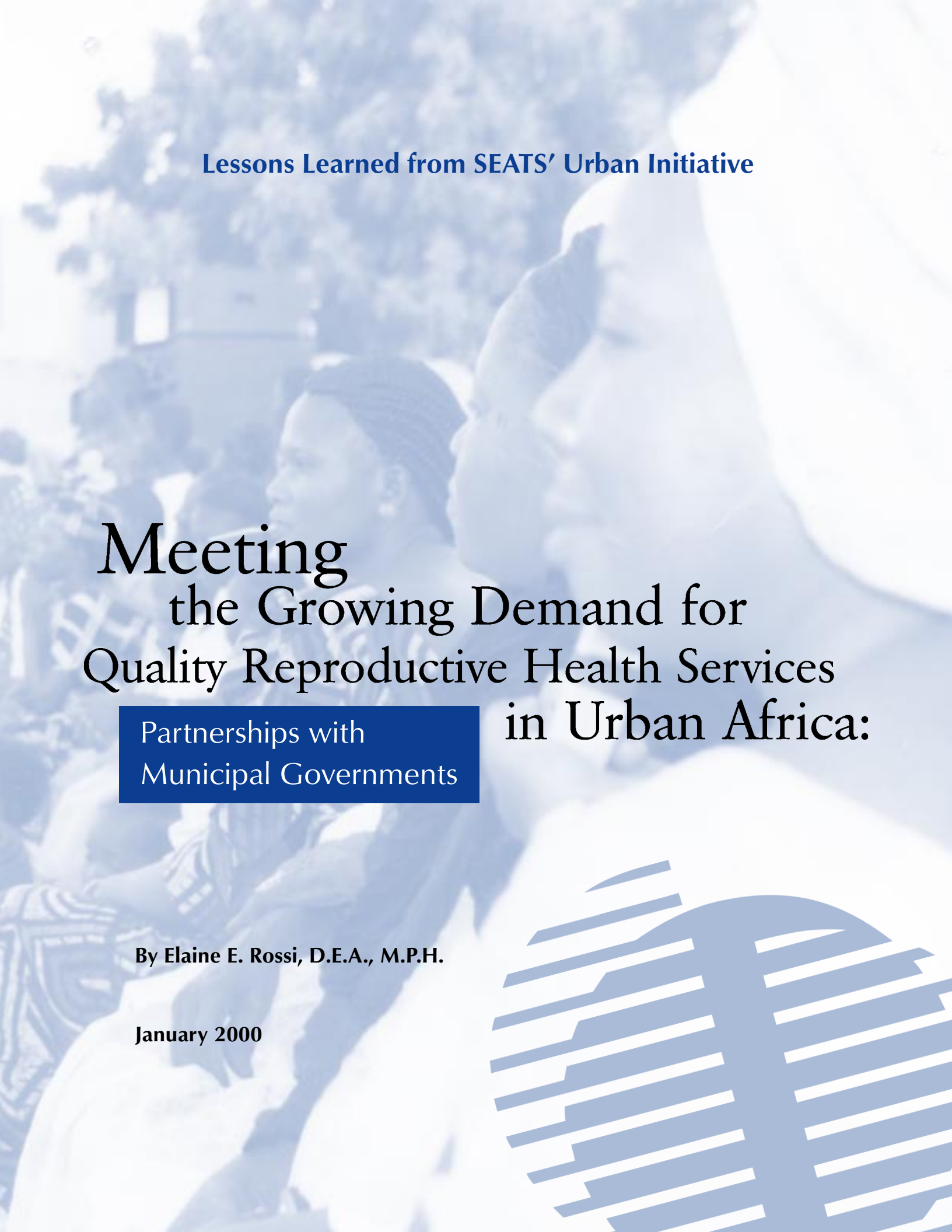

Lessons Learned from SEATS' Urban Initiative

# Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa:

## Partnerships with Municipal Governments

By Elaine E. Rossi, D.E.A., M.P.H.

January 2000

The goal of the Family Planning Service Expansion and Technical Support (SEATS II) Project is to expand the development of, access to and use of high-quality, sustainable family planning and reproductive health services in currently underserved populations. It built and followed on the SEATS I Project (1990-1995).

John Snow, Inc. (JSI), an international public health management consulting firm, headed a group of organizations implementing the SEATS II Project. These included the American College of Nurse-Midwives (ACNM), American Manufacturers' Export Group, AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and United States Agency for International Development (USAID) Missions and other partner organizations in each country where SEATS was active.

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Photos courtesy of Elaine E. Rossi D.E.A., M.P.H.

Lessons Learned from SEATS' Urban Initiative

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# *Acknowledgements*

The Urban Initiative was carried out by the Family Planning Service Expansion and Technical Support Project (SEATS), managed by John Snow, Inc. (JSI). The Urban Initiative grew out of crucial questions that SEATS and the Africa Bureau of the United States Agency for International Development (USAID) asked about the ability of African cities and their health programs to meet the growing demand for quality reproductive health services. Without the insight and support of Lenni Kangas, recently retired from the Africa Bureau, and the late Bonnie Pedersen of the Global Bureau, the Urban Initiative would not have been a success.

Many people have contributed valuable ideas, expertise, insight, and long hours to the Urban Initiative experiences. We especially want to thank Martin Gorosh of Columbia University Joseph Mailman School of Public Health; Melinda Ojermark, former SEATS Regional Director for Africa; and Nancy Harris, former Director of SEATS. Under their leadership, SEATS and its partners in twelve cities in seven countries worked together to forge new directions for achieving reproductive health in urban areas.

The Urban Initiative had its origins in the Urban Study (1991 - 1994) carried out under the SEATS I Project (1989 - 1995). The Urban Study would not have been possible without the support of the Africa Bureau and the technical assistance of the Centre for African Family Studies (CAFS) of Nairobi, Kenya; Columbia University School of Public Health's Center for Population and Family Health; the Population Council; and local institutions in Blantyre, Malawi; Bulawayo, Zimbabwe; and Mombasa, Kenya.

Colleagues from USAID assisted the Urban Initiative, providing technical, financial, and managerial support. They include: Cathy Bowes, Paul Hartenberger, Laura Kearns, Kathi Keel, Khadijat Mojidi, Roxanna Rogers, Laura Slobey, Hope Sukin-Klauber, and Abdi Wardere.

From the Urban Study through much of the Urban Initiative, Carolyn Vogel, formerly of JSI, managed technical implementation and the documentation of many activities with competence and humor. Other important contributors to the Urban Initiative from SEATS include: Joy Awori, Meriwether Beatty, Laurie Cappa, Pamala Cery, Diane Hedgecock, Alix Grubel, David O'Brien, Leslie Patykewich, William Sambisa, Mbaye Seye, and Cathy Thompson. Thanks also go to Drew Banks for document design and layout and Nancy Newton, SEATS consultant, for editorial assistance.

Above all, we appreciate the time, dedication, and commitment of SEATS many partners in the cities of Beira, Mozambique; Blantyre, Malawi; Bulawayo, Chitungwiza, and Gweru, Zimbabwe; Conakry, Kindia, and Labe, Guinea; Dakar and its mayoral districts, and Louga, Senegal; Lusaka, Zambia; and Mombasa, Kenya.

# *List of Acronyms*

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| CAFS | Centre for African Family Studies |
| CCE | The Client Capacity Estimator |
| COGEP | Consultants in Management, Research, and Projects, Inc. |
| CQI | Continuous Quality Improvement |
| CPR | Contraceptive Prevalence Rate |
| CYP | Couple Years of Protection |
| DHS | Demographic and Health Survey |
| FPPMES | The Family Planning Program Monitoring and Evaluation System |
| GTZ | Deutsche Gesellschat fur Technische Zusammenarbeit (German Agency for Technical Cooperation) |
| HAI | Health Alliance International |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education, and Communication |
| IUD | Intrauterine Device |
| JSI | John Snow, Inc. |
| LUDHMT | Lusaka Urban District Health Management Team |
| LTPM | Long-term and Permanent Contraceptive Methods |
| NGO | Nongovernmental Organization |
| OC | Oral Contraceptive |
| SEATS | Family Planning Service Expansion and Technical Support Project |
| STI | Sexually Transmitted Infection |
| USAID | United States Agency for International Development |
| VSC | Voluntary Surgical Contraception |
| ZNFPC | Zimbabwe National Family Planning Council |

# *Table of Contents*

# *Executive Summary*

Over a period of five years (1995 - 1999), in 10 urban areas within Guinea, Mozambique, Senegal, Zambia, and Zimbabwe, the Urban Initiative of the Family Planning Service Expansion and Technical Support Project (SEATS) assisted municipalities to implement projects and activities aimed at increasing the ability of municipal leaders to meet the growing demand for accessible, high-quality family planning and reproductive health services. While each country portfolio was unique, common elements included: data-driven planning; coordination of public and private-sector inputs; partnership with municipal officials; advocacy from all sectors, and different levels within sectors, to form coalitions to promote reproductive health; and "South-to-South" dissemination.


*Decentralization and democratization are gaining footholds in urban centers throughout Africa.*

The Urban Initiative developed innovative tools and replicable models for urban programming. The Best Practices Model and the Quick Study Model, each adapted to more than one urban context, proved to be flexible and effective approaches for obtaining improvements in access, quality, and sustainability. Each model produced increased support for reproductive health programs by municipal officials, greater knowledge and use of reproductive health data, and improved access to quality services. Results of the Urban Initiative included services to more than 81,000 new contraceptive users, 221,104 couple years of protection (CYP), and training for 1,702 service providers. SEATS' partners leveraged at least $400,000 against SEATS' funds from USAID.

As decentralization and democratization gain footholds in urban centers throughout Africa, the role of municipal officials in both planning and resource allocation for social services is growing. The Urban Initiative fostered partnerships with city health departments and elected officials and their staff. In some cases private and nonprofit groups were key players, and in other cases new coalitions of non-health and health authorities created new options for the future. The Urban Initiative processes also supported fledgling civil society institutions and reinforced the drive to improve community participation in the public decision-making process.

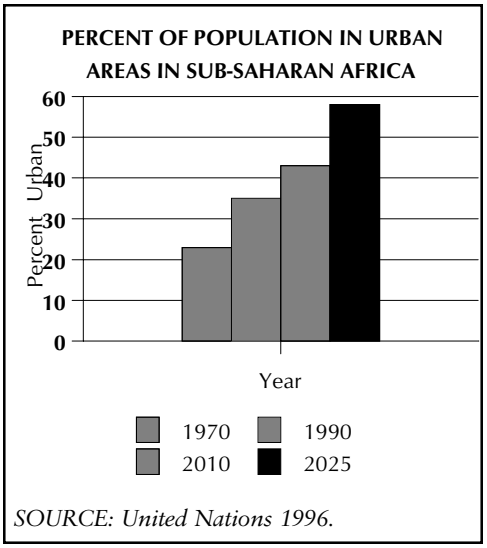
The lessons learned from these projects and activities provide insight into how to improve access to sustainable, quality reproductive health services in urban Africa and other regions. Some of the key lessons from SEATS' Urban Initiative include:

- Municipal governments–city health departments and mayors–can increase the efficiency and effectiveness of family planning service delivery programs.
- Municipal officials can–at least partially–manage the impact of increasing urbanization on access to and quality of reproductive health services, but they cannot do it alone.
- Key to maximizing access in urban areas are two strategies: 1) identify and mobilize underutilized existing resources; and 2) be creative in using new, even unconventional ones.
- Urban decision makers are often unaware of research findings that could be used to better plan and allocate resources for expanded access.
- Urban areas have more untapped resources available to support reproductive health programs than is commonly believed.
- Women in leadership positions can play a key role in advocacy and expanding services, especially in cities where reproductive health issues are sensitive.
- The high diplomatic cost of publicly exposing serious problems with quality of care needs to be weighed against the potential catalytic power this information holds.

# *Introduction*

Africa has the highest rate of urban growth of any region in the world. More than one in three Africans lives in an urban setting today, compared to only one in seven in 1950. The United Nations estimates that by 2020 more than half of the population of sub-Saharan Africa will live in cities (see box) (United Nations 1996). Both high natural population increase and extensive rural-to-urban migration of Africans seeking greater opportunities and more accessible services drive this rapid urbanization.

Most urban areas will require an enormous expansion of services in all sectors, if cities are to be workable living places. Population growth in both capital and secondary cities severely constrains the ability of national and urban governments to plan for and satisfy current and future demand for reproductive health and other services (Gorosh et al. 1995). The advantages of urban living—longer life expectancies, lower absolute poverty rates, and greater access to education and health care services—are in jeopardy (United Nations 1996). Indeed, the assumption that urban family planning services have advantages over rural services when it comes to quality of care has proven to be untrue (Pearlman et al. 1998). Nevertheless, donor and technical assistance agencies have tended to focus their attention primarily on rural areas, and until recently, few resources were aimed at aiding urban health services.



*SOURCE: United Nations 1996.*

Municipal and local governments are often overlooked as potential partners in efforts to expand access and improve quality of care in reproductive health services in Africa. These public-sector institutions have become more important during the past decade, as the movement for decentralization leads them to take on greater responsibilities for planning, financing, and delivering health services. As democratization expands, many newly elected officials with limited public administrative experience are tasked with handling urban health services. The increasing opportunities and need to strengthen municipal and local government agencies raise crucial questions about urban health programs in Africa and the role of municipal governments in their management:

- Can municipal governments increase the efficiency and effectiveness of family planning service delivery programs? If so, how ?
- Can municipal officials manage the impact of increasing urbanization on the access and quality of reproductive health services? If so, how ?

The Family Planning Service Expansion and Technical Support (SEATS) Project sought answers to these questions, first through its Urban Study (1991 - 1994) under SEATS I, and later through its Urban Initiative under SEATS II (1995 - 1999). This paper describes the origins and experiences of the Urban Initiative and identifies the innovations and lessons learned from the eight years of work in urban areas in Africa. The program models, tools, and lessons from this Urban Initiative should be applicable to increasing the ability of municipal leaders to meet the growing demand for accessible, high quality reproductive health services in urban Africa and other regions of the world.

### THE SEATS URBAN INITIATIVE: CHRONOLOGY

| | |
|---|---|
| 1989 - 1995: | SEATS I Project |
| 1991 - 1994: | Urban Study (Kenya, Malawi, Zimbabwe) |
| 1995 - 2000: | SEATS II Project |
| 1995 - 1999: | Zimbabwe, Zambia Activities |
| 1997 - 1999: | Senegal Activities |
| 1998 - 2000: | Guinea Activities |
| 1998 - 2000: | Mozambique Activities |


*Municipal governments - city health departments and mayors - can increase the efficiency and effectiveness of family planning service delivery programs.*

# *The Urban Study and the Genesis of the Urban Initiative*

In 1991, SEATS I proposed the following hypothesis: urban family planning service delivery systems are overwhelmed by recent rapid growth of urban populations and are not equipped to satisfy potential demand for contraceptive methods. The **Urban Study**, carried out in collaboration with the Centre for African Family Studies (CAFS) and with funding from the Africa Bureau of the United States Agency for International Development (USAID), examined how family planning service delivery programs in sub-Saharan African cities could become more efficient and effective. The Urban Study included three cities: Bulawayo, Zimbabwe; Blantyre, Malawi; and Mombasa, Kenya.[1]

Using quantitative and qualitative methodologies, SEATS, CAFS, and local research groups analyzed both existing data and data collected specifically for the study.[2] The findings (see box) highlighted shortcomings of urban family planning services and suggested major interventions to improve efficiency and effectiveness, including expanding the method mix and introducing cost recovery mechanisms. The Urban Study also drew attention to the often overlooked theme of family planning service delivery in urban Africa. Its focus on integrated reproductive health services foretold a key outcome of the International Conference on Population and Development held in Cairo in 1994.

National dissemination workshops in each of the three cities brought together municipal authorities and national leaders to review preliminary study findings. A regional dissemination conference in Blantyre, Malawi followed in early 1995. The Municipal Government of Lusaka, Zambia, interested in Urban Study results, also sent a delegation to the conference.

### SELECTED FINDINGS OF THE URBAN STUDY

- The capacity of urban health systems to maintain current contraceptive prevalence rates in the future is severely constrained.
- Method mixes are heavy in resupply methods.
- Weak areas include prevention of human immunodeficiency virus (HIV) and other sexually transmitted infections (STI), integrated reproductive health services, and staff knowledge.
- Most clients would continue using family planning services if required to pay for services.
- About 35 percent of private-sector facilities provide family planning services.
- The quality of services is mixed, with needed improvements specific to each site.

[1]Although the research design anticipated studying urban family planning systems in francophone West Africa also, support for this opportunity did not materialize.

[2]Detailed descriptions of the Urban Study methodologies and city-specific results are available in a summary report (Gorosh et al. 1995) and individual city reports for Bulawayo (Muvandi et al. 1995); Blantyre (Maggwa et al. 1995a); and Mombasa (Maggwa et al. 1995b).

The purpose of the Blantyre Conference was ambitious: it aimed to develop a "new vision for urban family planning programs in sub-Saharan Africa" (see box).[3] Officials from all three cities participating in the Urban Study expressed a real desire to use the results to enact changes in the delivery of family planning services. However, utilization of the Urban Study findings presented two challenges: development of sound technical strategies to apply research findings to program work and identification of donor agencies that would support the "new vision" for urban reproductive health service delivery. While SEATS I had the willingness and capabilities to offer technical assistance to cities, the Urban Study did not include resources for these next steps.

### A NEW VISION FOR URBAN AFRICA: IMPROVING MUNICIPAL REPRODUCTIVE HEALTH PROGRAMS

While the final declaration of the Blantyre Conference was a general vision statement, it reflected the diversity of city-specific needs identified by each municipal/national team. Critical needs that emerged from the meetings were:

- **Data-driven planning:** Municipal/local health authorities need access to comprehensive data and future projections to plan and manage effectively.
- **Beyond the public sector:** Municipal authorities must coordinate with the private sector to improve access to services in a cost-effective way that responds to client demand.
- **Advocacy from a united front:** Representatives from all sectors, and different levels within sectors, can form powerful coalitions to promote reproductive health.
- **South-to-South dissemination:** Many replicable strategies are implemented in cities but not disseminated for lack of established channels to share experiences.

## Launch of the Urban Initiative

The ideas and proposals from the Blantyre Conference as well as momentum from the whole Urban Study process led to the development and launch of the Urban Initiative in 1995 under the SEATS II Project.

The Urban Initiative promoted the use of an integrated and strategic approach to identifying and prioritizing reproductive health issues for an entire city, based upon use of data-driven decision making, advocacy, and coalition building. Two primary objectives of the Urban Initiative were: 1) to assist urban programs to increase their service delivery capacity to meet growing client demand while increasing efficiency and effectiveness; and 2) to identify weaknesses in access to or quality of services and design strategies for improvement. In keeping with SEATS' philosophy of responding to local need, the Urban Initiative was designed to accommodate the special circumstances of each country or city involved.

By 1999, SEATS II's partners in Guinea (Conakry, Labe, and Kindia), Mozambique (Beira), Senegal (Louga and mayoral districts of Dakar), Zambia (Lusaka), and Zimbabwe (Bulawayo, Chitungwiza, and Gweru) had undertaken 11 subprojects based on the new program models and utilizing the innovative tools and practices arising from the Urban Initiative.

[3]The conference objective was: *To foster a shared vision among municipal and national officials and donor agencies of the policy, service delivery, and management improvements needed to meet the challenges facing the sub-Saharan African cities in providing family planning and reproductive health services in the twenty-first century and to develop city-specific approaches for policy, design, and management innovations* (JSI 1995b).

# *Models and Processes for Urban Africa*

This section gives an overview of SEATS II's Urban Initiative. It presents the follow-up activities in the original Urban Study cities and describes the development, application, and results of the new program models—Best Practices Model and Quick Study Model—developed during the Urban Initiative.

## What Happened in Bulawayo, Blantyre, and Mombasa? A Tale of Three Outcomes

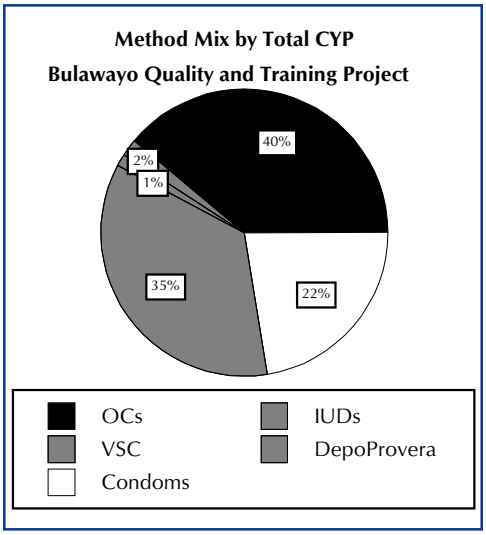
The three cities that participated in the Urban Study and planned for data-based changes in programming had widely varying experiences following the 1994 and 1995 dissemination conferences. Members from municipal teams and SEATS staff contacted USAID, other donors, and national organizations to identify sources for financial and technical assistance for the three cities. Among the USAID Missions, only USAID/Zimbabwe responded with firm and enthusiastic support for activities in Bulawayo. Consequently, Bulawayo was undoubtedly the city experiencing the greatest changes in capacity, quality of services, and actions towards sustainable programming. Because SEATS II was unable to obtain funding for follow-up activities in Blantyre and Mombasa, nor did it implement other subprojects in Malawi and Kenya, monitoring and reporting the long-term impact of the Urban Study in these two cities was difficult.

*Women in leadership positions can play a key role in advocacy and expanding services, especially in cities where reproductive health issues are sensitive.*

SEATS' partnership with **Bulawayo, Zimbabwe** benefitted from two key factors: USAID/Zimbabwe's keen interest and funding, and the proximity of SEATS' regional office in Zimbabwe's capital city Harare. Bulawayo, with a population of more than a half a million, is the second largest city in Zimbabwe and its agricultural hub. Urban Study and 1994 Demographic and Health Survey (DHS) results indicated that the contraceptive method mix was comprised mainly of resupply methods, causing heavy current and future services use. Health and family planning leaders in Bulawayo also believed there was unmet demand for long-term and permanent methods (LTPM), including voluntary surgical contraception (VSC), intrauterine devices (IUDs), implants, and injectable contraceptives. Available information pointed to other problems with access and quality,

ranging from medical and administrative barriers to shortages of properly equipped clinic space and operating rooms with appropriately trained staff. Finally, municipal authorities identified limited access to training and its high cost as barriers to sustainable, high quality urban family planning programs.

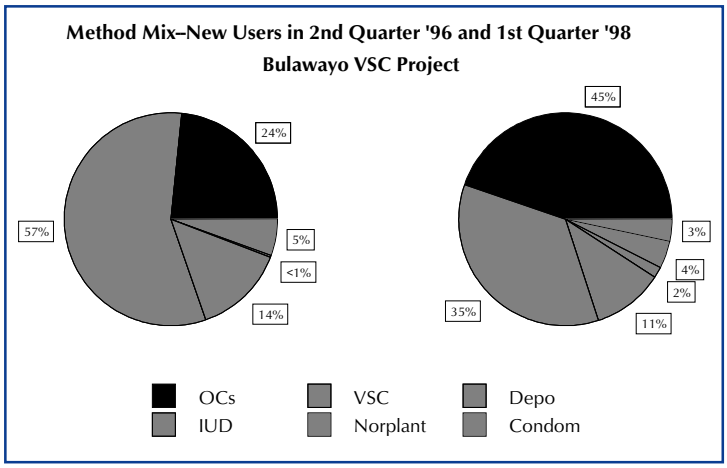
Using a participatory planning methodology, SEATS worked with a variety of health authorities in Bulawayo to develop two, three-year subprojects. The first, **Bulawayo Quality Improvement and Training**, began in March 1996, and the second, **Bulawayo Expanded Access to VSC**, started in May of the same year.




The Bulawayo City Health Department and the Zimbabwe National Family Planning Council (ZNFPC) worked collaboratively with SEATS II to design **Bulawayo Quality Improvement and Training**. The subproject included ambitious objectives for the establishment of a self-sustaining family planning training center with a trainee follow-up and support network and the implementation of a continuous quality improvement (CQI) system in city health clinics. In addition, the subproject aimed to contribute to increased access to LTPM through the training of additional providers, and improving counseling and referral services. Bulawayo Quality Improvement and Training met or surpassed objectives for quality and sustainability. Providers and managers gained a greater appreciation for client perspectives through the use of client exit surveys. With technical support from municipal administrators, the City Health Department convinced the Bulawayo City Council to adopt the newly established Family Planning Training Center, and the City Council allocated funds for the Center's budget. Although the method mix showed little variation over the two-year subproject period (approximately 60 percent of new users opted for oral contraceptives [OCs], 35 percent for Depo-Provera, and 5 percent for VSC or IUDs throughout the life of the subproject), 22, 575 new users were served. In addition, condoms represented a substantial portion of the 70,149 couple years of protection (CYP) achieved (see box) in this country where HIV prevalence rates among adults are around 25 percent (United Nations Joint Programme on HIV/AIDS and World Health Organization 1998).[4]

[4]The Quality Improvement and Training subproject tracked numbers of condoms distributed, but because many users of other methods also chose to accept condoms for protection from STIs, the subproject did not include condoms in its data on new and continuing users.

**Bulawayo Expanded Access to VSC**, carried out in collaboration with the city's two largest public-sector hospitals, Mpilo and United Bulawayo, and SEATS II's partner, AVSC International, focused on capacity building and broad quality improvement including clinical competencies, counseling, and elimination of barriers to the use of LTPM. Coordination and collaboration with a variety of national and municipal partners, including oversight by a Coordinating Committee, was a fundamental feature of the subproject. Specific indicators of access and quality, such as providers trained to offer a range of methods, showed improvement, and the addition of fees for VSC services and the institutionalization of on-the-job training for new service providers contributed to the financial and technical sustainability of VSC services. Contrary to expectations, the numbers of new clients choosing VSC did not increase substantially, although the total number of new users per quarter increased about 100 percent. Consequently, the method mix among new clients shifted away from one predominated by VSC to one with much greater variety (see box). Importantly, the proportion of clients using condoms increased greatly. It is possible that the introduction of fees for VSC affected this trend, although limiting information, education, and communication (IEC) activities to the facility may have also reduced demand for VSC.




After the Urban Study and dissemination workshop in **Blantyre, Malawi**, SEATS and the motivated municipal leaders from Malawi's commercial center were confident that the proposed subproject "Blantyre Urban 'Every Opportunity' Family Planning" would lead to improved access as it created an integrated family planning program at the main government hospital. Despite initial strong interest by USAID/Malawi, the subproject did not receive funding. Nevertheless, Blantyre's municipal officials continued to advocate for expanding service delivery capacity and intersectoral partnerships.

The municipal team from **Mombasa, Kenya** approached donors and national organizations working in reproductive health, but as a secondary city with disadvantages in terms of regular communications with donors based in the capital of Nairobi, it had difficulty moving forward. USAID/Kenya recognized the importance of the

Urban Study and requested that one of its intermediaries, Pathfinder International, provide Mombasa with support for service delivery and evaluation.

## Urban Initiative Best Practices Model: Beyond the Urban Study Cities

*A best practice is a documented approach or technique that contributes to the highest standard of family planning and reproductive health service delivery. In the Best Practices Model, promotion of dual protection, involvement of stakeholders in subproject design and management, and use of CQI were among the best practices that subprojects adopted.*

Out of the Urban Study experience grew several subprojects that began between 1995 and 1998 in East and Southern Africa. The municipal health departments of Lusaka, Zambia; Chitungwiza and Gweru, Zimbabwe; and Beira, Mozambique developed and implemented subprojects that adapted and applied technical best practices within an Urban Initiative structure of coordination and partnership, advocacy for reproductive health resources, and data-driven decision making. These urban health departments and their partners took Urban Study recommendations and utilized locally available data and proven best practices to design interventions that addressed specific issues of quality, access, and sustainability.

### STAGES IN THE URBAN INITIATIVE'S BEST PRACTICES MODEL

Stage 1: **Identification of Urban Stakeholders**. Potential partners in the public, private, and nongovernmental sectors—if interested in participating in the Urban Initiative—establish a calendar for design of subproject activities.

Stage 2: **Stakeholders' Assessment of Reality**. Key partner(s) manage analysis of reproductive health data and subproject needs assessment, and with SEATS assistance, identify potential best practices to adapt in their city.

Stage 3: **Joint Planning**. Urban partners, SEATS, and donors determine subproject objectives and best practice(s) to apply as well as needed resources and skills.

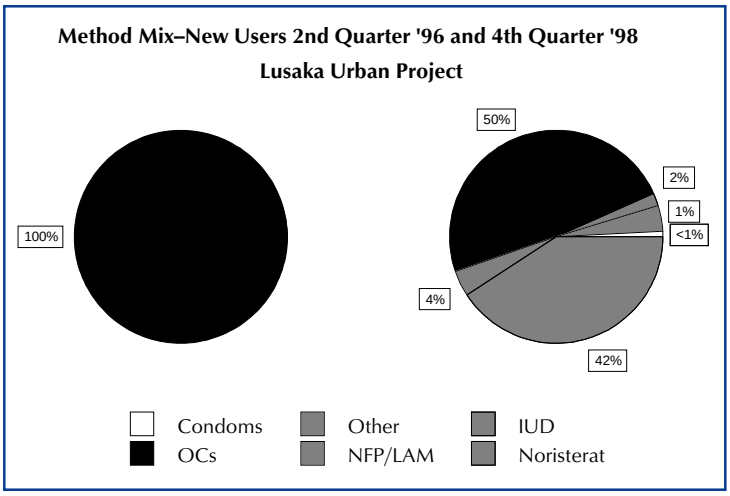
Stage 4: **Implementation**. SEATS provides technical assistance for the development of a municipal coordinating committee; skills in planning and advocacy; development of quality, sustainability, and evaluation plans; efficient use of available resources, including leveraging.

Stage 5: **Monitoring and Evaluation for the Long Term**. Partners use information and data to track progress towards high quality, sustainable reproductive health services accessible to a growing proportion of the city's population.

**Chitungwiza, Zimbabwe**, the main bedroom community of Harare and the third largest city in Zimbabwe, houses much of the low- and middle-income population that works in and around Harare. The Chitungwiza Municipality, Chitungwiza General Hospital, and ZNFPC collaborated with SEATS II on the subproject **Chitungwiza Quality Improvement and Training** (October 1995 - September 1998). This subproject built on a successful SEATS I subproject, utilizing evaluation data to develop objectives for increasing the proportion of trained family planning service providers, improving access to LTPM, improving client counseling, and upgrading facilities. Activities incorporated the best practice of promoting dual protection to prevent STIs and acquired immune deficiency syndrome (AIDS). Chitungwiza Quality Improvement and Training served almost 21,000 new clients, increased the proportion of nurses trained to provide family planning services from 36 percent to 49 percent, improved privacy and information provided to clients, and upgraded facilities in six clinics. Although OCs continued to dominate in the method mix, the percentage of clients opting for the IUD increased from less than 1 percent to 6 percent. As a result of the focus on dual protection, condoms made up an important part (about 10 percent) of the 66,700 CYP achieved.

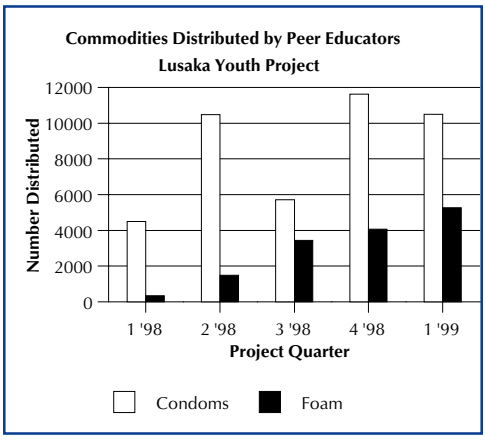
Chitungwiza Municipality continues to maintain its commitment to the long-term sustainability of high quality family planning services. The Municipality now has dedicated training center space, with sufficient equipment to train providers from other towns and cities, if needed, and trainee follow-up is systematic. City government, working through the subproject Coordinating Committee, is raising funds to expand the training program. Health authorities, with assistance from the municipal government, are pursuing cost recovery and other forms of self-financing.

While not an Urban Study site, the government of **Lusaka, Zambia** sent representatives to the 1995 Blantyre Conference and from that point became a major collaborator in the Urban Initiative. With a population of more than 1.2 million, about 75 percent of Lusaka's residents live in high-density compounds surrounding the city. SEATS II, the Lusaka Urban District Health Management Team (LUDHMT), and USAID/Zambia had recognized the successful CARE Community Family Planning Project already operating in eight clinics in Lusaka as a programmatic best practice. Together they decided to replicate this model in seven additional urban health centers, with a total catchment population of about one half million residents.




**Lusaka Urban** (April 1996 - March 1999) resulted in a remarkable change in the method mix as both access to more methods increased and counseling and information to clients improved (see box). Each quarter, an average of 1,800 new acceptors received services from these clinics. The subproject sustainability plan led to an increased likelihood that these improvements will be maintained, and the LUDHMT assumed responsibility for supplying commodities to the clinics.

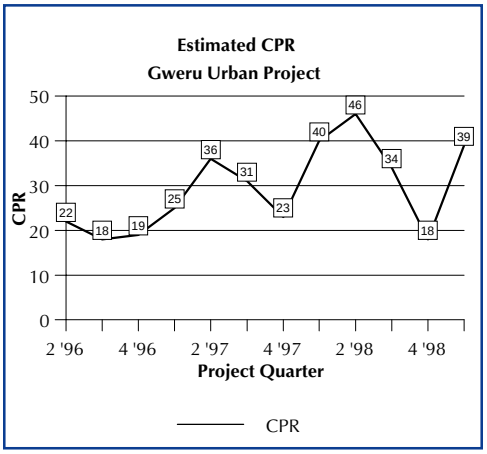
In late 1997, a new component was added to the collaboration with LUDHMT—**Lusaka Youth**. The LUDHMT and SEATS adapted and evaluated CARE's model approach to youth reproductive health services, applying best practices for youth service provision from around the world.[5] SEATS used the *Youth-Friendly Integrated Reproductive Health Care* curriculum, developed by the USAID-funded MotherCare Project, as the basis for training providers in all seven SEATS-supported clinics. Twenty trained peer educators, operating out of two model clinics, provided individual and group counseling, distributed condoms and foam, and made referrals to clinical services. Clinic exchange visits enabled staff and peer educators to learn from experiences at other sites and apply lessons to their own fledgling youth-friendly programs. Between January 1998 and March 1999, the peer educators reached more than 18,000 young people (5,800 young men and 12,400 young women) and distributed more than 57,000 commodities (see box). More than 4,000 youth received reproductive health services, ranging from antenatal care to treatment for STIs. The involvement of youth, the Neighborhood Health Committees, providers, parents, and other stakeholders in the design and management of the subproject was critical to its success.



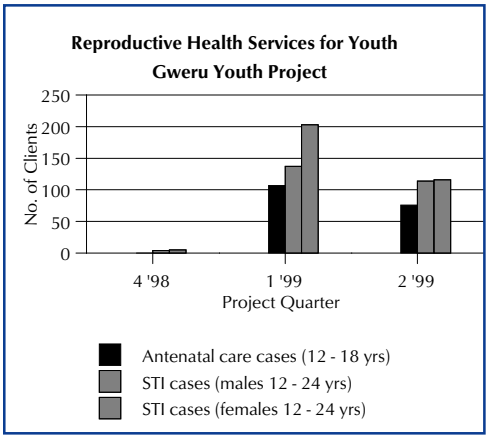

Similar to Bulawayo and Chitungwiza, the cost of and access to training for providers were serious obstacles to improving quality and access to services in **Gweru, Zimbabwe**; improved municipal training capacity would greatly contribute to programmatic sustainability in this city of 128,000 residents. **Gweru Urban** (April 1996 - March 1999) produced new training curricula that included dual protection, so that this STI/AIDS prevention best practice could be better promoted in another urban zone of high HIV prevalence. Providers, managers, and other facility staff received training in CQI.

[5]These best practices and a detailed analysis of the results of this and all SEATS' youth subprojects are documented in *Applying best practices to youth reproductive health: Lessons learned from SEATS' experience* (Newton 1999).

Gweru Urban served 7,200 new users, improved counseling, and instituted a supervision-linked training follow-up system. Condoms made up 26 percent of the CYP achieved. Based on estimates calculated using the Family Planning Program Monitoring and Evaluation System (FPPMES), this subproject attained contraceptive prevalence rates (CPR) of about 40 percent (see box). The subproject also benefitted from the municipality's commitment to sustainability and the efforts of the intersectoral Coordinating Committee in assisting the partners to work together to maintain improvements in reproductive health services.




Despite the City Council's acknowledgment of the reproductive health risks the young people in Gweru faced, it took more than a year to move from initial discussions to real planning for the **Gweru Youth** component of the subproject (September 1997 - June 1999). Although activities now receive enthusiastic support from various parts of the community, there were multiple sources of resistance to launching reproductive health information and services for youth. Gweru Youth demonstrated that the focus on stakeholder involvement in the Best Practices Model, particularly in the first stages, can make a difference in outcome. SEATS and Gweru health authorities invested heavily in building support among parents, religious and secular leaders, teachers, and service providers during the early stages of the subproject. By supporting municipal coalitions of various public-sector groups and private institutions, this Urban Initiative subproject assisted leaders to plan for advocacy activities with key groups and individuals. They were able to use information and data effectively to illustrate the need for a strategy to increase youth access to reproductive health information and services. The results of a baseline survey on youth reproductive health knowledge attitudes and practices, combined with best practices for youth services, provided the information for subproject design (Sambisa et al. 1999). Training providers in youth-friendly services, peer education, and the establishment of "youth corners" in municipal clinics led to greater access to dual protection and other reproductive health services for young people in Gweru (see box).




**Beira, Mozambique**, the country's second port city, was the last African city to become part of SEATS II's Urban Initiative Best Practice Model activities. SEATS and Health Alliance International (HAI), an international nongovernmental organization (NGO), initiated the *Nucleo*, an interagency group that addresses urban reproductive health issues. Nucleo includes the City Health Direc-

tor, representatives from the Department of Provincial Health, United Nations Children's Fund, the German development agency Deutsche Gesellschat fur Technische Zusammenarbeit (GTZ), and HAI. Nucleo conducted an assessment of current and potential service providers and service delivery sites, and selected officials completed a study tour to Lusaka and Gweru Urban Initiative sites. Implementation planning took into account resources available from various sources, and included support from SEATS and other donors. SEATS supported the establishment of a youth corner at one municipal clinic, training of peer educators and health personnel in youth-friendly services, and outreach and advocacy to sensitize community leaders about the need for these services for youth.

## The Quick Study Model: Francophone West Africa's Urban Mayors Use Existing Data to Improve Reproductive Health Programs

*Whether called a Coordinating Committee, a Nucleo, or an Urban Group, successful Urban Initiative subprojects had an inter-organizational group that provided oversight, support, and planning services to the city's reproductive health program.*

SEATS and USAID's Africa Bureau continued to seek opportunities to implement the Urban Initiative in West Africa. In 1997, **Senegal** became the first West African nation to begin Urban Initiative activities, and **Guinea** followed its neighbor's example in 1998.

The wealth of good quality research findings for urban areas in Senegal, the desire to empower municipal officials to mobilize resources to meet their cities' reproductive health needs, and the experiences with the Best Practices Model led to the development of a new Urban Initiative programmatic model—the Quick Study Model (see box). The Quick Study Model targeted elected mayors of cities and urban districts ("*arrondissements*" or "*communes*") under a strategy that aimed to support Urban Initiative goals as well as democratic institution building and new national policies of decentralization. This empowerment approach aimed to give mayors the knowledge and tools to understand the reproductive health situation in their zones and to design and market coherent programs to donors. In the Quick Study Model, the use of existing data, with only minor primary data collection to fill in critical gaps, greatly shortened the time needed to collect, analyze, disseminate, and use information to effect changes in programs. Thus Quick Study cities moved from research results to subproject activities in less than a year, compared to Urban Study cities, which took more than two years.

## URBAN INITIATIVE'S QUICK STUDY MODEL

The Quick Study Model is tailored to cities' needs and USAID's strategic objectives. The experiences of Dakar, Senegal offer an example of how the process unfolds.

**Stage I: Research and Outreach**. A local institution conducts primary research, secondary analysis, or a combination, with guidance from SEATS in an attempt to obtain a comprehensive picture of all services, private and public, offered in the city. Special focus areas, such as STI/HIV prevention, youth, or other pertinent local issues, may be studied. Initial contact is made with municipal officials, representatives from the private health sector, reproductive health experts, NGOs, and special interest groups in preparation for the next stage.

**Stage II: The First Workshop**. The research findings are presented to municipal officials, mayors and urban leaders, and donor and private-sector representatives, who are then placed into working groups. Based on the information presented and their own expertise, the groups then collaborate to produce draft action plans which iterate priority reproductive health problems, proposed solutions, and further research needs.

**Stage III: Finalization of Workplans**. The working groups determine any additional data and data analysis needs, and collaborate with researchers and SEATS to complete this work. Groups receive facilitation and technical support as needed to complete their work plans and meet with potential funders and partner groups in their localities.

**Stage IV: Coalition Building and Second Workshop**. Selected donors and partner organizations attend the presentations of the work plans and offer advice as well as support for their implementation. Round-table discussions between donors and municipal officials result in better understanding of procedures for accessing available resources and improve the quality of the subproject plans. Follow-up mechanisms are determined before the end of the workshop and municipal officials take on the primary responsibility for future group activities.

**Stage V: Subproject Implementation**. Individual municipalities and working groups implement their plans, using their own resources supplemented by those from donors, municipal development loans, and NGO partnerships. SEATS or other groups provide timely support and technical assistance for proposal refinement, mapping, or specific subproject start-up activities such as staff training or development of a referral system. SEATS also continues to provide facilitation to the follow-up committee as requested. Dissemination activities take place during this period.

Stage I of the Quick Study Model resulted in the selection of **greater Dakar (including Pikine Ouest, Pikine Est, and Guédiawaye)** and **Louga, Senegal** as urban centers with an interest in and need for Urban Initiative activities. In 1997, Senegalese researchers, along with SEATS and USAID staff, identified existing reproductive health research and completed secondary data analysis and minor additional data collection for the cities of Dakar (including Pikine Ouest) and Louga. The first workshop for city teams in September 1997 marked the formal launch of **Urban Initiative/Senegal**. The workshop attracted an impressive array of participants, including mayors and their representatives, and generated substantial interest among the local media and the donor community. The involvement of young people was an important feature. Based on the detailed findings of the research teams, working groups developed preliminary, data-based reproductive health workplans for their geographic areas. Municipal teams later presented the finalized plans to a select group of donor representatives in a second workshop. SEATS provided modest start-up funds on a competitive basis, giving cities with the best small grant proposals the opportunity to prove that they could design and implement activities.

The Urban Initiative strategy for Senegal produced coalitions of municipal officials, health authorities, and private-sector partners that advocated for additional resources to support high priority reproductive health activities, selected according to research findings and the potential for impact. Mayors and their advisors gained planning and proposal preparation skills and established basic relations with donor agencies. Donors, including GTZ, UNFPA, and the World Bank pledged an additional $340,000 in support of municipal-level activities; others are working to enable municipalities to access existing resources. An independent follow-up committee of Urban Initiative participants, the Mayors' Urban Initiative Group, maintains relations between the mayoral districts and the donors, and provides a structure for continued municipal advocacy and skills development. The strategy also introduced the maximum number of mayoral districts to principles of data-driven decision making for reproductive health, although SEATS anticipated that some would chose not to participate in activities once they understood the level of unfunded involvement required. Of the 19 municipalities invited to take part in the Urban Initiative, 11 completed the whole process, exceeding expectations.

### EMPOWERING MUNICIPAL OFFICIALS

Some may consider empowerment of municipal officials and health authorities an oxymoron—are they not already in power? SEATS views empowerment as a multidimensional process of engaging the full potential of individuals and groups. It requires open communication channels, democratic decision making, and access to information, resources, and skills. When applied to municipal officials, empowerment encourages them to actively seek solutions to ongoing problems and increases their abilities to mobilize and manage resources that respond to their constituents' needs.

Throughout the Urban Initiative process in Senegal, SEATS invited two representatives from **Conakry, Guinea** to each major meeting. Initially, the Director of Urban Health from the Ministry of Health and the Policy Advisor to the Minister of Health participated; afterwards, one of Conakry's five elected mayors (there are five districts called *communes*, each one with a mayor) accompanied the Director of Urban Health. The participation of these high-level officials not only allowed them to learn about the Urban Initiative and urban health in Senegal, but also enabled the Senegalese to benefit from their neighbors' experience and insight. The Guinean team briefed authorities in Conakry and USAID/Guinea, and Urban Initiative activities began in 1998. After an initial planning visit in mid-1998, three cities were selected for Urban Initiative participation: **Conakry**, the capital; **Labe**, the provincial capital of Middle Guinea; and **Kindia**, an important agricultural and commercial town. All seven of the eligible mayoral districts elected to participate and actively supported their research and program development activities. In fact, five mayors participated enthusiastically in implementation planning in July 1999. These leaders subsequently obtained European Union funding for additional consulting services to improve municipal health services.

# *Urban Initiative Innovations*

The Urban Initiative yielded a number of innovative tools, programmatic models, and sources of technical assistance. Some were first developed under the Urban Study, but further field tested and refined during the Urban Initiative. Many came out of the partnership of municipal officials with SEATS, underscoring the value of an empowerment approach not only in improving data-based planning and more targeted use of existing resources, but also in creating an environment that enabled the development and use of innovations.

*An* innovation *is the successful introduction of new techniques to strengthen and improve reproductive health service delivery. These techniques may be in program design and management, or in technical areas such as research and evaluation.*

## Innovative Tools

Many of the tools and innovations developed and/or field-tested under the Urban Initiative evolved from needs identified by Urban Study research partners or participants. The Urban Study research team designed an approach to evaluate the service delivery capabilities of African cities using a combination of new tools and adaptations of existing methods. These included the FPPMES, the Client Capacity Estimator (CCE), a streamlined version of the Population Council's Situation Analysis Study, DHS, and computer applications of mapping data. Other tools, such as the Municipal Handbook, arose directly from the Urban Initiative.

***The Family Planning Program Monitoring and Evaluation System* (FPPMES)**. The FPPMES (Miller et al. 1996), developed and tested by SEATS in Zimbabwe, was widely used in the Urban Study to estimate CPR in the urban areas at the time the research was conducted. The customized spreadsheet, which estimates CYP and CPR from dispensed to user data and estimates of population size and growth, is simple to use. Urban Initiative sites in Zimbabwe and Guinea applied it for monitoring, evaluation, and planning purposes. The FFPMES enables cities to track program growth and method mix, and to recognize local problems long before the next DHS survey would have pointed them out.

Further special studies in the application of the FPPMES in other cities established it as one of the most valuable tools to be introduced under the Urban Initiative. At least 12 countries have used it.

Some adapted the tool to estimate other rates and ratios useful for planning in public health (Bower et al. 1998; Weiss and Gorosh 1999).

***The Client Capacity Estimator* (CCE)**. The CCE, a software program, provides an estimate of the number of client contacts an urban family planning program will have to support in the future based on current CPR and method mix as well as population growth estimates (Miller and Gorosh 1995). By projecting the client load that various programs will face, policy makers can use this tool to help decide when and where to open new sites, and whether or not efforts to expand the method mix are needed. SEATS' partners in Bulawayo, Blantyre, Mombasa, and Senegal found the CCE simple and easy to learn. Targeted use of graphics from this tool created a major stir among policy makers in Senegal, who had been unaware of the large and growing gap between demand for and availability of services.

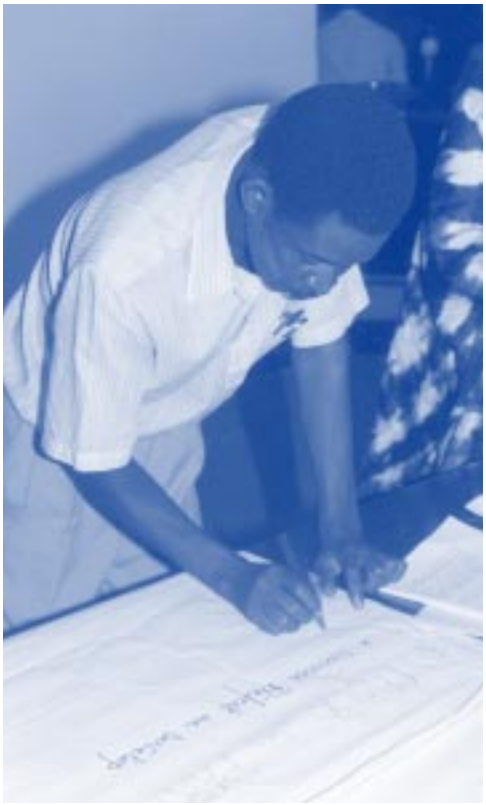
***Socio-sanitary Mapping***. The mapping exercises of the Urban Study proved extremely helpful to planning processes. At the time of the Urban Initiative, available maps did not reflect the realities of the newly decentralized urban zones of Senegal and Guinea; they contained either outdated political boundaries or showed health districts that did not correspond to the political districts that now controlled part of health district budgets. This led municipal leaders to request assistance in producing new maps that include not only public and private-sector health facilities but also other possible partner institutions or community resources. The maps helped municipal leaders gain a better understanding of all potential resources in their zones, and often revealed new places for outreach campaigns and opportunities to work with schools, churches, mosques, and industry.

***Municipal Handbook of Reproductive Health Donors***. City officials and private-sector leaders in Quick Study Model countries needed information about donors and technical assistance groups willing to fund and support reproductive health activities in their cities. A time-consuming job for any individual or small group of municipalities, collecting and consolidating this information into a useful format enabled urban partners in Senegal and Guinea to best access available resources. Municipalities used this handbook to identify potential donors for their specific proposals and key contacts for information on how to apply for funding.

## New Programmatic Models

The Urban Initiative also produced replicable models for urban reproductive health programming—the Best Practices Model and the Quick Study Model, described earlier. Each of these models was adapted to more than one urban context and produced increased support for reproductive health programs by municipal officials, increased knowledge and use of reproductive health data, and in many cases, improved access to and quality of services.

**City Health Departments and Mayors: An Underutilized Resource**. As decentralization and democratization gain footholds in urban centers throughout Africa, the role of municipal officials in both planning and resource allocation for health and social services is growing. Both the Best Practices and the Quick Study Models targeted a vital resource as partners: mayors and their teams. In some cases private and nonprofit entities were key players, and in other cases new coalitions of non-health and health authorities created new options for the future, such as those in Bulawayo, Chitungwiza, and Gweru. In the future, investments in municipal governments' ability to effectively manage services are likely to pay off with increased resources directed to fundamental issues that are supported by local advocates, improvements in efficiency, and more effective collaboration with the private sector.



*Both the Best Practices and Quick Study Models relied on mayors and their teams as a vital resource.*

## Non-Traditional Sources of Technical Assistance

The Urban Initiative's focus on empowerment and resource mobilization led it to draw heavily on locally and regionally available technical assistance. This approach reduced costs, strengthened partnerships, and fostered sustainability while it built skills.

**Local Identification of Technical Assistance Sources**. When asked to identify cost-effective sources of needed technical assistance, mayors and municipal health authorities identified consulting firms and professors, but they also found volunteer advisors, retirees, employees from other Ministries, business owners, local politicians, and others from their cities. These individuals were often willing and able to provide help at little or no cost, and they brought valuable additional perspectives from the community. For example, in Senegal, *Conseil en Gestion Etudes et Projets* (COGEP or Consultants in Management, Research, and Projects, Inc.), a local management consulting firm assisted teams with work planning and budgeting.

**City-to-City Collaboration and Technical Assistance**. To enhance South-to-South dialogue between countries and cities and to improve commitment to urban services, SEATS coordinated technical exchanges of municipal officials and family planning specialists in many of its Urban Initiative subprojects. For example, officials from cities with strong VSC programs or research skills spent time working with their counterparts from another city attempting to start up or improve similar programs. The benefits of an exchange of this type were realized at both the recipient and provider ends by promoting skill transfer, self reliance, empowerment, and sustainability. In addition, SEATS also used regional expertise, such as CAFS. In other instances SEATS invested in building skills within an institution such as COGEP, transferring new data collection, analysis, and presentation techniques such as the RAPID program, in order to create additional regional human resources for reproductive health.

### REPRODUCTIVE HEALTH OPEN DOOR DAYS

While politicians often visit hospitals or clinics, how often are citizens invited to visit the mayor and his or her staff to discuss health priorities? The Urban Initiative's sponsorship of "Open Door Days" in Senegal focused attention on reproductive health for a few hours, leading to interesting discussions and political awareness about the community's priorities. Often followed by specific community education campaigns (theater, traditional ceremonies, or sports events with health education discussions), "Open Door Days" made a direct link between locally elected officials and their staff, the community, and health service providers within their neighborhoods, sometimes for the first time.

*South-to-South exchanges between countries and cities promotes skill tansfer, self reliance, empowerment, and sustainability.*

# *Municipal Governments and Improved Reproductive Health Services in Urban Africa:*

## *Lessons from the Urban Initiative*

In terms of quantitative outputs, the results of the Urban Initiative included services to more than 81,238 new contraceptive users, 221,104 CYP, and training for 1,702 service providers. SEATS' partners in West Africa leveraged USAID resources to obtain more—with a value of at least $400,000—from non-USAID sources.

Perhaps of greater interest are the answers that emerged to the two broad questions about the role of municipal governments in improving access to and the quality of reproductive health services in urban Africa:

- Yes, municipal governments can increase the efficiency and effectiveness of family planning service delivery programs.
- Yes, municipal officials can—at least partially—manage the impact of increasing urbanization on access to and quality of reproductive health services.

However, they cannot do it alone, and they cannot do it in a sustainable manner without improved capacity to plan and manage *for the long term*.

### Summary Lessons

As municipal governments take on greater responsibilities for health infrastructure and personnel, they often face a simultaneous reduction in resources to solve the increasingly complex challenges of expanding access to and improving the quality of services for growing populations. Despite international and bilateral donor commitments to improved and expanded urban health infrastructure, investments in human resource development and interventions to overcome barriers to access and quality remain underfunded in many cities.

Exploring how the municipal governments and leaders involved in the Urban Initiative achieved the results they did and what kind of obstacles they encountered points to broader lessons about how to increase the capacity of municipal authorities to meet the growing demand for accessible, high quality reproductive health services and how outside organizations can assist them to do so.

**More effective use of existing urban resources requires: 1) partnerships among municipal governments and public - and private-sector groups; 2) data-based strategizing; and 3) consistent advocacy.**

Urban leaders and technicians control and manage specific health resources. Yet, efforts to identify solutions to ongoing problems that sap resources and create constant inefficiencies often focus on national departments and organizations and neglect municipal governments and local institutions. The Urban Initiative experiences demonstrated the potential of municipal coalitions to solve cities' problems using available resources, when their strategies reflect current data and local leaders engage in consistent advocacy for reproductive health. In each city, teams of urban professionals produced cost-effective and feasible ideas for increased access, quality, and sustainability of reproductive health services, while becoming powerful advocates for plans that reflected their priorities and strategies.

**Coordination among urban organizations with varied mandates is essential for optimal planning to meet growing needs for reproductive health services.**

The Urban Initiative recognized that no single organization or agency is capable of meeting the growing demand for quality services. Successful subprojects had an inter-organizational group or Coordinating Committee that provided oversight, support, and planning services to the city's overall reproductive health program, including activities in the private sector. For example, Gweru Youth had a Committee comprised of personnel from the Education Department, the public hospital, the Environment Department, local parent teacher associations, and other NGOs. In some countries, private-sector participation was minimal, but these relations helped to rule out unneeded replication of underutilized resources and to support the expansion of quality services to the underserved. Such multisectoral urban committees may serve as models for collaboration to meet shared objectives in sectors other than health.

**Empowerment and sustainability are reinforced when city teams select priority actions and subproject components and take on management responsibility.**

During the development of several of the Best Practices Model subprojects, municipal teams prioritized client groups or interventions that were different than those preferred by SEATS or USAID. In Senegal, using the Quick Study Model, municipal officials also identified other priorities not directly related to reproductive health. Finding compromises and supporting the data-driven processes of these models reinforced the position of urban leaders and their communities as key stakeholders. SEATS also recognized that local leaders must retain decision making authority and management responsibility, if urban programs are to become sustainable. Supporting local control also strengthened democratic processes and helped establish common ground among those from public- and private-sector institutions.

**Women in leadership positions can play a pivotal role in advocacy and expanding services, especially in cities where reproductive health issues are sensitive.**

Women mayors and municipal advisors were recruited specifically to assist in Urban Initiative advocacy in several countries. In Senegal, a Minister, two mayors and at least five mayoral advisors, all women, became public advocates for increasing reproductive health activities—even in controversial areas such as services for youth and AIDS care. One mayor received donor funding for her district's reproductive health action plan, and the Minister spoke on several occasions to the press about urban reproductive health issues. While it is not remarkable that women be effective in their professions, the proportionately high number of women playing key roles in both advocacy and expansion of service delivery was noteworthy. Reproductive health issues may be more personally relevant to women, and female politicians in African society, usually innovators in the sociological sense, may be more likely to champion difficult issues.

**Emerging urban programs require start-up funding to gain the experience needed to expand and leverage other resources.**

Only cities that received financial support from local USAID Missions succeeded in launching reproductive health services based on Urban Initiative research results. USAID Mission or Africa Bureau funds also allowed larger Urban Initiative service delivery and quality improvement programs to start in other cities. Once programs had established a track record, cities then leveraged these start-up funds to obtain additional resources from donors, municipal governments, and other sources. In addition, SEATS leveraged Africa Bureau funds to obtain an additional $3,000,000 from other USAID sources to support Urban Initiative activities.

**Competition among urban districts improves the quality of work produced.**

In Guinea and Senegal, where SEATS fostered competition for funds and recognition among cities or municipal districts, participants made greater efforts to provide timely reports, respond to requests, take initiative, and request technical support when needed.

**Urban Initiative models can also support efforts to improve governance and reinforce values of democracy and civil society.**

The Urban Initiative created opportunities for municipal health authorities and urban administrations to gain planning and management skills, foster community participation, support democratic decision making, and express values that include the right to quality services accessible to all regardless of age, socioeconomic status, or political affiliation. While the Quick Study Model benefitted from mayoral influence and newly gained urban budgetary authority in some cities, all involved took care to avoid any activity that might inadvertently support a given political party or candidate, or seem to provide assistance to a specific social or political order.

**Building regional partnerships and dissemination mechanisms for technical skills and urban service delivery models fosters replication of successful programs.**

SEATS' role in fostering "South-to-South" partnerships to improve urban programming and disseminate successful skills and models varied greatly from country to country. Activities included study tours for all Urban Study participants to Chitungwiza and Bulawayo

observe cost-recovery training programs and modest investments in creating a network among Senegalese and Guinean mayors and urban health authorities. The study tours and dissemination activities resulted in faster start-up for the Lusaka Youth subproject, higher local visibility leading to more political support in Bulawayo, and active fundraising for replication in Guinea. In addition, Senegalese participants provided technical support to the new Guinea program, further reinforcing a mutually beneficial partnership.

**Hiring local researchers increased capacity while producing faster results at lower cost.**

For the Quick Study Model, utilization of locally-based researchers instead of international or regional resources led to more efficient and less expensive research costs when compared with the Urban Study. Since researchers knew available data and how to access it, and had better contacts for field research and use of students in data collection, time was significantly shorter and costs were reduced. In addition, the researchers provided additional information to mayors and their teams during the workshops and remained a potential resource to the Teams.

**Municipal officials and some donors believe the Quick Study Model is applicable to planning in many sectors.**

In Senegal and in Guinea, urban leaders and funding agencies cited the cost-effectiveness and applicability of the Quick Study Model to various social service systems. There are plans for the Quick Study Model to be used in literacy, education, and sanitation services planning in Senegal and for broader urban health planning in Guinea.

**Working in secondary cities requires more time and technical support, and in some cases, is more costly than working only in the capital city.**

While secondary cities grow in number and demographic importance, they have less infrastructure and usually less access to both governmental and nongovernmental assistance. Less data were available about secondary cities, and subproject planning and implementation took longer than in capital cities. Municipal health departments and mayoral staff in secondary cities had more problems filling staff vacancies and keeping personnel. On the other hand, natives of a particular city often demonstrated great commit-

ment to their home town, and in Senegal, several secondary cities which self-selected to participate in the Urban Initiative had more impressive results than those municipalities with many more tangible resources. Outlying districts of a capital city, particularly those based on established communities surrounded by encroaching urbanization such as Pikine Ouest of Dakar, may more closely resemble secondary cities in terms of infrastructure, access to resources, and commitment to local development.

## Lessons Learned about Increasing Access to Reproductive Health Services

Increasing access to family planning and reproductive health services challenges Urban Initiative cities today and will continue to do so in the future, as urban areas continue to grow. SEATS' definition of access (see box) recognizes communication and education as important parts of access to services. SEATS also considers improvements in access, quality, and sustainability to be synergistic.

**Two strategies are key to maximizing access in urban areas:**

**1) identify and mobilize underutilized existing resources; and**

**2) be creative in using new, even unconventional ones**.

By applying both strategies, the Urban Initiative drew upon multiple resources that collectively contributed to expanded access in African cities.

- In addition to building capacity in family planning and reproductive health service delivery among untrained health providers, some cities made use of other underutilized human resources in the health sector. For example, in Senegal, retired health workers offered their services as health advisors to mayors.
- Involving sectors not usually associated with health service delivery, such as recreation, education, and public safety, also brought critical new resources for service expansion. For example, in Gweru, the dramatic increase from the first quarter to the next in the number of young men and women visiting city health clinics for STI services and antenatal care, was attributed largely to training peer educators and youth workers and conducting advocacy in churches, schools, and other community sites.

### SEATS EXPANDS THE DEFINITION OF ACCESS

Improving access includes both increasing the availability of services *and* ensuring that people are aware of them and have the information they need to reach and make use of the services. This calls for working beyond static service delivery points and extending efforts into the community (JSI/SEATS 1998a)

Engaging the private and nongovernmental sectors led to other sources of support. In Dakar, after a mayor spoke to factory workers about family planning and reproductive health, factory management agreed to be more active in promoting reproductive health. A leading NGO in youth services contributed its knowledge and expertise to mayors designing youth reproductive health programs.

**Urban decision makers are often unaware of existing research findings that could be used to better plan and allocate resources for expanded access.**

Beginning with the Urban Study cities, it was clear that providing the opportunity for officials and private-sector partners to understand reproductive health and the available data produced remarkable changes in the priority placed on reproductive health. However, municipal officials were often unaware of existing research on urban health because resource or coordination constraints limited its dissemination. From Zimbabwe to Guinea, urban leaders expressed surprise at statistics on unmet need, required service capacity to keep up with population growth, lack of knowledge of symptoms of STIs, and the amount of donor resources available to assist them to address these problems. In Gweru and Dakar, sharing available research that described the large and growing need for reproductive health services for youth and confirmed the high social costs of not providing these services convinced municipal authorities to make this underserved group a priority.

*Providing the opportunity for officials to understand reproductive health and the available related data can produce remarkable changes.*

**Cities that self-selected to participate had high interest in reproductive health and strong commitment to supporting changes to improve access.**

Rather than focusing limited resources on maintaining a specific number or variety of municipalities involved, the Urban Initiative models and processes reflected the premise that cities choosing to take part were more likely to succeed in achieving their goals than those participating to fulfill a quota. Some municipalities such as Gweru and those in Senegal took considerable time to decide whether they wanted to participate or not. These delays paid off in strong commitment to expanding urban reproductive health services. Other cities already had mayors or mayoral advisors with a keen interest or dedication to health. Consequently, these cities placed high priority on developing sustainable preventive health programs. As mentioned earlier, the gender of city leaders also seemed to influence the self selection of municipalities.

**Increasing access for underserved groups requires: 1) collecting and using good data about non-users; 2) mapping barriers to access; and 3) creating solutions specific to the needs of these groups.**

Residents of high-density, poor neighborhoods or slums with limited service delivery facilities are often under-represented in existing research on the quality of and barriers to services since they are under-represented among the client population. Programs need data to understand the cost, distance, and other barriers these underserved groups face and to design changes in existing services and structures. The experiences of Lusaka, Gweru, Senegal, and Guinea indicated that community-based outreach and education, combined with limited service delivery and referrals, may be the most reasonable way to improve access to quality services for subcommunities facing multiple barriers. Nevertheless, these programs seemed unlikely to achieve financial sustainability, pointing to the tensions between expanding access, reaching the underserved, and enhancing long-term sustainability.

**Socioeconomic differences create barriers between and within urban neighborhoods, making community information and outreach activities complex.**

Urban districts and health facility catchment areas are often not uniform in socioeconomic status. In addition, a clinic's catchment area may attract clients from beyond its limits. IEC activities that fail to take into account the differences between and within urban neighborhoods may not succeed. For example, in Senegal, outreach to residents of a slum adjacent to an area of middle-class apartment dwellers was not performed regularly. In Bulawayo, the failure to go beyond the facility to inform the population of new services most likely reduced demand for these services. Outreach can also help services better respond to client needs; in Senegal, activities revealed that lack of access to care for post-menopausal women was a concern that had been overlooked. Findings such as these reinforced the need for comprehensive, multiple channel communication activities in both the clinic and the community.

**Training service providers to be "youth-friendly" coupled with institutional commitment to education and services for youth and peer education leads to increased use of clinics by young people.**

Service providers' negative attitudes often limit young people's access to reproductive health services. In Lusaka and Gweru, the Best Practices Model pointed to cost-effective strategies for reaching youth. By adapting existing training materials to train providers to be more responsive to youth concerns and modifying existing services, these cities greatly increased the number of youth served without incurring the costs of establishing a separate program with its own staff and hours.

## Lessons Learned about Improving Quality of Care

SEATS used a number of conceptual frameworks to guide its interventions to improve the quality of reproductive health care (Ippolito et al. 1996). Throughout the Urban Initiative, SEATS collaborated with other USAID Cooperating Agencies and donors involved in quality improvement, reinforcing their activities and facilitating linkages to those groups.

*The high diplmatic cost of publicly exposing serious problems with quality needs to be weighed against the potential catalytic power this information holds.*

**The high diplomatic cost of publicly exposing serious problems with quality needs to be weighed against the potential catalytic power this information holds.**

In most Urban Initiative cities, leaders consistently wanted more—and more specific—information and data while simultaneously—and often vigorously—denying that the content applied to their municipal district or service delivery system. In some cases, leaders who had a difficult time accepting research findings were also those who did not continue participation in Urban Initiative activities, identifying another potential component of self-selection (discussed above). On the other hand, those who were convinced by the data, such as the mayors in Senegal who opted to focus on young people after learning about the magnitude of their reproductive health needs, became true advocates. Private-sector participants, particularly those from for-profit groups, were less interested in overall quality indicators than in increasing market share and profit margins without large investments or government oversight.

**Many standard research methods under-sample young men and women as a percentage of those of reproductive age, requiring additional data collection to design interventions to improve quality of care for young people.**

Young people are among the most underserved populations in urban areas. The results of studies, including DHS and Situation Analyses, often do not provide enough information on young adults, especially those who are not heads-of-household or married. Highly vulnerable youth such as street children, orphans, and sex workers, are almost never included in household surveys. After examining all available data, Gweru, Lusaka, and cities in Guinea and Senegal found that they needed to invest in primary data collection to gather more information about the reproductive health attitudes and practices of youth.

**Integrating quality improvement processes and analysis tools into service delivery structures requires ongoing technical assistance.**

Even strong, established, and well functioning family planning programs, such as those in Zimbabwe, needed technical assistance in implementing new quality improvement activities, including CQI. In all cities, service providers understood new tools and concepts, but they often found their application in a working clinical setting to be challenging. For example, in Gweru, supervisors and trainers were enthusiastic about a new training follow-up tool, but were unsure how they could best adapt it to fit their circumstances. Institutionalizing CQI and other approaches was even more difficult when all staff at a given site were not trained simultaneously.

**Successful Coordinating Committees may not be able to absorb leadership for CQI activities, and this may not be the best strategy even if they can.**

In Bulawayo, Gweru, and Senegal, the inter-agency, multisectoral Coordinating Committees assumed important leadership roles in both program oversight and developing longer-range visions of urban reproductive health services. However, they were not well suited to take on responsibility for management of technical quality improvement activities precisely because their composition did not reflect that of a Quality Council for the institutions involved.[6]

[6]In CQI, a Quality Council, usually composed of health facility or system administrators, shares responsibility with a Quality Team, made up of frontline service providers and others with a direct stake in service delivery, for continuously improving quality in a given facility or institution.

**Client exit surveys are an inexpensive, rapid means for providers and managers to identify areas in need of improvement and to assess if changes have improved quality in specific areas.**

Bulawayo, Chitungwiza, and Lusaka successfully incorporated client exit interviews into their quality improvement activities. Service providers and managers indicated that this methodology was influential in helping them understand how clients perceived services.

**The costs for diversifying the method mix to include more LTPM methods are often comparatively high in cities where resupply methods are popular.**

In Bulawayo and Lusaka, OCs and injectables predominated in the method mix. In these cities, as in other resource-scarce settings, decision makers felt compelled to weigh the short- and medium-term costs involved in improving access to LTPM methods against the potential for long-term savings. Expanding the method mix to include VSC, IUDs, and implants called for substantial investments in equipment and infrastructure as well as information, communications, and human resource development. In Bulawayo, the introduction of fees to recover some of the costs of VSC services may have contributed to reduced demand for this contraceptive. Resource restrictions may lead to choices between access to more methods for fewer clients or access to fewer methods for more clients as population growth outstrips the growth of municipal budgets. Regular personnel changes in the public sector also require ongoing training in order to continue to offer a wide range of methods, meaning that the costs of training new personnel rarely diminish.

## Lessons Learned about Enhancing Sustainability

Implicit in the Urban Initiative's mandate was the need to support the growth of sustainable, high-quality services that can continue to meet demand. SEATS integrated sustainability plans into all of its subprojects, building upon prior achievements and trying new strategies. The definition of sustainability that SEATS used to assess its work set a high standard for success (see sidebar).

Sustainability *is the capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to an underserved population while decreasing dependence on external aid.*

**Urban areas have more untapped resources available to support reproductive health programs than is commonly believed**.

Resources may exist within municipal budgets, as were the cases in Senegal, Bulawayo, and Chitungwiza. In other cases, new service fees, rental of clinical space, and the establishment of services for hire helped make continuing service delivery possible. Often, external funds were available for both public- and private-sector service delivery structures, but those eligible to request funds were unaware of these resources or unable to meet minimum requirements for obtaining support.

**Strengthening the linkages between municipal health departments and city governments can increase sustainability through joint planning and combining resources.**

Although city governments may be responsible for funding the delivery of health services to their populations, elected leaders are not always knowledgeable about the reproductive health needs of their communities nor the possible avenues to increase the sustainability of services. Dialogue and regular advocacy can transform municipal authorities into stronger allies of city health departments, resulting in the allocation of resources that contribute to sustainable service delivery. For example, in Bulawayo, the City Council endorsed the established Family Planning Training Centre and now provides it with funds to cover some recurrent costs and equipment maintenance fees. Simultaneously, the Health Department generates additional income through training external students on a fee-for-service basis.

**Building advocacy and leveraging skills among urban leaders is likely to increase long-term sustainability of urban reproductive health programs.**

In all Urban Initiative countries, urban leaders successfully leveraged SEATS' funds provided through USAID to obtain additional non-USAID funds and services in support of municipal family planning and reproductive health activities. In the West African countries of the Urban Initiative, donors such as GTZ, UNFPA, and the World Bank provided at least $400,000 in funding. In the East and Southern African countries, estimates of donor and private company contributions were similar. It is likely that these amounts have since increased. While leveraging is not always a precursor to long-term sustainability or programmatic effectiveness, it did enable munici-

palities to achieve some of their sustainability goals. In addition, it demonstrated partners' skills in innovative planning and advocacy as well as the general soundness of their plans, which were supported by multiple stakeholders. Depending on the city and its needs, SEATS provided technical assistance, training, and experience in advocacy, proposal writing, and donor networking. In some cases, SEATS helped establish contacts with potential funders.

**Matching municipal resources with donor funds contributes to local ownership of and commitment to reproductive health activities**.

Most municipal governments and agencies participating in the Urban Initiative partially matched the financial and technical assistance from SEATS. These municipal contributions were estimated to be a half million dollars and took the form of donated staff time, space and equipment, funds, and technical training. The cities making the largest monetary or in-kind contributions seemed most likely to complete their work plans—evidence of their dedication to improving reproductive health services for their constituents.

**Local technical assistance sources have the potential to create permanent planning and management capacities required for long-term sustainability of services.**

The Urban Initiative experience reconfirmed the importance of investments in building urban leaders' capacity to use data to plan for current and future needs and to efficiently manage resources. As the population in cities grows and the demand for quality services increases, so does the complexity of decision making for municipal authorities and health program managers. Local consultants and university staff proved to be cost-effective and acceptable partners for municipal officials, with the added benefits of longer-term availability and commitment to national development. These technical assistance sources can contribute to the institutional development and scaling-up necessary for sustainable services.

# *Conclusion*

SEATS' Urban Initiative has uncovered partial responses to crucial questions about urban health programs in African cities and the role of municipal governments in their management. The Best Practices and the Quick Study Models promoted partnerships with municipal officials, data-driven planning, advocacy, multisectoral coalitions, and "South-to-South" dissemination. The combination of these approaches has proven to be a powerful strategy for building cities' sustainable capacity to improve reproductive health care. With more than half of the populations in cities under the age of 15, the momentum for future urban growth is strong, and demand for reproductive health and other services is sure to increase. The methods and processes of the Urban Initiative have the potential to help cities around the world ensure that all of their inhabitants, and especially the urban poor and youth, will have access to high-quality reproductive health services.

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John Snow, Inc.
1616 N. Fort Myer Drive, 11th Floor
Arlington, VA 22209

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