Reproductive Health
Santé Reproductive

USAID, Bureau for Africa, Office of Sustainable Development

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Reproductive Health Brief

Bureau for Africa/Office of Sustainable Development Reproductive Health Portfolio

The Bureau for Africa's Office of Sustainable Development's (AFR/SD) goal is to increase African capacity to manage sustainable development by strengthening African institutions and improving the human resource base. AFR/SD's reproductive health strategic objective was established to improve the effectiveness and sustainability of family planning and health programs in sub-Saharan Africa.

The reproductive health team's strategy is to identify, document, and advocate for improved reproductive health policies. In collaboration with USAID's Global Bureau and cooperating agencies, the team supports a combination of research and analysis, technical assistance, and advocacy to develop more sustainable and effective strategies at the country and regional levels. The success of each activity depends on the creation of an enabling environment to develop, implement, and evaluate family planning programs. They rely on innovative advocacy strategies to increase support for expanded family planning programs. This program is coordinated to include the reproductive health needs of adolescents and males, urban family planning services, the integration of sexually transmitted infection (STI)/HIV/AIDS services, empowering women, capacity building for reproductive health programs, innovative advocacy strategies involving the media, and essential obstetric care.

Adolescent reproductive health (ARH) services

ARH contributes to increasing sustainable and quality family planning services by expanding strategies to address the needs of traditionally underserved populations. Adolescents are the fastest growing population in sub-Saharan Africa. Yet family planning programs have not consistently serviced this growing and vulnerable population. This program seeks to promote appropriate services and create a climate where adolescents' reproductive health needs are met.

Male involvement

In the past men have not been formally included in reproductive health programs. AFR/SD initiated a program focused on male participation to foster appropriate interventions for promoting partner communication and for providing reproductive health services to men. The program is designed to facilitate the assessment and removal of barriers to delivering health information and services to men. Furthermore, the program is structured to foster informed decision-making about reproductive health by men.

Improved urban family planning services

The expansion of urban family planning services complements AFR/SD's strategic plan by creating an enabling environment where sustainable and quality services can be designed, implemented, and evaluated to ensure that the needs of urban clients are met.

Integration of STI and HIV prevention with service delivery programs

This activity supports the use of improved, effective, and sustainable responses to reduce HIV

transmission and to mitigate the impact of the HIV/AIDS epidemic. The integration of family planning and STI/HIV prevention programs capitalizes on an existing client base and provider network as a means of addressing the need for STI and HIV prevention. Specifically, the activity contributes to achieving Global Bureau's three key approaches to STI/HIV/AIDS prevention by reducing "high-risk" sexual behavior through behavioral change interventions; increasing demand for and access to condoms; and treating and controlling sexually transmitted infections and diseases.

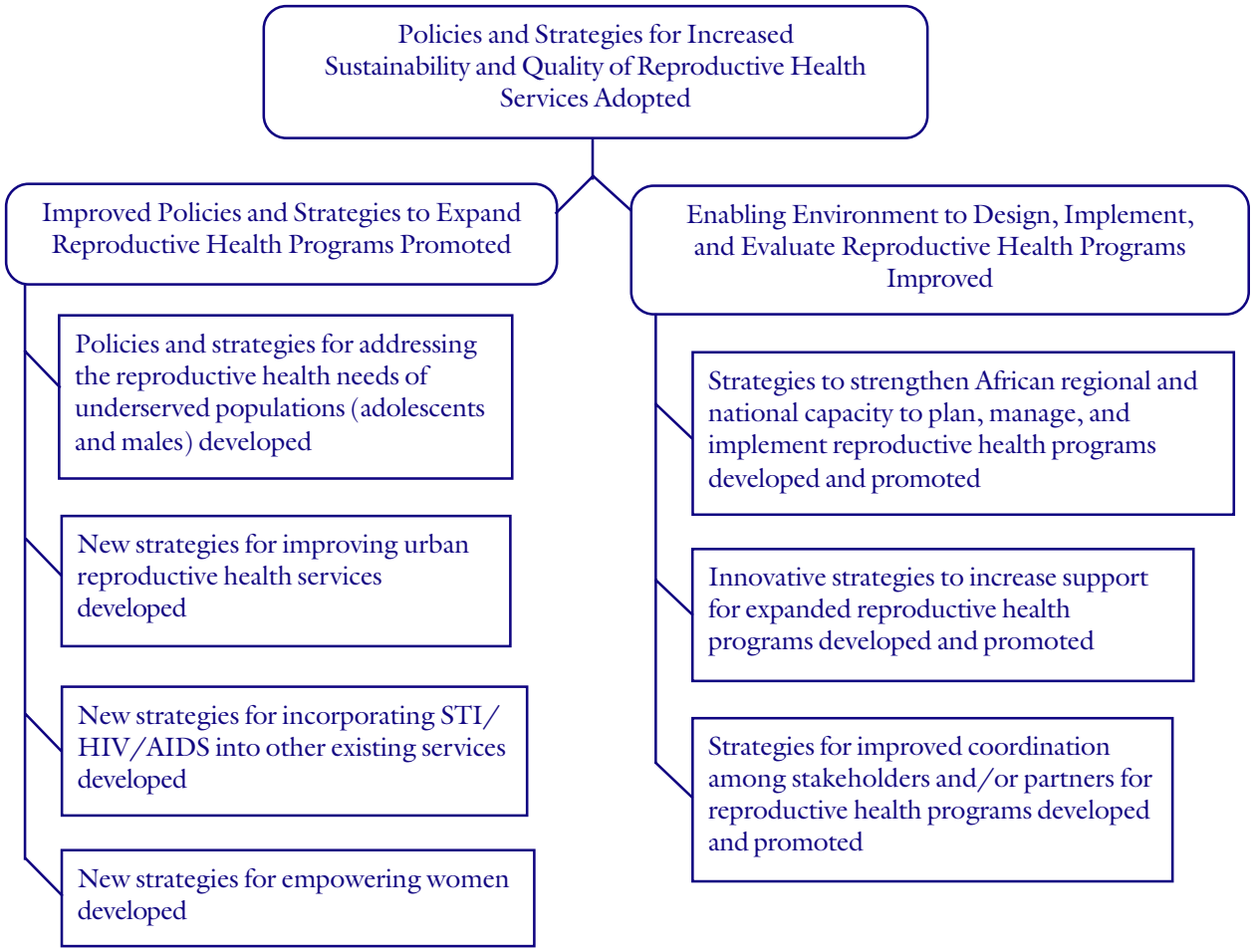
Empowering women

This program area is based upon the need for new strategies to empower women to exercise their right to control their own fertility. By managing their own health and sexuality, women are less at risk for health threats, such as female circumcision, unwanted pregnancy, and sexually transmitted infections including HIV/AIDS. These activities devoted to empowering women contribute to AFR/SD's overall plan to strengthen African development institutions, increase the stock of human capital, and promote greater involvement of women in national development.

Media

The media program area was designed to increase the number and quality of media products generated using data-based reporting with a focus on reproductive health policy and program needs. The program was developed to facilitate changes in media program operations, e.g., to establish regular news features on reproductive health, increase the number of reporters with technical expertise, and increase reporting on priority population and gender issues as requested by local ministries and other organizations.

Results Framework for Reproductive Health



Adolescent Reproductive Health: Overview

Background

One of the challenges most frequently cited by African health specialists is the need to improve reproductive health behavior among adolescents. Today there are nearly 220 million young people in Africa between the ages of 10 to 24. By the year 2025 that number is projected to increase by another 130 million, bringing the total to 350 million.[1] The growth of the adolescent population translates into a larger population traditionally underserved by family planning programs with grave consequences. The World Health Organization (WHO) reports that the highest rates of sexually transmitted infections (STIs) occur among 20-24 year olds, followed by adolescents ages 15-19. Young girls are at even a higher risk, largely due to earlier onsets of sexual activity.

Many African experts believe that changing sexual attitudes and behaviors, along with reducing disparities in gender roles and responsibilities, will be most easily achieved through the provision of information and services in the early, formative years. What is needed now are wider, deliberate actions to address these adolescent issues, however complicated and politically sensitive they may be. Despite increasing attention in recent years to adolescent reproductive health, the following important needs remain:

- Increased understanding of the barriers to and strategies for serving male and female adolescents
- Increased social acceptability of serving adolescents
- Expanded range of strategies and services for addressing the needs of both male and female adolescents
- Increased access to and quality of services for adolescents
- Documentation and dissemination of successful programs
- Increased advocacy efforts for adolescent reproductive health interventions.

Solutions for adolescent reproductive health problems will have to take into account the resource constraints under which most USAID missions and African governments operate, few of which can afford vertical adolescent programs. The key to finding solutions will be to identify how adolescent-focused interventions can be integrated into other reproductive health activities and a broader range of other types of programs, such as education and income generation. Another important problem will be to consider the different psychological and social profiles of males and females, while addressing the need for dual protection from unwanted pregnancies and HIV/AIDS/STIs. The Bureau for Africa/Office of Sustainable Development (AFR/SD) has already supported several significant activities addressing the range of needs just identified.

Illustrative activities

Develop new approaches to changing adolescent behavior and providing reproductive health services

Despite the sizeable increase in the number of adolescent peer education activities throughout Africa, few have been able to demonstrate effectiveness in getting adolescents to adopt safer reproductive health behavior. Alternative models for changing behavior need to be developed and tested. Initial results in Uganda and elsewhere in East and southern Africa indicate that voluntary counseling and testing (VCT) has led to a reduction of risky sexual behavior among adults. The Africa Bureau will support programs to test whether VCT, when incorporated into a broader behavior change strategy, is an appropriate approach for changing adolescent behavior.

In Zambia and Zimbabwe, the Family Planning Service Expansion and Technical Support (SEATS)

Urban Initiative tested several models for providing and improving services for adolescents, including provider training, youth corners in the clinics, peer educators in the clinic, and outreach. The results will be broadly disseminated as part of a strategy to advocate for improved adolescent services and the appropriate monitoring and evaluation of these programs. Adolescents often maintain that earning an income is much more important than protecting their reproductive health. AFR/SD will support research that looks at the possibility of combining income generation activities with reproductive health education as a means of improving the efficacy of the latter.

Develop strategic plans to address adolescent reproductive health needs and incorporate relevant activities into programs

Adolescent access to reproductive health information, education, and services would increase if existing programs incorporated activities that are relevant to the needs of young people. The AFR/SD reproductive health team will provide technical assistance to missions wishing to develop adolescent reproductive health strategies. These strategies will incorporate, where appropriate, the new and effective tools and approaches identified through AFR/SD-supported research. Missions will be assisted in developing strategies for integrating reproductive health programs with those addressing other adolescent needs, such as income and education, and in mobilizing other donor support for adolescent programs.

Compile and disseminate up-to-date information about adolescent reproductive health needs, constraints, and programs

To be effective, the development of advocacy, education, and service delivery programs for adolescents needs to be informed by current information. AFR/SD is supporting the Population Reference Bureau and MACRO International to compile and disseminate an updated and expanded version of the highly successful adolescent chart book. The relevant data will be made available to missions, cooperating agencies, donors, and African leaders and professionals. AFR/SD-supported research and analysis activities will assist in developing dissemination and advocacy plans. One area of particular interest is the ways in which programs for addressing reproductive health needs have been successfully integrated with those for improving income and education.

Advocate for programs to address adolescent reproductive health (ARH) needs and relevant social and political constraints

In many countries, government, social, and religious leaders do not have the capacity and tools to advocate for ARH programs. Advocacy materials and strategies will be developed to provide these audiences with information, arguments, and tools to build consensus on the need and means to address adolescents' reproductive health and reduce social and political barriers. A priority will remain to expand adolescent reproductive health education and services in Francophone West Africa where family planning rates, even for adults, are so low. The Centre for Applied Research on Population and Development (CERPOD) has used findings of its adolescent research to promote policy change in several Francophone West African countries. Its highly original and widely distributed booklet, *Youth in Danger*, which used research data to support policy and program recommendations, was so successful that a total of 13,000 copies had to be printed to meet demand. To date, CERPOD's new, more active approach to dissemination and advocacy has resulted in: increased funding for follow-up activities from USAID's regional program and other collaborating agencies; the addition of reproductive health to non-governmental organizations' youth programs in Burkina Faso; and an increase in both the quality and quantity of media coverage on adolescent reproductive health throughout the Sahel.

Disseminate information about and advocate for the prevention of female genital cutting (FGC)

Under the reproductive health program to empower women, support will be given to USAID efforts to combat the harmful practice of female genital cutting. FGC may be performed on girls from just after birth to adolescence and results in a life-long negative impact on their health and human rights. In collaboration with the Global Bureau, AFR/SD will support this effort, which will include a Michigan Population Fellow to direct advocacy activities, prepare materials, and organize dissemination and advocacy meetings. For further details, see the Female Genital Cutting brief.

[1] United States Bureau of the Census, 2000.

Empowering Women

Background

Control over one's reproductive health is a basic need and a basic right for all women. Achieving reproductive health, however, requires more than simply providing contraceptives. Family planning and sexual health involves the most intimate of human relations, complex behaviors, and substantial risks. To control their own reproduction, therefore, women must also be able to achieve social status and dignity, to have access to appropriate health services, to manage their own health and sexuality, and to exercise their basic rights in society and in partnerships with men.

Mike Bailey, JHU/CCP

Among the many obstacles to improving women's health and well being, one critical issue is the need to increase protection over women's own sexuality. Traditional attitudes and beliefs have led to such health-threatening practices as female genital cutting (FGC) and rape of young girls, in the belief that this will avoid AIDS. These are very sensitive areas, involving deeply seated traditions that must be addressed with great sensitivity. In fact, these practices will only change as the result of efforts of African civil society, particularly with assistance from indigenous nongovernmental organizations, human and women's rights groups, and the media. The Bureau for Africa/Office of Sustainable Development (AFR/SD) efforts will focus on promoting an enabling environment within which legal, policy, and societal changes can take place.

To increase knowledge of the magnitude and consequences of sexual abuse, coercion, and male dominance, AFR/SD promotes the inclusion of questions on sexual coercion and harmful behavior and practices in regional household surveys and independent studies. Other planned activities aimed at increasing understanding about the issues, as well as strategies for overcoming problems, include the synthesis and dissemination of information on a variety of themes using multiple formats and channels. The reproductive health team will also facilitate network links and support the dissemination and advocacy efforts of human rights' and women's groups by supporting their participation in international, regional, and national conferences; providing advocacy training; and linking groups to relevant donors, women's policy centers, and regional research institutions.

In 1998, AFR/SD and the Global Bureau jointly supported a Fellow for two years in USAID's Office of Population to focus on the elimination of FGC. Specific responsibilities included collecting and analyzing information, raising awareness within USAID of ways to assist local groups in their efforts to change social traditions, and coordinating activities among programs. Support has been continued for advocacy and policy initiatives launched and coordinated by the Fellow.

Illustrative activities

Since 1996, AFR/SD has supported a West Africa media activity (Pop'Mediafrique 1996-1998) that informs a network of senior-level print editors, radio producers, and health officials about the implications of current research in the area of reproductive health. Based on the success of this activity, AFR/SD plans to launch a new initiative designed to strengthen the role of women journalists

in advocating for women's rights. Its primary objectives are to:

- Raise the profile of reproductive health and gender issues by expanding and sustaining quality, data-based reporting
- Strengthen relationships between national print and radio senior editors, women reporters, and local health and social affairs officials
- Capitalize on the new era of free press to engage civil society and leaders in debates on relevant women's issues.

Danielle Baron, JHU/CCP

According to a recent assessment, women journalists have a tendency to seek support from each other (e.g., create women's media networks), thus perpetuating a sense of isolation within the broader, largely male dominated media community. To reduce the marginalization of women journalists, this initiative seeks to build bridges between key players, such as beat-level women reporters and their male senior editors, and strengthen relationships among officials in the fields of women's journalism and policy.

Specific activities include bringing women journalists together with key public policy makers and media outlet editors from five-to-six countries for semi-annual seminars on selected topics. Following each seminar, participants produce a series of print articles and broadcast programs on priority gender issues and contribute to the Pan Africa News Agency's (PANA) biweekly newswire bulletin, which is consulted by press organizations throughout sub-Saharan Africa. Potential collaborative institutions include Africa Consultants International, the Association of African Communication Professionals (APAC), and PANA.

These innovative strategies have successfully promoted the expansion of family planning programs by increasing knowledge about the consequences of sexual abuse, coercion, and male dominance. They have also capitalized on the networks of women's advocacy organizations to communicate messages about women's reproductive rights and needs.

In an effort to sustain the improved and expanded services, AFR/SD expects the activity to yield the following results:

- Continued exchange of information between women's organizations, relevant research institutions, policy audiences, and international donors, e.g., internet listservs/e-mail, seminars, mailing lists, innovative formats
- Increased number of quality media products (newspaper articles and radio programs) demonstrated by data-based reporting with a focus on women's policy and program needs
- Changes in media outlet program operations such as the establishment of new regular news features on women or evidence of new collaboration for advocacy between media outlet senior editors, women reporters, regional news agencies, and local health and social affairs officials.

Reproductive Health Brief

Expanded Urban Family Planning Services

Background

The urban population of Africa is growing faster than any other region of the world. Africa's urban population represented 33 percent of the total population in 2001 and is projected to increase to 45 percent by 2010. The speed of urbanization, coupled with the financial difficulties currently facing many urban programs, is threatening urban program planners' ability to maintain the contraceptive prevalence rates they have already achieved, much less to expand and improve programs to accommodate growing numbers of clients.

Since 1996, the Urban Initiative has moved beyond the research and tools development stage to implementation with broad support from a range of partners. Thus, the Bureau for Africa/Office of Sustainable Development (AFR/SD)'s role is ending and financial investment will gradually phase out over the next two years. Implementing partners have demonstrated tremendous success in leveraging funds for scaling up and expanding the initiative over the past few years. The Urban Initiative has demonstrated its ability to attract and leverage alternative funds to address urban family planning services in selected cities in both East and West Africa. AFR/SD will encourage this trend as it disengages its support. Efforts are being made to document and disseminate lessons for leveraging other donor and local city council support for expanding urban family planning and reproductive health services to high risk and vulnerable groups.

The program area works in collaboration with reproductive health program areas including sexually transmitted infection (STI)/HIV/AIDS integration, adolescents, and male involvement.

Illustrative activities

AFR/SD has worked with two cooperating agencies, John Snow, Inc. and Pathfinder, to implement the Urban Initiative. The interest of municipalities in participating in the new regional urban initiative in East and southern Africa has grown rapidly. Four cities developed strategic action plans (Lusaka, Zambia; Gweru, Bulawayo, and Chitinguiza, Zimbabwe), implemented those plans, tracked progress, and obtained their own funds. The strategic plans were based on systematic situational analyses and projected demand and improved coverage and quality services.

Liz Gilbert, Courtesy of the David and Lucile Packard Foundation

Improved quality of services for youth

Three additional cities (11 sites) have begun to implement strategic action plans developed through systematic analysis of city-specific data. The key focus of these activities was to expand services to youth and emphasize dual protection methods for all clients. This was accomplished by:

- Training service providers, clinic staff, and community members with youth-friendly integrated reproductive health curriculum
- Establishing Youth Corners in area health centers
- Training peer educators in reproductive health and outreach.

JHU/CCP; Alex Niyonzima, Home Needs Network

A monitoring component was added that allows AFR/SD to evaluate the model for replication elsewhere. The monitoring component was completely funded by the FRONTIERS project operated by the Population Council. A youth-focused outreach project was designed and implemented by Pathfinder in early 1999 to reach adolescents with reproductive health information in a Nairobi slum. Results from this effort will be documented and disseminated.

Development of partnerships with public and private sectors

After having attended results dissemination workshops, Senegalese and Guinean officials expressed interest in developing strategic plans and implementing urban family planning initiatives in their cities. A program was developed to:

- Collect and analyze reproductive health data in Guinea
- Coordinate municipal planning and dissemination workshops.

Implementation of similar activities began in Dakar and Louga in Senegal in FY99.

These activities have fostered greater communication between communities and their governing municipalities and resulted in joint planning and leveraging of resources to meet the reproductive health needs of area populations.

Reproductive Health Brief

Female Genital Cutting (FGC)

Background

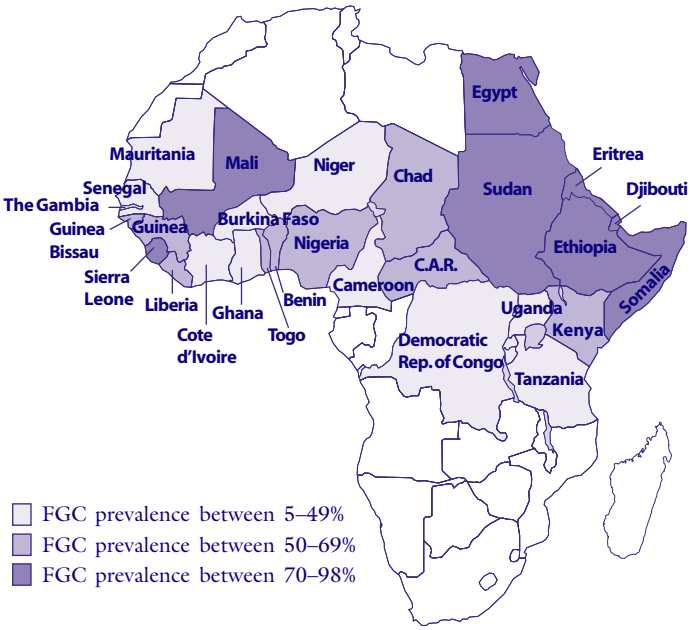
Female genital cutting (FGC), also known as female circumcision (FC) and female genital mutilation (FGM), is a harmful traditional practice in many countries around the world, but is most prevalent in Africa.

FGC is a serious human rights violation of women and girls that has grave health consequences. It directly violates both Article 3, "Everyone has the right to life, liberty, and security of person," and Article 5, "No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment," of the Universal Declaration of Human Rights. As the Universal Declaration's Article 7 states, "All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination."

Short-term health consequences of FGC include pain, injury to adjacent tissue of the urethra, hemorrhage, shock, acute urine retention, infection, and failure to heal. Long-term health effects can include recurrent urinary tract infections, pelvic infections, infertility, keloid scars (cysts), damage to the urethra or anus, and problems during childbirth. These effects significantly damage a girl's lifetime health, although the type and severity of consequences vary depending on the particular procedure.

FGC affects a significant proportion of the population that is absolutely critical for healthy development, economic growth, prosperity, and sound development. These development implications and such widespread human rights violations make FGC a matter of global concern.

Today, the number of girls and women who have been subjected to FGC is estimated at over 130 million worldwide, and a further 2 million girls are annually at risk of this practice.



Source: USAID Intra-Agency Working Group on FGC

Most of the girls and women who have undergone genital cutting live in 28 African countries, although some live in Asia and the Middle East. They are also increasingly found in Europe, Australia, Canada, and the U.S., primarily among immigrant populations.

An FGC policy designed to support USAID's Strategic Plan has recently been approved. This policy, effective September 1, 2000, states that USAID recognizes FGC as a harmful, traditional practice that violates the health and human rights of women and hinders development. USAID opposes any practice of or support for female genital cutting and works toward the goal of total eliminaton of FGC. Under no circumstances does USAID support the practice of FGC by medical personnel.

USAID will undertake the following actions to ensure that the issue of FGC is effectively integrated into and deliberately considered within Agency policy, programs, and strategies:

- Update the Agency strategy to guide future activities in the areas of health (especially reproductive health), human rights, education, gender, democracy, governance and other relevant areas

- Support indigenous nongovernmental organizations, women's groups, community leaders, and religious organizations to ensure that eradication activities are culturally appropriate and will reach all stakeholders, including men and boys

- Acknowledge that, while USAID supports host country legislation against the practice of FGC, a successful elimination process is one that ends the demand for the practice. Therefore, USAID will continue to work in close partnership with indigenous groups at the community level, as well as with global and national policy makers, to promote broader education and dissemination of information on the harmful effects of FGC in order to reduce demand

- Establish a regular liaison with other donors/activist groups to gather information and develop a framework for research and advocacy that will enhance collaboration and coordination of elimination efforts, share lessons learned, and stimulate public understanding of FGC as a health damaging behavior and a violation of fundamental human rights.

FGC is addressed under two of USAID's main goals: (1) stabilization of global population and protection of human health; and (2) building democracy. Initiatives are implemented through cooperating agencies in the areas of strategic planning, policy development, education, training, advocacy and research. In Burkina Faso, Egypt, Eritrea, The Gambia, Ghana, Guinea, Kenya, Mali, and Senegal, local and regional women's organizations working to eliminate FGC have received funds and technical assistance from agencies collaborating with USAID and/or USAID missions.

Aimee Centivany

An Intra-Agency Working Group on FGC was established in 1994 and has taken the lead in building capacity and commitment to addressing FGC elimination. Members represent the Bureau for Africa, the Center for Population, Health and Nutrition, the Office of Women in Development, the Bureau for Policy and Program Coordination, and the Bureau for Humanitarian Response. The Agency's approach is cross-sectoral, recognizing that FGC affects female reproductive health, the status of women, democracy, and human rights. To coordinate activities of the Intra-Agency Working Group, a fellow from the Population Leadership Program of the Public Health Institute, jointly supported by the Bureau for Africa/Office of Sustainable Development and the Global Bureau, is currently assigned to USAID.

Reproductive Health Brief

Integrating STI/HIV/AIDS Services into other Service Delivery Programs

Background

Many national programs and donors in sub-Saharan Africa are shifting their programmatic strategies toward a broader reproductive health service approach, which includes the integration of sexually transmitted infection (STI) and HIV/AIDS services into existing maternal and child health-family planning (MCH-FP) programs.

An especially important factor in the shift toward integration is clear evidence that prevention and control of STIs is a potentially key element of a strategy to reduce the spread of HIV. In Africa, where the primary mode of HIV transmission is heterosexual intercourse, the presence of certain STIs (particularly genital ulcers and infections which cause genital discharge) is thought to increase significantly the likelihood of sexual transmission of HIV. A number of studies have indicated at least a two to nine-fold increased risk of HIV transmission among persons who have other STIs.

Moreover, STIs themselves have serious implications for women's reproductive health. In sub-Saharan Africa, the complications associated with untreated or inappropriately treated infections can be severe. STIs in pregnant women are associated with premature delivery, consequent low birth weights, eye infections—and possibly blindness—in newborns, intrauterine growth retardation, and higher rates of spontaneous abortion, stillbirth and neonatal death. UNAIDS estimates that over 500,000 infants were infected with HIV in 1997 through mother-to-child transmission before or during birth or through breastfeeding. Thus, integrating STI/HIV/AIDS services into existing MCH programs is a programmatic strategy to be considered for improving conditions of children affected by HIV and strengthening measures to prevent mother-to-child transmission of HIV.

One programmatic advantage in the integration equation is that the specific elements of an STI control program are fairly well known. They include preventing new infections in the general population; treating persons with symptoms of infection; improving health-seeking behavior among those who self-diagnose infection; strengthening detection and treatment of those with an asymptomatic infection; and improving the effectiveness of STI case management and treatment.

Applying these principles to primary health care programs, however, remains a huge challenge. We know that the most frequent and accessible point of contact between health care programs and low-risk women is through the provision of MCH-FP services, which are the backbone of primary health care programs throughout the region. A rationale exists, then, for developing and testing strategies that integrate STI/HIV prevention and management services with existing MCH-FP services. Yet despite the international consensus supporting integration, there are inherent limitations in the tools that are currently available for use, and not all populations are equally effective in achieving real public health impact.

While integration allows access for some women and youth who may not be well served in traditional STI and primary care clinics, it does not necessarily capture individuals who are core STI transmitters. The nature of many STIs is that they are sustained and spread by individuals who engage in frequent, unprotected, high-risk sexual behavior and thus have a high likelihood of infection and transmission. These core transmitters include commercial sex workers and their partners, truckers, military personnel, and sexually active adolescents. Thus, intervention programs must also target those who engage in high-risk behavior and play an essential role in spreading STIs.

Much of the Bureau for Africa/Office of Sustainable Development's (AFR/SD) investment in the integration issue over the past five years has focused on documenting case studies, reviewing "best practices" in Africa and elsewhere in the world, and supporting workshops and symposia to exchange ideas and experiences in the region. AFR/SD's key partners in this effort have included USAID's Regional Office for East and Southern Africa (REDSO/ESA), the Population Council, Pathfinder International, the BASICS project, and Family Health International's AIDSCAP project. As a result of work undertaken by these organizations and their local collaborators, a "draft road map" is starting to take shape revealing

the directions and structures that integrated programs should adopt to maximize their impact. As important, these same efforts have helped to identify knowledge gaps and research needs, which, if addressed, could shed light on the key remaining unanswered questions.

The Africa Bureau/Office of Sustainable Development recommends the following approach as a means of supporting this activity:

- Develop effective strategies for integrating STI/HIV/AIDS prevention with MCH-FP and other reproductive health programs
- Develop, improve, and promote cost-effective HIV/AIDS strategies
- Coordinate with donors and other partners to improve HIV/AIDS programs
- Strengthen African regional and national capacities to plan, manage, and implement HIV/AIDS programs.

Illustrative activities

Aggressive prevention efforts to reduce infections and improve health-seeking behavior

A major problem in STI treatment is inadequate knowledge among providers of how women and men perceive and define symptoms of reproductive-tract morbidity. To foster changes in health seeking behavior, AFR/SD recommends that existing information should be collected. AFR/SD supported research by Population Council in Ghana and Burkina Faso that explored the perceptions of reproductive tract morbidity and associated health-seeking behavior. AFR/SD also recommends developing, testing, and applying gender-specific information and education strategies that improve women and men's health seeking behavior in both clinics and community-based programs. For example, outreach programs that reach women and men in the informal sector will be pursued. Another means for encouraging integration is to support and strengthen condom use as a contraceptive and as a method of disease prevention.

Promotion of advocacy and policy communications

Policy makers and program managers remain handicapped by a paucity of data on client profiles and STI prevalence, data that are needed if these leaders are to make informed decisions whether or not to pursue an integrated approach to STI case detection and management within the general population. Consequently, more attention needs to be given to clinic- and population-based surveys that could provide data about STIs, information on who uses MCH-FP and other service programs, and cost analyses that provide comparable data on cost per case treated through a variety of service delivery settings.

Likewise, as new technologies for diagnosing and treating STIs become available, and as we learn more about how to integrate services effectively, this information will need to be widely available in accessible formats. Thus, AFR/SD will focus efforts on disseminating current knowledge of priority interventions and new research results as they emerge, and helping donors and African partners advocate effectively for appropriate interventions and resource allocations.

Promotion of counseling and testing clients for STIs/HIV

AFR-SD supports introducing voluntary counseling and testing in MCH-FP and other service delivery settings to:

- Enable and assist infected women and men to plan their future sexual relations
- Minimize the potential of transmitting HIV
- Reinforce the efforts of uninfected women to maintain this status
- Inform women of the options available to them for delivery and breastfeeding to reduce the likelihood of transmission of HIV to the newborn and infant
- Develop and test alternative approaches to strengthening STI and HIV counseling and testing services. Specific activities should include operations research on different delivery approaches, cost analyses, and dissemination of lessons learned and "best practices" to policy and program audiences.

Promotion of adolescent programs

Currently, the adolescent reproductive health program includes activities that complement the service integration program. The reproductive health team will continue to promote activities designed for adolescents that encourage integration of STI prevention and treatment and family planning services through joint education, counseling, referral, skills development, and peer support programs (see Adolescent Reproductive Health brief). Elements of activities to be supported will include documenting "best practices" for advocacy and Information, Education and Communication capacity building and delivery of youth-friendly information and services to address STI transmission among sexually active youth.

Reproductive Health Brief

Postabortion Care Advocacy in East and Southern Africa

Background

A study carried out in 1995-96 showed that between 15 and 30 percent of maternal mortality in East, southern, and Central Africa was due to unsafe abortion. However, programs and policies were not responding to this problem. To address these gaps, the Bureau for Africa aimed to sensitize USAID missions and national governments to the reproductive health problems associated with unsafe abortions and to increase both financial and technical support for postabortion care.

The Bureau for Africa/Office of Sustainable Development (AFR/SD) partnered with USAID's Regional Office for East and Southern Africa (REDSO/ESA) and the Policy Project to build on the evidence presented in the Commonwealth Regional Health Community Secretariat (CRHCS) study on unsafe abortions and the interest of the ministers of health in East and southern Africa on the issue. (See brief on Research to Stimulate Policy Dialogue on Unsafe Abortion in East and Southern Africa.)

Summary of Activities

The postabortion care (PAC) initiative, with the support of the Postabortion Care Working Group for East and Southern Africa, assisted the Policy Project to develop a brochure, entitled *What Can You Do?*, that was widely disseminated and used.

REDSO/ESA and Policy Project staff visited six USAID missions (Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe) to sensitize them on PAC issues. A presentation made to all Population, Health, and Nutrition (PHN) Officers helped increase awareness of PAC. PAC assessments/situational analyses were conducted in Uganda and Zambia, with local counterparts. An intervention was designed in Uganda and a proposal for PAC in the private sector has been developed in Kenya. In Ghana, REDSO/ESA staff participated in a workshop to publicize the results of research showing how effective midwives can be in responding to PAC needs.

Eight policy makers and health providers from South Africa, Tanzania, Uganda, and Zambia participated in a study tour to look at alternative approaches to PAC care in Ghana.

Two national assessments were conducted, in Zambia and Uganda. The Zambian assessment found very limited access to and high costs for safe and legal abortions. The majority of postabortion patients were young women, often teenagers who faced expulsions from school if found to be pregnant. It was found that limited access to family planning services, especially in rural areas, was a contributing factor to the high rates of unsafe abortions in the country. Care for emergency postabortion admissions was constrained by limited staff in many Zambian health facilities and limited knowledge about the manual vacuum aspiration (MVA) method for treating such complications of unsafe abortion.

In Uganda, data indicated that over half of women 20-24 years old had had an abortion, resulting in many postabortion infections and related complications. Although MVA was known, its practice depended upon individual doctor knowledge and experience.

In both countries, strong interest existed in improving postabortion care services and improving family planning services reduced the number of unwanted pregnancies and abortions.

Results

The PAC initiative has helped to publicize existing findings on the magnitude and issues of unsafe abortion as a public health concern in the region. It also reminded USAID implementers of the Agency's support for PAC, added new information about country-specific situations, and identified mechanisms for donor assistance and options for promoting and implementing PAC activities.

The initiative's strong influence on USAID missions and partners operating in the region has helped to support existing and generate further country interest, and translate interest into programmatic strategies and interventions.

This activity included a strong advocacy component designed primarily to inform and sensitize USAID missions and their counterparts in Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe to PAC issues. Personal visits, discussions and formal presentations were used to advocate for and plan regional forums to share information and promote networking.

Presentations were also made at key donor and partner meetings, such as at an all-Africa CARE meeting on maternal mortality and the REDSO/ESA Regional Quality of Care and Guidelines and Standards meetings in 1997 and 1998, and to World Bank staff in Washington.

PAC was the theme of a Women's Action Group workshop in Zimbabwe which provided training to group members in the use of social theater as an advocacy tool with communities.

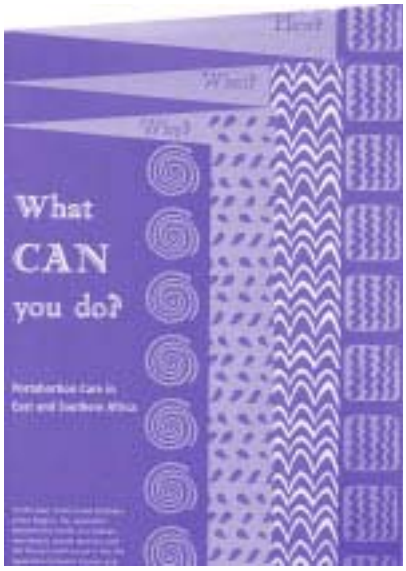
Changes in Policy and Programs

- REDSO/ESA has developed and is implementing a coherent regional strategy for the systematic promotion of PAC.
- The assessment on PAC in Zambia paved the way for a comprehensive pre- and in-service training program in Zambia.
- Uganda has launched a new PAC intervention, with USAID bilateral project funding, to test new approaches and feed into the process of updating national policies.
- Eight study tour delegates from South Africa, Tanzania, Uganda, and Zambia and their colleagues in Ghana now form a core network intent upon continuing to exchange information in support of PAC.
- A proposal has been developed in Kenya to train private nurse/midwives to provide PAC services, advocacy, and community data collection.
- $100,000 of USAID funds have been made available for PAC. Contractors have also allocated funds to the PAC initiative in Kenya and Uganda.
- In Zambia, the policy on what role midwives can play in PAC has been updated, at least in part due to USAID-led advocacy in the region.
- Currently, efforts are underway to initiate PAC activities in West Africa.

Lessons Learned

- The adoption of policy recommendations (in this case, by the CHRCS health ministers) can be supported with well-designed advocacy to increase resources for implementing them.
- USAID missions are receptive to PAC programming, once they fully understand the magnitude of the problem, USAID's support for PAC, and feasible program options that fit with their strategic objectives.
- REDSO leadership can be extremely effective as a catalyst, through frequent contacts with missions, donors, and partners.
- REDSO is an important player in coordinating the efforts of partners and donors at a regional level, thus allowing for a more systematic and rational strategy.

Key Product



Reproductive Health Brief

Santé Familiale et Prevention du SIDA (SFPS)[1]

Background

Since 1996, USAID's Bureau for Africa has supported the Santé Familiale et Prevention du SIDA (SFPS) project, the centerpiece of the West Africa Regional Program (WARP).[2] SFPS is implemented by a consortium of four U.S.-based private voluntary organizations, (JHPIEGO, Tulane University, Johns Hopkins University/ Center for Communication Programs, and Population Services International). The project was established as a response to the closure of several missions in the early 1990s, and to boost USAID's presence in the region. The overall goal is to increase the use of selected family planning, HIV/AIDS, and child survival practices in West and central Africa, with the primary focus on Burkina Faso, Cameroon, Côte d'Ivoire, and Togo. The SFPS project aims to increase the use of modern family planning methods, condoms and oral rehydration salts (ORS) and build the regional capacity to implement and develop sustainable health interventions. For the past several years, the Bureau for Africa/Office of Sustainable Development (AFR/SD) has provided technical and backstopping support in promoting quality family planning/reproductive health (FP/RH) health services in the region.

The SFPS project uses an innovative management approach where these four collaborating agencies share equal responsibility for program management, coordination and implementation. The strategic partnering with regional African institutions is instrumental for SFPS to promote a sustainable regional presence. Donor collaboration has been a high priority to increase the number of development partners (missions, governments, regional and national partners, and field support), as well as increasing the percentage of financial resources mobilized.

Illustrative Activities

Increasing the capacity of regional African institutions

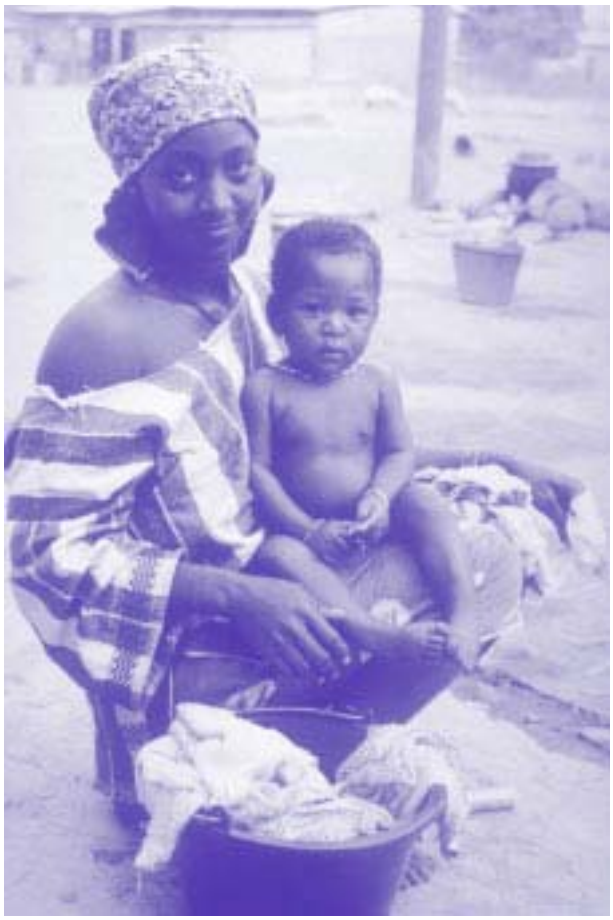
SFPS designed and carried out a series of institutional development assessments (IDAs) at ten selected regional institutions. Each assessment examined the capacity of three organizational dimensions: management, financial management, and technical. The IDAs revealed several common capacity areas in need of strengthening:

- Long term strategic planning
- Marketing strategy
- Project/resource management
- Grant/proposal writing
- Technical skills

Initial follow-up included a series of workshops for developing long-term strategic plans to guide decision making for allocation of resources and choice of activities. Yearly indicators were identified to evaluate the progress of each of the institutions, concentrating heavily on their ability to attain strong capacity in at least three of the five institutional capacity building areas.

[1] SFPS, also known as the Family Health and AIDS (FHA) Project, merged with the West African Regional Program in September, 2000. WARP was established to promote a viable and sustainable regional program. While no direct funds are provided by AFR/SD, the reproductive health technical team continues to backstop and provide technical support to the WARP.

[2] Formerly known as FHA-WCA.



Aimee Centivany

National and regional adoption of SFPS approaches and tools

Within the four target countries, SFPS selected a total of 206 service delivery points for its site-based activities. The results of these activities include:

- Improving the Quality of Care (QoC) training of supervisors and providers in interpersonal communications and counseling (IPC/C), emphasizing friendly reception, use of key messages, good client flow, referrals, and clinic outreach

- Improving Infection Prevention (IP) practices that were introduced to non-SFPS sites in all four-target countries by SFPS-trained personnel

- Increasing the supply of contraceptives at the project sites, securing products from alternate donors, and improving logistics management to prevent stock-outs

- Engaging Ministries of Health to establish facilitative supervision systems with a tested supervisory approach to improve performance at the service delivery sites and beyond. In Cameroon and Togo, this SFPS supervisory strategy has been adopted nationally.

Establishing dialogue and influencing programming through advocacy

SFPS advocated to include health issues, such as male involvement in family planning, sexually transmitted infection prevention, adolescent health, and HIV/AIDS policy development, at key regional meetings with other regional programs/donors.

Increasing knowledge in FP and HIV/AIDS prevention

One project targeting mobile populations along migratory routes diffused knowledge on HIV/AIDS prevention widely in Benin, Ghana, and Mali. Yamba-Songo, a radio serial drama that incorporated health and population messages into its themes, was broadcast on Africa #1 radio station, and thus heard by Africans throughout the region. Wake Up Africa, a project that brought together 23 renowned African musicians to record a motivational song about AIDS prevention and caring for people living with HIV/AIDS (PLWHA), was disseminated in all four SFPS countries and on Africa #1 radio station where it was listed as #11 on the Hit Parade Kilimanjaro. Requests have been made by Ministers of Health and nongovernmental organizations (NGOs) to expand Wake Up to non-SFPS countries.

Tools and approaches applicable beyond target countries

SFPS has created regional information, education and communication (IEC) kits for health service providers/field agents to better inform clients/communities and motivate interest. Over 1,600 kits have been distributed to the SFPS sites and partner NGOs, as well as health programs and NGOs in Benin, Chad, Guinea, Haiti, Mali, and Senegal.

Throughout the SFPS project, the West Africa Regional Program has drawn upon the knowledge and experience of institutions that have delivered or supported the delivery of reproductive health, family planning services and safe motherhood services in the region. Working closely with African partners, the project is able to replicate cost-effective best practices to reduce duplication and build regional capacity to expand better practices and services in the sub-region.

Reproductive Health Brief

Repositioning Family Planning in Sub-Saharan Africa

Background

While the impact of HIV/AIDS in sub-Saharan Africa (SSA) has received a great deal of media coverage and programs to mitigate the impact of that disease have increased, resources and political will for family planning programming appear to have stagnated. Family planning (FP) program performance has remained weak in most countries in the region. Poor reproductive health in SSA has contributed to some of the world's highest infant and maternal mortality ratios, as well as a loss of human capital contributing to stagnant economic growth and increased poverty. Even in the environment of the HIV/AIDS epidemic, Africa's 2002 population of 840 million people is expected to surpass 1 billion by 2025[1], with population decline occurring in only a few southern African countries. This continued rapid population growth not only contributes to poor reproductive health in SSA, but also erodes development efforts across all sectors. Efforts are needed to refocus attention on the serious reproductive health problems facing SSA, given continued rapid population growth, high fertility, high infant and maternal mortality, and continued high unmet need for modern contraceptives.

In September 2001, the United States Agency for International Development (USAID) organized an interagency task force encompassing several bureaus and offices (Bureau for Africa, Global Health Bureau – Office of Population and Reproductive Health, and Office of HIV/AIDS).[2] The task force reviewed country-level USAID funding trends, data from Demographic Health Surveys, and conducted interviews with field missions to better understand family planning performance within the context of increased funding and attention to HIV/AIDS.

H. Kakande, DISH II Project

What do the findings reveal?

- In 21 of the 25 SSA countries in which USAID has FP programs, contraceptive prevalence rates (CPRs) are less than 20 percent. Among those countries, there are only four that have CPRs higher than 20 percent—Malawi (26.1%), Kenya (32%), Zimbabwe (50.1%), and South Africa (55.1%).[3]

- While total fertility has been declining globally over the past 15 years, women in most SSA countries still have between five and seven children—nearly twice that of their counterparts in the rest of the world. The total fertility rate has declined slowly to less than five children per woman in only four SSA countries.

- Maternal mortality in the region is the highest in the world. Eleven out of 13 countries reviewed have unacceptably high maternal mortality ratios (MMRs) ranging from 586 maternal deaths per 100,000 live births in Ghana to over 1,800 in Ethiopia—nearly two to three times that of the rest of the developing world.[4] Continued high fertility among women of reproductive age, difficult pregnancies, and poor birth outcomes, including unsafe abortion, are major health issues facing women throughout SSA.

HIV has exploded in parts of southern and East Africa, while the majority of West African countries continue to maintain HIV prevalence rates of 5 percent or less.

[1] 2002 World Population Data Sheet, Population Reference Bureau.

[2] Task force members include Hope Sukin, Margaret Neuse, Khadijat Mojidi, Nomi Fuchs, Michelle Moloney-Kitts, Daniel Kabira, Adrienne Cox, Jyoti Schlesinger, Katharine Kreis, Daniel Halperin, and Kendra Phillips. Dana Vogel contributed to the task force's initial thinking.

[3] Demographic Health Surveys: Kenya 1999; Malawi 2000; South Africa 1998; Zimbabwe 1999.

[4] Hill K, et al. *Estimates of maternal mortality for 1995*, Bulletin of the World Health Organization 79(3), WHO 2001: 182-193.

Although HIV has remained relatively low in these countries, improvements in family planning and maternal and child health have been stagnant in recent years. In contrast, many of the countries hardest hit by HIV/AIDS have much higher CPRs and lower maternal and infant mortality ratios. Even in these higher HIV-prevalence countries, particularly in southern and East Africa, there still remains the need to strengthen access to family planning services. USAID, cooperating agencies, other key donors, and national governments and institutions are thus initiating a dialogue to refocus attention for continued funding and support for family planning programs.

Why is repositioning FP in sub-Saharan Africa important and what is its operational significance? [5]

Efforts to revisit and reinvigorate family planning programs are critical. Family planning is important as a fundamental principal of enabling women and men to freely control their fertility. It is a serious breach when access to modern contraception is severely limited or unavailable to those who need it the most. A women's ability to control her fertility enables her to choose the number, timing and spacing of her children. Family planning expands women's options to protect their reproductive health, improve their children's survival and health outcomes, and offer options for attaining education, and pursuing economic activities. Achievement of these events contributes to national development and economic growth for the region.

Repositioning family planning means recognizing the missed opportunities for integrating or reintroducing family planning in many ongoing and basic reproductive health services. It emphasizes that there are no missed opportunities in responding to the needs of sexually active persons. Repositioning implies "going back to basics" in the programming of other key health interventions to ensure opportunities for addressing men's and women's reproductive health are fully maximized.

Repositioning family planning also means identifying interventions and strategies that we know to be effective in improving access to quality reproductive health services. Repositioning family planning does not necessarily imply new or additional resources, but demands a more effective approach in programming resources aimed at improving reproductive health. It means ensuring that we avoid the temptation of establishing vertical programs, especially in resource-poor settings. It stresses that we focus on strategic programming of resources that support the reproductive health intentions of those persons at risk for both unwanted pregnancy and sexually transmitted infections (STI), including HIV. Some key approaches for repositioning family planning in SSA might include:

- **Promoting FP in HIV/AIDS settings** by ensuring FP information and services are an integral part of voluntary counseling and testing and mother-to-child transmission programs directly or through referrals.

- **Promoting child spacing in pre-natal settings** by reintroducing the positive effects of breastfeeding on child survival, and the importance of increasing birth intervals to improve birth outcomes.

- **Promoting post-partum FP** by making more effective clinical contraceptive methods available through updating service provider skills and increasing FP options for newly-delivered mothers to plan their next pregnancy.

- **Addressing unmet need** by developing targeted approaches to respond to the existing unmet need for family planning in SSA among both married and unmarried sexually active women. Across the SSA region, unmet need for family planning is often three to four times higher than actual contraceptive use.[6]

- **Protecting adolescent reproductive health** by responding to the needs of sexually active teenagers who have a substantial unmet need for FP for both pregnancy and HIV/STI prevention. Youth need a mix of quality reproductive health information and services that address delaying sexual debut, reducing the number of sexual partners, condom use, access to family planning methods, and post-abortion care services.

- **Promoting male involvement in FP** by including men not only as partners, but also as policymakers, technical experts, and clinicians. Men's involvement in HIV prevention programs provides an entry point for also discussing the benefits of family planning, supporting their partner's use of modern contraceptive methods, and addressing gender equity and sexual violence.

[5] Repositioning FP also referred to by the task force members as revisiting or resuscitating programs.

[6] All women 15-49 years of age. *Demographic Health Surveys* in selected African countries, 1978-2001.

Reproductive Health Brief

Adolescent Reproductive Health: Research, Dissemination and Advocacy in the Sahel

What problem or gap did this activity address?

Little attention was given by governments to the reproductive health needs of adolescents. Complicating the problem was the absence of reliable data on youth. It was known, however, that:

- Between one-third and one-half of young African women have a child by age 19.
- A high proportion of adolescents in most African countries are sexually active and are exposed to unwanted pregnancies, induced abortion, the transmission of sexually transmitted infections (STIs), including HIV/AIDS, and curtailed schooling.
- Health facilities in four Sahelian countries serve less than half of the population, thereby further marginalizing adolescents.
- Changes in sexual attitudes and behaviors result from the provision of information, counseling, and family planning and other reproductive health services for pre-teen and teenage youth.
- Adolescent reproductive health was not fully on national agendas in Africa nor had programs been clearly defined or implemented.

To address these gaps in the data, the Bureau for Africa/Office of Sustainable Development asked the Center for Applied Research on Population and Development (CERPOD) to conduct a study on reproductive health behavior among adolescents in the Sahel region. The presentation of the new data was expected to sensitize and motivate decision/policy makers in Francophone West Africa to address those issues. It was expected that the findings would generate debate and discussion and lead to a set of recommendations for action by policy makers and program implementers.

Research findings

Key findings of the research by CERPOD included:

- Age at first marriage in the Sahel is among the lowest in the world, especially in rural areas (19% of girls in Senegal and 45% in Niger are married by age 15).
- The proportion of single adolescents who have experienced a birth varies between 9 and 18 percent.
- Between 22 and 48 percent of women in capital cities admit to having pre-marital sex before age 20—these figures are probably higher in reality.
- Increasing numbers of urban women are single at 20, exposing them to the risks of premarital sexual activities.
- The percentage of married adolescent women who approve of family planning is much higher than that of their spouses.
- Adolescents' knowledge of STIs and HIV/AIDS is often superficial.
- Parents recognize that communication is lacking between themselves and their children, and between themselves.
- "Shame," "lack of anonymity," "lack of money," and "the attitude of the medical staff" are cited by adolescent as obstacles to their seeking treatment of STIs.

Application of research findings

The research provided the first systematic description of the demographic characteristics of Sahelian youth and their sexual behavior, and identified the gaps in their knowledge about reproductive health and access to appropriate services. The study demonstrated that lack of information and services targeted at adolescents, as well as negative attitudes on the part of service providers, are major barriers to adolescent reproductive health.

CERPOD presented options identified by adolescents themselves and adults in the community. A booklet, *Youth in Danger*, was prepared and several thousand copies were disseminated to policy makers, program managers, and others throughout the region.

Advocacy

Although advocacy was not planned in the original objectives, it was clear to CERPOD and participants at initial dissemination meetings that extensive efforts would be needed to sensitize and motivate program and policy makers on the issues identified by the research. Country core groups identified advocacy activities for implementation.

The dynamism of the core groups for country-level dissemination/advocacy has been varied, depending largely on the presence of one or more "policy champions," individuals who are fully motivated to carry forward the planned activities.

The following advocacy efforts occurred within individual countries:

- The Burkina Faso core team organized a week-long series of seminars, cultural events, and media coverage involving both youth and influential leaders to showcase the study and advocate for adolescent reproductive health.
- The Mali team organized a three-day event.
- In Senegal, the issues were taken up by a group working with schools and youth not originally involved in the research. The group organized eight workshops on adolescent reproductive health in different regions of Senegal as well as a national weekend celebration. Key issues from the CERPOD study were thus brought to the attention of students, youth association members, parents, religious and community leaders, and health workers. High school students were encouraged to take responsibility for further dissemination and advocacy activities.

Changes in policies and programs

The new data and their active dissemination contributed to changes in the policy environment, policies, and programs. Specific examples of changes in the policy environment are as follows:

- USAID has committed additional funding to promoting advocacy on adolescent reproductive health.
- Burkina Faso and Senegal have identified specific follow-up activities to improve reproductive health programs.
- CERPOD itself has brought issues of adolescent health onto its regional agenda and is planning new country support activities in the area of HIV/AIDS monitoring and evaluation.

What lessons have been learned from this activity?

Working with a regional institution to carry out research and advocacy had clear advantages for reaching key constituencies. CERPOD leadership in this activity facilitated the involvement of other African institutions. Also, ownership of the results spread across the countries in the Sahel and added depth and immediacy to the relevance of the research findings. CERPOD's credibility allowed its staff to take a proactive role in promoting country advocacy efforts.

CERPOD's flexibility and commitment to utilizing new methodologies (e.g., advocacy) with participating institutions, despite the unforeseen effort required, has been key to obtaining the unexpectedly high level of interest and activity to date.

Dissemination and advocacy require considerable financial resources, technical expertise, and time (almost 50% of the total effort in this case). Each of these components must be built into the design of research activities and adequately funded.

Public health policy/program advocacy requires ongoing funding which will be generated only in part from fee-for-service technical assistance or sale of materials. External support is likely to be required for several years into the future.

Reproductive Health Brief

Adolescent Reproductive Health: Social Marketing for Adolescent Sexual Health (SMASH)

What problem or gap did this activity address?

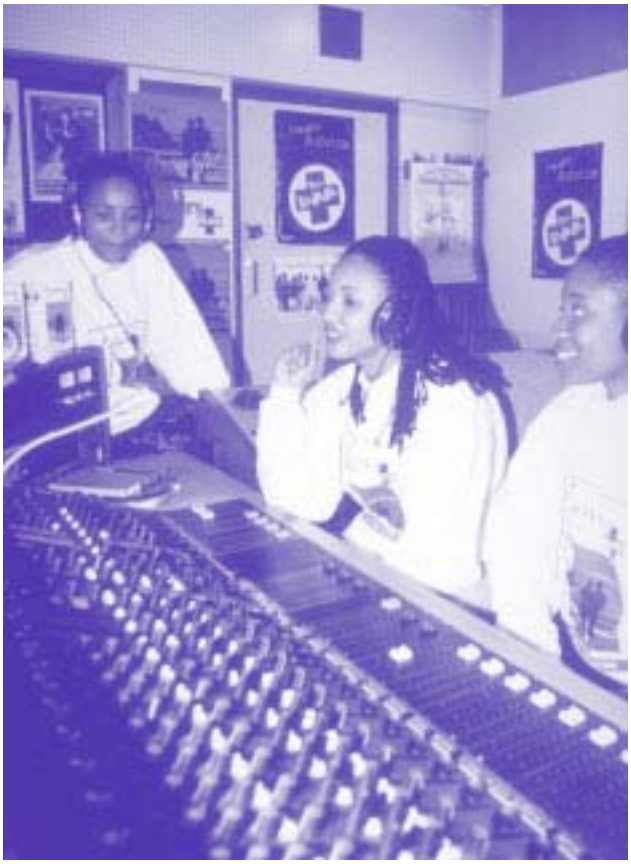
Young people are at high risk of HIV/sexually transmitted infections (STIs); experimentation is normal, sexual knowledge is limited, and information and other services that adolescents will and are able to use are incompletely developed. In southern Africa, many adolescents are sexually active by their mid-teens. A study in Lusaka, Zambia found 6 percent of 15-year-old girls to be HIV-infected. The 15-24 age group tends to have the highest HIV infection rates of any age group.

Many HIV/AIDS service organizations, national HIV/AIDS programs, and others recognized that young adults needed both more accurate and better targeted information and reproductive health services. Activities and messages meant to appeal to and influence adolescents remained unfocused. The means to market condoms to adolescents was little understood. Where they could get accurate information, few adolescents seemed to take the steps needed to protect themselves from HIV infection or pregnancy.

USAID's Bureau for Africa/Office of Sustainable Development (AFR/SD) supported an operations research project, implemented by Population Services International, to identify approaches for providing reproductive health information and services to influence adolescent sexual behavior.

The activity sought to show increases in adolescents' awareness and use of reproductive health services and products through teen-targeted media campaigns and condom distribution networks and adolescent peer education and promotion activities. The research started in Botswana and lessons learned were incorporated into the Cameroon, Guinea, and South Africa study designs.

The project used the Health Belief Model as a framework for developing indicators and measuring project results. The model asserts that health behavior is affected by an individual's perceptions about: (1) the severity of the health problem; (2) whether one is susceptible; (3) benefits of preventive action; (4) barriers to preventive action; and (5) whether or not one feels capable of addressing the problem (known as "self-efficacy.")



Population Services International (PSI)

What were the outcomes of the activity?

Interventions lasted less than one year, limiting the level of impact that could be expected. But, the results are impressive and provide valuable lessons for future programming.

The most successful program, in Cameroon, had a positive impact on young women's health behavior. Evidence showed that the program delayed women's onset of sexual activity, increased the use of condoms and abstinence for preventing

pregnancy, and increased the likelihood that young women tried condoms.

In Botswana, Cameroon, and South Africa, the programs influenced women's health beliefs. The project increased awareness among young women that abstinence and condom use can prevent unwanted pregnancies and other sexual risks. However, the projects had a mixed impact on their perception that sexual activity carries the risk of AIDS or STIs, and on their confidence that they can protect themselves.

The project had less effect on young men overall compared to young women. In Botswana and Guinea, the programs had no effect on young men's awareness of the risks of sexual activity or the benefits of protecting themselves from AIDS. In Cameroon, the program only increased awareness that condoms and other contraceptives can prevent unwanted pregnancy.

Young men's behavior changed slightly after the project interventions. In Cameroon, more young men reported abstaining from sexual activity, reducing their number of partners, and using contraceptives other than condoms to prevent pregnancy. In Botswana, men reported having fewer casual partners.

What results have been achieved?

The project was most successful in improving adolescents' awareness of the benefits of protecting themselves from AIDS and unwanted pregnancy, and in reducing the barriers to using condoms. Less impact was seen, overall, on young people's perceived susceptibility to reproductive health problems, such as the belief that sex carries the risk of AIDS, and on actual changes in behavior. Only in Cameroon was there an impact on several areas of health beliefs and behavior, among young women and (to a lesser extent) young men. In all four countries, the projects had greater impact on young women than young men.

Changes in policies and programs

Resources for targeted social marketing for adolescents have been leveraged in all study countries. In Botswana, the government contributes the funding to continue the overall program, an overwhelming portion of which is targeted to adolescents. In South Africa, the Department of Health, the UK Department for International Development, and others are contributing, while in Cameroon, USAID supported the activity. In Guinea, funding comes from ongoing USAID programs and new funding is being sought.

SMASH helped secure a $5 million foundation award for similar adolescent health social marketing activities in Cameroon, Madagascar, and Rwanda.

Capacity building

In Cameroon, several trained peer educators have found positions in similar organizations. One peer educator in Botswana is currently doing graduate work at Johns Hopkins University School of Public Health. In Guinea and Cameroon, national family planning or AIDS agencies helped design and implement interventions, and local research and advertising organizations were involved in the field work.

What lessons have been learned from this activity?

- Changing adolescent behavior may require intensive program efforts of at least two to three years.
- Social marketing programs targeting youth are most effective if they include a carefully designed mix of mass media promotion and interpersonal communication.
- A better understanding of the different sexual health concerns of young men and women is likely to increase the effectiveness of adolescent interventions.
- Involving the target audience in developing project activities and messages is a good way to assure that they will be effective. However, adolescents need guidance to stay focused on critical issues.

Key products

To date, thirteen working papers and a research brief, *Impact of the Botswana Tsa Banana Program on Adolescents' Health Beliefs*, have been developed.

A report of the project, *Social Marketing for Adolescent Reproductive Health: Results of Operations Research Projects in Botswana, Cameroon, Guinea and South Africa*, is available in English and French at www.measurecommunication.org.

Reproductive Health Brief

Adolescent Reproductive Health: *Africa Alive!*

What problem or gap did this activity address?

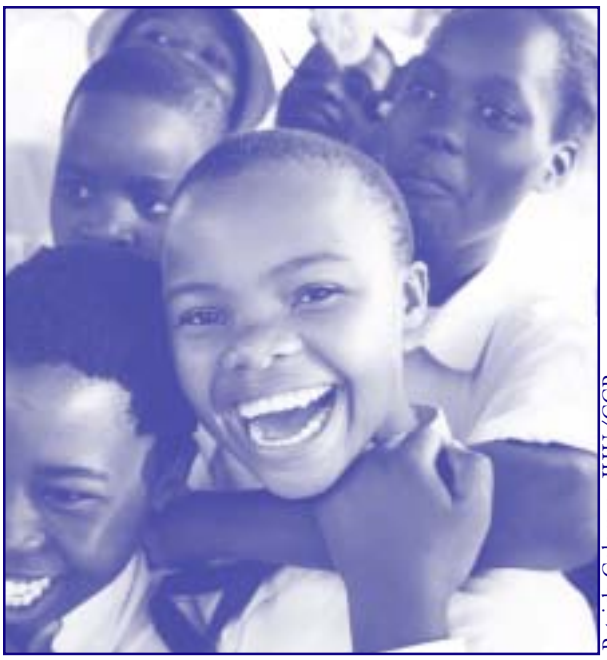
Millions of young Africans are at risk for unwanted pregnancies, HIV and other reproductive health problems. The statistics are staggering: every minute, six young people are infected with HIV; of them, five live in Africa. In the eight African countries with an HIV prevalence rate over 15 percent, approximately one-third of all teenagers living today will die of AIDS. Due to the socio-economic disadvantages that adolescent girls find themselves in, they are up to six times as likely as boys their age to be HIV positive.

Research indicates that in Africa, awareness of HIV/AIDS is high, yet personal risk assessment and adoption of effective and consistent safe sexual practices to prevent HIV transmission remains low. Current theories and research on creating positive behavior change among the youth of Africa acknowledge the critical importance of combining multiple channels, from mass media to community action and interpersonal communication; of scaling up proven interventions in a cost-effective manner; and of engaging youth from concept to completion of any project.

To reduce the impact of undesired reproductive health outcomes on African youth, USAID's Bureau for Africa/Office of Sustainable Development (AFR/SD) supported the establishment of *Africa Alive!* in November 1998 as a regional adolescent reproductive health (ARH) and HIV/AIDS prevention initiative.

The *Africa Alive!* initiative is a partnership of African public and private organizations, international donors, the private sector, and other stakeholders, comprising over 100 youth and AIDS organizations working in seven sub-Saharan African countries (Kenya, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe). Its goal is to reduce the occurrence of teen pregnancies and the spread of STDs and HIV/AIDS among African youth and to scale up the response of youth by empowering young people to take positive action. *Africa Alive!* encourages youth to advocate to other youth through the use of popular entertainment—combining music, mass media and community action.

Africa Alive! has conducted three main activities to date: empowering role models, reaching and empowering youth through youth rallies and music contests, and establishing a strong and effective network of partners for advocacy. *Africa Alive!* held workshops for influential figures in youth culture who are in effect "local heroes." These local heroes discussed what it means to be role models, and developed innovative ways to reach youth with positive behavior change messages to help them stay healthy. Youth rallies and music contests were held in Nigeria, Tanzania and Zambia, using music, drama and sports to engage youth and help them to be better informed about their reproductive health. Youth were encouraged to take concrete steps to protect themselves, as well as to advocate with local political leaders and community organizations and get involved in local youth programming and activities. These partnerships have helped *Africa Alive!* implement its activities on a broader scale and reach more youth. Together with these groups, *Africa Alive!* has placed youth issues on the agenda of various forums including the World Economic Forum, UNGASS, the Commonwealth, and HIV/AIDS Conferences in Lusaka, Durban, Burkina Faso and Barcelona.



Patrick Coleman, JHU/CCP

What were the outcomes of the activities?

In Zambia and Tanzania, the youth rallies and music contests incorporated various levels of involvement by youth. Youth contributed to the organization and

implementation of events, and were active participants in the dramas and music contests. Youth developed message content, and performed songs and dramas incorporating positive behavior change messages onstage in front of their peers. In Zambia, local organizations assisted in the planning and implementation of the activities, and were keen to continue supporting youth involvement in AIDS activities after the youth rallies ended. In Tanzania, *Africa Alive!* was part of a national campaign to promote AIDS awareness and prevention amongst youth, which included ongoing collaboration with several organizations and celebrity role models.

What results have been achieved?

- Through several role model workshops in Kenya, South Africa, Tanzania and Zambia, *Africa Alive!* empowered over 100 musicians, athletes and DJs, discussing what it means to be a role model, how they can better promote their efforts, innovative ways to reach out to youth with pregnancy and STI/HIV prevention messages, how to promote RH services, and how they can support each other's efforts for greater impact. These role models have used their status to engage youth in ARH awareness and prevention messages in the media and at organized community and entertainment activities popular with youth.
- Through advocacy efforts, *Africa Alive!* has ensured that youth issues in the most remote areas have influenced policy documents both nationally and internationally. Youth issues have become a priority area for most agencies. One example is the World Economic Forum, where HIV/AIDS has become a major issue and is now featured in all WEF programs. *Africa Alive!* is one of a handful of NGOs invited to participate in these discussions.
- The youth rallies were useful for reaching large numbers of youth in one setting. Approximately 5,000 people attended each rally in Zambia, and nearly 4,000 attended those in Tanzania. Nearly 200 youth participated directly in the rallies, and one-third of attendees surveyed in Zambia said they learned a lot about AIDS, and enjoyed getting informative messages in an entertaining format.
- The youth rallies and music contests have advocated for increased public involvement in addressing the ARH problems, especially among the youth. In Tanzania, this included mobilizing political, religious and community leaders who attended the shows and were given an opportunity to speak. In Zambia, musicians were used as role models to encourage youth to make wise decisions regarding their health. Many popular and local African artists now regularly include behavior change messages in their performances; *Africa Alive!* artists included health messages while performing at the AIDS conference in Durban and at UNGASS in New York.
- Capacity building included the involvement of many youth groups and AIDS organizations in the local areas where the youth rallies were held. In Tanzania, the ISHI (meaning "live" in KiSwahili) campaign helped to put up the first foundations of partnership among the organizing groups. In Zambia, *Africa Alive!* collaborated with a number of local organizations who will be taking the youth rallies and music contests concept forward in the areas of Zambia in which they work. Through local activities, *Africa Alive!* has been able to increase the capacity of organizations and young people to manage, implement, and organize projects, and has developed youth leadership skills.

What lessons have been learned from this activity?

- Youth involvement in development and implementation of ARH programs is critical for assuring youth buy-in. However, it can be difficult to retain the interest and commitment of youth who are not being paid and are expected to volunteer their time.
- Strong networking and collaboration ensures effective use of resources, and sharing of experiences and lesson learned.
- The entertainment education approach is a useful tool for reaching youth with behavior change messages and empowering them to make changes.

Key products

- Role model training curriculum and training kit
- Country Specific Needs Assessments
- Partnerships with youth and AIDS organizations, international donors and key stakeholders
- *Africa Alive!* CD
- Innovative website and listserve
- Sponsorship kit

Africa Alive! is operated by Johns Hopkins University/Center for Communications Programs. For more information on the program, please contact info@africaalive.org.

Reproductive Health Brief

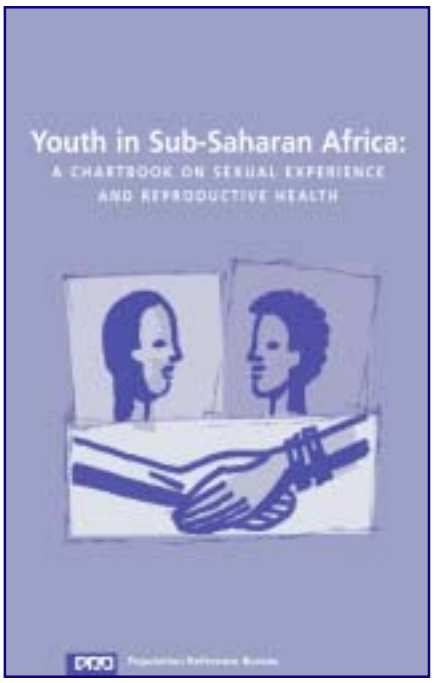
Youth in Sub-Saharan Africa: A Review of Adolescent Experiences and Needs

Background

Sub-Saharan Africa has one of the world's youngest populations. At the beginning of the 21st century, about one out of every four people is 10 to 19 years old. This is the largest group of young people ever in the region to enter adulthood.

Helping African youth make a healthy transition to adulthood is critical to the continent's development and the prosperity of its future population. Many population and health specialists suggest that continued school attendance as well as delayed sexual initiation, marriage, and childbearing are important components of a healthy transition to adulthood. Ideally, adolescence is a time when young people develop—physically, emotionally, and intellectually—before becoming parents or primary wage earners.

USAID's Bureau for Africa, Office of Sustainable Development supported the production of a chartbook, *Youth in Sub-Saharan Africa*, that examines factors that are important to a healthy transition to adulthood, including education and exposure to information, sexual experience and marriage, HIV/AIDS, childbearing, contraception, and maternal health. The chartbook draws primarily on Demographic and Health Survey (DHS) data, profiling adolescents in 11 sub-Saharan countries: Côte d'Ivoire, Ghana, Kenya, Madagascar, Mali, Mozambique, Senegal, Tanzania, Uganda, Zambia, and Zimbabwe.

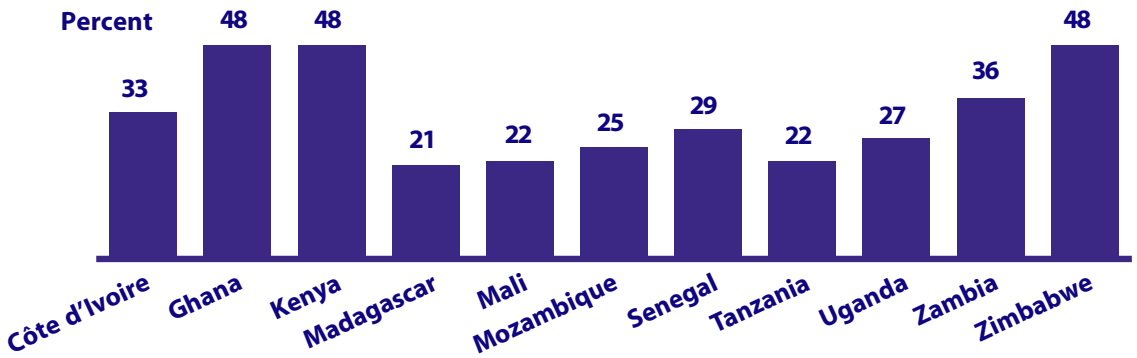


The analysis focuses chiefly on adolescents between the ages of 15 and 19.

What do the findings reveal?

- Education levels have risen dramatically in most countries surveyed. Still, less than half of adolescents between the ages of 16 and 20 attend school, and "gender gaps," or differences between

Births Reported as Unintended Among Adolescent Women Ages 15-19*



**Births that occurred withing 3 years before the survey*
Source: Demographic and Health Surveys, 1994-1998.

boys and girls, persist in school enrollment and in access to the mass media.

- In nine out of 11 countries surveyed, at least one-third of young women married before age 18 and at least half had sex before age 18. However, the premarital period is lengthening, and young women are spending a longer time being single than their mothers.

- In countries with data available, 13 percent to 38 percent of single teenage women and 8 percent to 39 percent of single teenage men have either received or given gifts or money in exchange for sex during a recent period. In relationships where payment is received for sex, adolescents may be unable to negotiate condom use or fidelity, leaving them at a greater risk of sexually transmitted infections (STIs) and unintended pregnancy.

- In most of the countries surveyed, more than half of adolescents believe that they have little or no risk of getting AIDS, even though in many of these countries, HIV prevalence levels are high among young people.

- In many settings, teenage women are more vulnerable to AIDS; HIV infection levels are often higher among teenage women than teenage men. One of the reasons for higher infection levels among young women is that their partners are likely to be older, more sexually experienced men rather than men their own age.

- In eight out of 11 countries, teenage birth rates show some sign of decline, but levels of unintended pregnancies among teenagers are high. More than one-fifth of recent births by young women were reported as unintended.

- Less than 5 percent of married adolescent women report use of a modern contraceptive method in seven out of the 11 countries surveyed. Modern contraceptive use among single, sexually active women ranges from 5 percent in Mozambique to 23 percent in Ghana.

- In eight out of 11 countries, at least 10 percent of 16-year-olds have started childbearing. This is of concern since very young mothers tend to be at a much higher risk of pregnancy-related complications and infant death than women in their twenties or thirties.

- In 10 out of 11 countries, less than 55 percent of young women reported receiving professional care during delivery.

What are the key program and policy implications?

- *Reproductive health information needs to be provided to both married and single adolescents.* Due to changing patterns of sexual initiation and marriage, many single, young women have a higher risk of premarital pregnancy and of acquiring an STI than earlier generations of young women.

- *Reproductive health programs need to better serve single, sexually active women.* Many single, sexually active women still rely on traditional methods of contraception such as periodic abstinence, which do not afford the same levels of protection against pregnancy as modern methods, nor do they offer protection against STIs.

- *Measures are needed to increase the use of professional delivery care services among adolescent women* because of a high risk of obstetric complications for teenagers and a higher risk of health-related problems and death for the children of teenage mothers.

- *Gender-sensitive program approaches for reproductive health care are necessary.* In some countries, for example, young women's sexual activity tends to take place just before or within marriage, while most young men's sexual activity takes place outside marriage.

- *AIDS education needs to emphasize the risk factors for HIV infection.* A number of young, sexually experienced youth believe themselves at little or no risk of AIDS because they "stick to one partner."

- *Programs must address the social and cultural factors that hinder or prevent young women from protecting themselves from HIV/AIDS.* Many factors place young women at risk including a lack of power within their sexual relationships and biological vulnerabilities.

This brief is excerpted from Youth in Sub-Saharan Africa: A Chartbook on Sexual Experience and Reproductive Health *written by Dara Carr, Population Reference Bureau, April 2001.*
For copies please send request to prborders@prb.org

Reproductive Health Brief

Abandoning Female Genital Cutting (FGC)

What problem or gap did this activity address?

More than 130 million girls and women worldwide have undergone female genital cutting (FGC), and each year nearly 2 million more girls are at risk. FGC is a traditional practice that involves cutting or altering the female genitalia. It can have serious health consequences, including hemorrhage, shock, pain, infection, difficulties during childbirth, and psychological and sexual problems. Additionally, when FGC is performed on girls and nonconsenting women, it violates a number of recognized human rights.

Over the past twenty years, FGC has been increasingly recognized as a health and human rights issue among governments, the international community and professional health organizations. Anti-FGC laws have been passed in 10 African countries, and other countries have imposed decrees or general legislation regulating or outlawing FGC. Despite these efforts, the World Health Organization (WHO) estimates that 18 African countries have FGC prevalence rates of 50 percent or more. Moreover, this mainly sub-Saharan and Northeastern African practice has spread to other regions of the world through migration.

Education and information are crucial to help reduce the prevalence of FGC. In an effort to inform, USAID's Bureau for Africa/Office of Sustainable Development (AFR/SD) supported the Population Reference Bureau's (PRB) report, *Abandoning Female Genital Cutting*, which analyzes recent FGC data, summarizes successful FGC-abandonment programs, and proposes actions for policymakers and program managers.

The report draws on Demographic and Health Survey (DHS) data from nine countries: Burkina Faso, the Central African Republic (CAR), Egypt, Eritrea, Kenya, Mali, Sudan, Tanzania and Yemen. In addition, it summarizes the key findings of a report by the Program for Appropriate Technology in Health (PATH) and the WHO on FGC abandonment approaches, and highlights promising projects in four countries (Egypt, Kenya, Senegal, and Uganda).

Research findings

Key findings from the DHS data include:

- FGC national prevalence in the countries studied ranges from nearly universal (90 percent or more) in Egypt, Eritrea, Mali and Sudan to 18 percent in Tanzania (see graph).
- In Burkina Faso, CAR, Eritrea, Kenya and Tanzania, there is some evidence of a decline in the practice among younger women.
- In Burkina Faso, CAR, Eritrea and Kenya, there is a striking contrast between high prevalence of FGC and low approval for the practice.
- In Egypt, Mali, and Sudan, however, where this is persistent, strong approval for the practice, there has been virtually no change in FGC over time.
- Urban women with some education are typically less likely to practice and approve of FGC; however, this is not the case in all countries.
- FGC occurs among all religious groups in Africa, although no religion mandates it. Ethnic affiliation is also associated with female genital cutting.
- Traditional practitioners, who are not usually medically trained, perform the majority of FGC procedures.

Program approaches

Efforts to end FGC require a long-term commitment to establish a foundation for sustained behavior change. PATH and WHO's report describes the most effective FGC abandonment programs as having a focus on community-based behavior change. For example:

- In Egypt, the Coptic Evangelical Organization for Social Service integrated FGC abandonment into a range of social and economic development initiatives that focus on women's empowerment.
- The Center for Development and Population Activities in Egypt identified individuals who oppose FGC and promoted them as role models in their communities.
- In Kenya, Maendeleo Ya Wanawake Organization developed alternative rite of passage rituals to substitute for the traditional cutting ceremonies.
- In Senegal, Tostan empowered women through literacy training and education on human rights, problem solving, and health to give these women the information and self-confidence to abandon FGC and to build community support for ending the practice.
- In Uganda, the Reproductive, Education and Community Health Program used an intensive social marketing approach to involve community elders in evaluating the costs and benefits of continuing or abandoning FGC.

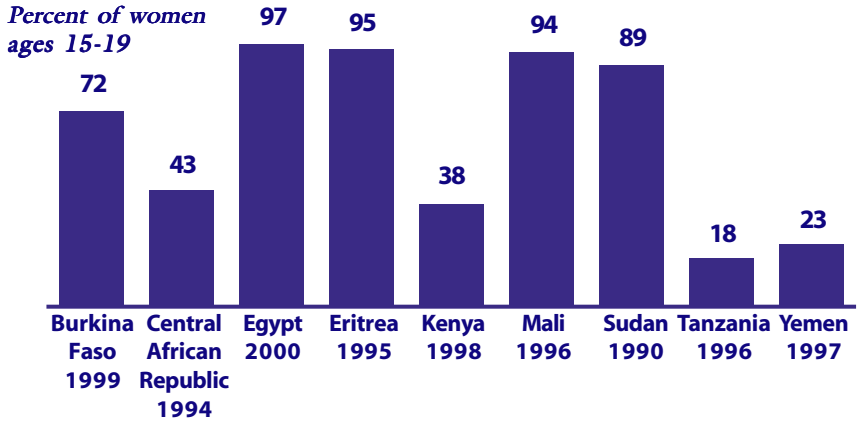
What lessons have been learned from this and other activities?

Data on FGC attitudes and practices and lessons from program experiences provide an important context for formulating abandonment campaigns. From these lessons, the following recommendations can be made:

- Support the groundswell of agencies working on FGC abandonment with financial and technical assistance.
- Enhance governments' commitment to strengthen FGC abandonment policies and laws.
- Institutionalize FGC issues into national reproductive health and development programs.
- Train health providers to recognize and treat the complications of FGC.
- Coordinate FGC abandonment activities among governmental and nongovernmental organizations.
- Increase advocacy efforts that foster a positive policy and legal environment, and support for programs and public education centered-around FGC abandonment.

The experience of community-based programs suggests that the practice of FGC may be waning. While community-based programs are at the core of efforts to abandon FGC, national and international laws, policies, and resources are also needed to create a supportive environment for these local initiatives.

Prevalence of Female Genital Cutting



Source: Special tabulations of Demographic and Health Survey data by Principia International, Inc. (Chapel Hill, NC) and published data from ORC Macro (Calverton, MD).

This brief is an excerpt from Abandoning Female Genital Cutting *written by Liz Creel, Population Reference Bureau, August 2001. For copies, please send request to prborders@prb.org*

Reproductive Health Brief

Improving Reproductive Health Policies and Programs through the Media: Pop'Mediafrique

What problem or gap did this activity address?

Reproductive health issues have been low priority on West African national agendas. Health systems have lacked the resources and political will to address fully the range of reproductive health issues of women, men and youth. Moreover, public awareness of many reproductive health issues has been low. Although the popular media offered effective ways to reach policy audiences and the public, little had been done to mobilize this powerful communication channel systematically.

Changes in the relationship of the press to government and society were evident by the mid-1990s. Regional constraints on the press were relaxed and new opportunities appeared for using the media to convey important health messages.

The Center for Applied Research on Population and Development (CERPOD)'s research on adolescent reproductive health issues in West Africa provided an initial, credible, and tangible topic for discussion between journalists and health specialists. The purpose of the activity was to increase the knowledge and appreciation of reproductive health issues among media gatekeepers—senior print editors and broadcast producers—to promote health issues in the popular press. Not only would there be more public information, but the attention to reproductive health issues in the media was expected to accelerate policy dialogue and encourage new constituencies for programs in those areas.

As a vehicle for the activity, CERPOD and the Support for Analysis and Research in Africa (SARA) project, with support from the Bureau for Africa/ Office of Sustainable Development, brought journalists and health specialists together for annual seminars on selected themes. To expand media coverage, participating journalists were requested to produce local newspaper supplements and radio programs following each seminar. Fifteen high-level journalists and health specialists from five countries (Burkina Faso, Cote d'Ivoire, Mali, Mauritania, and Senegal) participated. The first media seminar in 1996, supported by the Population Reference Bureau, focused on the topic of adolescent reproductive health. The second was held in 1997, focusing on HIV/AIDS and the third, a year later, on STIs other than HIV/AIDS.

Sié Offi Somé

What were the outcomes of the activity?

The journalists who participated in the workshops have become better informed on reproductive health issues, which is reflected in both more frequent and accurate coverage of those issues. The health researchers and managers have more fully recognized the importance of the media in sensitizing the public and lobbying policy makers. Also, the cross-country exchanges among print and radio editors added new perspectives and interests, as they read/heard one another's stories.

Advocacy

The activity widened and deepened the support at country levels for reproductive health policy changes and program improvements. Both researchers and journalists gained a better appreciation of the power

of the media to convey information and sway opinion, this latter being particularly evident in coverage of HIV/AIDS.

While in the past health research findings usually did not find their way into newsworthy stories, this activity took advantage of changes within the media to quickly disseminate findings to a far broader audience. In addition to general dissemination, the activity explicitly sought greater media coverage of the policy and program implications of recent reproductive health research to sway public opinion and generate discussion among policy-level audiences.

Changes in policy and programs

Many of the stories appearing after the 1996 seminar utilized local examples and data to reinforce the story line. Journalists consulted health specialists for information and interpretation on stories they were developing.

Requests for media coverage of critical social issues by groups not involved in the seminars was generated as a direct result of articles produced under the activity.

The links with journalists expanded CERPOD's range of tools for advocacy campaigns. Further, as a regional organization, CERPOD is now better positioned and able to share information and experiences across borders through their new media contacts and is seeking to hire staff to expand its ability to work with the media and train others to do so.

CERPOD's expectation that improved media attention to health issues would inform and influence national policy makers was fulfilled. For example,

- Yedali Fall (editor-in-chief from Mauritania) is now publishing special supplements on reproductive health issues on days when there is a political event to take advantage of large number of sales, thus increasing the audience. He is working with World Vision on a new community project to raise awareness of HIV/AIDS, and, in collaboration with the participating health official, conducted a national seminar on adolescents and HIV/AIDS.

- Yedali Fall also wrote an extensive article on adolescents (a very sensitive issue in Mauritania) and was subsequently asked by the Secretary of State on Women to cover all seminars on women's issues. The United Nations Fund for Population Activities asked him to write a special series on girls' education.

- Yamaba Yameogo (editor-in-chief from Burkina Faso) has increased the number of journalists reporting on HIV/AIDS from two to four, and now searches the UNAIDS internet line for information to report each morning.

- Nicholas Sagou (editor-in-chief from radio Cote d'Ivoire) has initiated regular information flashes on HIV/AIDS during his radio station's weekly health journal program and provided training to staff to change negative attitudes and improve responsible reporting on HIV/AIDS.

Capacity building

Over fifteen journalists and health specialists have become more familiar with one another's knowledge and processes. That is evident in improvements in the content of media stories on reproductive health and HIV/AIDS and CERPOD's desire to add staff for media work. A recent participant evaluation documents how journalists and the participating health official within each country have forged new relationships built on a common purpose.

What lessons have been learned from this activity?

- The implementation of journalist seminars through a credible regional (or local) research institution gives impetus to the application of new skills and information.

- The implementation through CERPOD provided a channel for expanded dissemination of current and emerging research findings.

- Given accurate information presented in innovative formats, senior media leaders are prepared to give greater attention to health issues and provide responsible, data-based coverage of issues in greater depth.

- Structured exchanges between health professionals and journalists can be very productive in strengthening relationships and contributing to creative actions.

Male Involvement in Family Planning and Reproductive Health through Sports

What problem or gap did this activity address?

There is a growing understanding that men's participation is a necessity to maximize the effectiveness of reproductive health programs. Involving men and obtaining their support and commitment to reproductive health is particularly crucial in the Africa region where men make most decisions that affect family and political life. Therefore, improving their participation in reproductive health services and changing their attitudes and reproductive health behavior strengthens their role as health promoters at the family, community, and national levels.

The Bureau for Africa/Office of Sustainable Development (AFR/SD)'s male involvement efforts have been in three main areas: (1) raising awareness of the need to involve men in reproductive health (RH); (2) mobilizing interest and funding among the donor community and decision makers in 28 countries; and (3) providing training for advocacy groups.

In 1995, Johns Hopkins University/Population Communication Services conducted two regional workshops for government and nongovernmental organization authorities on male involvement and provided follow-up support for organizations engaged in the implementation of field programs. The two regional conferences (Harare and Ouagadougou), each with over 75 participants, were structured to share information and gain commitments of participants to apply that information in specific activities within their own organizations or countries.

The Support for Analysis and Research in Africa (SARA) project conducted a review of relevant literature and program initiatives in Africa dealing with male involvement in family planning (FP), including a list of lessons learned and suggestions for next steps. An English and a French version of the review, *Male Involvement in Family Planning*, were produced. The findings from that review were presented during the Reproductive Health Network Scientific Meeting in 1995 and at the two regional conferences.

Among the general lessons that emerged in the literature and intervention review were:

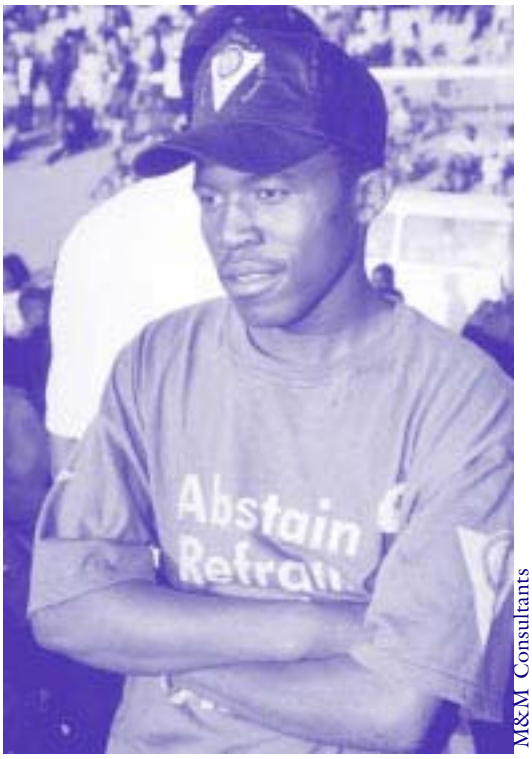
- Well-designed and focused information, education, and communication (IEC) campaigns can have a positive impact on men, but carry the risk of reinforcing the stereotype of male decision-making authority.
- Workplace interventions are usually well-received by companies.
- Male peer education, sporting events, and involvement of male opinion leaders all showed positive impacts.
- Condom social marketing had good results, but perhaps as a result of the focus on disease prevention rather than contraception.
- Men prefer clinics that offer a range of RH services.
- Young males are rarely targeted for FP messages or services.

What results have been achieved?

The set of activities helped alter the narrow perception of male involvement in RH/FP and to define the issue in terms of male RH needs, couple communication, and as a complement to services for women. The conferences helped to operationalize general interest and concern and focus efforts. Conference participants, in two separate declarations, outlined collective actions and pledges to expand male involvement in FP/RH.

The CUP Initiative

As greater interest in and awareness of the role of male involvement approaches grew, AFR/SD sought to take advantage of this climate by demonstrating to program planners how these approaches could be operationalized. The model of male involvement through sports was chosen for demonstration, and a program called the Caring, Understanding Partners (CUP) Initiative was put into place. This activity sought to expand the dialogue among young men about HIV/AIDS and their role in prevention by using



M&M Consultants

sporting events and sports figures to raise issues and encourage open discussion.

Over one million dollars (cash and in-kind) was leveraged to help implement HIV/AIDS education through sports in 12 African countries. Training and behavior change communication activities were integrated into scheduled soccer events. The events (which attracted over 230,000 participants) were attended by government ministers, religious leaders, and members of parliament.

Trained journalists published 63 articles over the two-week tournament period and afterwards, thus contributing to discussion of HIV/AIDS/sexually transmitted diseases. Twelve TV and radio interviews were aired, and coverage on the Voice of America reached up to 100 million listeners throughout the region.

In western Kenya, approximately 5,000 persons sought RH services at a model clinic set up at the stadium, and following this same tournament, attendance at male clinics in three locations registered an all-time high for the year. Similar findings emerged in other participating countries.

Changes in policies and programs

There were clear changes in the environment for considering male involvement in RH/FP as a result of the set of activities described here. The activities stimulated wide interest, discussion, and pledges to action across the continent. What had been a peripheral topic in FP meetings and discussions quickly assumed a more central focus. For example, the Francophone Reproductive Health Network added a two-day seminar to its regular meeting in 1996 to discuss the issue of male involvement and included the issue on the agenda of the two subsequent annual meetings.

After the regional CUP tournament in Kenya, the Ministry of Education endorsed the campaign's prevention materials. A new government directive to include HIV/AIDS education in schools was issued after the tournament. While this activity can not take credit for this, it did contribute to the process by reinforcing previous efforts.

The USAID mission in Rwanda has included CUP Initiative activities in its budget for HIV/AIDS. This work will include youth and male reproductive health/HIV/AIDS campaigns, featuring a media intervention using the CECAFA soccer tournament in Kigali, youth counseling in soccer clubs, a "Run For Your Life Marathon" in 8 regions, and a campaign focusing on minibus drivers in Kigali.

The Senegal National AIDS Program and the Ministry of Women's Affairs have submitted a proposal to the USAID mission in Senegal for support for CUP–type activities. Tanzania and Nigeria have also expressed interest in follow-up activities.

Many donors have added support for male involvement programs and training. These include the United Nations Fund for Population Activities, the International Planned Parenthood Federation, CARE, German Aid (GTZ), and the Population Council.

What lessons have been learned from this activity?

- The activity stimulated latent interest of RH and FP groups in male involvement and provided solid evidence of key issues and experiences to guide that interest in operational directions.
- By linking evidence with targeted advocacy, it is possible to move an agenda quickly and have an effect on country programs.
- Working with organized groups of male role models and opinion leaders through sports is a valid strategy and a good entry point for influencing attitudes and for moving men along the behavior change continuum.

Reproductive Health Brief

Prepackaged Treatment Kits for Sexually Transmitted Infections for Men

Background

Each year, Africans living south of the Sahara incur an estimated 65 million new cases of curable sexually transmitted infections (STIs), excluding chancroid. Approximately 44 percent of these cases are gonorrhea and chlamydial infection. For every 1,000 sub-Saharan Africans between the ages of 15 and 49, this translates to 245 new cases per year. STIs are more than unpleasant. Left untreated, they can lead to lasting side effects most severe in women and children, including infertility, ectopic pregnancy, and congenital infections.

Furthermore, evidence over the past decade has revealed that the presence of an STI can also make it easier for the Human Immunodeficiency Virus (HIV) to pass from one person to another. Because the treatment of STIs can slow HIV transmission rates while improving overall public health, affordable and sustainable STI services should be incorporated into national public health policies and strategies.

Given the limited resources available in many countries, syndromic case management using pre-packaged STI treatment (PPST) kits can increase access to effective STI treatment for men. Syndromic case management does not typically rely on clinical diagnosis or laboratory tests, offering an advantage to resource poor areas. Syndromic case management of STIs is designed to provide effective treatment, promote the use of condoms, and encourage partner referral. PPST kits can provide the essential treatment needed in one convenient package. In addition, PPST kits using generic drugs, makes them more affordable to the general public and highly cost-effective compared to existing treatment practices.

Syndromic management with PPST kits can offer a "one-stop shopping" intervention to improve STI treatment. Currently in sub-Saharan Africa, the only application of STI syndromic management with social marketed PPST kits is the treatment of gonococcal and chlamydial urethritis in men.

PPST Kits include:

- An antibiotic to treat STI pathogens
- Condoms – a small supply for the duration of the treatment
- 2 partner referral cards
- educational and informational leaflet on the STI and the antibiotic

Illustrative activities

With the support of USAID's Bureau for Africa, Office of Sustainable Development, a comparative review of two PPST programs took place in Uganda and Cameroon, with the hope that syndromic management of PPSTs would ultimately improve STI case management and decrease the rates of STI transmission, and indirectly HIV transmission.

As a result, 10 years after the pilot program in Cameroon, syndromic management is familiar and accepted by most governments in sub-Saharan Africa, and, in some countries, is part of the regular training of health personnel.

Also, in:

- Uganda, the Ministry of Health trained public sector staff to equip them with adequate knowledge and skills to manage male urethritis using a PPST Kit. Over 250 providers qualified to not only market the kit, but to also deliver educational messages on urethritis, apply professional ethics when handling patients with urethritis, correctly diagnose, prescribe, and dispense PPST kits;

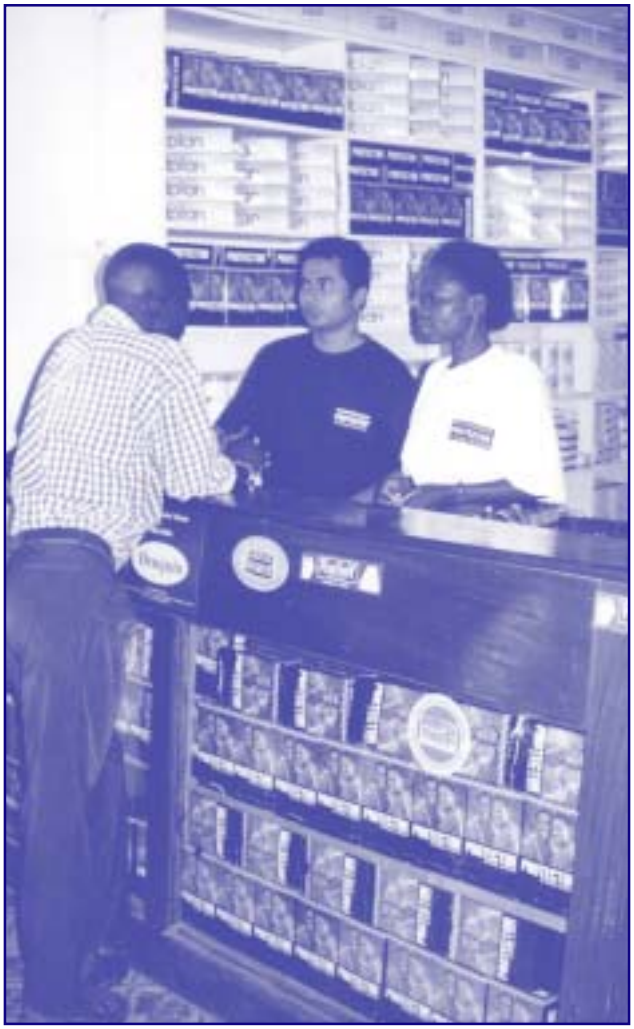
- Côte d'Ivoire, trained health care providers enabled more accurate diagnosis of STIs; and

- Mozambique, preliminary results indicated that STI treatment is improving, condom use has increased, and partner referrals have gone up.

A review of pilot PPST programs in sub-Saharan Africa reveals several key ingredients to program success, including formative research, provider training, targeted distribution, consistent monitoring, a permissive regulatory environment, affordability, and information, education, and communications (IEC). Advocacy among the governmental regulatory authorities and private sector health providers also may be necessary. Authorities are concerned with controlling the distribution of antibiotics to avoid an emergence of drug-resistant strains; providers, in addition to giving appropriate medical care, are concerned with the viability and profitability of their practices. Sufficient time and funding for program development, advocacy, introduction, and evaluation are generally the most significant considerations for any PPST intervention.

Social marketing of PPST kits through private sector outlets such as pharmacies and drug sellers can have significant health impacts. Creative IEC and promotional activities encourage men to seek treatment in a timely manner and notify their sexual partners, thereby increasing program reach. By training private providers and distributing treatment through the private and commercial sector outlets where people currently seek treatment, PPST kits offer an effective and affordable method to deliver necessary STI treatment services, especially for men.

Introducing PPST kits in a setting that has already embraced syndromic case management and has a list of recommended generic antibiotics for treating STIs could result in an affordable kit independent of donor subsidies. Syndromic management using PPST kits is feasible on a drug cost-recovery basis. PPST kits can be an important part of an overall national strategy for improved STI treatment and management, and consequently, reduced HIV infection.



This brief is excerpted from Sexually Transmitted Infections in Sub-Saharan Africa: The Use and Effectiveness of Treatment Kits *by Population Services International, 2001.*
For copies please send request to generalinfo@psi.org.

Research to Stimulate Policy Dialogue on Unsafe Abortion in East and Southern Africa

What problem or gap did this activity address?

An estimated 1.5 million abortions occur annually in Africa. Most of these occur without adequate medical attention for the women involved, resulting in increased morbidity and mortality among women. About 30 percent of maternal deaths in East and southern Africa (ESA) were attributable to complications of unsafe abortions. However, there had been insufficient recognition of the magnitude of the problem of unsafe abortion (both spontaneous and induced) and a lack of attention to postabortion care among ministries of health and donor organizations.

To bring greater attention to this issue, USAID's Bureau for Africa/Office of Sustainable Development asked the Commonwealth Regional Health Community Secretariat (CRHCS) to review regional literature and conduct a study in four hospitals each in Malawi, Uganda, and Zambia on the extent, cost, and quality of services for postabortion care. The provision of sufficient data on the magnitude and consequences of unsafe abortion was expected to inform and influence policy makers within the ESA region to address these issues.

Research findings

Key findings of the CRHCS research included:

1) Magnitude of unsafe abortion

- Many women with complications from unsafe abortion receive treatment. In Kampala, for example, abortion cases accounted for 53 percent and 64 percent of annual gynecological admissions in two hospitals, respectively. In one Malawi district hospital, 70 percent of the total annual gynecological cases admitted were for complications from abortion.
- Abortion complications contribute greatly to hospital-based maternal mortality and morbidity (accounting for more than half of all maternal deaths in a few studies).
- Community-based studies also suggested that abortion complications are a leading cause of overall maternal mortality.
- Young unmarried women with few children are over represented among abortion patients studied in hospitals.

2) Cost

- Treatment of abortion complications represents a significant cost to health care systems in sub-Saharan Africa (as measured by the use of resources such as staff time, medications, and space). In Malawi, for example, the cost of treating one incomplete abortion was approximately US$3.00, as compared to the annual per capita budget of US$2.55 for full health coverage.

3) Contraception and abortion

- Contraceptive use among women experiencing abortion is relatively low.
- Postabortion family planning services/linkages are limited.

4) Abortion laws

- In most countries, restrictive laws foster the existence of clandestine, poorly performed abortions.
- In Zambia, more liberal laws existed, but most health workers and members of the public were unaware of the laws.

Application of research findings

The research findings provided the first systematic, comprehensive description of abortion-related problems, including morbidity and mortality, clinical issues, cost issues, contraception and abortion, male perspectives, and legal aspects. The problems for women's health and health services were greater than most authorities expected before the research.

CRHCS produced a report, following analysis of the data, entitled *Monograph on Complications of Unsafe Abortion in Africa*, the most comprehensive study published in East and southern Africa on the issue. Several hundred copies were distributed to policy makers and program managers and those who advocate for postabortion care. Findings of the research were also published in several journals.

Advocacy

Detailed research results were extracted from the *Monograph*, distilled into a more concise "policy-friendly" pamphlet, and published under the title *Addressing Complication of Unsafe Abortion in Sub-Saharan Africa: Programme and Policy Actions.* This advocacy piece was widely disseminated to African policy makers and USAID missions in Africa.

Advocacy activities have included presenting the results of the consequences of unsafe abortion studies to Ministers of Health at CRHCS's advisory and executive group meetings and at policy seminars in five countries. In South Africa, a women's advocacy group prepared a presentation for a parliamentary subcommittee with data from the *Monograph*.

Changes in policies and programs

The environment for addressing postabortion care as a public health priority has definitely changed from 1993 to 1998, in part because of the research undertaken within this activity. Specific examples of these changes included:

- Health ministers of the Commonwealth Secretariat adopted recommendations to mitigate the problems of unsafe abortion and sought assistance in implementing the recommendations.
- South Africa adopted new laws relating to maternal health services, at least partly on the basis of the research findings.
- The Society of Gynecologists/Obstetricians in Francophone Africa included postabortion care in its priority list of strategies.
- The Information Dissemination Center in Zimbabwe hired a theatre group to create and perform a play on the consequences of unsafe abortion.
- A USAID Postabortion Care Regional Initiative was launched in 1996 to increase the level of advocacy around the issue.
- WHO, UNICEF, and the International Council of Midwives issued statements and guidelines calling for increased midwives' participation in providing PAC services.

What lessons have been learned from this activity?

Advocacy efforts at a number of different levels are important, particularly in politically-sensitive and new fields for which there is a paucity of program experience, such as postabortion care.

The activity affirmed the importance of a champion or core group of concerned people to move an issue. In this case, the activity benefited from the efforts of committed individuals within CRHCS to identify the problem, gather the data to demonstrate its magnitude, offer solutions, and manage a multi-layered advocacy campaign to have their recommendations adopted by appropriate policy and decision makers.

The activity affirmed that working with a regional research and advocacy institution such as CRHCS/ECSA improved chances of affecting policy and program changes by:

- Ensuring the lead role of Africans in design and implementation of research
- Encouraging positive policy changes in areas of reproductive health by reaching African policy makers directly and with credible data
- Presenting a set of feasible recommendations to policy makers.

Reproductive Health Brief

Advocacy for Safe Motherhood

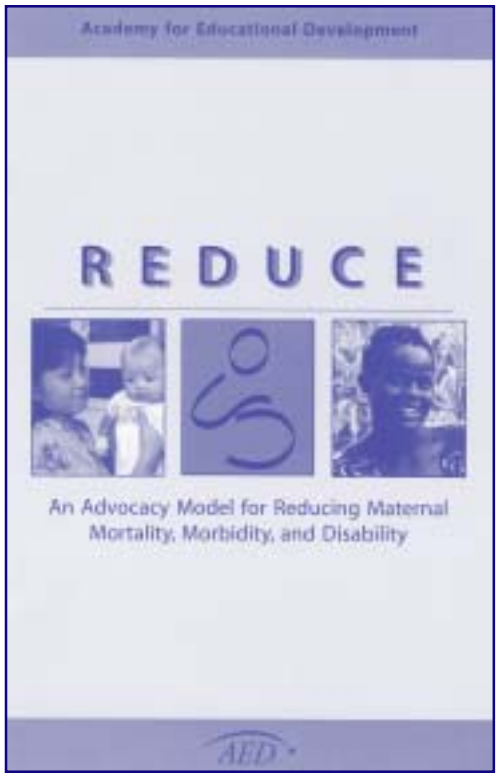
Background

Pregnant women in Africa are dying at rates higher than in any other region in the world. In fact, of all human development indicators, the maternal mortality ratio is the most disparate between sub-Saharan Africa and industrialized countries. The lifetime risk of maternal mortality in Niger, Mali, and Senegal is 1 in 9, 1 in 10, and 1 in 11, respectively, while the risk is only 1 in 7,300 in Norway and 1 in 3,500 in the United States.

Despite increased attention to maternal mortality and growing scientific evidence of the magnitude and consequences of poor maternal health, governments continue to place low priority on the problem. To raise awareness of the high costs of inadequate attention to this problem, USAID's Bureau for Africa/Office of Sustainable Development (AFR/SD) supported the Support for Analysis and Research in Africa (SARA) Project, managed by the Academy for Educational Development, in the development and testing of a safe motherhood advocacy and policy tool called REDUCE.

The goal of REDUCE is to mobilize decision-makers to take appropriate action to reduce maternal mortality and morbidity, including the promotion of family palnning and child spacing interventions. REDUCE brings together a multidisciplinary team of health professionals, economists, demographers, sociologists, and other local champions of safe motherhood during a two-week participatory workshop. Team members examine health and obstetric factors contributing to maternal mortality, morbidity, and disabilities, including:

- Hemorrhage
- Infections, such as sepsis
- Tetanus
- Unsafe abortions
- Pregnancy-related high blood pressure
- Obstructed labor
- Malaria and anemia.



The team uses interactive computer models with international and country-specific data to estimate the impact of poor maternal health and care on:

- Maternal and infant deaths;
- Short- and long-term illnesses, injuries, and disabilities; and
- Productivity.

Through a consensus-building process, the team outlines priorities and strategies for safe motherhood, uses the data to develop a clear and compelling presentation, and prepares a communication plan to continue advocacy in the months following the workshop.

Illustrative activities

The REDUCE process has engaged government agencies, international donors, NGOs, and regional institutions in advocating for safe motherhood using evidence-based tools. The first two applications of

Follow-up REDUCE Activities in Senegal

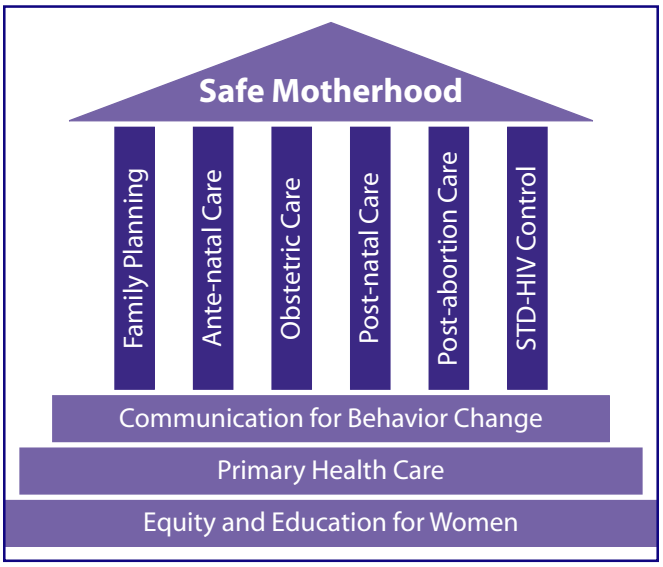
The USAID bilateral Senegal Maternal Health/Family Planning Project has used REDUCE for:

- *National-level advocacy.* Senegal is currently in the process of updating its national reproductive health laws and making them more consistent with health policy. During a three-day workshop for parliamentarians, REDUCE was presented and a plan developed for maternal health advocacy.
- *District-level advocacy.* The REDUCE presentation, translated into Wolof, has been used in four district advocacy events, attended by approximately 1,000 people (policy-makers, local decision-makers, religious leaders, traditional opinion leaders, members of women's and youth networks, and the media).
- *Training.* REDUCE was presented during four training of trainers workshops on advocacy. The 120 participants at these workshops came from 15 districts and 113 rural communities covered by the project.
- *Communications.* The REDUCE presentation has stimulated lively discussions and debate as well as features on maternal health on national and regional radio stations and in daily newspapers. The REDUCE analysis was the basis for a 90-minute radio call-in show that generated numerous phone calls to the radio station requesting additional information.

REDUCE, funded by USAID/AFR/SD, were in Uganda and Senegal. Upon seeing the presentations developed in those countries, the World Health Organization's Regional Office for Africa (WHO/AFRO) recognized the role REDUCE could play as part of its Making Pregnancy Safer initiative. WHO/AFRO supported REDUCE applications in Mauritania and Mozambique with some technical assistance provided through USAID/AFR/SD. WHO/AFRO also sponsored a Nigeria application, as well as a sub-Saharan African regional application workshop.

Each country where REDUCE is introduced presents a unique set of opportunities and challenges. In Mauritania, the REDUCE process helped various donors coordinate their advocacy efforts. In Mozambique, it contributed to increased financial pledges for maternal health and safe motherhood interventions. In Nigeria, the REDUCE team made the presentation at the district level, prepared a videotape based on the REDUCE presentation and script, and published an attractive advocacy brochure on maternal health. In Senegal, REDUCE proved to be a critical advocacy tool for USAID's bilateral reproductive health project.

The various ways that REDUCE has been used show that it is a flexible tool that can be used to raise awareness about safe motherhood, create a forum for discussion, and stimulate action.



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Reproductive Health Brief

The Urban Initiative: Adolescent Reproductive Health Services

What problem or gap did this activity address?

Reproductive health is a lifelong concern. Yet health services often fail to take into account the sexual and reproductive health needs of youth. Building the capacity of organizations to promote, protect, and improve young people's sexual and reproductive health was a focus of USAID's Family Planning Service Expansion and Technical Support (SEATS) project activities in Albania, Cambodia, Eritrea, Russia, Senegal, Zambia, and Zimbabwe. USAID's Bureau for Africa/Office of Sustainable Development supported the activities in Africa.

Bill Horn, Lutheran World Relief

Approach and key activities

The project had three goals: to build knowledge and skills for healthy decisions; to increase access to youth-friendly reproductive health services; and to create a supportive environment for youth reproductive health information and services. Both documented best practices and novel approaches were used to meet them and country programs differed in the settings in which they worked and the ages of the young people concerned.

Activities included:

- Learning about youth perceptions and community concerns through focus group discussions, baseline surveys, and participatory learning and action methods
- Involving youth and community members in program design and management
- Training 326 peer educators
- Conducting individual counseling and group education sessions
- Distributing condoms and spermicides
- Training service providers in youth-friendly service delivery
- Providing youth-friendly, integrated reproductive health services in clinics and youth centers
- Creating youth corners in clinics
- Producing and distributing informational and educational materials
- Holding advocacy and outreach meeting with parents, teachers, and community leaders.

What results have been achieved?

1) Peer education reached more than 200,000 youth with information, condoms, and spermicides.

- In Eritrea, youth leaders carried out a campaign to increase awareness of female genital cutting.
- In Zambia and Zimbabwe, youth rated peer educators as friendly, skilled, and good listeners—higher than nurses in clinics.

2) More than 25,000 young people used youth-friendly clinics, receiving services for contraception, sexually transmitted infections, antenatal care, and treatment of abortion complications.

- In Zambia and Zimbabwe, youth clients rated nurses as friendly, skilled, and able to solve their problems.
- In Burkina Faso, Eritrea, Senegal, and Zimbabwe, more people came to clinics for information and counseling than for health services.

3) Communities, providers, and governments supported youth reproductive health information and services.

- In Eritrea, the National Union of Eritrean Youth and Students became a national leader in youth reproductive health.
- In Senegal, municipal authorities in two cities recognized youth reproductive health as a priority and obtained additional donor funding to address needs.
- In Zambia, members of the Zambia Nurses Association established youth-friendly services in their work places.
- In Zimbabwe, the government of the City of Gweru made a commitment to sustain services.

What lessons have been learned from this activity?

- Adult-friendly programming may be as important as youth-friendly services.
- The public sector is willing to pioneer new ventures in reproductive health services for young people.
- Data can be very persuasive in monitoring providers, parents, and the community to support youth reproductive health initiatives.
- Basic human rights—clients' rights and reproductive rights—are a compelling rationale for offering reproductive health education and services to young people.
- Young people and service providers expressed need for integrated reproductive health interventions.
- Integrated reproductive health services that include sexually transmitted disease (STD) prevention and screening can attract young men.
- Offering reproductive health information and services in non-clinical settings such as Youth Centers can also attract youth who may otherwise avoid a health facility.
- A "champion" for youth within a clinical setting can help maintain a youth-friendly environment.
- The costs associated with referral services are a barrier to access.
- Young people also prefer a choice of contraceptive methods.
- Programs require support, advice, and assistance in addressing community resistance and opposition to youth reproductive health interventions.
- Identifying a sustainable and appropriate package of compensation and incentives for peer educators is complicated.
- Young people can be effective agents for eradication of harmful "traditional" practices.
- Standard family planning and reproductive health monitoring indicators do not capture the results of youth projects.
- Evidence of sexual activity among girls 12 and younger points to the need to develop appropriate interventions targeting this age group.
- The sensitivity surrounding reproductive health services for young people is not an insurmountable barrier to demonstrating their feasibility.

Reproductive Health Brief

The Urban Initiative: Reaching High-Risk Groups

What problem or gap did this activity address?

Africa has the highest rate of urban growth in the world. Rapid urbanization can undermine the ability of national and local governments to plan for and satisfy current and future demand for health and social services. Through the Bureau for Africa/ Office of Sustainable Development funding, the Family Planning Service Expansion and Technical Support (SEATS) project implemented by John Snow, Inc. focused on increasing the capacity to provide sustainable, high-quality reproductive health services to the growing volume of clients in 10 cities in Guinea, Mozambique, Senegal, Zambia, and Zimbabwe.

JHU/CCP

Approach and key activities

SEATS II applied strategies identified by studies of family planning programs in African cities, conducted under SEATS I. These strategies included partnerships with municipal and local authorities to develop the skills of elected officials, collecting and analyzing data for evidence-based planning and management, coalitions of public-sector and private-sector organizations, advocacy from a united front across different sectors, and South-to-South exchange and sharing of lessons learned.

Specific activities of SEATS II's Urban Initiative included:

- Developing, adapting, refining and applying innovative tools and two new program models for planning and program implementation
- Providing technical assistance in: advocacy; quality of care, sustainability, and evaluation planning; efficient use of available resources; and donor identification and networking
- Establishing inter-organizational groups to provide coordination, support, and planning services to cities' reproductive health programs
- Establishing youth-friendly services in three cities by training family planning trainers, over 1,700 service providers, and more than 100 community-based educators
- Conducting outreach and community mobilization in support of reproductive health services
- Mobilizing additional funds from donors and municipal authorities for reproductive health services.

Innovative tools and new program models for urban areas

Tools and models generated under the project contributed to improving evidence-based planning, more targeted use of existing resources, and the creation of an environment that enabled the development and use of innovations. See brief on The Urban Initiative: Innovative Tools and New Program Models.

What results have been achieved?

More people are using family planning in the 10 cities where SEATS worked. Statistics for four cities show 81,000 new contraceptive users served and

221,000 couple years of protection generated. Clients have access to a wider variety of contraceptives. In Lusaka, Zambia, the number of methods offered increased from one to eight.

Youth now have access to reproductive health information and services. Over 126,000 youth were reached with reproductive health information and 5,000 young people received contraceptive and other reproductive health services.

More than 100 new or improved service delivery points are available and two cities in Zimbabwe have municipal family planning training centers supported by the city government.

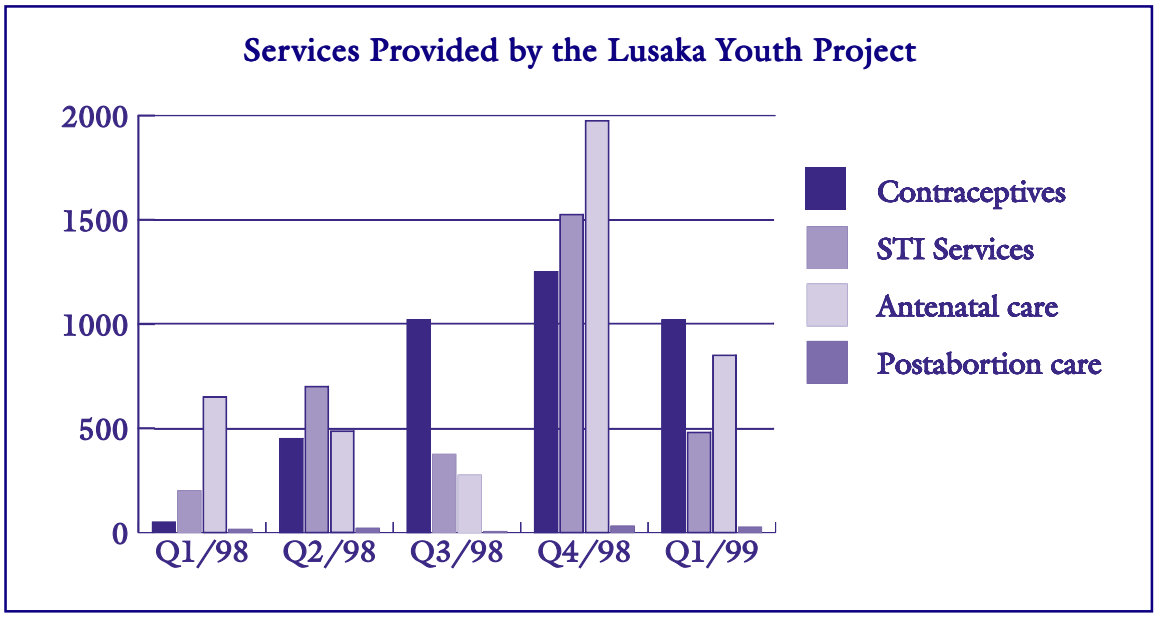
Municipal officials provide greater support for reproductive health programs in each city. Local authorities have more knowledge of reproductive health data and make better use of them. Mayors obtained at least $400,000 from non-USAID sources to improve and expand reproductive health services.

What lessons have been learned from this activity?

- Municipal governments can increase the efficiency and effectiveness of family planning service delivery programs.
- Municipal officers can manage the impact of increasing urbanization on access to and quality of reproductive health services, but they cannot do it alone.
- 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.
- More effective use of existing urban resources requires: (1) partnerships among municipal governments and public- and private-sector groups; (2) strategic use of data; and (3) consistent advocacy.
- Women in leadership positions can play a pivotal role in advocacy and expanding services, especially in cities where reproductive health issues are sensitive.
- Local technical assistance sources can strengthen planning and management skills that are required for sustaining program services in the future.

Key Products

Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa: Partnerships with Municipal Governments is a report detailing key lessons learned from the Urban Initiative. It can be found at http://www.seats.jsi.com/seats_pubs.html.



Reproductive Health Brief

The Urban Initiative: Innovative Tools and New Program Models

Supported by the Bureau for Africa/Office of Sustainable Development, the SEATS Project's emphasis on urban areas generated a number of innovative tools, programmatic models, and sources of technical assistance. These contributed to improved evidence-based planning, more targeted use of existing resources, and the creation of an environment that enabled the development and use of innovations.

- ***The Family Planning Program Monitoring and Evaluation System***. This easy-to-use, customized spreadsheet enables cities to track program growth (with couple-years of protection, number of users, and contraceptive prevalence rates by method and quarter) and recognize local problems without having to wait for national survey results.
- ***The Client Contact Estimator***. This software program estimates the number of client contacts an urban family planning program will have to support in the future so policy makers can decide when and where to open new sites and whether or not to introduce additional contraceptive methods.
- ***Socio-Sanitary Mapping.*** These exercises produce new maps that identify potential resources, new places for outreach, and opportunities to work with non-health sectors.
- ***Best Practices Model.*** This model engages municipal health departments and private-sector partners in analyzing local reproductive health data and adapting best practices to address specific concerns of access, quality, and sustainability. Partners advocate for increased resources and use data to track progress.
- ***Empowerment Model.*** Also known as the "Quick Study" model, this approach targets elected mayors and supports democratic institution building and decentralization policies. It encourages local officials to actively seek solutions to ongoing problems and increases their abilities to mobilize and manage resources that respond to their constituents' needs.
- ***Non-Traditional Sources of Technical Assistance***. Using locally and regionally available technical assistance reduces costs, strengthens partnerships, and fosters sustainability while building skills. Mayors and municipal health authorities draw upon consulting firms, university professors, retirees, employees from other Ministries, business owners, and local politicians.
- ***City-to-City Collaboration and Technical Assistance.*** Technical exchanges of municipal officials and family planning specialists involved in urban subprojects promotes skill transfer, self reliance, empowerment, and sustainability.
- ***Reproductive Health Open Door Days.*** Citizens visit the mayor and his or her staff to discuss health priorities and focus attention on reproductive health. Open Door Days make a direct link between locally elected officials and their staff, the community, and health service providers within their neighborhoods, sometimes for the first time.

For more information or to get copies of the tools, please contact:

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Maternal & Neonatal Health

country profiles

Burkina Faso

Burkina Faso is a landlocked country situated in the heart of West Africa. Considered part of the Sahel region of Africa, Burkina Faso struggles with few natural resources and brittle soil. The minimal rainfall in the north of the country has an enormous influence on the availability of food and, therefore, the nutritional status of the population. More than 45% of the country's population lives below the poverty level, making Burkina Faso one of the poorest and least developed countries in the world.

Total Population
11.9 million

Maternal Mortality Ratio
484/100,000 live births

Neonatal Mortality Rate
43.7 per 1000

Infant Mortality Rate
108.6 per 1000

Total Fertility Rate
6.4 children per woman

Duration of Exclusive Breastfeeding
1.6 months

Mission and Objectives

The Maternal and Neonatal Health (MNH) Program in Burkina Faso is working to improve maternal and newborn survival both in Burkina Faso and across the West and Central Africa region. In Burkina Faso, the Program is developing a model to increase the use of skilled providers in targeted sites in the country's Koupéla district, approximately 150 miles east of the capital city of Ouagadougou. In addition, as a committed member of the USAID Family Health and AIDS (FHA) Project and a contributor to the West Africa Regional Project (WARP), MNH/Burkina Faso is using its experience in the Koupéla district to inform the development of maternal and neonatal health services across the region.

Background

The MNH Program received funding from the regional USAID Family Health and AIDS/West and Central Africa (FHA/WCA) Program in 1999. MNH/Burkina Faso was developed as a three-year pilot project with the expectation that approaches and tools used in the Koupéla district could be disseminated to other districts of Burkina Faso and other countries in the region.

Strategy

MNH/Burkina Faso uses a two-tiered strategy that emphasizes both increasing the use of skilled providers and strengthening the operational capacity of the district health system. The strategy includes four main technical components: interagency collaboration, policy and advocacy, performance and quality improvement, and community demand for and access to health services.

Interagency Collaboration

Collaboration is key to the success of the MNH Program in Burkina Faso. The Program has partnerships with international organizations such as UNICEF, the Centers for Disease Control and Prevention (CDC), Santé Familiale et Prévention du SIDA (SFPS), Peace Corps and PLAN International as well as with national organizations. The partnerships have generated a variety of collaborative activities, including the following:

- A research project on malaria in pregnancy, with CDC and Centre National de Recherche et de Formation sur le Paludisme (CNRFP), began in July 2001.
- Supplies and equipment, provided by UNICEF, are being used to furnish four model health sites with the tools they need to provide quality care.
- A community program to promote insecticide-treated bed nets was developed with PLAN International.

MNH/Burkina Faso facilitates quarterly team building workshops and monthly management meetings at which the partner organizations address infrastructure, training, management and

information needs for improved service quality and increased use by the community of skilled maternal health services.

Policy and Advocacy

The Ministry of Health (MOH) recognizes the need to improve maternal and newborn health services and, as a first step, has worked with SFPS and MNH/Burkina Faso to prepare updated Service Delivery Guidelines for Safe Motherhood that include standards for essential and emergency obstetric care. Using these new service delivery guidelines, MNH/Burkina Faso has worked with MOH counterparts to standardize a core group of trainers in essential obstetric care.

The Program is also working with USAID to improve preservice training in emergency obstetric and neonatal care by supporting the development of a preservice curriculum by a group of regional maternal and neonatal health experts. As part of this process, MNH/Burkina Faso funded and co-facilitated a workshop for partners from 11 countries in West and Central Africa to finalize the curriculum. The curriculum will be available to other countries in the region and will serve as a prototype that each country can use to modify existing curricula for health professionals.

In Burkina Faso the current guidelines for treatment of malaria during pregnancy call for pregnant women to take a curative dose of chloroquine, followed by weekly prophylactic doses. Research conducted in Malawi and Kenya, however, has shown that a regimen of intermittent preventive treatment (IPT) using two doses of sulfadoxine-pyrimethamine (SP) is both efficacious and practical for preventing placental malaria and low birth weight. The World Health Organization now advocates the use of IPT with SP rather than weekly prophylaxis, and MNH/Burkina Faso is working with the CDC and the National Center for Research and Training in Malaria in Ouagadougou to study malaria during pregnancy and to make appropriate revisions to Burkina's malaria protocols. In the spring of 2002, MNH/Burkina Faso and CDC, with support from the Africa Bureau, will sponsor a regional conference covering recent research on malaria in pregnancy. The conference will launch the regional policy dialogue about revising malaria policies.

Performance and Quality Improvement

The Koupéla model health delivery system incorporates aspects of both clinical care and community participation and strengthens the training and supervisory capacity of the District Health Management Team (DHMT), which oversees health facilities in rural towns and villages. The MNH Program trains healthcare providers to identify and resolve problems using a performance improvement approach. The Program also provides standardized, competency-based knowledge and skills updates in infection prevention and essential obstetric care.

Since the Program's inception, MNH/Burkina Faso and its collaborators have made great strides in improving both the quality of services and the competence of providers in the Koupéla district. For example:

- The district's referral hospital can now handle management of complications. After training from MNH Program expert trainers, the hospital's surgeon averted 13 evacuations and conducted seven cesarean sections in a 3-month period.
- Four health centers now have infection prevention supplies.
- Four model health sites have infection prevention measures in place.
- Two regional experts were trained by the MNH Program and are now training other providers throughout the country.
- Thirty-six service providers in four model health centers have been trained in evidence-based practices for care during pregnancy, childbirth and the postpartum period.

Increased Demand and Access

Through its social mobilization component, the MNH Program aims to reinforce the capacity of the Koupéla district's health management committees in their role as the intermediary between the community and the health posts. These committees help the community identify problems and find solutions for maternal and neonatal care, reinforcing community knowledge of the importance of antenatal and postnatal visits and the presence of a skilled provider at childbirth. In collaboration with UNICEF, the health management committees assist health facilities with developing evacuation plans for urgent care of women and newborns as well as strategies for communicating with other health centers.

MNH/Burkina Faso is also working with local nongovernmental organizations with extensive experience in rural communities in Burkina Faso, and with PLAN International to mobilize local community groups around issues of maternal and newborn health. In addition, the Program recently trained 10 community facilitators, 12 nurses, and two DMHT staff in developing goals, interventions, indicators and monitoring tools for social mobilization.

The MNH Program in Burkina Faso is using its district-level experience in Koupéla to inform the development of maternal and neonatal health services across the region.

For more information about the MNH Program visit our website: www.mnh.jhpiego.org

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