

CONFERENCE PROCEEDINGS

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**ADOLESCENT
REPRODUCTIVE HEALTH**

**MOVING THE AGENDA FORWARD:
A ONE-DAY FORUM ON ADOLESCENT
HEALTH AND DEVELOPMENT
FOR USAID STAFF AND EXTERNAL
USAID PARTNERS**

**THURSDAY, JUNE 8, 2000
WASHINGTON, DC**

POPTECH ASSIGNMENT NUMBER 2000.179

**JAMES E. ROSEN, POPTECH CONSULTANT
JUNE 23, 2000**

INTRODUCTION

On June 8, 2000, USAID's Center for Population, Health, and Nutrition (PHN) and USAID's Adolescent Interest Group hosted an all-day meeting in Washington D.C. to discuss adolescent health issues. A total of 85 participants attended the meeting, including 18 from USAID and 65 from outside partner organizations.

The objectives of the meeting were twofold:

- to provide a forum for USAID partners to make suggestions to USAID regarding future adolescent health programming out of the Center for Population, Health, and Nutrition; and
- to explore mechanisms for USAID and its partners to expand the exchange of technical information and experiences in order to encourage incorporation of best practices in adolescent programming.

The forum was structured as a "working" meeting, and used highly participatory techniques—primarily small groups—to elicit the maximum amount of dialogue and exchange of ideas. The POPTECH project provided logistical support for the meeting and POPTECH consultants Tom Leonhardt and James Rosen helped in the meeting's facilitation and design.

MEETING HIGHLIGHTS

Introductory Remarks

Linda Sussman, co-chair of USAID's Adolescent Interest Group, sketched a picture of the enormous challenges facing the field of adolescent reproductive health: 15 million births to young people each year; five young people infected with HIV every minute—adding up to 2.6 million infections a year; 2.0 billion 10-24 year olds by 2025. She reminded the audience that behind these statistics there are individual young people—each with his or her joys, fears, friends, abilities, and potential. In reviewing the meeting objectives, Sussman noted that the Center for Population, Health, and Nutrition is currently designing an adolescent health activity that USAID plans to implement in 2001, and that her expectation is that this meeting provide suggestions to help guide USAID in the project design. She also expressed the hope that the meeting would help USAID explore mechanisms so that USAID can help agencies working in adolescent health share information and lessons learned, and incorporate best practices into adolescent programming.

Paul Hartenberger, director of the Office of Field and Program Support of the PHN Center, representing senior management of the PHN Center, stressed the need for collaboration among agencies, particularly because of the magnitude of worldwide needs and scarcity of funding. In his view, the PHN Center is increasing attention to adolescent health, particularly given the large size of the adolescent group and the range of problems it faces. For USAID, addressing adolescent health is essential to

fully achieving the agency's broad development goals, especially as it relates to one of USAID's overarching objectives: stabilizing world population and protecting human health. This objective cannot be achieved without confronting the problems of youth, Hartenberger said. Indeed, achieving four of the PHN Center's five goals (reducing unintended pregnancies, reducing maternal deaths, reducing child deaths, and mitigating HIV/AIDS) that support the broader agency objective will depend upon focusing attention on adolescent needs.

The challenges to achieving these goals are real and include:

- *the division of responsibility between USAID's Office of Population and Office of Health.* Adolescent lives cannot be compartmentalized; they cut across the whole spectrum of issues. Meeting their needs represents an important challenge for greater coordination and collaboration within the PHN Center;
- *the need to go beyond the health sector to influence adolescent health through, for example, the education and jobs sector.* USAID's vertical funding structure makes it difficult to respond to such cross-sectoral challenges. The PHN Center needs to push the envelope to address this cross-cutting issue;
- *working better with other donors.* In a major policy breakthrough, UNICEF has identified adolescent health as one of three key themes for its upcoming Summit on the Child. USAID is eager to find new ways to work with traditional and new donors on adolescent issues; and
- *doing a better job of sharing the knowledge and experiences gained to date with adolescent programs.* Research on adolescents has grown and programs have proliferated. However, programs remain politically controversial, mostly small scale, and mostly without rigorous evaluation.

Hartenberger noted that the process to design the new adolescent project is long and complex. As with any new initiative, USAID is looking to its partners for input to help the Agency focus its resources and to contribute to a concept paper that USAID hopes to share widely. Senior management, he noted, will vet the concept paper, propose strategies, and have a strong voice in whether and how the PHN Center moves forward with a new activity. Hartenberger ended his remarks by reminding participants that the PHN program operates in a highly politicized environment. Thus, financial, staffing, and political constraints could influence the ultimate design of any new adolescent activity.

USAID and Adolescent Reproductive Health (ARH): Assessment of Programming Options and Future Directions

Shanti Conly, co-chair of the Adolescent Interest Group focused her remarks on existing USAID adolescent health initiatives. She noted the large need for sexual and reproductive health programs oriented specifically towards youth, because youth are different from adults, lack knowledge and access, and have different needs than adults—particularly when it comes to education and information. Conly emphasized that adolescent needs have been hugely neglected primarily because of their political

sensitivity, and that only since the 1994 Cairo Conference have adolescents begun to receive greater attention.

Conly noted that USAID's PHN Center developed its first specialized adolescent reproductive health project in 1995. The ten-year project's aims are: an improved political environment for adolescent health; increased capabilities of USAID and its partners to carry out adolescent programs; improved tools and technologies; and strategies for expansion developed and implemented. The first phase of the ten-year project is being carried out under a cooperative agreement for the FOCUS on Young Adults project. She noted that FOCUS was funded well below the originally anticipated level. USAID now plans to extend the FOCUS activity through November of 2001.

In mid-1999, the PHN Center began considering what should be done in the second phase of the ten-year program, and carried out an assessment of programming options that reviewed the original program design, FOCUS achievements, and other youth activities. (The full report is available on the web at:

<http://www.poptechproject.com/reports.htm>.) She noted that many other USAID projects—both centrally-funded and those funded through regional bureaus and via bilateral agreements with USAID missions—focus on adolescents. Yet, the assessment found little strategic coordination, relatively few cooperating agency staff with expertise on adolescents, and little rigorous program evaluation. Other donors, particularly the UN system and private foundations also have committed significant resources to adolescent programs.

Since the assessment, USAID staff have formed a team to shape future programming for the Center, and spent much of the last six months addressing gaps in evaluation and documentation of adolescent programs. USAID commissioned Judith Senderowitz to compile a paper elaborating on effective program approaches. The USAID team also has heard from numerous groups implementing youth programs. Key findings over the past six months include:

- a huge unmet need for integrated pregnancy and HIV/STD prevention programs, as well as a range of other needs including maternal health and nutrition;
- the greatest needs are in the 10-19 age group with 10-14 year olds almost totally neglected;
- gender issues are critical;
- a need to emphasize condoms for sexually active unmarried adolescents—still not the norm in many traditional family planning programs;
- the health sector needs to identify how to link to other sectors and specific mechanisms to do so; and
- the adolescent health field needs to work towards a more coordinated and strategic approach and find ways to bring programs to scale.

Approaches to ARH: Moving Forward

Judith Senderowitz, an independent consultant and expert on adolescent reproductive health, highlighted the recommendations of her recent paper commissioned by USAID, *A Review of Program Approaches to Adolescent Reproductive Health*. (The report also is available on the POPTECH website.) The objective of the paper was to review, synthesize, and assess the range of program activities, and to assist the Center in identifying promising program approaches for funding under a new activity. Senderowitz pointed out that many of the program approaches the paper describes encompass more than one of the three major objectives of ARH programming, which include: (1) fostering an enabling environment; (2) improving knowledge, skills, attitudes, and self-efficacy; and (3) improving health-seeking and safer sex practices. Moreover, she emphasized, good programs often combine several program approaches.

The paper highlights effective programs—those that have had some impact on either the target or intermediate audience (such as peer educators), on the environment or political situation, or on other entities or levels other than adolescents. Across all three objectives there is evidence of impact in developing countries—not equal impact, but impact nonetheless. Senderowitz highlighted the following findings from her review:

- *most of the work in this field has been “projectized.”* There are many successful projects, but they haven’t continued and haven’t expanded. Sustainability and scaling up are, thus, two very important issues; and
- *the need to build on what we have.* If organizations have a model that can work specifically for adolescents, that’s a good place to start. Programs are becoming youth friendlier and can get there. However, many implementation problems (e.g., training) compromise the attraction and retention of youth to facilities. Young people prefer not to get their services in medically-oriented clinics. They want to get services—condoms especially—from more informal, comfortable, anonymous sources. We need to put more imagination and resources into finding these comfortable places.

Senderowitz then briefly discussed the main conclusions from her review, summarized as follows:

1. Programs should be conceptualized and designed to move from the current “project mentality” of scattered, one-time efforts into a more sustainable and comprehensive program framework using multiple interventions.
2. Program planners must undertake preparatory actions to foster an enabling environment before introducing an ARH intervention, and select designs appropriate to the community’s readiness to support these activities.
3. The choice of partner agencies and the selection and training of staff are critical to achieving ARH program objectives.
4. Youth should be viewed as assets within ARH programs, which should serve them early in adolescence, be responsive to their needs and seek their active involvement.

5. Given the significance of gender dynamics for young women's ability to practice safe sex and establish good reproductive health, program options need to be devised, and successful approaches expanded.
6. Mass media and informal communications can be selectively used at all levels of program readiness and development, and can help programs achieve the three major program objectives related to a supportive environment, enhanced information and skills, and improved health services.
7. Both formal and informal sex/HIV education programs should be increased, going to scale where possible, and, in addition, identify youth-popular venues for reaching young people with needed information.
8. Young people should have access to a variety of commercial, private, NGO, and public health services, where they can receive respectful and confidential treatment for their RH needs.
9. Considerable research is needed to better understand determinants of adolescent risk-taking in developing countries, the potential for alternate venues to provide ARH education and services, ways in which programs can be expanded and scaled up and more effective ways to conduct research with young people and assess ARH programs.

In response to a question on scaling up, Senderowitz commented that she is coming around to the view that we should only do projects that either have some feasibility of expanding or of having a lasting effect on policy or readiness climate. Although perhaps an extreme view, she remarked that we have an extreme situation where large numbers of adolescents urgently need services.

In answer to a question regarding the degree to which USAID planned to involve country counterparts—both program staff and beneficiaries—in the design of the new activity, Shanti Conly responded that the review paper by Judith Senderowitz is only one piece of what USAID is doing to design the activity. USAID also plans to incorporate feedback from its field missions, and some staff are visiting adolescent programs in developing countries. A consultation also is planned with youth-serving organizations from developing countries. At this point, however, USAID is not planning any systematic consultation with developing country governments.

Responding to a question about the role of adults and the possibility that we are marginalizing their participation in the development and implementation of adolescent programs, Senderowitz emphasized that youth involvement is important but that programs should not marginalize adults. In fact, many peer education programs fail because there is not an adult that kids can turn to or refer peers to when their own knowledge is insufficient.

Envisioning the Future State of Adolescent Health

As a prelude to the work in small groups, meeting facilitator *Tom Leonhardt* asked participants to first undertake an exercise to describe their vision for the state of adolescent health five years from now. In a brainstorming session, participants put

forward a remarkably wide range of “visions” which are compiled in summarized form and attached as Annex 3 to this report. The common themes among the future visions included:

- an improvement in health behaviors and outcomes;
- the existence of a supportive environment—from politicians, funders, parents, and the community;
- the elimination of practices that harm adolescents;
- greater autonomy and respect for adolescents; and
- better programs using a more holistic approach to meeting the needs of youth.

Priority Recommendations to USAID for the New Adolescent Activity

Participants formed seven small groups to discuss and respond to the following questions:

1. What should be the priority tasks of a specialized adolescent health activity?
2. What are the best ways to link a specialized adolescent health activity with other adolescent initiatives within the Center for Population, Health, and Nutrition and with USAID regional and bilateral programs?
3. What should be the scope of a new specialized activity? Should USAID limit it to reproductive health or include other health activities and even linkages to other sectors outside of health, such as education and youth livelihoods?
4. How should a new activity address gaps in our knowledge about adolescent programming?
5. Where should USAID put its limited resources vis-a-vis other donors (including private foundations)? How can it better coordinate with other donors?
6. How can we promote the sharing of knowledge through a new activity?

Each group was led by a facilitator from USAID and assisted by volunteer rapporteurs. The groups were asked to maintain a record of their discussions and to present two or three key recommendations to the larger group (Annex 4). A number of common themes emerged from the discussions and presentations:

1. The need for greater donor coordination;
2. The importance of advocacy;
3. The importance of a multi-sectoral approach;
4. The need for both targeted and comprehensive approaches to achieve adolescent reproductive health outcomes;
5. Fostering a youth development approach that involves youth and considers youth assets;
6. Promoting communications/information exchange;
7. Focusing on scaling-up;
8. Building on data and real experiences;
9. Doing more institutional capacity building;
10. Doing a better job of including the community perspective;

11. More commitment and more money for adolescent reproductive health;
12. Focus programs more on gender equity; and
13. Linking programs more to democracy issues;

Mechanisms for Coordination and Technical Exchange

A staged “provocation” between two USAID participants highlighted the pros and cons of some of the common mechanisms used for an exchange of information aimed at promoting best practices: working groups, conferences, meetings, publications, and the internet. The debate served as a jumping off point to brainstorm ideas for information sharing. Five small groups presented their two or three most important ideas. Among the common themes and recommendations that emerged from the discussion were the following:

1. Making information sharing a higher priority;
2. The need to clearly identify audiences for dissemination and information and to target different products to different audiences;
3. Better use of existing materials and channels for communications; and
4. Giving the new USAID adolescent activity responsibility to act as a clearinghouse for information and dissemination

Conclusions and Next Steps

In the concluding session, Shanti Conly thanked participants and noted that despite the healthy differences in perspectives, there was considerable overlap and many commonalities among the ideas put forth, making it easier to move forward. She went on to highlight some of the key themes that emerged during the day including:

- *Advocacy and Commitment to Reproductive Health.* The need for greater attention to advocacy came through loud and clear and is definitely an area where more work is needed. The decision by UNICEF to choose adolescent well-being as one of the three key themes for the upcoming UN Summit of the Child also represents an important advocacy opportunity. [Bruce Dick of UNICEF extended an invitation to all present to provide him with input in anticipation of the summit, which will be held next year];
- *Youth development approach and multisectoral linkages.* Forging these links presents many challenges for USAID and at this point there are more questions about how to move forward than there are answers. The USAID team plans to spend time on this over the next few months exploring the practicalities of linkages that recognize the many dimensions of adolescents' lives;
- *Gender roles and dynamics are key.* We need, however, to think more about what kinds of interventions are needed; and
- *Mobilizing Financial Resources, Donor Coordination, and Scaling Up.* These themes are closely interwoven and require increased attention. With respect to donor coordination, USAID plans to contact many of the donors on a one-on-one basis in the near future.

Conly then described the next steps in the design process as well as ideas for continued sharing of information:

- *Concept Paper.* USAID staff are continuing to fill gaps in their knowledge, and working towards developing a concept paper for future programming to share with the broader adolescent health community. At the same time, the team will consult with senior PHN center management on the major elements and scope of a new adolescent project;
- *Information Sharing.* A range of dissemination and information sharing activities already are occurring under the FOCUS project. USAID will explore initiating some of the activities suggested at the meeting today under the final year of the project;
- *Future Technical Meetings.* As a way of continuing a more in-depth dialogue around specific technical issues raised in this meeting, Conly solicited ideas from the group for particular topics that might be addressed in periodic half-day or full-day meetings (partly modeled on the successful meetings hosted by the Men and Reproductive Health Subcommittee of the USAID InterAgency Gender Working Group). Topics suggested by Meeting participants include:
 - Explore scaling up issues in depth. What have we learned? What do we need to learn;

- **Education, Livelihood and Reproductive Health. Making the linkages without losing the reproductive health focus;**
- **Sexual health (a broader area than reproductive health);**
- **Evaluation of adolescent reproductive health programs, recognizing that adolescent reproductive health is different from adult health and requires different approaches, different indicators for success, etc.; and**

Hold a yearly meeting to discuss the status of USAID adolescent reproductive health initiatives.

ANNEX 4

Small Group Exercise: *Priority Recommendations to USAID for its New Adolescent Activity*

Participants in the small groups responded to and discussed the following questions:

1. What should be the priority tasks of a specialized adolescent health activity?
2. What are the best ways to link a specialized adolescent health activity with other adolescent initiatives within the Center for Population, Health, and Nutrition and with USAID regional and bilateral programs?
3. What should be the scope of a new specialized activity? Should USAID limit it to reproductive health or include other health activities and even linkages to other sectors outside of health, such as education and youth livelihoods?
4. How should a new activity address gaps in our knowledge about adolescent programming?
5. Where should USAID put its limited resources vis-a-vis other donors (including private foundations)? How can it better coordinate with other donors?
6. How can we promote the sharing of knowledge through a new activity?

The following reflect each group's priority recommendations.

Group 1

Facilitator: Dianna Frick

Rapporteur: Kathleen Kurz, International Center for Research on Women

Priority Recommendations

- *As an overall recommendation, the project should use an adolescent development approach to achieve ARH and well-being outcomes. There are many things that we thought could be part of an adolescent development approach, including being:*
 - Assets-based
 - Rights-based
 - Livelihood-based
 - Education-based
- 7. *Continue and expand policy work to promote an enabling environment. We know that the FOCUS project and Policy Projects are already doing this sort of work and the idea is build on the experiences and move forward in terms of advocating in-country and in coalitions and moving forward in terms of both formal and informal policies. We want even more of that. Because we think that in order for ARH to be more than just very small programs that don't reach very many adolescents, there needs to be more constituency-building and policy and advocacy communications*

kinds of approaches to make it take off. We'll never scale up without the political will to scale up. Constituency-building also needs to take place here in the United States.

- *Establish mechanisms within the project to actively consult with partners (broadly)*
 - Other donors in this field. There could be much more communication. We know it's a lot of work but we think it's really important.
 - Local NGO's and Cooperating Agencies
 - Governments
 - Clients
- *We also agree with the framework and 3 recommendations put forth earlier by Judith Senderowitz that include:*
 - Improving adolescent knowledge skills, attitudes, self-efficacy
 - Fostering an enabling environment
 - Improving adolescent health-seeking and safer sex practices
- *Research, evaluation, and dissemination should all be key project components.* Research should include all kinds—surveillance, operations research, pre/post studies, etc.

Group 2

Facilitator: Krista Stewart

Rapporteur: Susan Rich, Wallace Global Fund

Priority Recommendations

1. *Design project/program based on realities of the USAID structure and operations*
 - Limited funding
 - Have to look at the strengths and constraints of field support/core support and bilateral programs
 - USAID needs to establish mechanisms for multiple donor funding. Lawyers of private foundations need to sit down with the lawyers from USAID and figure out how this can happen
2. *USAID should adopt a strategic approach:*
 - Based on data, based on evidence
 - The strategic approach should be clearly reflected in agency-wide priorities – at AID Washington and at the country level
 - Should be reflected in funding levels and allocations
 - Country selection and target population should be also based on data or based on reasons why
- Use Performance Improvement/Systems approach to (e.g., improve parent and provider interactions with youth) to optimize program impact

3. *Resource Mobilization and Public Relations.* USAID should raise the profile of ARH and feature successful programs to mobilize support and raise funds
 - Political support, building a constituency here in the United States
 - Financial—increasing funding for ARH
 - Dissemination “lessons learned”—to learn from our mistakes and from our share of successful programs
4. *USAID should take the lead to coordinate multi, bilateral and private donors on ARH to maximize funds and impact.*

Group 3

Facilitator: Minki Chatterji

Rapporteur: Seema Chauhan, Center for Development and Population Activities

Priority Recommendations

- *Shift from project mentality to ‘bold’ comprehensive programming.* To start looking at how you can do adolescent development programming and how to link different sectors. Not necessarily having one organization do everything that young people need, but have linkages and each organization building on their strength. But what goes out to the young people is the whole piece.
- *USAID should promote donor collaboration to ‘fit’ all pieces of a big picture.* When you design youth programs, look at all the needs of young people, then recognize that not all donors could necessarily fund the entire spectrum of need. However, in collaboration, donors could focus on areas of strategic interest to them. Then we could really have a fit.
- *USAID needs to do more advocacy at these levels:*
 - Government to government. Governments are perhaps ready to take these bold risks and do youth programming. But they need a push. USAID could give this push, encouraging government to implement the UN documents they have already signed on to.
 - USAID to UN agencies. Work within and to the UN agencies to make sure that youth programming is active
 - In-country, Inter-ministerial. USAID missions can promote this collaboration at the country level and help bring different ministries together
- *Develop a communication strategy.* There is a massive need for information exchange.
 - USAID needs to look at appointing a youth coordinator within the PHN center to implement this communication strategy. And that the youth coordinator be a young person themselves.
- *Youth involvement – set up an advisory group.* USAID needs to think of youth involvement from the outset. Right from the design stage if possible. Hearing from young people on the design and through the implementation and evaluation. [In response to a question on how a youth advisory group would work logistically, the following suggestions were made: (1)

bring youth from developing countries together for a week's workshop (done previously under a collaboration with CEDPA and UNFPA to get young people's input on what should go into the Cairo and Beijing documents); (2) take it to a regional and in-country level; (3) have US CAs that work with youth – serving organizations help in the selection of young people to make sure they are not token; (4) set up a *parent's* advisory group to generate ownership of the program]

Group 4

Facilitator: Sigrid Anderson

Rapporteur: Evelyn Landry, AVSC International

Priority Recommendations

- *Needs to be strategic inter-sectoral and interagency (donor) coordination at country and community level. Identify key age groups, for example the 10-14 age group which is typically neglected.*
- *“Unpack” ARH needs at country and community level, prioritizing goals (limited) at community level.*
- *Training of teachers, parents, providers (everyone) about adolescent needs/issues. Creating a leadership issue, making it the norm to include adolescent issues in all sorts of courses.*
- *Ensure adequate long term funding for program implementation. Talking more about USAID, but also getting funding from different donors is important.*
- *To make sure we are evaluating and assessing the costs, quality, and coverage of the programs being implemented. To promote the institutionalizing of norms to work with youth.*
- *Flexibility, creativity and focused program design at the country level!*

Group 5

Facilitator: Anastasia Gage

Rapporteur: Margaret Greene, Center for Health and Gender Equity

Priority Recommendations

- *Closer coordination between STD/HIV prevention and pregnancy prevention efforts. This point has to do with the politics of working with young people and the need for all of us to think about additional rationales for supporting ARH. STD/HIV prevention is relatively unambiguous and somewhat less politically charged.*

- *Advocacy and capacity building for advocacy on Young Adult Reproductive Health.* USAID should be doing advocacy itself and promoting advocacy within the governments and among NGOs it works with.
- *Develop strategies for working with adults on roles they play in Adolescent Reproductive Health.* Adults play many important roles in influencing ARH. For example, in intergenerational sexual relationships where girls have sex with older men. Where are the interventions working with those older men? Addressing the roles of the adults in the lives of adolescents.
- *Develop projects with a view to scaling up.* Also document (+replicate) the process of scaling up. Because scaling up has been such a struggle with so many organizations.
- *Develop programs with young people at the core...rather than institutions.* So much of work on ARH looks at institutions, for example clinics, and thinking how can we fix these clinics and have youth come and use services. Instead of starting with a look at existing institutions, to look at what are the resources that young people use—is it the grandmother; the other girls or boys in the area. Look at what is happening in the lives of young people rather than starting with those institutions that are already petrified.

Comments: In response to question about whether scaling up is really achievable in practice, the rapporteur noted the many programs for adolescents that can be considered “small jewels,” that are just wonderful but you can’t possibly do on a larger scale because of cost issues. The participant from FOCUS noted that FOCUS is in the process of mailing out a tool on scaling up which will hopefully enlighten people about what scaling up means, where it’s happened, and how to do it.

Group 6

Facilitator: Linda Sussman

Rapporteurs, Jill Gay, Consultant and Ann McCauley, Horizons

Priority Recommendations

VISION

We need a framework that incorporates all aspects of adolescence and adolescent well-being.

- *We need to develop this framework with groups outside of USAID and also within USAID across sectors.*
- *The framework would facilitate identification of roles.* Each group and organization could identify their role and how they would interact with other group, and that it would promote cooperation among various groups.
- *The framework would promote collaboration/cooperation.* This approach would let everyone see that their particular piece (micro-credit, etc) is additive to the larger framework. This approach, with each group specializing, might reduce competition. It isn’t micro-credit programs or health programs, but both have a place.

PASSION

Advocacy for Adolescents. We want someone—we didn't identify them—passionate about adolescents. We want someone out there advocating, persuading, bringing people along and really making the case for adolescents. We want someone who is a speaker, a real glad-handler, who can get all the organizations we work with and Congress excited about working with adolescents. This person would:

- Collect data and make arguments we haven't made yet, including economic arguments and arguments about the positive contributions of young people.
- See opportunities at all levels

ACTION

Create Specific Guidelines. We do know a lot about this field and we do know some things that are absolutely crucial and that we don't need to do a big literature review and determine whether these issues are important. Therefore we want someone to develop specific action guidelines on some of these really tough issues. Examples of two areas where we need to apply action:

- Gender.
- Youth as a positive force. Let's figure out how youth can be used to change their own world. What lessons can we learn from the positive deviants. How can we apply their experience to help other kids.

Group 7

Facilitator: Karen Welch

Rapporteur: Justine Sass, Population Reference Bureau

Priority Recommendations

- *While the scope should remain focused on ARH outcomes, intermediate results should reflect cross-sectoral strategies as well as more conventional reproductive health strategies.*
- *Lessons learned should be utilized to the maximum by supporting evaluation, TA, capacity building, replication, and advocacy. Monitoring and evaluation needs to be part of a specialized activity as well as mainstreamed in other activities supported by the PHN Center.*
- *This activity should take a leadership role in terms of donor coordination at the country level for both advocacy and information sharing purposes. USAID may not be the best organization to take on the coordination role at the global level, but may be well-situated to do this at the country level.*

**AFRICAN FORUM ON ADOLESCENT
REPRODUCTIVE HEALTH**

**JANUARY 20-24, 1997
ADDIS ABABA, ETHIOPIA**

**COORDINATED BY THE CENTER FOR DEVELOPMENT AND
POPULATION ACTIVITIES (CEDPA)**

ANNEX E: WORKSHOP HIGHLIGHTS

1. DAY 1 WORKSHOP Summaries

1.1 Topic: **RESEARCH METHODS FOR PROGRAM AND POLICY DEVELOPMENT** *Organizer: Addis Ababa University*

Lessons learned:

- Research should be coordinated through a clearinghouse to be accessible and eliminate repetition. NGOs need to share information and to coordinate research. Researchers and practitioners should form networks so they can collaborate more closely.
- All of those concerned with the research should be involved in the research design at the appropriate level.
- More operations research is needed.
- Researchers should talk to young people first to determine their needs and preferences. These notions should guide the research design.
- Researchers should use existing sources of information such as Ministry of Health statistics.
- Research should be demystified by becoming participatory. Researchers should design methods that program people can use themselves. The process of research should empower the community and be part of the implementation of the program. Participatory research:
 - helps the community set priorities;
 - transfers the analytical skills to all involved;
 - can be part of the process of addressing adolescent reproductive health needs;
 - is more likely to be used by the community.
- We need to use multiple sources in doing research. The results will be more complete and useful.
- Research priorities should be decided by indigenous organizations to meet specific needs. However, local organizations can negotiate with donors about research designs.
- University researchers should be more open to working with researchers who are outside the university setting.

1.2 TOPIC: THE TREATMENT OF ABORTION COMPLICATIONS AND POSTABORTION CARE

Organizer: IPAS and Pacific Institute for Women's Health

Unsafe abortion is prevalent in Africa. Adolescents represent a disproportionately high number of those having abortions and an even higher number of those who die from complications. Restrictive policies limit young adults' access to family life education (FLE) and family planning services and have little influence over their sexual activity. Postabortion care programs designed to meet the needs of adolescents can have a major impact on their future reproductive health.

Participants offered experiences from their own countries, which demonstrated that youth-friendly training for service providers, the adoption and expansion of traditional IEC, education about the risks of unsafe abortion, and MVA as a cost-effective option to unsafe abortion are among the examples of successful adolescent reproductive health initiatives.

Issues include:

- lack of access to family planning counseling services;
- implications for health care workers providing services where the law is restrictive;
- even where the laws are not restrictive, lack of facilities and services;
- access to safe services, requiring full consent and confidentiality;
- poor provider attitudes, constituting a barrier to access;
- insufficient empathy for the young woman and the situation leading to the unwanted pregnancy;
- staffing problems due to restrictive legal policy;
- poor quality of emergency services;
- overworked personnel, who have little time for follow-up;
- lack of acknowledgment of related reproductive health problems.

1.3 TOPIC: ASSESSING THE TRENDS IN STDS/AIDS IN AFRICA

Organizer: AIDSCAP

Lessons learned:

- Prevention and control of STDs and HIV/AIDS among youth can be successfully accomplished. The potential for success can be improved through: 1) involving youth in every stage of the project, 2) understanding the needs of specific youth groups by carrying out relevant research for project implementation, 3) using proper monitoring and evaluation as part of project implementation, and 4) applying best practices from other similar projects.
- The participation of the wider community is indispensable if an intervention is to be effective. On the other hand, a program which is based only on the needs and interests of a single segment of the society may not produce satisfying results.
- The continuity of a youth AIDS project should be assured over a relatively long period and studies of youth needs should be undertaken at intervals and applied in project design.
- Use of multiple communication media (especially drama, puppet shows, sporting and social events, and films) encourages youth to attend project events and participate in project activities.
- Employment of youth peer educators as project coordinators or project staff improves implementation of the project. *Examples:* The Save Your Generation Project and the AIDS Prevention for Out-of-School Youth Project (Ethiopia).
- Through collaboration with the authorities of an institution (including a school), an institution-based youth project can gain credibility and support, which can enable it to achieve sustainability. The integration of a module on AIDS in university curricula ensures sustainability and continuing education on AIDS to a wider audience beyond

the initial target audience of a project. *Example:* The Nigeria Youth AIDS Project.

- A well-developed peer education project, supported with excellent IEC materials, facilitates the reduction of STDs among youth in educational institutions.

Discussion and the exchange of experiences revealed the following points:

- Youth programs need to be evaluated and adapted over time to respond to emerging needs and interests of young people. In the case of the Ethiopia project, additional activities (such as football) were added and parent and teacher associations were involved.
- Committed youth will gradually take over from program staff.
- Broad participation from several segments of society, especially parents, teachers, and religious and community leaders, enhances program credibility and impact.
- Adequate measures—tested and monitored—are needed to ensure the sustainability of youth AIDS programs, especially regarding peer education.
- The Nigeria project introduced a reproductive health curriculum (including STDs and HIV/AIDS) into tertiary institutions, piloted a program to enhance parent-child communication, trained college-based peer educators, and promoted the creation of anti-AIDS clubs in schools to sustain peer education activities.
- Programs must be developed for out-of-school youth.

1.4 TOPIC: QUALITY OF CARE IN ADOLESCENT REPRODUCTIVE HEALTH *Organizer: JHPIEGO*

A brainstorming session followed by discussion enabled participants to define "quality" in adolescent reproductive health programs and articulate lessons learned concerning improved services for adolescent reproductive health care.

Quality adolescent health care services should have the following characteristics:

- accessible location;
- affordable or free entertainment that is relevant to services or will attract young people to services (games, sports);
- youth-friendly male and female providers, with open, friendly attitudes;
- well-trained, experienced providers—those who are too youthful tend to lose credibility;
- good management;
- consult with youth before the service is set up and in monitoring services;
- confidential, prompt (short waiting time) but not rushed;
- attractive setting (cushions, pleasing colors);
- brochures and other information relevant to youth;
- emphasis on wellness rather than disease;
- age limit;
- different entrances and hours for youth and adults;
- suitable opening time for adolescents;
- approach adapted to the community;
- integrated comprehensive services: family planning, STDS, counseling and education before services are provided;

- counseling to help adolescents abstain from sex;
- non-judgmental attitude to allow the client to make an informed choice;
- accessible contraceptives, such as condom machines.

An example is a model clinic in Eritrea located in a youth center: the clinic is upstairs, and a drama troupe gathers downstairs.

1.5 TOPIC: STRATEGIES TO ELIMINATE FGM

Organizer: PATH

PATH presented the following summary of lessons learned from its interventions in female genital mutilation (FGM).

What works:

- Attitude and behavior change can be achieved through comprehensive, inexpensive interventions.
- Interventions that emphasize capacity-building and community education at the grassroots level seem to be most effective.
- Garnering the support of traditional and key opinion leaders helps achieve and sustain results.
- Actively involving the target audience in project design is an effective strategy.
- Basing all aspects of the intervention on the formative research results in a realistic and effective project.
- Creating support groups for communities and legal support for families who dared to stop circumcising and answering difficult questions that arise during the project are crucial. FGM projects bring about social change along a continuum; change must be sustained over a long period.

Obstacles to change include:

- long-standing traditions and social norms;
- Myths and community enforcement mechanisms;
- long process to affect behavior change;
- fear of women's sexuality in a modern era.

Obstacles in project implementation include:

- need for incentives or alternative income for circumcizers/health professionals;
- need for a long period of capacity-building;
- transportation problems;
- difficulty relying on volunteers.

Lessons learned:

- The community is the main target and actor in the elimination of FGM. The community must be approached with caution, sensitivity, dignity, and respect for their culture.
- Baseline data (survey, general information) is needed on the prevalence of FGM in a given society.

- Knowledge of the age of circumcision is vital in the development of appropriate strategies to eliminate FGM.
- Trainers involved in raising awareness of communities about the deleterious effects of FGM should be knowledgeable, sincere, and committed and include members of the community itself.
- Awareness-raising meetings should be held with different groups of the community, for example, community elders and leaders, women, men, youth, boys, girls. This should be followed by a meeting of all members of the community to achieve consensus and continued support. The campaign for the elimination of FGM should be sustained until there is a critical mass of supporters.
- Link the elimination of FGM with the provision of comprehensive adolescent reproductive health services. Address FGM as an integral component of reproductive health, including outreach services for awareness raising.
- Raising the awareness of policy-makers, program managers, and service providers is important, but these officers should refrain from making public statements that may antagonize or provoke the community to take an uncompromising stand. Some people do not like publicity. The lesson is to raise awareness and involve the community first, and then bring in the support of administrators/public officers.
- Create a broad-based "National Committee on the Elimination of FGM," with members from NGOs and various ministries. This leads to the incorporation of at least some information on FGM in the activities of the participating ministries and NGOS.
- Obtain videotapes showing top religious leaders denouncing the practice of FGM. This would stop lower-level religious leaders from making erroneous statements linking the practice of FGM to religious beliefs.
- With the increasing number of girls going to school, the practice of circumcision is not being passed on to the daughters.
- The decreasing number of traditional circumcizers and the well-documented complications of FGM are leading to an increasing call for medicalization of FGM.
- We need to support the community on the preservation of the positive elements of the initiation ceremony of passage without FGM. Some communities working on the elimination of FGM have modified the practice by giving a symbol, such as a book or bracelet.
- Educational materials and discussion guides on the issue of FGM are needed.
- Introducing discussion about FGM into school curricula is one of the strategies for its elimination, but it was observed that girls refuse to participate in the discussions. The lesson is either to talk about both male and female circumcision or talk about it separately with boys and girls.
- Donors expect results by funding an FGM project for two years. This is unrealistic as the elimination of FGM is a long process.

II. DAY 2 WORKSHOP SUMMARIES

2.1 Topic: WORKING WITH CULTURAL AND TRADITIONAL CONSTRAINTS

Organizer: IPPF

Lessons learned:

- African experiences and history need to be written and recorded, noting both the positive and negative aspects of culture and society.
- Positive aspects of culture and tradition should be included in school curricula.
- Adolescents need to be informed about the negative effects of cultural and traditional practices.
- Modern technology should integrate the old oral tradition into communication strategies.
- Traditional healers are accepting modern contraception, therefore it is important to approach this group and involve them in adolescent reproductive health activities.
- The media should strengthen its role in the advocacy of positive cultural and traditional practices.

2.2 TOPIC: INCREASING MALE INVOLVEMENT AND RESPONSIBILITY

Organizer: John Snow, Inc.

Lessons learned:

- The use of different communication channels (multi-media approach) has generally had great impact.
- Involving men in family planning and reproductive health issues has proven successful: for example, in a project in Zimbabwe, there was increased contraceptive prevalence rate and knowledge of family planning methods.
- Multiple evaluation methods clearly document the success of various approaches in meeting men's and women's reproductive health needs.
- Participatory approaches are necessary to bring out male reproductive health responsibilities.

III. DAY 3 WORKSHOP SUMMARIES**3.1 TOPIC: HOW TRADITIONAL INSTITUTIONS CAN CHANGE TO RESPOND TO THE NEEDS OF YOUTH**

Organizer: YWCA

Workshop participants identified the following traditional institutions as having an influence on adolescent reproductive health:

- religious institutions;
- the family;
- educational institutions;
- health institutions;
- media;
- cultural institutions (including festivals, rites, ceremonies, and other activities associated with young people's transition into adulthood);
- legal institutions.

Lessons learned:

- Appropriate research, advocacy, and training can help in overcoming difficulties

encountered in dealing with many traditional institutions.

- Several of the traditional institutions have positive aspects. Adolescent reproductive health initiatives could be integrated into these institutions to make them more relevant to young people's needs.
- Not all religious and traditional institutions are against adolescent reproductive health programs. Where there are supportive groups, these should be encouraged to act as role models and agents of change.
- The family is the most crucial institution in terms of promoting change, for it represents the first level of socialization for children. Families should be strengthened to respond to adolescent reproductive health issues. Increased collaboration between family and parent-teacher associations would help.
- Training in traditional institutions is important to provide people with skills to initiate change.

3.2 TOPIC: HOW SCHOOL-BASED POPULATION PROGRAMS CAN SUCCEED IN CHANGING THE BEHAVIOR OF YOUTH

Organizer: UNFPA

Lessons learned:

- The use of the integrated approach in implementation has not been effective. Therefore, the single-subject approach is strongly advised.
- Research and evaluation are insufficient for programming. However, the research and evaluation that have been done show a decline in school drop-out rates and STDs and pregnancy among students
- Needs assessments should be conducted before using IEC materials such as posters, textbooks, flipcharts, pamphlets, films, etc. These materials may not be successfully used unless they respond to clear needs.
- Adolescent reproductive health programs are more successful when school authorities, teachers, and parents are involved.
- In addition to secondary schools, senior primary school classes also urgently need adolescent reproductive health-related information and skills. Population and FLE programs should incorporate this educational level.
- Capacity-building, in terms of training and refresher courses for teachers and peer educators, is necessary in order for correct, relevant, and appropriate information and skills to be transmitted to students.
- Innovative teaching methods, such as used in the Enter-Educate approach, are more successful than conventional lecture methods.
- Coordinators and youth counselors in peer education programs should be selected from a variety of grades and classes to ensure sustainability and successful behavior change.

IV. DAY 4 WORKSHOP SUMMARIES

4.1 TOPIC: LEGAL AND POLICY NEEDS SEEN THROUGH THE LENS OF THE PROGRAM MANAGER

Organizer: FOCUS

Lessons learned

- Even in a positive policy environment, a strategy is needed for the development and approval of adolescent reproductive health policies.
- The support of all interested parties, from parents to policy-makers, is important in the policy-making process. You win support from people by working *with* them at all stages.
- Know the law and the legal systems. People often assume that when a policy-maker makes a statement it reflects official policy. In fact, it is often a private opinion.
- If you know the law, you can find ways to use it in support of adolescent reproductive health.
- Identify the important policy-makers and work with them.
- Collaborate with others who are advocating for the same issues. Collaboration prevents sabotaging each other's work.
- Program planners must form alliances with lawyers to win cases that improve or protect adolescent reproductive health.
- Program planners must inform lawyers about adolescent reproductive health to get them interested in working on the issues.
- Program planners must learn about human rights issues.

4.2 TOPIC: SOCIAL MARKETING TO YOUTH

Organizer: Society for Family Health, South Africa

Lessons learned:

- A replicable methodology called "action media" is available to encourage youth in the development of media products and methods.
- Processes of dialogue with target communities are an important part of message-making.
- Qualitative research can be used to understand problems faced by youth and to identify the resources required to respond to these problems.
- Media products should be seen as supporting action to change behavior rather than as able, in and of themselves, to change behaviors.
- Media and products should incorporate local languages.
- Attention should be given to how a media product is distributed and used, and to what actions it seeks to stimulate.

V. WORKING GROUP: BEST PRACTICES IN DEVELOPING NATIONAL ADOLESCENT REPRODUCTIVE HEALTH PROGRAMS

5.1 A PRESENTATION BY ADJUA AMANA, REGIONAL ADOLESCENT HEALTH ADVISOR, UNFPA/CST, ADDIS ABABA

Situation analysis:

Case studies of adolescent reproductive health projects from a number of African and Latin American countries point to certain facilitating factors for successful projects

These include:

- provisions for conducting a needs assessment with a view to analyzing problems and developing strategies for effective interventions;
- involvement and collaboration of multisectoral partners to develop a comprehensive program integrated into other youth-oriented services (FLE programs, outreach activities, recreational activities, health facilities, etc.);
- support from policy-makers, community leaders, and other opinion leaders and consensus-building among all stakeholders;
- adoption of a peer education strategy;
- training and capacity-building (program implementers, peer educators, teachers, parents, etc.) in adolescent sexuality and reproductive health and in communication skills;
- involvement of young people themselves in the development, implementation, and management of projects;
- effective use of mass and folk media for advocacy and IEC;
- effective monitoring and evaluation systems.

Problems in existing adolescent reproductive health programs:

- Many programs find it difficult to attract adolescents to use the services—why?
- Many projects remain at pilot stage, unable to move to full scale.
- Most projects are operated by NGOs with little government support. This limits coverage.
- Cost-effectiveness is difficult to achieve in sustainable, comprehensive national projects.

Needs in adolescent reproductive health programs, based on best practices from Africa and Latin America:

- Conducting needs assessments to assess problems and develop strategies for effective interventions.
- Collaborating with multisectoral partners to ensure the development of a comprehensive project which addresses adolescent needs holistically.
- Advocating with policy-makers and opinion and community leaders through sensitization and lobbying to solicit support and commitment.
- Developing appropriate and relevant training materials.
- Building capacity at all levels, including training program implementers, peer educators, teachers, parents, and leaders, in adolescent sexuality, reproductive health, and effective communication skills.
- Utilizing peer education strategy.
- Building linkages with youth center-based adolescent reproductive health projects and other services.
- Developing a system for monitoring and evaluation as an integral part of program management.
- Involving young people themselves in the design, implementation, and management of project activities, including selection of peer educators, to give them a sense of fulfillment and ownership.
- Effectively using mass and folk media for advocacy and IEC activities. This is linked

with the production and distribution of relevant print and audio-visual materials.

- Using adolescent reproductive health projects as entry points for addressing other health problems.
- Other factors: availability of counseling services and recreational services, skills development programs, incorporation of income-generation schemes, and the integration of gender issues in adolescent reproductive health programs.

**INTEGRATION OF
STI/HIV/AIDS SERVICES INTO
OTHER SERVICE DELIVERY
PROGRAMS**

**INTEGRATING STI/HIV MANAGEMENT
STRATEGIES INTO EXISTING MCH/FP
PROGRAMS: LESSONS FROM CASE
STUDIES IN EAST AND SOUTHERN AFRICA**

BAKER NDGUGGA MAGGWA

IAN ASKEW

**AFRICA OR/TA PROJECT II
THE POPULATION COUNCIL**

NAIROBI, KENYA

A prototype model for integrating STI/HIV Services into MCH/FP Programs

- Applicable for MCH/FP clinics with no or limited access to laboratory facilities
- Integrated service offered primarily to new family planning and antenatal clients
- Package of services offered at single visit.

Four components of STI management added to FP/ANC services:

- 1) Case finding and treatment of asymptomatic women or women not recognizing existing symptoms through:
 - clinical history taking
 - general clinical examination
 - pelvic exam if possible (full preferably)
 - if signs/symptoms identified, categories into general syndrome
 - provide appropriate curative treatment, on site, preferably by same person doing diagnosis and at same time as diagnosis
 - encourage partner notification by client for screening.
- 2) HIV/AIDS management through:
 - HIV testing and counseling through referral to nearest specialist site for clients with signs and symptoms, or for those explicitly requesting testing
 - IEC on prevention of HIV transmission and signs/symptoms of HIV infection to all clients.
- 3) Finding and treatment of maternal syphilis through:
 - screening all antenatal clients on first visit for syphilis infection through referral for test and/or result
 - encourage contact tracing through partner notification by client.
- 4) Information and education to prevent new infections and to improving health-seeking behavior if infected through:
 - raising awareness of signs and symptoms of possible infection
 - education on safer sexual behavior and practices
 - promotion of condom use
 - group health talks
 - print materials available in waiting rooms, during individual consultations and to be given to clients
 - individual consultations with MCH/FP clients
 - group and individual talks within the clinic catchment areas through community health workers including STI/HIV with MCH/FP messages
 - advertising availability of services.

7) Recommendations for program strengthening and suggestions for further research

■ **Accurate data are not generally available to inform MCH/FP program managers which diseases are most common among their clientele, and so managers do not know what level of STI service utilization rates to expect or the requirements for ordering drugs.**

↳ Wherever possible, population-based surveys of reproductive morbidity, and especially STI prevalence, should be undertaken by program managers prior to developing integrated programs. Ideally these would use inexpensive bio-assay tests,²⁹ but well-designed questionnaire surveys could also be used subject to further validation.

Research: Feasibility of population-based surveys of STI/HIV prevalence, including validation of questionnaire surveys on reproductive morbidity and improvement of simple bio-assay tests.

Research: Utility of facility-based measurement given selection biases of population attending clinics.

■ **Clients' awareness of symptoms associated with STIs, their ability to identify and describe them, and providers' ability to understand clients' descriptions of symptoms are poor and need to be improved for the syndromic approach to work effectively.**

↳ Increase clients' awareness of symptoms through IEC activities within clinics and, where possible, through community-based programs.

↳ Train staff in local terminology and concepts used to describe potential signs and symptoms.

Research: Document perceptions, definitions and descriptions of reproductive morbidity in catchment area populations

Research: Test IEC interventions in clinics and through outreach programs to raise awareness of symptoms and signs among general population.

■ **Risk assessment and clinical history taking are essential components of finding potential STI cases among mainly asymptomatic MCH/FP clients**

²⁹ The development of such tests is a priority concern for those involved with reproductive health and their application through population surveys is equally important. The DHS pilot-tested an approach in Ethiopia with promising results (Macro International, 1997). It should be noted that although the specimen collection is quite simple, and appears to be acceptable, transporting the specimens for testing remains a substantial logistical, and expensive, task.

but are not performed consistently or according to guidelines.

- ↳ Train clinic staff in discussing sexual behavior with clients and in being more aware of clients' self-assessment of their risk of being infected.
- ↳ Develop service delivery guidelines that take into account the potential difficulties faced by staff in their implementation.
- ↳ Provide clear written guidelines and checklists for clinic staff to follow that specify exactly which questions to ask and how to interpret the answers.
- ↳ Ensure guidelines are reviewed and updated regularly, preferably based on observations of staff performance and validation studies.
- ↳ Redesign MCH/FP client record cards so that risk assessment and STI clinical history and signs can be recorded.
- ↳ Improve levels of privacy available during consultations so that sexual behavior and STIs can be more easily discussed.

Research: Comparison of time taken to undertake "normal" MCHIFP client consultation with one that includes comprehensive STI risk assessment and clinical history taking.

Research: The acceptability of an "integrated" consultation from the provider, client and clinic manager's perspectives.

Research: Clients' and providers' attitudes towards discussing sexual and STI issues in clinic environment.

Research: Test and validate different factors and weights to include when using scoring within a risk assessment.

■ **A thorough general clinical examination and a pelvic examination, essential for detecting signs and symptoms associated with STIs, are not always undertaken.**

↳ Reinforce the need for staff to undertake a thorough general physical exam to assist in detecting non-genital signs.

↳ Ensure that client record cards are able to record all information needed for a general physical examination.

↳ Ensure that all MCH/FP clinics have the basic equipment and supplies needed for an internal pelvic examination (e.g. speculum, gloves, adequate light) and that there is sufficient privacy for the examination.

↳ Train staff in providing appropriate psychological support to reduce client nervousness.

↳ If these conditions are met, reinforce the requirement that an internal pelvic examination be undertaken for all new family planning clients, annually for all returning family planning clients, and for all MCH/FP clients with symptoms and signs associated with STIs and/or assessed to be at risk through the risk assessment / clinical history taking.

■ **In the absence of laboratory facilities, the syndromic approach has been adopted for diagnosing and treating a person detected to have signs and symptoms of an STI, but it has not always been correctly applied.**

↳ Program managers should constantly monitor new developments in syndromic management procedures and update their guidelines regularly.

↳ Whenever guidelines are updated the new information should be passed on immediately to staff through appropriate means (e.g. circulars, in-house refresher training).

↳ To increase efficiency, the person undertaking the finding and diagnosis of potential STI cases should also be able to prescribe and provide treatment during the same visit.

Research: Test and validate the syndromic approach amongst MCH/FP populations and in areas with different STI prevalence levels.

Research: Test the feasibility and effectiveness of adding risk scoring to the syndromic approach.

■ **Most MCF/FP clinics refer less straightforward cases to facilities with laboratories for further testing, but current referral arrangements are**

time-consuming and frequently the client is lost before diagnosis and/or treatment are complete.

- ↳ Existing referral arrangements need to be examined closely to look for ways to improve their effectiveness.
- ↳ As simpler screening tests become available programs should develop the capacity to use them at an increasing number of secondary and even primary level facilities.

Research: Test the feasibility and effectiveness of introducing simple STI testing facilities (e.g. microscopy equipment and supplies, staff training, RPR tests) at MCHIFP clinics.

■ **The syndromic approach is intended to simplify treatment of STIs by requiring a small range of drugs that can treat several types of infection, but the supply of these drugs at clinics and their purchase by clients are major problems in all but the strongest programs.**

- ↳ Improve staff understanding of the different treatments available, through training and written guidelines, and update these regularly to reflect changes in drug sensitivity.
- ↳ Strengthen existing drug supply mechanisms and forecasting/ordering procedures for MCH/FP clinics to include drugs that can be used for treating STI syndromes and other illnesses, and to ensure that essential drugs are routinely available at clinics.
- ↳ Ensure that sufficient funds are available to program managers, through government or donor sources or cost-recovery mechanisms, to maintain a continuous supply of drugs to the clinics.
- ↳ Wherever possible, ensure that the client receives / purchases the drugs at the same clinic to ensure correct treatment provided.

Research: Ascertain the willingness and ability of clients to pay for STI services when provided during an MCH/FP consultation.

Research: Test the elasticity of demand associated with varying drug prices.

Research: Test alternative cost-recovery mechanisms.

■ **Condom promotion should be an integral component of all information exchanges with MCH/FP clients, but is undertaken to differing extents by each program.**

- ↳ Use of the condom for protection from STIs should be promoted more

strongly, either on its own or possibly in conjunction with another contraceptive method (i.e. dual use).

Research: Test the feasibility and effectiveness of different messages and supply of condoms on use and continuity of use

Research: Assess the acceptability and effectiveness of promoting dual contraception

■ **Partner notification is essential to prevent re-infection in the woman herself, but the procedures followed (asking the woman to notify her partner verbally and for him to visit the clinic) were found to be universally weak.**

↳ Staff should make sure that the importance of partner notification is always included in the counseling given to all clients treated for an STI and whenever discussing STIs in general.

↳ Programs should look for ways to make partner notification sensitive to the woman's personal and social situation, and especially to the possibility that the diagnosis may not be accurate and the infection may not be sexually transmitted.

Research: Test alternative ways of increasing partner visits for screening.

■ **For MCH/FP clients suspected to have HIV, or who have asked for a test, all programs refer elsewhere for testing and counseling because testing facilities are not widely available and counseling is felt to be a specialized activity which MCH/FP staff are not able to undertake.**

↳ Programs should review the acceptability and effectiveness of current procedures for referring clients for HIV testing and counseling to determine if they can be strengthened and whether the counseling can be decentralized to the MCH/FP clinic.

Research: As rapid and simple HIV tests become more available, explore ways of introducing HIV testing and counseling into MCHIFP clinics.

■ **All programs have mandatory syphilis screening for antenatal clients but because this normally requires the client to return at a later date for the result and requires payment, few women have the test and even fewer return for the result.**

↳ Current procedures for collecting and testing specimens, giving the result to the client, and ensuring treatment for infected clients *and* their partners must be examined closely to improve their effectiveness if they are to continue.

↳ The feasibility and cost-effectiveness of introducing antenatal screening for other STIs (especially gonorrhea) should be considered given their association with adverse pregnancy outcomes.

Research: Test alternative strategies for strengthening the effectiveness of detecting and treating antenatal syphilis infections.

Research: Test the cost and effectiveness of increasing the availability and use of low-cost, simple syphilis screening tests.

Research: Test the cost-effectiveness of introducing screening of antenatal clients for other STIs, especially gonorrhea.

■ All MCH/FP programs mandate that group health talks should be held at their clinics daily, but these are infrequently held and information on STIs and HIV/AIDS is only given occasionally.

↳ If health talks are to continue then they need to be strengthened through ensuring that they are always held, planning which issues are to be covered, training staff in effective communication techniques, and providing guidelines and materials, especially for topics such as the symptoms and signs of STIs.

Research: Effectiveness of group talks and print materials on communicating information about STIs to MCH/FP clients

■ The availability of STI/HIV/AIDS services is not well advertised at MCH/FP clinics, preventing clients from pro-actively seeking counseling or screening, or initiating discussion of STIs during a consultation.

↳ Clinic managers must ensure that clients are fully aware of all services available at the clinic, including when and where they can be obtained, through signs and posters inside and outside the clinic. Moreover, this advertising should stress that the service is available during regular MCH/FP consultations and so does not require a separate visit, and that strict confidentiality will be maintained.

In conclusion, this analysis suggests that integration of services is occurring primarily through finding and treating potential STI cases among MCH/FP clinic clients. Some IEC activities are being integrated to encourage preventive behavior, but much remains to be done to strengthen this component. There appear to be two broad priority issues which operations research should be used to address next.

First, the case studies show that although it is *feasible* to find and treat STI cases, program managers must pay close attention to many issues, particularly quality staff training, clear procedural guidelines, regular drug supplies, effective and sensitive partner notification, and continuous IEC in the clinic catchment areas. What is emerging clearly from this and other analyses, however, are the dual concerns with the *effectiveness* of the approach in correctly finding, diagnosing and treating clients with STIs, and the *cost-effectiveness* of this approach compared with others. Its effectiveness is being questioned because recent studies are showing that the validity of syndromic management, even with risk scoring, may be too low.

Although many policymakers and donors in the region have endorsed the use of syndromic management in the context of MCH/FP clients, this has been based more on its utility in the absence of accessible and low-cost laboratory tests than on demonstrated effectiveness. The key priority issues to be addressed through operations research is, therefore, establishing the validity of the syndromic approach (including with and without risk scoring) in MCH/FP clinic settings. If proved to be acceptably effective, studies should then measure the marginal cost of adding this service, and comparing its cost-effectiveness with alternative strategies for detecting and treating STIs among MCH/FP clients.

The second priority for operations research is to evaluate the impact of this approach on reducing the transmission and prevalence of STIs, including HIV, in the general population. This is an important issue for policymakers and donors as it is unknown whether this essentially *curative* approach would have an impact on STI prevalence. Moreover, whether it would be more effective than a *behavior change* approach that focused on providing information and education about prevention of infection is also not known. Indeed, little is known about the impact on STI prevalence of preventative strategies integrated with MCH/FP programs. These types of studies would be resource-intensive, however, as they require longitudinal surveys with population-based bio-assay measures of STI/HIV prevalence.

**MALE INVOLVEMENT IN
REPRODUCTIVE HEALTH**

BETTER TOGETHER
A REPORT ON THE AFRICAN REGIONAL
CONFERENCE ON MEN'S PARTICIPATION
IN REPRODUCTIVE HEALTH

DECEMBER 1-6, 1996
HARARE, ZIMBABWE

WORKING GROUPS

Among the working groups, there was consensus on a number of cross-cutting issues. They agreed that recognizing men's diversity in all its dimensions--in age, education levels, socioeconomic status, family situation, work environment, etc--and deciding how to reach and serve the needs of these different categories of men are the communicators' biggest tasks. Programs must use diverse channels of communication to reach men at home, at work, at religious and social events, in schools and community centers and whenever they receive educational or commercial messages.

Conference participants identified five key sub-themes which should be given consideration in the design, implementation and management of effective communication programs for men. Five working groups were organized around each sub-theme and met on three afternoons:

- 1) Men as **different audiences**
- 2) **Young men** and their particular concerns
- 3) **Integration** of IEC for men into reproductive health
- 4) **Cultural challenges** to men's participation
- 5) **Sustainability** of men's programs.

At a minimum, all men need reproductive and sexual health education; most men will also benefit from individual counseling (and, when appropriate, couple counseling). Additionally, many men will require clinic services for physical exams, diagnosis and treatment of STDS, further counseling, contraceptive supplies, and, as they complete their family, the choice of long-term and permanent methods. Like women, men should have a free and informed choice of whether to use a contraceptive method and, subject to his partner's agreement, whether to have a child. This standard package of care is a "common denominator" for all men in all cultures.

Information, Education, and Communication:

- *more and better IEC materials* directed towards men;
- *more messages* which support the idea of *increased communication between partners*;
- *and new and updated training curricula* to address the specific issues of counseling men.

Interpersonal communication and service delivery:

- *more men recruited and trained* as service providers--whether as CBDs or in clinics or in the workplace;
- *better support* from private practitioners, PVOS, and NGOs to offer services to men (every employer can provide reproductive health education and referral to services as part of their employee benefits);
- *a greater variety of service approaches* which respond to men's needs.

Policy and Advocacy:

- *better advocacy* among leaders to support laws, policies, and funding that ensures that all young men and women receive basic education about reproductive and sexual health and have better access to services.

What follows are the **Challenges and Strategies and Recommendations** of each of the working groups, excluding the cross-cutting issues mentioned above.

WORKING GROUP 1 MEN AS DIFFERENT AUDIENCES

To increase men's participation in reproductive health, communicators must first see men as many different audiences (see table below) and address them with different messages. While segmenting these varied messages is important, an underlying purpose of all such IEC remains to encourage men, either individually or as partners in couples, to communicate about sexuality and family planning, and to ensure that both partners share equitably in reproductive health decision-making.

Age 20-35 years	Age 36-45 years	Age 46+ years
<ul style="list-style-type: none"> • Potential child-spacers—unmet need for FP, especially temporary methods • High desire for children • May have little communication with partner • Concerns about unsafe abortion, need for abortion counseling with partner • Needs work, income and housing • Highly mobile, may do migrant labor • Have ambitions, looks to the future • Can be reached through peer group, workplace education, clinics, mass media, and role models • Media conscious 	<ul style="list-style-type: none"> • Potential limiters—unmet need for FP, especially long-term or permanent methods • Married, usually with desire number of children • May have little communication with partner • Potential polygamists, frequently with prostitutes (high risk of STDs/HIV/AIDS) • Economically established • More conservative than younger age groups • Can be reached through peer groups, workplaces, clinics (accompanying wife and children), media, and men's clubs 	<ul style="list-style-type: none"> • Unmet need for permanent contraception, and access to vasectomy information and services • Married, usually with desired number of children • May have little communication with partner • Economically established • Traditional values • Can be reached through peer groups, workplaces, media and men's clubs

Challenges

Currently, few men of any age, or cultural or geographically group, have access to information in their communities, at clinics, or on the job, because reproductive health programs are tailored to women's needs. Typically, this means that:

- More women than men are recruited as service providers;
- Clinic hours and home visits are not convenient for working men;
- Staff are not trained to understand men's reproductive health needs; and
- IEC materials are not available for men.

As a result, men often have little respect and few positive attitudes toward services and service providers even though survey results show they are supportive of the *idea* of family planning; young men are usually the least welcome and the least comfortable visiting clinics.

Strategies and Recommendations

Several strategies were suggested to bring information and services to different groups of men.

New Communication Strategies:

- Produce IEC materials for men which motivate them and their partners to seek services together and share information and decision-making;
- Improve the image of providers to male (as well as female) clients
- Test innovative communicators, such as traditional healers and birth attendants, peer counselors, marriage counselors, school counselors, sports teams (see Challenge Cup below), or male elders;
- Address the issue of "Sugar Daddies" and irresponsible male sexual behavior in IEC campaigns. Men should be sensitized to the consequences of their behaviors (unwanted pregnancies, school dropouts, unsafe abortions, STDs/HIV. Consider the theme: "It could be your daughter."
- All campaigns should emphasize the dual use of condoms for family planning and disease prevention and all services should combine condom counseling and resupply with education and referral for STD and HIV treatment.

Communication and service delivery:

- Integrate reproductive health into the curricula and at schools, vocational training institutions, universities, and in other youth and adult education programs;
- Redesign training curricula to address the special issues of counseling for different audiences of men--single men, men in couples, abusive men, young men;
- Recruit men as providers (or reassign men to work more with male clients);
- Create male-friendly CBD and EBD programs.

WORKING GROUP 3 YOUNG MEN

Challenges

Young men and young couples require particular attention and special programs. Young men are usually neglected in typical reproductive health activities because those programs are female-focused. Young men are particularly unwelcome because their sexual activity is not sanctioned, is sometimes even illegal. Services are not yet geared to meet the needs of youth: school-based programs are rare, as are youth-friendly health clinics. While some young women may receive basic information about reproductive health from family or health workers when they menstruate or become pregnant, most young men do not learn from the health system but from peers, whose information is often inaccurate.

Strategies and Recommendations

Information, Education, and Communication

The group recommended a wide range of strategies to reach youth who are known as a difficult audience to reach. The key was identifying their needs, their habits, the media they use and the places where they can be reached.

Self-esteem, confidence, responsibility, self-respect, and the power to say no are key issues for youth which need to be addressed through IEC. To reach youth, campaigns need to reach youth where they meet: in schools, religious organizations, discos, pool halls, video arcades, on the street, and during agricultural shows and local fairs.

Media that have been used successfully to reach youth include radio variety shows, local popular theater, peer education networks, youth center activities (social, educational and recreational), telephone hotlines, newsletters, and traveling road shows.

Advocacy

The group re-iterated the need for strong advocacy to support laws, policies, and funding which ensure that all boys and girls receive basic education about reproductive and sexual health (in- and out-of- school) and that they have access to contraceptive information, services and supplies. The group supported legalization of medical abortion; the provision of post-abortion care for young women recovering from unsafe abortions, including counseling for their male partner; and passage and enforcement of laws requiring a minimum age of 18 at marriage. They want to see improved school policies on pregnant students and partners, allowing students to complete their schooling, and counseling and services to encourage sexual responsibility, sexual health, family life/parenting skills, and to discourage unplanned pregnancy.



Young people in Uganda gather around the *Hits for Hope* stage as their peers perform songs they composed about sexual responsibility.

Communication and Service Delivery

In the provision of services and IEC materials for youth, the group recommended that reproductive health organizations should:

- Increase accessibility and convenience of services to youth;
- Ensure youths' privacy under any setting;
- Link services to schools or youth centers wherever possible;
- Provide special training to staff on adolescent counseling in reproductive health;
- Provide (or refer to) post-abortion care for young women and counseling for their partners; and
- Train peer counselors to talk to other young men and women.

Community Participation

- Community leaders can encourage parents to learn about reproductive health with their children;
- Leaders can encourage and support later marriage; and
- Communities use local music and drama groups to communicate their key messages.



A ZNFPC Provincial IEC Officer distributes condoms to eager young men.

WORKING GROUP 3 INTEGRATION

Challenges

IEC, whether for young or adult men, must be integrated into a wide range of community and work-related activities. Men who need family planning counseling and supplies are not sick; they are much less likely than women to go to a clinic or CBD for help. But men could receive this information where they work or play, at their jobs or at sports, social, or cultural events). Messages integrating family planning and STD prevention are also vital in reaching men, many of whom are less concerned about avoiding pregnancy and more concerned about avoiding STDs and HIV than women are.

Strategies and Recommendations

The Integration working group drew attention to the lack of effective IEC and counseling for men in the media, at the community level, and in clinics, recommending integration of:

- Male-focused IEC into different communications channels; and
- Reproductive health and STD services into traditional family planning programs.

Various approaches to integration are possible, including advocating new national government and broadcasting company policies as well as community education and health service delivery policies. The goal is to ensure that IEC and counseling aimed at men include both family planning and STD prevention.

Integrating IEC for Men Into Health Services

Reproductive health organizations should:

- Provide comprehensive, high-quality reproductive health services to men;
- Integrate IEC materials and counseling tailored to men's needs and concerns;
- Involve district management in all phases of program design and implementation;
- Include IEC materials and counseling methods for men in all training of all staff;
- Adapt the STD assessment instrument to local communities and retrain staff in its use;
- Link STD/HIV risk assessment and the syndromic approach to family planning counseling;
- Promote dual benefits of condom use throughout all agencies and programs; and
- Establish counseling policies and follow-up procedures for notifying partners of STDs/HIV exposure.

Advocacy: Integrating IEC for Men Into All Reproductive Health Communications

A series of advocacy objectives at the policy and program levels were recommended.

Policy level—Government ministries, such as Health, Education, Family/Social Affairs, Information, Labor, Agriculture, and others, should work together to coordinate the promotion of men's participation in reproductive health in all their health-related activities.

Program level—Mass-media managers and "gatekeepers" should integrate reproductive health for men into all appropriate communication activities and that managers mobilize community and religious leaders to integrate reproductive health IEC for men into community activities such as community meetings, bazaars, sports events, beer haus.

WORKING GROUP 4

CULTURAL CHALLENGES

Challenges

Communication programs can play a central role in changing the social and cultural norms that work against reproductive health. This group discussed cultural barriers to the use of contraception and safe sex, and listed the following cultural challenges to involving men in reproductive and sexual health:

- Lack of communication and shared decision-making in couples;
- Breakdown of traditional family and community systems;
- Traditional respect for large families and for polygamy;
- Anti-family planning interpretations of religion;
- Gender preference for male over female children;
- Myths about modern family planning as unhealthy, unreliable or immoral;
- "Double standard" tradition allowing men to have multiple partners;
- Perceptions of family size as a reflection of male virility;
- Perceived need for child labor;
- Likelihood of need for economic support in old age; and
- Family planning as a "foreign" or "sinful" practice.

The group identified the difficulty men and women face discussing sexual and reproductive health matters and coming to mutual decisions, as the single most important challenge to involving men. Barriers to interpersonal communication include embarrassment, social taboos, or concern over how others perceive them. Men fear being perceived as weak, especially in light of traditional roles and expectations that equates male strength with autocratic behavior.

Strategies and Recommendations

Information, education, and communication aimed at men and couples must emphasize the benefits of improved partner communication. Benefits accrue to both the man and his family if all family members share responsibilities and are better cared for, healthier, and happier. Partners' communication can alleviate misunderstandings, fears, jealousies, and suspicions troubling relationships. Cooperation may reduce multiple partners and the resulting transmission of STDs/HIV.

Men can be helped, through peer, CBD, and provider counseling and education, to understand the advantages to themselves and others of partner communication. This will allow them to understand issues fully and clearly when making any health-related decisions. They learn that "a changing world requires changing attitudes and behaviors." They can learn how communication builds trust, understanding, and cooperation between spouses, and can even improve the quality of a couple's sexual relations.

The working group generally agreed that the key messages for men should focus on the benefits of smaller families. IEC can explain the traditional barriers to other families and show how they may no longer apply, as well as show the negative socioeconomic and health consequences of large families. With fewer children:

- Fathers are more able to fulfill their familial and financial responsibilities;
- Men's health and that of their wives and children may improve;
- Healthier and better educated children can care better for their fathers in old age;
- Fewer children will mean greater inheritances for each;
- Smaller families appear more "modern," fit the modern way of life.

Communications Strategies

Policy level—Governments and the private sector provide an environment for shared, free, informed choice in sexual and reproductive decision-making.

Program level—Messages should remind men of their interdependence with women, both in economics and in health sensitize (men and women) and highlight the importance of partner-to-partner communication ("two heads are better than one", "united we stand, divided we fall" or "one finger cannot pick up a stone"). The group also suggested that IEC programs explain the consequences of gender-preference for sons on family life and family health, promote condom use, and explain the risks of having sex with multiple partners.

Community level—Communication channels include traditional opinion leaders, chiefs and village councils, religious leaders, traditional ceremonies and social networks, local languages, traditional marriage counselors, drama groups, CBD agents (especially men), and clubs and associations. Local communication strategies should include sensitization meetings and training of trainers for local community leaders to become advocates; group communication should make the best possible use of community mobilization activities like celebrations and festivals, sports events, and road shows.

Advocacy

The group had strong advocacy recommendations: Leaders at all levels should support men's participation in reproductive health; district and community health teams should appoint or hire a community outreach organizer to involve the community in person-to-person and small group discussions on men's role in reproductive health. Governments and cultural and community leaders should advocate and support women's rights and discourage cultural norms preventing the advancement of girls and women (e.g. providing equitable access to basic education for young women and young men).

Legislative strategies were also recommended. New laws or changes to existing laws are needed to encourage men's participation in family health, and to discourage practices (like polygamy) harmful to women and girls. The group suggested that lawmakers pass equitable maternity and paternity laws to encourage men to be more involved with child care, and to make child support mandatory; that they institute new child benefit laws discouraging large families (e.g., cap child benefits at four children); that they ban destructive cultural practices such as inheriting wives, sharing wives, and female genital mutilation; and that they pass equitable laws regarding spousal consent to contraception-- consent should either be required of both husband and wife or of neither partner.

WORKING GROUP 5 SUSTAINABILITY

Challenges

Men's programs can best be sustained in the long run when they use cost-recovery methods. Many steps can be taken to help ensure lasting, high-quality programs, but few programs will survive, no matter how well designed, if they do not move towards more effective cost-recovery. Imaginative efforts, both reported on and planned at Harare, have been designed to persuade men (who are more likely than women to be able to afford it) to pay for reproductive health care.

This working group focused on the question, "How can men understand and accept reproductive health as a way of life?" They believed the primary obstacle to men's continuing use of and support for reproductive health services is that many men do not yet realize that sustained, life-long, reproductive health behaviors are essential to all adult health, much like proper immunization, nutrition, and hygiene. They are not simply options to be used occasionally.

Strategies and Recommendations

This working group considered three levels of sustainability as important: policy support, financial sustainability and community commitment.

Policy Support

They reiterated the need for advocacy at all levels of government and community. They stressed the need for good training of trainers, for curriculum revisions, quality control, and for monitoring and evaluation of all interventions.

The group stressed that all development programs that involve substantial numbers of men (such as schools, workers' education, agricultural extension programs, vocational training, military training, and prison education) should agree to include regular reproductive health education.

Financial Sustainability

The group agreed that national leaders (presidents, vice-presidents, Ministers of Health, and other national figures) should commit funds to integrating reproductive health for men into existing health programs; should increase funding for research into male contraception and male reproductive health knowledge, attitudes, and practices; and should lower or eliminate taxes and import duties on contraceptives, or provide subsidies for contraceptives. They also agreed that family planning organizations should advocate a private-sector role in men's programs.

Community Support

At the community level the group suggested that family planning organizations should actively involve the whole community in the design, planning, and implementation of men's reproductive health activities. Public education could include leadership seminars, discussions by men's groups; community and religious leaders should speak out for men's participation in reproductive health. Communities should provide funds, land, buildings, and volunteer labor for men's programs; communities should share in costs (along with fees for men's services); men in each community should play a leading role in activities that will earn money to support men's reproductive health services.

HARARE DECLARATION ON MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH IN AFRICA

Preamble

We, the 66 participants at the Africa Regional Conference on Men's Participation in Reproductive Health representing 15 nations of sub-Saharan Africa, having met to discuss and discover new approaches and solutions to communication, service, and policy challenges to increasing men's participation in reproductive health, hereby declare that we fully support efforts to build upon the important work of many African governments and NGOs as well as the UN agencies to promote men's responsible, equitable role in reproductive and sexual health and the health of women and children.

Challenges to Men's Participation

We face similar serious challenges in increasing men's participation at the:

- *Individual level*, where many African men lack information about reproductive health, and couples are often unable to discuss and reach shared decisions about sexuality and contraception;
- *Community level*, where religious and traditional values favor men having large families, and where changed social structures result in increased STD/HIV transmission, unwanted pregnancies, and other reproductive health problems;
- *Institutional level*, where men's access to reproductive health information and services is hindered by existing structures that do not meet their needs;
- *Policy level*, where laws and regulations limit men's access to reproductive health information and services.

Areas for Action

We believe that all such challenges must be addressed to build effective participation of men as caring and understanding partners.

Communication to Increase Men's Participation

Strategic communication programs should effectively address the information needs of diverse groups of men and change social norms to provide an enabling environment for partner communication and shared decision-making. Young men need particular attention. Programs should build on traditional African values such as men's responsibility for the welfare of their families, the importance of spacing pregnancies, and respect for traditional authorities.

Communication in the Context of Service Delivery

A broad range of integrated, quality reproductive health services including information and counseling tailored to men's needs should be provided by public, private, and commercial organizations. Special training is needed to counsel men.

Policy Advocacy

Public and private institutions and individuals should create, through effective advocacy, a legal, regulatory, and political environment at all levels that encourages and sustains men's participation in reproductive health.

In conclusion, we maintain that reproductive health is neither "men's" nor "women's," but requires participation of both. Communication must ensure that both partners are reached with information and enabled to access services that meet their varied needs.

**MEN: KEY PARTNERS
IN REPRODUCTIVE HEALTH
A REPORT ON THE FIRST CONFERENCE
OF FRENCH-SPEAKING AFRICAN
COUNTRIES ON MEN'S PARTICIPATION
IN REPRODUCTIVE HEALTH**

**MARCH 30-APRIL 3, 1998
OUAGADOUGOU, BURKINA FASO**

KEY CONFERENCE RESOLUTIONS AND RECOMMENDATIONS

Participants in the Ouagadougou conference made recommendations directed to national policy-makers and program managers and to international donor and technical support organizations, including the conference organizers, facilitators, and sponsors UHU/PCS, AED, UNFPA, USAID, AVSC, CARE, INTRAH, IPPF, GTZ, FHA/WCA[REDSO], Population Council):

Resolutions for Policy-maker's and Program Managers

- Introduce the concept of men's participation in reproductive health as identified at this conference in each country (i.e. in work groups, workshops, symposia, and other appropriate forums).
- Initiate a review of reproductive health policies and programs to help policy-makers and program managers take men's participation issues into account better.
- Undertake advocacy activities focused on national and community leaders, as well as interested groups in the public and private sectors in order to build support for men's participation.
- Make use of existing survey data on men's reproductive attitudes and practices and conduct complementary qualitative research to improve understanding of men's needs and the social setting that affects men's participation in reproductive health.
- Develop communication strategies to respond to needs of different groups of men.

Recommendations for Donors and Technical Assistance Organizations

- Follow up on this conference by providing support to national and regional efforts, especially in conducting research, training service providers, establishing men's clinical services, and developing IEC for male audiences.
- Expand and reinforce advocacy activities for men's participation in reproductive health among international organizations and country governments in order to mobilize additional financial and technical resources.



Panel members discuss lessons learned on opening day.

OUAGADOUGOU DECLARATION ON MEN'S PARTICIPATION

FIRST CONFERENCE IN FRENCH-SPEAKING AFRICAN COUNTRIES ON MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH

Ouagadougou, Burkina Faso

March 30-April 3, 1998

Ouagadougou Declaration on Men's Participation in Reproductive Health

The International Conference on Population and Development (ICPD), which took place in Cairo in September, 1994, marked a turning point in the definition of the concept of reproductive health. This concept was based on a holistic vision which emphasized equality and equity in gender relations and responsible sexual behavior.

As a follow-up to the ICPD, there were a series of regional conferences, including the following: the Maximizing Access and Quality of Care (MAQ) Conference, which took place in Ouagadougou in 1995, the Conference on Reproductive Health Educational Reform in Medical Schools and Schools of Public Health in West and Central Africa (September 1996), and the forum on Adolescent Reproductive Health (Addis Ababa, January, 1997). These conferences allowed African countries to reach a consensus on the definition of reproductive health, including a gender approach and the four main components of reproductive health.

In December, 1996, the Conference on Men's Participation in Reproductive Health in Anglophone Africa took place in Harare.

For the first time in French-speaking African countries, this conference in Ouagadougou, from March 30 to April 3, brought together approximately 110 participants from 14 French-speaking countries to examine the theme of men's participation in reproductive health. The goal of this conference is to share lessons learned from existing programs in order to develop new strategies and approaches.

The conference participants identified numerous barriers to men's participation in reproductive health. Following are some of the greatest barriers:

- Lack of information about reproductive health in general and men's reproductive health in particular.
- The often controversial interpretation of religious texts regarding reproductive health
- Powerful traditional and cultural barriers.
- Lack of appropriate reproductive health services for men.
- Neglect of men's reproductive health in existing programs and policies.

Men should be seen as springboards to the strengthening of their role as reproductive health advocates within their families, their communities and their countries, in order to achieve gender equity.

Ouagadougou Declaration on Men's Participation (continued)

Resolutions

Being aware of their responsibility to promote changes which encourage increased participation of men in reproductive health, the conference participants pledge to undertake the following:

- Introduce the concept of men's participation in reproductive health as defined at this conference in their respective countries, through appropriate channels (work groups, workshops or symposia).
- Initiate advocacy activities targeting authorities, communities and private and public sector associations in order to gain their support for integrating men's participation into reproductive health programs.
- Initiate the review of policies and programs in order to take into account men's participation.
- Conduct complementary qualitative research to increase the understanding of men's needs and social determinants which impact their participation in reproductive health.
- Develop communication strategies to respond to needs of different target groups.

Recommendations

The participants make the following recommendations to the sponsoring organizations:

- Follow up on the conclusions of this conference and support national and regional efforts, especially in research, service provider training, establishment of clinical services and IEC.
- Expand and reinforce advocacy activities for men's participation in reproductive health among international organizations and country governments in order to mobilize additional resources.

*Written in Ouagadougou, Burkina Faso on April 3, 1998
by the conference participants*



Conference participants at the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health held in Ouagadougou, Burkina Faso, March 30-April 3, 1998.

EMPOWERING WOMEN

ORGANIZATION OF AFRICAN UNITY DECLARATION AND PLAN OF ACTION

The First OAU Ministerial Conference on Human Rights, meeting from 12 to 16 April, 1999 in Grand Bay, Mauritius;

Considering that the promotion and protection of Human Rights is a matter of priority for Africa, and that the Conference provides a unique opportunity to carry out a comprehensive analysis and reflection on the mechanisms for the protection of Human Rights to guarantee Human Rights for accelerated development of the Continent;

Recalling the Declaration on the Political and Socio-Economic Situation in Africa and the Fundamental Changes Taking Place in the World adopted by the Assembly of Heads of State and Government of the OAU in 1990, as well as the Declaration establishing within the OAU, a Mechanism for Conflict Prevention, Management and Resolution adopted by the Assembly of Heads of State and Government of the OAU in Cairo (Egypt) in June 1993;

Acknowledging that observance of human rights is a key tool for promoting collective security, durable peace and sustainable development as enunciated in the Cairo Agenda for Action on relaunching Africa's socio-economic transformation adopted by the extraordinary session of the Council of Ministers held in Cairo, Egypt, from 25 to 28 March, 1995;

Taking Note of the growing recognition that violations of human rights may constitute a burden for the international community;

Reaffirming its commitment to the purposes and principles contained in the OAU Charter, UN Charter, the Universal Declaration of Human Rights as well as the African Charter on Human and Peoples' Rights;

Deeply Concerned by acts of genocide and other crimes against humanity perpetuated in certain parts of Africa;

Emphasizing that respect for Human Rights is indispensable for the maintenance of regional and international peace and security and elimination of conflicts, and that it constitutes one of the fundamental bedrocks on which development efforts should be realized.

Considering the democratization processes taking place on the Continent and the

expressed desires of African peoples to live in a state of law which secures the full enjoyment of Human Rights and fundamental freedoms for all peoples, regardless of their gender, race, place of origin, religion, social status, ethnic background, political opinions or language;

Further Considering the importance of the right to development, the right to international peace and security and the principles of solidarity and friendly relations between States provided for in the African Charter on Human and Peoples' Rights;

Recalling the determination of the collective leadership in Africa to establish conditions which will ensure social justice and progress and thus enable African peoples to enjoy better standards of living in greater freedom and in the spirit of tolerance towards all;

Reiterating the need to constructively examine Human Rights issues in a spirit of justice, impartiality and non-selectivity, avoiding their use for political purposes; Recognizing the progress achieved by African States in the domain of Human Rights and the significant contribution of the African Continent to the universalization of these rights;

Further Recognizing the contribution made by African NGOs to the promotion and protection of Human Rights in Africa;

Recalling the recommendations made by the Second Conference of National Human Rights Institutions held in Durban in 1998;

Determined to consolidate the gains made in Africa in the promotion and protection of Human and Peoples' Rights;

SOLEMNLY ADOPTS THE GRAND BAY (MAURITIUS) DECLARATION AND PLAN OF ACTION

1. The Ministerial Conference affirms the principle that Human Rights are universal, indivisible, interdependent and inter-related and urges governments, in their policies, to give parity to economic, social and cultural rights as well as civil and political rights;
2. The Conference also affirms that the right to development, the right to a generally satisfactory healthy environment and the right to national and international peace and security are universal and inalienable rights which form an integral part of fundamental Human Rights;
3. The Conference further affirms the interdependence of the principles of good governance, the Rule of Law, democracy and development.

4. The Conference recognizes that the development of the rule of law, democracy and Human Rights calls for an independent, open, accessible and impartial judiciary, which can deliver justice promptly and at an affordable cost. To this end, such a system requires a body of professional and competent judges enjoying conducive conditions.
5. The Conference recognizes that the core Values on which Human Rights are founded, particularly (a) respect for the sanctity of life and human dignity (b) tolerance of differences (c) desire for liberty, order, fairness, prosperity and stability, are shared across all cultures. In this connection, integrating positive traditional and cultural values of Africa into the Human Rights debate will be useful in ensuring their transmission to future generations.
6. The Conference notes that Women and Children's rights issues remain of concern to all. Therefore it welcomes the decision to elaborate a Protocol to the African Charter for the more effective protection of Women's rights and calls on the OAU to convene a meeting of Government experts to examine the instrument. It urges all African States to work assiduously towards the elimination of discrimination against women and the abolition of cultural practices which dehumanize or demean women and children. The Conference also recommends to States to take the necessary measures to stop the practice of child-soldiers and to reinforce the protection of civilian populations, particularly children in conflict situations. The Conference further recommends that States adopt measures to eradicate violence against women and children, child labor, sexual exploitation of children, trafficking in children and to protect children in conflict with the law as well as refugee children.
7. The Conference notes that the rights of people with disability and people living with HIV-AIDS, in particular women and children are not always observed and urges all African States to work towards ensuring the full respect of these rights.
8. The Conference is aware that violations of Human Rights in Africa are caused among others by:
 - a. Contemporary forms of slavery
 - b. Neo-colonialism, racism and religious intolerance
 - c. Poverty, disease, ignorance and illiteracy
 - d. Conflicts leading to refugee outflows and internal population displacement
 - e. Social dislocations which may arise from the implementation of certain aspects of structural adjustment programs
 - f. The debt problem

- g. Mismanagement, bad governance and corruption
- h. Lack of accountability in the management of public affairs
- i. Monopoly in the exercise of power
- j. Harmful traditional practices
- k. Lack of independence of the judiciary
- l. Lack of independent human rights institutions
- m. Lack of freedom of the press and association
- n. Environmental degradation
- o. Non-compliance with the provisions of the OAU Charter on territorial integrity and inviolability of colonial borders and the right to self-determination
- p. Unconstitutional changes of governments
- q. Terrorism
- r. Nepotism
- s. Exploitation of ethnicity.

There is therefore the need to adopt a multi-faceted approach to the task of eliminating the causes of human rights violations in Africa.

9. While welcoming the improvements which have taken place in addressing the refugee problem, the Conference believes that the high number of refugees, displaced persons and returnees in Africa constitutes an impediment to development. It recognizes the link between human rights violations and population displacement and calls for redoubled and concerted efforts by States and the OAU to address the problem.
10. The Conference recognizes that the development and energization of the civil society, the strengthening of the family unit as the basis of human society, the removal of harmful traditional practices and consultation with community leaders should all be seen as building blocs in the process of creating an environment conducive to human rights in Africa and as tools for fostering solidarity among her peoples.
11. Deeply concerned about the acts of genocide, crimes against humanity and other war crimes being perpetuated in certain parts of Africa, the Conference appeals to African States to ensure that such acts are definitively eradicated on the Continent and recommends that these serious acts of violation be adequately dealt with.

12. Also concerned by the scourge of terrorism as a source of serious Human Rights violation, especially the most basic of such rights - the right to life - the Conference urges African countries to formulate and implement an African Convention for Cooperation in combating this scourge.
13. The Conference reaffirms the commitment of Africa to the promotion, protection and observance of Human Rights obligations. In this framework, the Conference requests those states which have not yet done so to give consideration to the ratification of all major OAU and UN Human Rights Conventions, in particular –
 - a. The African Charter on Human and Peoples' Rights;
 - b. The African Charter on the Rights and Welfare of the Child;
 - c. The Convention Governing Specific Aspects of Refugee Problems in Africa;
 - d. The Protocol on the Establishment of an African Court on Human and Peoples' Rights;
 - e. International Covenant on Economic, Social and Cultural Rights;
 - f. International Covenant on Civil and Political Rights;
 - g. United Nations Convention on the Rights of the Child;
 - h. United Nations Convention on Refugees and its Protocol;
 - i. Convention on the Elimination of All Forms of Discrimination Against Women;
 - j. The Four Geneva Conventions governing the Treatment of War Wounded, Prisoners of War and Civilians as well as the Two Additional Protocols;
 - k. UN Convention Against Torture;
 - l. UN Convention on the Elimination of All Forms of Racial Discrimination
 - m. The Statute of the International Criminal Court.
14. The Conference recognizes the necessity for States to give effect to the African Charter, International Humanitarian Law and other major international Human Rights instruments which they have ratified, in their national legislations for wider effect throughout Africa.
15. The Conference reiterates the fact that the primary responsibility for the promotion and protection of Human Rights lies with the State. It therefore

- urges States to establish national human rights institutions and to provide them with adequate financial resources and ensure their independence.
16. The Conference recognizes that the reporting obligation of States Parties under the African Charter on Human and Peoples' Rights provides an important mechanism and an opportunity for African governments to engage in a process of continuous dialogue with the African Commission. Accordingly, the Conference recommends that States Parties take appropriate measures to meet their reporting obligations under the Charter.
 17. The Conference recognizes the importance of promoting an African Civil Society, particularly NGOs, rooted in the realities of the Continent and calls on African governments to offer their constructive assistance with the aim of consolidating democracy and durable development.
 18. The Conference calls upon all international organizations – governmental, inter-governmental and non-governmental – to cooperate and harmonize their initiatives with the OAU and its relevant organs as well as the various sub-regional blocs within Africa for a more coordinated approach to the implementation of Human Rights in Africa and for maximum effect of such programs and initiatives.
 19. The Conference notes that the adoption of the UN Declaration on the Protection of Human Rights Defenders by the 54th Session of the UN Commission on Human Rights marks a significant turning point, and calls on African governments to take appropriate steps to implement the Declaration in Africa.
 20. The Conference appeals to the Secretary General of the OAU and the African Commission on Human and Peoples' Rights to develop appropriate strategies and take measures to sensitize and raise the awareness of African populations about Human Rights and International Humanitarian Law through formal and non-formal educational processes comprising among others, a special module in school curricula.
 21. The Conference recognizes that the media are important actors for building bridges between governments and peoples; it, therefore, urges States Parties to guarantee a free and independent press within their national borders to enable it play a role in the promotion of human rights in Africa. To this end, the Conference appeals to the Secretary General of the OAU to look into the possibility of providing assistance to media organizations on the Continent.
 22. To ensure that Human Rights considerations are integrated into all OAU activities, the Conference recognizes the need for Human Rights to be reflected in the programs of the Continental Organization.
 23. The Conference noting that the working of the African Commission on Human and Peoples' Rights is critical to the due observance of Human Rights in Africa, believes that there is a need to evaluate the structure and functioning of the Commission and to ascertain the extent to which it is

implementing the Mauritius Plan of Action during the period of 1996-2001, and to assist it to remove all obstacles to the effective discharge of its functions. There is also an urgent need to provide the Commission with adequate human, material and financial resources.

24. The Conference notes that, under the African Charter on Human and Peoples' Rights, it is the Assembly of Heads of State and Government that is authorized to take decisive action on the activity reports of the African Commission on Human and Peoples' Rights and expresses the hope that the Assembly would consider delegating this task to the Council of Ministers.
25. The Conference underscores the fact that co-operation between the African Commission and national human rights institutions will greatly enhance respect for Human Rights in Africa. In that regard, the Conference welcomes the decision by the African Commission on Human and Peoples' Rights to grant affiliated status to National Human Rights Institutions.
26. Concerned by the fact that the external debt burden is crippling the development efforts of Africa and undermining the fostering and sustenance of respect for Human Rights, the Conference appeals to the international community, especially multilateral financial agencies, to alleviate the external debt and take all steps necessary to reduce this burden on States to enable them to fully realize the economic emancipation of their peoples and enhance the maximum enjoyment of Human Rights by African peoples.
27. The Conference requests the Secretary General of the OAU to submit this Declaration to the Assembly of Heads of State and Government, all African national governments, the African Commission on Human and Peoples' Rights, the UN High Commissioner for Human Rights and other relevant UN organs and agencies and to examine the feasibility of making this conference a regular feature of OAU activities.
28. The conference recommends to States to formulate and adopt national action plans for the promotion and protection of human rights.
29. Finally, the Conference requests the Secretary General of the OAU to submit a Report to the next Session of the Council of Ministers on the outcome of this Conference.

Adopted at Grand Bay, Mauritius on 16 April, 1999

SIXTH AFRICAN REGIONAL CONFERENCE ON WOMEN

**NOVEMBER 22-26, 1999
ADDIS ABABA, ETHIOPIA**

SELECTED WORKSHOP OUTCOMES

Workshop 1. Women and Poverty and Economic Empowerment

Workshop 6: Political Empowerment of Women

Workshop 7: Women's Health, Family Planning and Population

Workshop 1. Women and Poverty and Economic Empowerment

Facilitators: - Marguerite Monnet
- Beth Mugo

Presenter: - Perpetua Katepa Kalala

In presenting the paper on *Women and Poverty and Economic Empowerment*, the consultant underscored the extent of poverty on the continent with approximately 44 per cent of population in Africa living below the poverty line of \$US39 per capita per month. However, there is some regional disparity. In sub-Saharan Africa, 51 per cent of the population live below the poverty line of \$US34 per capita per month, while in North Africa, 22 per cent of the population live below the regional poverty line. Women comprise a disproportionately larger share of the poor than do men. The presentation recalled the objectives in the Beijing Platform for Action for addressing poverty reduction among women and their economic empowerment.

Objectives

These objectives covered the following areas:

Objectives in the area of poverty reduction

- Formulate macro-economic policies and development strategies which support women in poverty;
- Adopt laws and administrative practices for equal rights and access to resources;
- Promote women's access to savings and credit mechanisms as well as institutions;
- Promote gender-based methodologies, including the availability of disaggregated data; and
- Undertake research to address the feminisation of poverty.

Objectives in the area of economic empowerment

- Promote women's economic rights and independence;
- Ensure women's equal access to resources, employment, markets and trade;
- Business services, training and access to markets;
- Strengthen women's capacity and commercial networks;
- Eliminate occupational segregation and discrimination; and
- Promote harmonisation of work and family responsibilities for both women and men.

Progress and achievements

Given the inter-linkages between these two areas of focus - poverty reduction and economic empowerment – it was important to have a combined assessment with regard to the progress and achievements made in implementation of the Beijing Platform for Action. The progress and achievements to date were summarised at three levels: (a) policies and institutional frameworks, (b): programmes and projects activities, and (c) at the level of impact.

Institutional frameworks: Countries reported that they have established and strengthened institutional mechanisms for gender equality, increased the political participation of women and established women’s institutional machineries such as ministries, desks, and commissions. They have adopted legislation and policies to increase women’s access to resources and have conducted research into gender-sensitive budgets. SADC was cited as an example of an institution that has started a subregional gender programme.

Activities: Some governments have ensured the provision of credit, job-creation and increased income-earning opportunities; support for women entrepreneurs to participate in trade fairs and study tours; campaigns against poverty; capacity building and skills training to increase income-earning capability and enhancement of food security.

Impact: Greater awareness of issues surrounding the gendered nature of poverty has led to programmes for poverty reduction targeted at women. However, the paucity of data or benchmark indicators, particularly of disaggregated data, has been a major constraint in measuring impact. A global assessment of growth figures from 1995 to 1998 did not indicate the rate of reduction in poverty that would enable attainment of the goal set at the 1995 Social Summit, which was to reduce poverty by half by 2015.

Constraints: The constraints that were mentioned in implementation of the Beijing Platform for Action included: lack of resources, women’s multiple roles, which prevent them from fully participating in development programmes, the national debt burden, war and civil strife.

Emerging issues: In the next five years, emphasis should be placed on:

- **Policies and programmes that show increased political will;**
- **Enhanced gender mainstreaming in all policies and programmes;**
- **Implementation of programmes for economic growth;**
- **Continued support for women in poverty and women’s participation in the economy;**

- **Involvement of poor women in articulating, implementing, and monitoring programmes to reduce poverty;**
- **Promotion of inter-country trade and collaboration among women;**
- **Increased training for women;**
- **Establishment in particular, of benchmarks and indicators for monitoring, as an early priority in the next 12 months; and**
- **Identification and implementation of effective monitoring and reporting mechanisms.**

Outcome of the workshop

1. At the level of institutional mechanisms

Strategies

The workshop identified a number of strategies that had been put in place to implement the Beijing Platform for Action, including the following:

- Creation of institutional committees on access to land by women, for instance in Zambia;
- Creation of social safety nets and funding;
- Job creation to young graduates in Algeria;
- Establishment of national credit institutions that take gender dimensions into account, for example, in Burkina Faso and Burundi and, further developed in Madagascar.

Constraints

A number of constraints were identified at the level of institutions, which impede implementation of the Plan of Action. These included the following:

- Insufficient funds allocated to sectors in which most women are employed, for instance, in the agriculture and informal sectors; and
- Lack of gender sensitivity at the level of programme officers.

Recommendations

The workshop came up with a number of recommendations to enhance the implementation of the Programme of Action, which included the following:

- Greater involvement of civil societies in the design of policy, the planning, implementation and monitoring of programmes and projects;

- Transparency and greater accountability of government in resource use;
- Strengthening of national capacities (including women's organisations) for international negotiations, e.g., at the World Trade Organisation (WTO);
- Harmonising positions among African countries at international negotiations (e.g., at WTO);
- Debt cancellation and allocation of ensuing resources for poverty reduction.

2. **At the level of activities**

Strategies

The workshop identified a number of activities that had been undertaken in various countries, for example:

- Encouraging women to go into commercial food processing;
- Providing credit facilities particularly to women;
- Job creation;
- Establishing mutual banks and solidarity funds;
- Engendering or genderizing national budgets;
- Adopting systematic affirmative action to facilitate women's participation in decision-making;
- Strengthening regional networking institutions among experts of gender approaches; and
- Facilitating women's access to training.

Constraints

Despite these efforts, a number of constraints were identified by the workshop, including the following:

- High interest rates charged for micro-credit;
- Short duration of loans;
- Inappropriate micro-financial systems;
- Disruption of household financial arrangements;
- Lack of capacity to manage the loans;
- Lack of adequate land tenure, security, and services for the urban poor;
- Consequences of HIV/AIDS; and
- Consequences of war and conflict.

Recommendations

Infrastructure and finance

- Improve national infrastructural facilities, e.g., roads, information networks, water, electricity;
- Create funds designed to improve general infrastructures such as health centres, schools and child-care centres;
- Develop programmes to enhance land tenure and security and appropriate infrastructure and services for poor urban dwellers, addressing both issues of poverty alleviation and economic empowerment;
- Create specific funds for developing women's income-generating activities;
- Develop micro-financing systems that are adapted to local needs, and that can effectively be used in poverty alleviation, for example, for improving indigenous credit systems such as tontine;
- Establish an African Bank for Women; and
- Increase women's access to formal banks.

Access to information, technology and markets

- Adopt national practical strategies that promote the access of rural women to information and communication and functional literacy;
- Subsidise agricultural inputs including fertilisers and implements;
- Adopt appropriate technology to alleviate women's workload;
- Encourage the sharing of existing indigenous technology among different African countries;
- Promote access to markets at the intra-African and international levels;
- Devise coping mechanisms to enable women to better manage their time; and
- Reduce military budgets and re-allocate these resources to poverty alleviation, health and education.

Workshop 6: Political Empowerment of Women

- Facilitators:** - Sylvia Tamale
- Linda Vilakazi - Tselane
- Presenter:** - Anthony Mawaya

The presentation pointed to several limitations in the preparation of the report. Firstly, not all national reports were available at the time of its preparation. Secondly, mostly English national reports were considered. Many countries which reports were not available provided complementary information on their situation during the workshop.

Following adoption of the Dakar and Beijing Platforms for Action, commitments were taken by:

- African countries by ratifying CEDAW, elaborating National Plans for Action, and adopting affirmative action and quota systems;
- The UN system by adopting quota systems;
- Subregional organisations, particularly SADC, which adopted a Declaration on Gender and Development endorsing its decision to establish, *inter-alia*, a quota system.

Constraints:

While several implementation activities took place, progress was slow. At times, it was difficult to measure impact. The limitations in the implementation of strategies included capacity and management problems, lack of disaggregated data, and inadequate methodologies and indicators to measure progress. Resources were inadequate and it was not easy to determine the sources or the amount allocated to the political empowerment of women. This, and lack of indicators affected mechanisms for monitoring and evaluation.

Challenges:

Traditional/cultural barriers and the division of labour within the household should be addressed.

Recommendations:

To increase the political empowerment of women, the concept of political empowerment should be articulated and an overall vision with strategies and benchmarks adopted.

The workshop process: The workshop focused on the broader meaning of decision-making, within the public, corporate, and social sectors, stressing the need to build women's participation and leadership in all these sectors.

Reasons for slow progress:

Political

- Lack of political will among political leaders and parties;
- Absence of affirmative action;
- Lack of political and leadership training;
- Inadequate civic and voter education for the masses;
- Inadequate allocation of resources to women's structures;
- Absence of a critical mass of women in decision-making bodies; and
- Discriminatory laws and practices against women.

Structural

- *Institutional sexism;*
- The patriarchal system that undermines solidarity among women;
- Low level of women's education

Cultural

- Traditional and cultural barriers.

Social

- Capable women avoid the risks and exposure involved with political positions;
- Socialisation;
- Sexist attitudes and perceptions towards women.

Contextual

- Lack of effective monitoring mechanism at the national, regional and UN levels;
- Lack of resources;
- Need for sponsoring women to run for political positions;
- Lack of women role models;
- Lack of solidarity among women.

The lessons learned which need to be built on:

1. Quota systems and affirmative action work best when they are accompanied by capacity building and enforceable measures that are applicable to government and all political parties (such as the case with the ANC in South Africa).
2. There must be strong political will and commitment.

3. Countries with a background of political struggles seem to have made more progress in access than those that have been fairly “stable.”
4. Time frames and targets must be set for achieving equal representation and participation of women at all levels of decision-making.
5. Decentralisation programmes have enabled more women at grassroots level to enter into decision-making.

The indicators of women’s political and decision-making empowerment

The following framework with quantitative and qualitative indicators developed by SADC was adopted for the purpose of elaborating indicators, challenges and recommendations. The framework covers the issues of:

- Access, which is a quantitative issue;
- Participation, which is qualitative;
- Transformation, which is qualitative; and
- Monitoring, at national, subregional and regional levels.

Indicators

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
Access	<ul style="list-style-type: none"> ▪ Quotas ▪ Support for women candidates ▪ Voters ▪ Public support and awareness 	<ul style="list-style-type: none"> ▪ Affirmative action ▪ Supportive networks ▪ Selection and recruitment policies ▪ Public awareness and support
Participation	<ul style="list-style-type: none"> ▪ Representation of women in the decision- making structures of parliament (speaker, chairs of committees) ▪ On which committees women are represented ▪ To what extent women ask questions/debate/lobby ▪ Training ▪ Retention rate ▪ Knowledge and control of processes 	<ul style="list-style-type: none"> ▪ At what levels of the public/private sectors (directors, chief directors, DGs, permanent secretaries, etc.) ▪ In which ministries; in which areas of private sector (finance, human resources, etc.) ▪ Extent of influence ▪ Training and promotion policies
Transformation Internal	<ul style="list-style-type: none"> ▪ Meeting times ▪ Child care ▪ Gender-sensitive language 	<ul style="list-style-type: none"> ▪ Work times (flexible time) ▪ Child care ▪ Gender-sensitive language

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
	<ul style="list-style-type: none"> ▪ Gender-sensitive environment ▪ Attitudinal change 	<ul style="list-style-type: none"> ▪ Gender-sensitive environment
Transformation External	<ul style="list-style-type: none"> ▪ Integration of gender considerations into legislation 	<ul style="list-style-type: none"> ▪ Integration of gender consideration into policies and programmes

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
<p>Access <i>(Quantitative)</i></p>	<ul style="list-style-type: none"> ▪ Traditional/cultural/stereotypical attitudes ▪ Social barriers for married and single women ▪ The brutality, loneliness, machination associated with politics ▪ Lack of affirmative action ▪ Quota system has limitations ▪ Lack of commitment by governments ▪ Laws are not implemented ▪ Lack of training for leadership ▪ Lack of financial resources ▪ Conflict situations ▪ Inadequate attention to women with disabilities by women leaders 	<ul style="list-style-type: none"> ▪ Create awareness among different groups of population ▪ Increase women's participation in local elections ▪ Scrap all discriminatory laws and entrench the equality clause in all constitutions ▪ Endorse and entrench a quota system/mechanism in national and political party constitutions ▪ Review electoral systems and adopt those most conducive to women's participation (for example, proportional representation) ▪ Political parties should adopt the principle of equality ▪ More women in political parties ▪ Target youth for leadership positions ▪ Identify women with leadership qualities, including from countries in conflict and disabled women, and increase their presence in regional and subregional fora ▪ Establish a fund at international, regional and national level to provide women with access to resources to stand for political positions ▪ Networks at national, subregional and regional level
<p>Participation <i>(Qualitative)</i></p>	<ul style="list-style-type: none"> ▪ Traditional and cultural values ▪ Attitudes and behaviour ▪ Lack of affirmative support ▪ Women's multiple roles in society ▪ Conflict/war situations ▪ International embargoes ▪ Women are not aware of the risks 	<ul style="list-style-type: none"> ▪ Create a gender-sensitive environment in the public sphere, e.g., accessible language, session/ meeting hours, child-care facilities ▪ Networks/linkages at national, sub-regional and regional

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
	<p>involved with politics</p> <ul style="list-style-type: none"> ▪ Limited knowledge and control over parliamentary processes ▪ Donors do not finance women ▪ Women lack confidence ▪ Lack of training and analytical skills for leadership and decision-making ▪ Low retention rate of women parliamentarians ▪ Need for more research 	<p>levels</p> <ul style="list-style-type: none"> ▪ Create training centres for women leaders ▪ Carry out training in analytical skills, including media and communication ▪ Electoral processes should avoid conflicts before and after polling days ▪ Promote inter-party caucuses/ networks among women parliamentarians ▪ Develop research

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
<i>Transformation (Qualitative)</i>	<ul style="list-style-type: none"> ▪ Traditional/cultural attitudes and behaviour ▪ Gender perspective is not integrated ▪ Expectation and pressure for women in decision-making to act like men ▪ Women are not used to being in power positions ▪ Women leaders have no constituency ▪ Lack of solidarity among women 	<ul style="list-style-type: none"> ▪ Effective communication and support networks at national, subregional and regional level ▪ Establish a dialogue between women and men leaders ▪ Revisit the role of women's wings/units ▪ Promote a gender-sensitive media ▪ Encourage effective self-regulating mechanisms in the media, to ensure positive portrayals of women in decision-making positions ▪ Interface of women politicians and women's groups at grassroots level ▪ Research patriarchy, sexual politics and power in contemporary Africa ▪ Transform institutional culture, through transformative leadership training ▪ Set up exchange programmes among countries to share experiences and best practices ▪ Target male politicians with gender-awareness programmes ▪ Women parliamentarians should make use of the Action Plan of the Inter-Parliamentarian Union (IPU) ▪ More involvement in parliamentary processes such as preparation of agendas
<i>Monitoring</i> - National - Sub-regional - Regional	<ul style="list-style-type: none"> ▪ Lack of resources ▪ Lack of indicators ▪ Lack of a regional mechanism 	<ul style="list-style-type: none"> ▪ Regional and subregional institutions should take up the challenge of monitoring, i.e. mechanisms at the level of OAU and subregional institutions to monitor the implementation of national

Issues	<u>Women in Politics</u>	<u>Women in Public, Private, and Professional Sectors</u>
		<p>commitments</p> <ul style="list-style-type: none"> ▪ Monitor the electoral process including registration of voters ▪ Monitor the use of money as a dominant factor in electoral politics ▪ Establish annual national review processes, and regular workshops and training on review techniques ▪ Monitor the use of national budgets ▪ Establish biannual subregional review processes ▪ Establish regular regional reviews ▪ Monitor the use of donor funds at international and regional levels ▪ Allow media to attend parliamentary sessions to cover debates continuously and expose those raising their voices against women's issues such as access to land ▪ Develop a database on women in leadership positions through UNIFEM's website

Workshop 7: Women's Health, Family Planning and Population

- Facilitators:** - Jane Kwawu
- Pap Syr Diagne
- Presenter:** - Daraba Saran Kaba

The summary of the report on health, family planning and population that was presented included the objectives of the African Platform of Action in these areas as well as the main findings of twenty national reports. These were submitted to the African Centre for Women (ACW) by ECA member States by July 1999. Since that time, more country reports have been received by ACW and the final regional report will be amended accordingly.

In implementing Beijing and Dakar Platforms of Action, many countries have revised their policies and reoriented programmes/activities to meet the challenges of the Platforms. But they have faced many constraints during the past five years. The main ones relate to inadequate financial, human and material resources and the high level of illiteracy. These constraints are all related to the widespread poverty situation at all levels: governmental and individual. Different objectives have been identified in the national plans of action, among which are: reducing maternal and infant mortality, improving health services, reducing HIV/AIDS and reducing sexually transmitted diseases impact, improving and facilitating access of family planning services to populations and improving social security.

Despite commitments made by governments at several meetings, including the meetings of the Commission on the Status of Women, the meetings of the Committee on CEDAW, the annual meetings of WHO, access to health services for women is still very limited for the majority of African countries. The women's health situation is, in some cases, even worse. The governments and NGOs are urged to take more aggressive actions to overcome the constraints they are facing. In that regard, health issues should be considered as crosscutting issues in the various sectoral programmes.

Summary of discussions

In elaborating the evaluation report, participants in the workshop drew lessons from different sources such as ICPD+5, as well as their own country experiences. In so doing, considerable achievements were reported in certain health sectors. However,

the workshop observed that the evaluation report on “Improvement of Women’s Health, including Family Planning and Population-related Programmes” was not exhaustive.

In the area of reproductive health and reproductive rights, 39 countries have taken measures to improve the quality of care, which entailed extensive training of health-care providers including traditional birth attendants; expanded and improved facilities, revised protocols and procedures for health-care services; and undertook evaluation and monitoring of health-care services. The female condom is being piloted with success in several countries and is gaining popularity because it ensures an appropriate choice to women’s reproductive needs.

Most countries reported on the urgent need to address the issue of adolescent reproductive health. Thirty-four countries have taken some measures to do so by adoption of national youth policies, and development of youth strategies and action plans. Others have launched new initiatives involving young people such as IEC/advocacy campaigns, youth-friendly services including peer education, counselling services and sexual health programme that serve the needs of youth. However, much more remains to be done given the demographic size of this group.

Twenty-six countries noted that civil society including NGOs continue to play a major role in providing reproductive health services to members of the community including adolescents.

Several countries have also initiated or expanded programmes promoting male responsibility in reproductive health through advocacy campaigns and specific services to men. Some countries are conducting socio-cultural research to understand better how to address the reproductive needs of men. In a few countries, coalitions against gender violence have been formed to address gender violence. However, ongoing initiatives for promotion of gender equality were not sufficient.

Africa was reported to be the only continent where maternal mortality rates had continued to rise. All the causes were known, but the necessary political will to put appropriate emergency obstetric care in place was still lacking. This was an area in which Africa had to re-strategize in order to reduce maternal and infant deaths.

Despite the fact that the majority of African countries had made health the priority, women's health as a special area had not been given due attention, neither in advocacy programme development nor in resource allocation.

In particular, the life-cycle approach to women's health has neither been understood well nor implemented appropriately. This means, for example, that the health of elderly women is not addressed and the nutritional status of young girls and nursing mothers is not receiving the necessary attention.

It was also clear from the assessment that women's health was most often interpreted in terms of maternal health, which excluded women not of reproductive age. In particular, the concept women's sexuality as a legitimate health concern had not begun to receive attention.

Although several initiatives have started to combat violence against women, the lives of too many women still remain endangered, because these initiatives need to be institutionalised in the health sector. Likewise, initiatives against FGM and other harmful practices are still heavily being spearheaded by NGOs; although some governments have enacted laws against FGM, the consequences on women's health remain grave.

Another emerging threat, according to the assessment was from the tobacco industries, which had suffered marketing losses abroad and were now focusing their attention on Africa, targeting especially young people and women.

Finally, the assessment noted that HIV/AIDS remains one of the most devastating pandemics and a major health concern for Africa. Women in particular are not only vulnerable to the disease, but also provide almost all the long-term care for AIDS sufferers in their families and communities.

Constraints

Major constraints observed in the workshop include:

- (a) Lack of sufficient skills among service providers particularly in the rural health facilities;
- (b) Brain drain of skilled health personnel to developed countries where their skills are utilised effectively and they are well remunerated;
- (c) Emphasis on medical treatment rather than prevention ;
- (d) Limited partnership in some countries among governments, NGOs, private sector, and civil society;
- (e) WHO recommendation on 10% allocation of the national budget to the health sector has not been followed by most countries;
- (f) Limited contraceptive choice in several countries;
- (g) War and internal conflict have devastated health systems and structures;
- (h) Lack of political will to support adolescent reproductive health and services;
- (i) Lack of reliable data on important aspects of women's health including maternal morbidity and mortality;

- (j) Inadequate indicators of programmes outcome, which makes it difficult to document successful programmes;
- (k) Lack of health insurance schemes, particularly for women working in the informal sector, coupled with the high cost of drugs are also major issues;
- (l) Infertility as a gender issue is not yet being addressed;
- (m) The health of disabled women – the blind, deaf, etc.- is completely ignored by health programmes, exposing them to the double tragedy of gender and disability discrimination and neglect; and
- (n) Globalisation, privatisation of health systems and servicing of the debt burden, have severely reduced the availability of resources, even at the level of women as consumers of health services.

Recommendations

HIV/AIDS

1. Adopt policies of non-discrimination towards people suffering from HIV/AIDS;
2. Provide support and livelihood opportunities for people suffering from AIDS;
3. Adopt multisectoral approaches in addressing HIV/AIDS programmes and their resource allocation.

Reproductive health and family planning

1. Reinforce education of men about the importance of reproductive health and family planning;
2. Strengthen programmes in both urban and rural areas to address sexuality, family planning, and sexually transmitted diseases, including HIV/AIDS;
3. Design programmes that address the needs of special groups such as the visually impaired, the deaf, and refugees, and take their programmes to scale.

Maternal mortality

1. Develop an Africa - specific strategy to address the rising rates of maternal mortality and develop mechanisms at regional, subregional and national levels to track the number of deaths, as opposed to maternal mortality rates.

Others

1. Develop global and integrated approaches to health issues;
2. Standardise data collection and availability to ensure that data is collected for and about women;
3. Adopt policies that block the designs of tobacco companies;

4. Increase the availability and coverage of social security programmes;
5. End traditional practices harmful to women's health;
6. Encourage collaboration between NGOs, governments and international organisations;
7. Enforce laws on domestic violence;
8. Increase government's commitment to the women's health objectives of the PFA, by increasing resource allocation to curtail the brain drain of health professionals and ensure expansion of current programmes;
9. Set mechanisms in place to reduce the debt burden of African countries in order to increase resource flows to the health sector and mitigate the effects of globalisation;
10. Ratify and implement the government commitments related to the health of women and use them as benchmarks for addressing women's health needs.

Conclusions

In spite of many achievements in the women and health sector, a great deal still needs to be done to implement the Beijing Platform of Action fully. Many challenges lie ahead which need recognition and re-addressing. The existing gaps in health policies, programmes, resources, and institutional arrangements are of concern both at regional, national and programme levels. More emphasis is required on non-discriminatory policies and practices and on multisectoral programmes to promote women's health, rights and equality, as well as community strategies for health care and male participation.

Of crucial importance is the need to recognise that five years after the Beijing Conference, Africa as a continent, has a peculiar need for women-specific-health strategies. These needs are underscored by the accelerating rate of maternal mortality and HIV/AIDS pandemic. As long as women continue to be vulnerable to the risk of mobility and death, either from pregnancy or HIV/AIDS, African women's opportunities for progress would be limited. These different issues which create an excessive burden of ill-health of women in Africa must be brought to the top of Africa's development agenda.