID Missions representatives. Results of the questionnaires and interviews, as well as other information on accomplishments, applications of country level action plans, lessons learned, emerging priorities — all linked to the conference — will be shared and disseminated to delegates, USAID missions, Africa-based Technical Committee members, the Office of Population, cooperating agencies and international donors working in the region via a newsletter to be managed by JHPIEGO.

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Appendix 2

Newspaper Coverage of Conference

***Le Journal du Soir*, Wednesday, March 15, 1995**

Regional Conference on Reproductive Health and Family Planning

Developing National Programs

By Dramane Sessouma

The Regional Francophone Conference on the Improvement of Access and Quality of Reproductive Health and Family Planning Services in Africa is being held in Ouagadougou, from March 12 to March 17, 1995. Participants will discuss the development of national programs of action aimed at improving the health of populations.

Bucharest '74, Mexico City '84, Cairo '94 — three dates and three cities which successively hosted international conferences on population and development stand as proof positive of the importance that population issues, and particularly the health of populations, have assumed among the international community. Indeed, no development strategy can hope to succeed unless it also includes a population component. The Ouagadougou conference is a logical follow-up to the previous meetings, the Burkina Minister of Health pointed out. It reaffirms the objectives of the Lomé (Togo) meeting in July '94, and is in line with the direction taken by current maternal and child health policies of the different nations. The conference is jointly organized by FHI (Family Health International), JHPIEGO (Johns Hopkins Program for International Education in Reproductive Health) and INTRAH (Program for International Training in Health), in collaboration with the Burkina Ministry of Health and USAID. Over one hundred participants from ten African nations (Benin, Burkina Faso, Cameroon, Ivory Coast, Guinea, Madagascar, Mali, Niger, Senegal and Togo) are in attendance at the conference. About twenty cooperating agencies and international donors have sent representatives as observers.

During the opening ceremony at the Sofitel Silmandé Hotel, Mrs. Maikibi Dandobi, member of the Technical Preparatory Committee, the U.S. Ambassador to Burkina Faso, and Mr. Christophe Dabiré, Burkina's Minister of Health, stressed the timeliness and the urgency of the theme of the conference. All three recognized the need to organize viable and reliable action programs aimed at improving quality and making reproductive health and family planning services available.

Life expectancy in the countries represented at the Ouagadougou conference is still low, infant mortality continues to exceed 100 per 1,000 live births and maternal mortality rates are still too high. The conference is being held to explore possible solutions to these concerns, all of which are priority issues.

The goal of the conference is to encourage the involvement of national and regional lobbyists to promote changes in national programs, policies, procedures and methods. The conference also seeks to improve access to and quality of reproductive health and family planning for all. Recommendations forthcoming from the meeting are eagerly anticipated, in view of widespread recognition that any development policy must be coupled with sound population policy in order to succeed.

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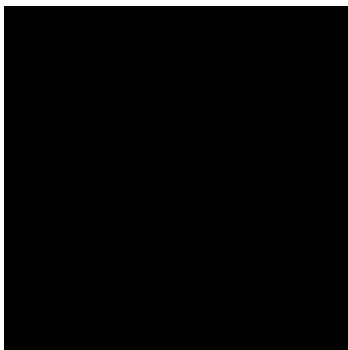
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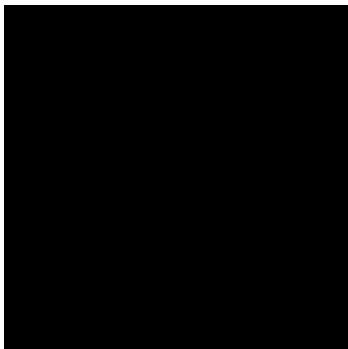
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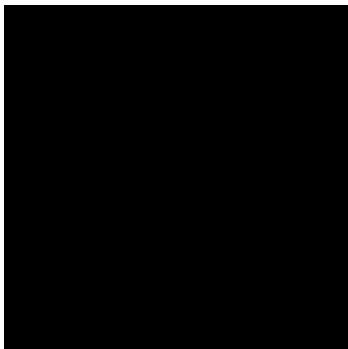
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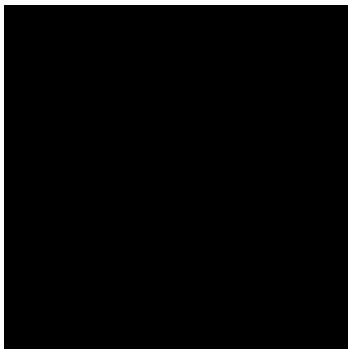
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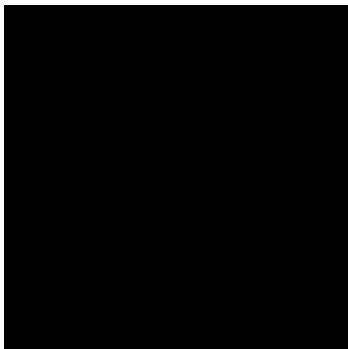




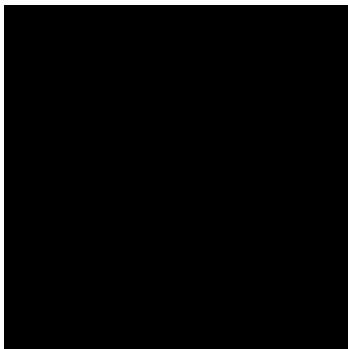


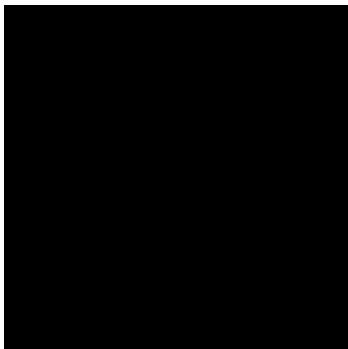












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17:15-18:00	Meeting of the delegations by country to work on action plans	
17:00-18:00	Meeting of CAs, HPNs and donor agencies and mini-evaluation of the day	
18:30-20:00	Reception at the American Ambassador's residence	

WEDNESDAY March 15	Session	Presenters/Resource Persons
8:00-8:20	Introduction and program of the day, questions and other matters	Dr. M. PINA
8:20-10:20	<p>THEME: Factors Influencing the Status of FP and RH in the Region</p> <p>Harmful Traditional Practices</p> <p><u>General Objectives of the Session:</u></p> <ol style="list-style-type: none"> 1. To identify harmful traditional practices and their impact of RH. 2. To exchange different countries' experiences with the struggle against harmful traditional practices. 3. To identify legal and social measures to reduce/eliminate these practices. <ul style="list-style-type: none"> * Introductory exposé * Traditional harmful practices in Burkina Faso * The ASDAP/CEDPA intervention in Mali * Traditional practices having harmful effects * Harmful traditional practices * The experience of struggling against harmful traditional practices 	<p><u>Moderator:</u> Mme P. SEBGO</p> <p><u>Film:</u> "Deception"</p> <p>M. P. NITIEMA Mme. M. LAMIZANA</p> <p>Mme. F. TRAORE Mme. C. KOROMA Mme. O. DJATOU Mme. F. BASSOLE</p>
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