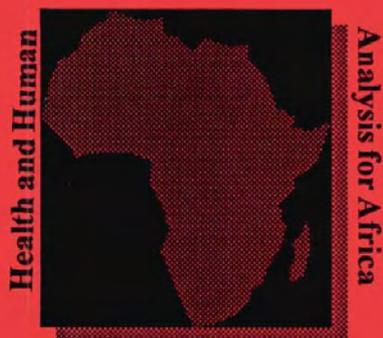


Resources



**HHRAA
AFR/SD/HRD**

**Mid-Term Assessment
Briefing Book**

**Volume 3: Population/
Family Planning**

November, 1994

TABLE OF CONTENTS :

Strategic Framework **1**

Analytic Agendas **2**

Sub-Sector Report **3**

RTA Reports **4**

Publications List **5**



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AFR/SD/HRD STRATEGIC FRAMEWORKS DEVELOPMENT

ANALYTIC AREA	SARA POINT PERSON(s)	ARTS/HHR POINT PERSON(s)	STATUS as of 10/04/94
1. Population/Family Planning	Rhonda (PRB) Toure (Morehouse) SPJ, DS	R. Haladay & L. Kangas	Final draft dated 5/11/94
2. Education	Jeanne Moulton (AED) SPJ	J. Rea J. DeStefano	Current draft dated 9/28/94
3. Child Survival a. Sick Child b. Behavior change c. Human resources development	Hermann (Morehouse) J Graeff (AED) B. Bertrand (Tulane) SPJ, DS	P. Gestrin P. Gestrin A. Ross	Current draft dated April 94 Current draft dated 9/19/94 Issues paper being discussed
4. HIV/AIDS, STDs, & TB	(Morehouse) M. Post (Tulane) DS	W. Lyerly	Current draft dated 08/25/94
5. Malaria & Emerging Health threats	D. Krogstad (Tulane) DS	W. Lyerly	Current draft dated 08/11/94

6. Safe Motherhood & Reproductive health	Lala Toure (Morehouse) May Post (Tulane) DS	Lenni Kangas	Current draft dated July 94 was discussed by working group on 6/15/94
7. Nutrition: Infant & child feeding	Ellen Piwoz SPJ	H. Sukin	Current draft dated April 94 was discussed a consultative meeting 6/30/94
8. a. Health financing & sustainability	N. Mock (Tulane) Kutzin (consultant) H. Waters DS, SPJ	A. Bekele	Current draft dated 6/16/94
9. Information dissemination	(AED) JB	Subhi Mehdi	Being drafted

Population/FP

**A Strategic Framework
for Research, Analysis, and Dissemination Activities in
Population and Family Planning**

Draft

5/11/94

**U.S. Agency for International Development
Bureau for Africa
Office of Analysis, Research, and Technical Support
Health and Human Resources Division (AFR/ARTS/HHR)
HHRAA Project**

ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
APAC	:	African Population Advisory Committee
AFR/ARTS	:	Africa Bureau, Office of Analysis, Research and Technical Support
CA	:	Cooperating Agency
CERPOD	:	Centre d'Etudes et de Recherche sur la Population pour le Développement (Centre for Applied Research on Population and Development)
CPO	:	Center for Population Options
CSM	:	Contraceptive Social Marketing
DHS	:	Demographic and Health Surveys
FHI	:	Family Health International
FLE	:	Family Life Education
FP	:	Family Planning
FPA	:	Family Planning Affiliates (UNFPA)
G/R&D/POP	:	Global Programs, Field Support and Research Bureau/Bureau for Research and Development/Office of Population
HHRAA	:	Health and Human Resources Analysis for Africa
HIV	:	Human Immunodeficiency Virus
HPN	:	Health, Population and Nutrition (Office)
IE&C	:	Information, Education, & Communication
INTRAH	:	Program for International Training and Health
IPAS	:	International Project Assistance Services
IPPF	:	International Planned Parenthood Federation
IUD	:	Intra-Uterine Device
JHPIEGO	:	The Johns Hopkins Program for International Education in Reproductive Health
KAP	:	Knowledge, Attitudes and Practice (survey)
NGO	:	Nongovernmental Organization
OC	:	Oral Contraceptives
OPTIONS	:	Options for Population Policy
PAI	:	Population Action International
PRB	:	Population Reference Bureau, Inc.
PSI	:	Population Services International
RAPID	:	Resources for the Awareness of Population Impacts on Development
REDSO	:	Regional Economic Development Support Office (USAID)
RTI	:	Reproductive Tract Infection
SARA	:	Support for Analysis and Research in Africa
STD	:	Sexually Transmitted Diseases
UN	:	United Nations
UNFPA	:	United Nations Population Fund
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

TABLE OF CONTENTS

POPULATION OBJECTIVE TREE	i
EXECUTIVE SUMMARY	ii
I. BACKGROUND	1
II. PURPOSE OF THE STRATEGIC FRAMEWORK	2
III. OBJECTIVES	3
IV. ISSUES IDENTIFICATION	4
V. BASIS FOR THE STRATEGIC FRAMEWORK: PRIORITIZATION OF INFORMATION NEEDS	5
A. Adolescent Reproductive Health	6
B. Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access	8
C. Gender Issues in Family Planning	9
D. Strengthening Reproductive Health Services: Integrating Family Planning and STD/HIV/AIDS Programs	11
E. Post-Abortion Management and Family Planning Service Provision	12
F. National Population Policies	13
G. Accelerating Urban Family Planning Programs	15
H. Vertical and Integrated Approaches to Family Planning Programs	17
VI. FRAMEWORK RATIONALE: INFORMATION NEEDS AND GAPS	18
A. Policy	
1. National Population Policies	19
2. Sectoral Policies	20
B. Demand for and Supply of Services	22
1. Adolescent Reproductive Health	22
2. Gender Issues in Family Planning	25
3. Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs	26
4. Post-Abortion Management and Family Planning Service Provision	28
5. Accelerating Urban Family Planning Programs	29
6. Vertical and Integrated Approaches to Family Planning Programs	30

C.	Costs and Financing	32
	1. Cost Recovery	32
	2. Public/Private Sector Collaboration	33
	3. Costing Methodologies	34
	4. Resource Allocation, Use, and Management	34
D.	Cross-cutting Issues	34
	1. Decentralization	35
	2. Human Resources: Assessing Manpower Deficits	36
VII.	POTENTIAL APPROACHES TO ADDRESS PRIORITY NEEDS	37
	REFERENCES	45
	ANNEX: Results of Priority Issues Questionnaire/Respondents	

Narrative

Population/Family Planning Objective Tree

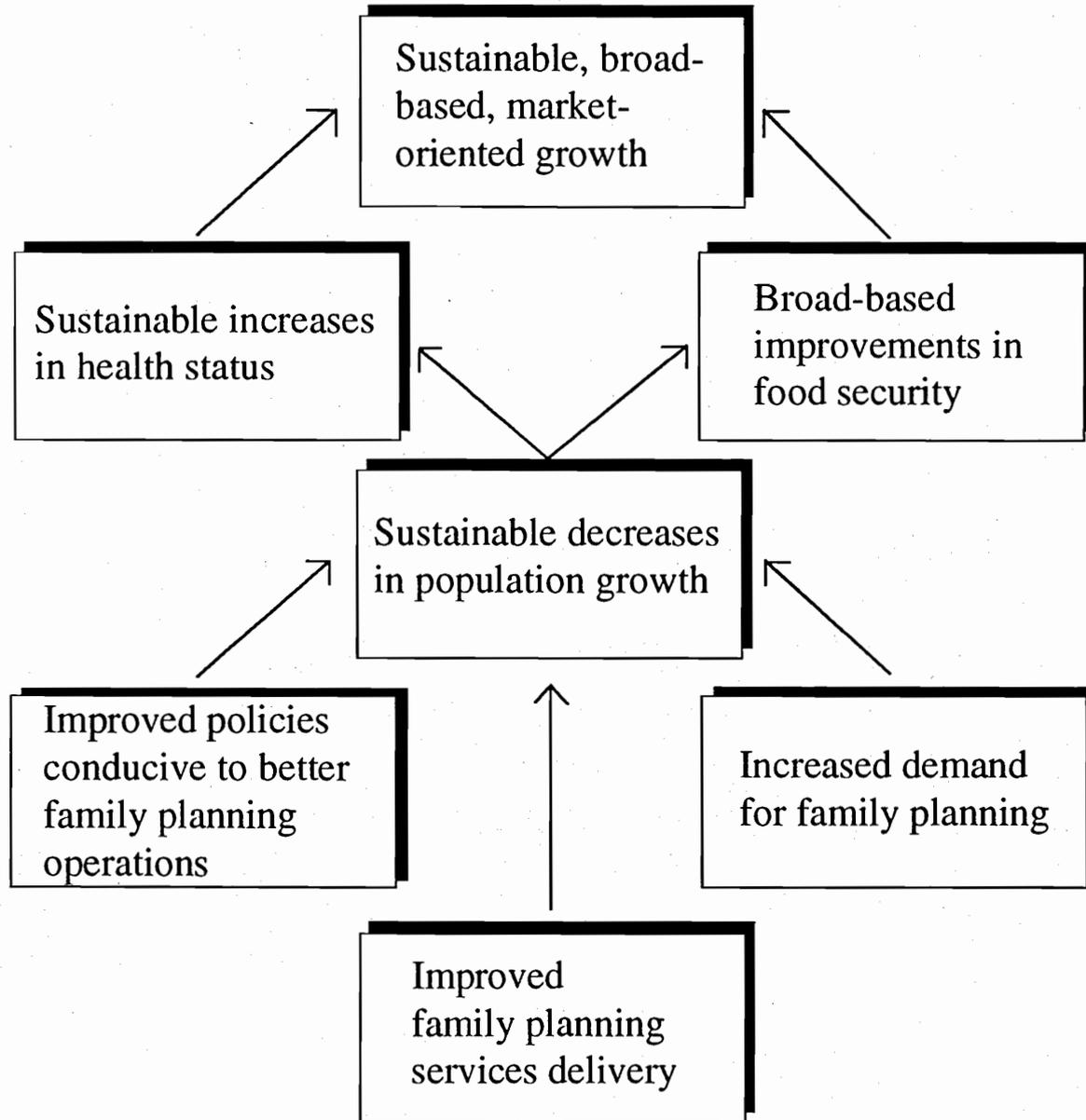
Level

Goal

Sub-Goals

Strategic Objective

Targets



Indicators

- increased per capita GNP
- reduced under- and malnutrition rates
- reduced infant mortality rates
- reduced child mortality rates
- reduced maternal mortality
- decreased total fertility rates
- decreased growth rates
- enhanced pop/FP policies, strategies, and program protocols
- increased modern contraceptive prevalence
- expanded range of contraceptive methods and delivery approaches

EXECUTIVE SUMMARY

The Office of Analysis, Research and Technical Support (ARTS) of the USAID/W Bureau for Africa emphasizes regional-level activities that influence the strategic resource allocation and operational decisions of USAID, African governments, the private sector and other donors. The goal is to increase the effectiveness of the broad range of resources available for African development. The Health and Human Resources Analysis for Africa (HHRAA) Project, in the Health and Human Resources (HHR) Division of the ARTS Office, has been authorized as a mechanism to increase the utilization of research, analysis, and information in support of improved strategies, policies, and programs.

In the area of population and family planning, the Bureau for Africa works within a broader Agency strategy, which focuses on four principal objectives:

- To help couples and individuals exercise their internationally recognized rights to determine freely and responsibly the number and spacing of their children;
- To improve individual reproductive health, with special attention to the needs of women and adolescents;
- To achieve population growth rates consistent with sustainable development; and
- To establish programs that are responsive and accountable to the people who use them, especially women.

This strategic framework has been developed to guide the Bureau in the selection of analytic activities. The framework contains the following sections: (1) a population objective tree; (2) a brief background summary of the importance of this analytic area; (3) the purpose of the framework; (4) a ranked listing of potential topics identified to date; (5) criteria for prioritization; (6) the framework rationale including a review of information needs and gaps; and (7) a list of potential approaches to address priority needs.

To ensure greater impact, AFR/ARTS/HHR devoted a significant amount of time over this last year to identifying priority issues for Africa, as well as information needs and gaps, in the area of population and family planning. The process included a review of current AFR/ARTS/HHR analytic activities; formal consultations with African decision-makers, cooperating agency representatives, and USAID field staff; formal and informal literature reviews on potential issues; and organized discussion groups with population experts. The Bureau also created a population objective tree that provides a framework for assessing how sector-level targets will contribute to the overall Development Fund for Africa strategic goals and objectives (see page i).

During the issues identification process, a number of topics consistently emerged. These topics were reviewed and ranked by consultative group members, USAID staff, and African family planning and reproductive health experts. Priority issues identified thus far are as follows:

- A. Adolescent Reproductive Health
- B. Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access
- C. Gender Issues in Family Planning
- D. Strengthening Reproductive Health Services: Integrating Family Planning and STD/HIV/AIDS Programs
- E. Post-Abortion Management and Family Planning Service Provision
- F. National Population Policies
- G. Accelerating Urban Family Planning Programs
- H. Vertical and Integrated Approaches to Family Planning Programs

This framework also contains a rationale and a description of information needs for family planning cost and financing issues, and for two additional issues that cross-cut several sectors: program decentralization and manpower deficits.

Each year, the AFR/ARTS/HHR Office will draft an analytic agenda using the strategic framework as a reference. Because research, analysis, and dissemination activities need to be demand driven, the Bureau for Africa will revise and update this framework as new information and requests are presented by African population experts and decision-makers, and USAID mission and field staff.

I. BACKGROUND

In 1960, African population growth rates were not high in relation to those of Asia and Latin America (2.5 percent per year versus 2.5 and 2.9 percent respectively). Today, however, Africa's has risen to 3.0 percent while Asia's and Latin America's have fallen to 2.1 and 1.9 percent. The growth rate has remained high because mortality rates have dropped and the fertility rate – the average number of births per woman – remains exceptionally high, at more than six. Since 1965, the total fertility rate has decreased only about 5 percent, from 6.7 to 6.4 births per women.

According to UN estimates, at least 45 percent of the population is under age 15 in most African countries. This large proportion of children creates a built-in momentum for future population growth. Even if fertility were to drop immediately to replacement level, the region's population would still increase by an estimated 250 million people by the year 2025.

This extraordinary population surge will be accompanied by massive pressures for social services, food security, and jobs at a time when governments are facing a number of crises: economies are stagnating, external indebtedness is mounting, and people are becoming poorer. The challenges to addressing these issues will become more strenuous in the face of competing demands for national and international resources, the restructuring of domestic economies, and the emergence of other problems such as AIDS, environmental degradation, rapid urbanization, and growing numbers of unemployed, disillusioned youth. In summary, population growth is outpacing the ability of economies to expand, thus swamping Africa's development efforts.

Furthermore, high fertility rates are an enormous impediment to improving maternal and child health in sub-Saharan Africa. Many infant deaths could be prevented through birthspacing: babies born less than two years after a sibling are almost twice as likely to die as those born after an interval of at least two years (PRB, 1991). Maternal mortality could also be dramatically reduced through greater use of family planning. At 640 deaths per 100,000 live births, women's death rates from pregnancy and childbirth in Africa are the highest in the world.

Not only can family planning provide immediate health benefits to mothers and children, it also contributes to significant cost reductions in health and education services. For example, as a result of Zimbabwe's successful family planning program, 1.3 million fewer student-years of primary school education were required between 1965 and 1990 than would have been required if 1965's high fertility rate had continued. At an average cost of \$110 per year of primary school education, the savings to the government and the people of Zimbabwe were more than \$140 million. Likewise, at an average cost of \$16 to fully immunize a child, the savings to the immunization program alone was nearly \$23 million (The Futures Group, 1992).

Currently, the U.S. Agency for International Development (USAID/W) is responding to the development challenges of the 1990s by focusing efforts in four areas critical to sustainable development: broad-based economic growth, the environment, population and health, and democracy. New strategies have been developed for each area which emphasize support for sustainable and participatory development, partnerships, and integrated approaches, with special attention to the needs and roles of women.

Specifically, in the area of population assistance, USAID/W is now operating under renewed U.S. leadership and a supportive policy environment. Priority family planning needs in the 1990s include catching up with unmet need, currently estimated at 120 million women in the developing world; keeping up with the growing demand for family planning; and satisfying current users by ensuring wide availability of quality services (Maguire, 1993). There are also tremendous reproductive health challenges that are inextricably linked to the promotion and expansion of family planning counseling and services. These challenges include lowering pregnancy-related morbidity and mortality, reducing unsafe abortion – frequently a consequence of unmet need for family planning – and preventing and treating sexually transmitted diseases (STDs), including HIV/AIDS.

The USAID/W's Bureau for Africa recognizes that only a few African countries have made progress in establishing comprehensive reproductive health services, increasing contraceptive prevalence rates, and reducing fertility. Thus, the Bureau aims to work within the broader agency strategy, focusing on the three principal objectives that have guided USAID/W's population assistance program since its inception: to enable couples to freely choose the number and spacing of their children; to reduce maternal, infant and child mortality; and to bring population growth rates in line with sustainable development.

II. PURPOSE OF THE STRATEGIC FRAMEWORK

This strategic framework defines the priorities of the Office of Analysis, Research and Technical Support (ARTS) of the Africa Bureau and the Health and Human Resources Analysis for Africa (HHRAA) Project for supporting research, analysis and information dissemination related to the population and family planning sector. Both the ARTS Office and the HHRAA Project emphasize improving policies, strategies, program design, implementation and evaluation in health, nutrition, education, and population. Their purpose is to provide timely and appropriate information to USAID offices, African governments, nongovernment organizations, and donors that will assist in making appropriate decisions about setting priorities and allocating resources.

Increasingly, African countries are establishing national population polices and are beginning to appreciate the importance of integrating demographic variables into development plans and objectives. However, turning these stated objectives into effective actions remains elusive. Policymakers, program planners, and donors need critical information to enable them to make effective decisions. Many questions must be addressed concerning mobilizing human and financial resources; implementing a broader approach to family planning and reproductive health; designing quality programs with maximum access; and building a broader constituency. All of these areas directly relate to issues of vital importance to ARTS and HHRAA such as increasing the utilization of research to affect policies and programs, increasing the efficiency of investments, and reaching key policymakers and opinion leaders. By analyzing and disseminating existing data and lessons learned, and by helping to fill in the information gaps identified during the last year, ARTS and HHRAA can make substantial contributions to policy, programmatic, and operational decisions throughout the region.

III. OBJECTIVES

To fulfill its commitment to leadership on population issues, USAID will give priority to four major objectives (Atwood, 1993):

- To help couples and individuals exercise their internationally recognized rights to determine freely and responsibly the number and spacing of their children;
- To improve individual reproductive health, with special attention to the needs of women and adolescents;
- To achieve population growth rates consistent with sustainable development; and
- To establish programs that are responsive and accountable to the people who use them, especially women.

The Africa Bureau's proposed activities in the area of population and family planning directly address these objectives. Specifically, the objectives of research, analysis and dissemination in this area are:

1. To identify and promote policy and programmatic changes that will improve service delivery and enhance quality of care.
2. To reduce unnecessary barriers to family planning access by supporting the updating of service delivery and training guidelines;

3. To strengthen reproductive health services by examining the organizational, programmatic, technical, and financial implications of service integration.
4. To increase demand generation by promoting policies and program approaches that encourage contraceptive use by special groups: adolescents and youth; men; post-abortion clients; and rural and urban poor.
5. To help ensure long-term financial sustainability of family planning and reproductive health programs.
6. To facilitate the incorporation of population and family planning information/research into policies and programs by:
 - supporting innovative dissemination approaches;
 - documenting and disseminating experiences about research application; and
 - developing tools to help decision-makers understand the policy and program implications of analytic and research findings.

These objectives are consistent with the strategic objective of sustainable decreases in population growth and the three targets listed in the population/family planning objective tree (see p.i): (1) improved policies conducive to better family planning operations; (2) improved family planning services delivery; and (3) increased demand for family planning.

IV. ISSUES IDENTIFICATION

The issues identification process for population was initiated in December, 1992 through a brainstorming session attended by population experts including USAID/W representatives, a member of the African Population Advisory Committee (APAC), and HHRAA staff. The resulting preliminary list of key topics was subsequently reviewed in the field by various USAID mission and REDSO staff and a number of prominent African specialists at the African Regional Population Conference in Dakar, Senegal.

Approximately 20 key topics emerged from these discussions. To facilitate the identification of specific information needs, the Support for Analysis and Research in Africa (SARA) staff conducted an extensive literature review and produced an annotated bibliography of each topic along with a summary discussion of key issues relevant to sub-Saharan Africa. These documents were then used as background materials for a consultative group meeting held in May, 1993. The group, comprised of six African population specialists and 24 experts representing nine major cooperating agencies, R&D/POP, R&D/Health, and the Africa Bureau, identified and

ranked a large number of potential research, analysis, and dissemination activities. The Africa Bureau further shared these potential topics in questionnaire form with participants at the Population Council's end-of-project Operations Research Conference held in Nairobi, Kenya, October 6-9, 1993. The result is a priority listing of population issues from some of Africa's leading family planning experts. This list is attached in Annex 1 and is reflected in the section on prioritization of information needs.

In addition, a number of key regional institution staff members provided valuable insights into the Africa Bureau's issues identification process over the last year. These groups include APAC, the Centre for Applied Research on Population and Development (CERPOD) – representing the nine member states of the Sahel subregion – and the Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa (CRHCS – ECSA). This framework also benefited from the recommendations included in six studies on population dynamics in sub-Saharan Africa recently produced by the National Academy of Sciences and presented at an international conference held in Washington, July 1993.

V. BASIS FOR THE STRATEGIC FRAMEWORK: PRIORITIZATION OF INFORMATION NEEDS

The following criteria have been selected to establish the priorities of the ARTS office and the HHRAA Project for supporting research, analysis, and dissemination activities in the population and family planning sector:

- Linkages to the AFR/ARTS population sector objective tree;
- Regional significance;
- USAID and the Africa Bureau's comparative advantage over other organizations in working in this area;

and, to avoid duplication,

- Complementarity with ongoing USAID programs and the activities of other donors/institutions

To assist with the development of a priority list of activities, each of the above-mentioned criteria has been applied to the most important topic areas that emerged over the last year during the issues identification process.

Priority topics identified thus far are as follows:

- A. Adolescent Reproductive Health
- B. Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access
- C. Gender Issues in Family Planning
- D. Strengthening Reproductive Health Services: Integrating Family Planning and STD/HIV/AIDS Programs
- E. Post-Abortion Management and Family Planning Service Provision
- F. National Population Policies
- G. Accelerating Urban Family Planning Programs
- H. Vertical and Integrated Approaches to Family Planning Programs

A. ADOLESCENT REPRODUCTIVE HEALTH

Linkages to the Objective Tree

Focusing on the establishment or expansion of programs aimed at this important target group primarily supports two of the objective tree targets: improved family planning service delivery and increased demand for family planning.

Regional Significance

The rapidly escalating number of youth constitutes one of the single most compelling challenges for sub-Saharan Africa. Today, there are nearly 188 million young people between the ages of 10 and 24. By the year 2025, that number is projected to increase by another 246 million, bringing the total to 434 million (PRB, 1994). Currently, in some parts of Africa between one-third and one-half of young women have a child by age 19. Clearly the number of pregnancies, and probably abortions, will increase dramatically, along with the incidence of STDs and HIV infections. Many African experts believe that changing sexual attitudes and behaviors, and reducing disparities in gender roles and responsibilities will be achieved best through the provision of information, counseling, and services in the early, formative years.

USAID/Africa Bureau's Comparative Advantage

Currently, UNFPA and IPPF have a limited focus on selected country-specific projects working primarily with government agencies and institutions. African experts suggest that USAID's history of working with governments as well as private sector organizations gives it a comparative advantage in being able to (1) mobilize more broad-based support; and (2) capitalize on regional experiences with a variety of

family planning delivery modes that lend themselves to the expansion of adolescent and youth services (e.g. community-based and social marketing programs).

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF is coordinating pilot "youth-to-youth" projects in Senegal, Egypt, and Sierra Leone. The program aims to empower young people to promote and produce their own teaching and information materials in local languages. IPPF is also encouraging FPAs to remove legal, educational and physical obstacles by assisting governments to develop sexual and reproductive health policies.
- UNFPA primarily works with government programs to support formal and non-formal population education programs such as strengthening family life education and IE&C projects.
- The Center for Population Options (CPO), sponsored primarily by UNFPA, Ford, and PAI, supports youth programs in Africa by: offering seed grants and technical assistance to help groups initiate programs; working with professionals, policymakers, and the media to focus attention on adolescent reproductive health issues; and developing curricula for use by programs.
- The Rockefeller Foundation has recently developed a reproductive health strategy that focuses on abortion care and STD services for adolescents under 20 years of age. The strategy emphasizes two types of research activities: documentation research to supply missing evidence about the nature and magnitude of the risks, illness burden, resource drain and need for services; and intervention research to test models for delivering reproductive health services.
- Population Action International, through CPO's Seed Grants Program, supports youth programs in Nigeria and Kenya, and helps sponsor the Centre for the Study of Adolescents in Nairobi.
- Family Planning International Assistance works with youth programs in Lesotho, South Africa, Zambia and Zimbabwe. The group's activities include enhancing FLE programs, establishing youth advisory services, creating teen education programs with NGOs, and linking family planning services to youth programs outside of a clinic setting.

B. REDUCING MEDICAL AND OTHER BARRIERS TO FAMILY PLANNING ACCESS

Linkages to the Objective Tree

Efforts to reduce barriers to family planning access will have a positive impact on all three objective tree family planning targets. Medical barriers, are defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton, 1992). Major medical barriers include inappropriate contraceptive eligibility criteria and excessive laboratory testing prior to contraceptive provision. Removing these barriers, as well as other unnecessary hurdles such as provider bias or unjustifiable restrictions on who may provide contraceptives, directly affect policies conducive to improved family planning service delivery. Moreover, the elimination of restrictive policies and program level protocols will likely result in increased client satisfaction, with a strong potential for increasing demand.

Regional Significance

Although many countries are beginning to eliminate access restrictions, concerns about quality issues and the role of allied professionals persist. Owing to isolation and lack of current scientific information, particularly in Francophone Africa, progress has been slow. Potential approaches to address priority needs in this area include region-wide questionnaire sampling and periodic conferences involving participants from a number of subregional countries. These approaches enhance the possibilities of cross-country analyses and promote the exchange of experiences among technicians and decision-makers. By focusing on the removal of barriers, family planning services – particularly nascent programs – may be able to accelerate service expansion.

USAID/Africa Bureau's Comparative Advantage

A member of the HHRAA Project's technical assistance consortium, JHPIEGO, has extensive experience in working to reduce medical barriers throughout the world. JHPIEGO has participated in regional medical barriers conferences in Asia and Latin America, and was the lead agency for this year's Anglophone Africa conference (January, 1994). In addition, owing to the number of USAID-supported CAs currently involved in medical barriers activities, the Africa Bureau is being asked to share costs and build on existing initiatives rather than to create new projects or to accept the entire financial responsibility of any one activity.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

A number of collective activities are currently in process:

- G/R&D/Pop, in collaboration with WHO and IPPF, is working to develop a set of guidelines to identify process "hurdles" and to promote a more epidemiologically and programmatically rational set of eligibility criteria. Group members are focusing on process issues associated with contraceptive initiation (Norplant, minilaparotomy) and the management of side effects.
- G/R&D/POP, in collaboration with representatives from selected CAs in population, established a working group to collect country-level information on restrictions to access from HPN officers worldwide. The group has completed a preliminary assessment of 43 responding countries.
- A third working group, initiated by G/R&D/POP, is currently carrying out organized educational events, primarily through a series of Contraceptive Technology Update regional conferences. An Anglophone sub-regional conference in Zimbabwe (partially-funded by the HHRAA Project) took place in January, 1994. A Regional Francophone Medical Barriers Conference is under discussion.

C. GENDER ISSUES IN FAMILY PLANNING

Linkages to the objective tree

Promoting greater male involvement in family planning and developing a better understanding of couple interactions is primarily linked to one objective tree target – increasing demand for family planning.

Regional Significance

Traditionally, family planning programs in Africa have largely targeted women. The emphasis appears to be changing, however, as more national family planning program managers recognize the importance of men's roles and motivation in fertility decision making and prevention of STDs. The importance of examining gender issues is receiving additional reinforcement owing to a new regional emphasis on family planning as a fundamental right of both sexes, and sexual decision making as the joint responsibility of partners. To date, no country program appears to be initiating

activities in a systematic fashion. Operations research projects and further analysis of existing programs are needed to give decision makers and program managers a basis for developing comprehensive strategies.

USAID/Africa Bureau's Comparative Advantage

USAID has a long history of supporting programs that provide family planning and HIV/AIDS prevention information, services and supplies to men. These male involvement programs have included: contraceptive retail sales (Population Services International, SOMARC); employment-based education and services (Enterprise, TIPPS); mass media promotion of family planning directed at men; and use of male village distributors in community-based distribution programs. Largely through USAID-funded social marketing programs, condom sales have increased dramatically in both Anglophone and Francophone countries. Doubtless much of this increase can be attributed to concern about AIDS, but the increased attention to condoms has also increased their use as a family planning method. USAID could capitalize on its marketing and media experience to expand efforts in gender-related research and in promoting male involvement and couple interactions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF provides technical assistance and financial support to FPAs primarily to develop IEC campaigns aimed at increasing awareness and knowledge among men; promote condom use; and conduct KAP surveys.
- AVSC has recently established a program office devoted to male involvement in family planning worldwide. Their activities in Africa include supporting a new all-male clinic in Nairobi, and completing a series of vasectomy decision-making studies in Tanzania, Kenya, and Rwanda.
- The G/R&D/Pop Office supports the CSM III Project (The Futures Group) which is currently working to establish broad-based contraceptive retail sales (particularly condoms) and mass media promotional campaigns in seven sub-Saharan African countries.
- The Population Services International has several agreements with USAID missions to conduct social marketing of health and family planning products. PSI, currently operating in 15 sub-Saharan African countries, also works to combat AIDS through IE&C campaigns and the promotion and distribution of condoms.

D. STRENGTHENING REPRODUCTIVE HEALTH SERVICES: INTEGRATING FP AND STD/HIV/AIDS PROGRAMS

Linkages to the objective tree

Although the advantages and disadvantages of program integration are still unclear in sub-Saharan Africa, experiences from other regions suggest that integration, particularly at the client level, could improve the efficiency and effectiveness of both family planning and reproductive health services. To the extent that providing integrated services is perceived as increasing service quality, activities associated with program integration could have a positive impact on family planning demand.

Regional Significance

First, scarce resources in sub-Saharan Africa mandate careful examination of the potential benefits of program integration. Secondly, the significance of this topic is accentuated by the growing incidence of HIV infection found throughout the region. Infections of the reproductive tract – including the common STDs and HIV/AIDS – are of central concern to policymakers and providers of health/FP services as these infections influence the safety and quality of programs, the prevalence of infertility, impact on the demand for fertility regulation, and drain limited government resources. Much remains to be learned about the feasibility, costs, and outcomes of integrating services.

USAID/Africa Bureau's Comparative Advantage

USAID has extensive experience in designing and implementing family planning services and increasing experience in the management and prevention of sexually transmitted diseases (JHPIEGO, PSI, Population Council, FHI, CSM III). USAID bilateral assistance agreements frequently include support to both health and family planning programs and thus can facilitate the implementation of a broader approach to reproductive health services.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- IPPF/Western Hemisphere Region (WHR) sponsors an STD/HIV prevention program designed to improve the ability of FP providers to meet the sexual and reproductive health needs of clients through the integration of FP and STD services. Integrated projects are currently being implemented in six countries in the Caribbean and Latin America.

- According to IPPF representatives for Africa, IPPF is addressing this topic through country-level FPAs in Africa. To date, IPPF has provided limited guidelines: provision of HIV/AIDS/STD information in IE&C programs; provision of condoms; and the education of staff about infection control. Their program thrust seems to be at the community-level to establish dialogue between FPA staff and community members regarding sexual behavior and attitudes.
- WHO has produced guidelines on AIDS and Family Planning for MCH/FP program managers (WHO, 1990).
- The Rockefeller Foundation has recently developed a reproductive health strategy. Focusing on STDS, the strategy emphasizes two types of research activities: documentation research to supply missing evidence about the nature and magnitude of the risks, illness burden, resource drain and need for services; and intervention research to test models for delivering reproductive health services.
- Since 1989, JHPIEGO has been working with WHO to adapt simplified, problem-oriented approaches to managing sexually transmitted genital tract infections for use at the primary, secondary and tertiary levels. Training materials have been developed and field tested in Morocco and Kenya.

E. POST-ABORTION MANAGEMENT AND FAMILY PLANNING SERVICE PROVISION

Linkages to the objective tree

Collecting primary and secondary data that illustrate the magnitude and costs of the problem, and promoting effective post-abortion management linked to quality family planning services contribute to all three population targets: supporting policies conducive to better family planning operations; improving family planning services delivery; and increasing demand for family planning.

Regional Significance

Since unsafe abortion is a leading cause of disease and death among women of reproductive age in Africa, post-abortion management, counseling, and family planning service provision is a high-impact, focus area of concern. Evidence indicates that, in general, the target group – women who have had abortions – is not receiving effective contraceptive information or post-abortion family planning services.

USAID/Africa Bureau's Comparative Advantage

USAID plays a major leadership role in population and family planning that strongly influences actions and priorities throughout the world. The problem of abortion-related morbidity and mortality has long been neglected. African experts and other donors believe that if USAID chooses to focus on this issue, it will help draw attention and resources – particularly at the national level – to this serious and growing public health problem. Moreover, Africa would benefit from USAID's extensive research, analysis, and dissemination experience in order to document the current situation and effectively present the problem to policymakers. The HHRAA Project's links to regional and subregional institutions will also help facilitate entry into countries to work on a subject that has been traditionally viewed as politically sensitive.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- The International Projects Assistance Services (IPAS) has been conducting studies and supporting services related to the treatment of incomplete abortion in Africa for many years. Specifically, they have worked with institutions in Nigeria, Kenya, Zimbabwe, Ghana, Ethiopia, and Zambia.
- Population Action International provides training and equipment for the treatment of incomplete and septic abortions in several African countries, and helps fund selected IPAS activities.
- IPPF is looking at the problem of abortion in six African countries. This activity is designed to give IPPF a general idea – rather than a rigorous data analysis – of the magnitude of the problem and the current situation with regard to policies and programs. The study was presented to regional FPA representatives at a conference in Mauritius (March 1994).

F. NATIONAL POPULATION POLICIES

Linkages to the objective tree

National population policies both directly and indirectly affect family planning policies, service delivery, and demand generation. Current efforts to formulate national population objectives include helping countries to develop realistic and measurable demographic and contraceptive prevalence targets. Setting and officially adopting quantifiable objectives enhance political commitment and sector-level

accountability toward achievement of goals. National policies directly address the issues associated with high fertility and rapid growth, and frequently emphasize family planning programs. Indirectly, population policies advance the acceptance of family planning by supporting broad-based social sector programs that aim to reduce maternal and child morbidity and mortality, focus on the needs of adolescents and youth, increase formal education opportunities, and enhance women's status. Improvements in these key areas have all been linked to increased family planning demand and contraceptive prevalence.

Regional Significance

The formulation and implementation of national population policies is gaining momentum throughout the region. The creation of these policies and concern for their effective implementation are serving as an impetus to keep population and family planning issues high on national agendas.

Population experts also underscore the importance of placing a special emphasis on fostering population policies and family planning programs in Francophone Africa. Historically, Francophone countries have assumed a more pronatalist stance than their Anglophone counterparts, which was reinforced by colonial and religious attitudes, particularly in West and Central Africa. Although government attitudes and national policies are changing, strong pronatalist tendencies and sociocultural barriers to family planning persist.

USAID/Africa Bureau's Comparative Advantage

USAID, largely through the RAPID and OPTIONS Projects, has assisted many African governments with the development of population policies and the establishment of coordination mechanisms since the early 1980s. Thus, USAID is well placed to advance policy implementation by capitalizing on more than a decade of experience in Africa and other regions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- The G/R&D/POP Office supports two projects that include objectives aimed at strengthening national population policy efforts: (1) the RAPID Project, which works to raise leadership awareness of relationships between population growth and development; and (2) the OPTIONS II Project, which is designed to support the policy development process and to help countries formulate comprehensive national population policies.

- The African Population Advisory Committee, funded by the UNFPA, IPPF, World Bank, USAID, and a number of individual governments, in collaboration with the Global Coalition for Africa, has proposed an Intensified Action Plan to improve the implementation of population programs. Key proposal objectives include assisting countries to operationalize population policies (develop intensified country action plans); mobilizing human and financial resources for policy implementation; improving donor, government and NGO coordination; and accelerating support for population initiatives at the community and grass-roots levels.
- The Center for Applied Research on Population Development (CERPOD), in collaboration with UNFPA and the USAID-funded OPTIONS Project has been working to help countries in the Sahel formulate national population policies. The next steps include sponsoring a series of workshops designed to assist governments in developing implementation frameworks and utilizing demographic data in development planning.

G. ACCELERATING URBAN FAMILY PLANNING PROGRAMS

In Africa, many family planning programs originated with a handful of clinics in the largest cities, usually run by private agencies or health providers. As programs expand, urban residents are clearly a prime target audience for family planning programs: they tend to be better educated, more accessible, and more motivated to limit and space births than rural residents. Yet today, the demand for family planning in urban areas continues to outstrip available services. How can public and private sector providers mount more vigorous programs and intensify urban operations?

Linkages to the objective tree

Identifying the causal factors that lead to successful urban family planning programs, and determining how to use this information to improve service operations directly link to two objective-tree targets: supporting policies conducive to better family planning operations; and improving family planning delivery. By establishing a network of high-quality, convenient family planning services in urban areas, programs could build up a stable clientele and have a significant impact on the third population target – generating demand.

Regional Significance

Africa is rapidly urbanizing and many villagers regularly travel to town and cities. Historically, family planning acceptance has spread from cities to the countryside, and African countries appear to be following this example. Thus, it is important that urban family planning programs be maximally effective so that they will serve as models for replication and promote an ever-increasing following of satisfied clients who will encourage others to adopt contraception. Comprehensive assessments of existing services could serve as the basis for new projects to upgrade services and as the rationale for directing bilateral assistance in a more concerted way to meet urban family planning needs.

USAID/Africa Bureau's Comparative Advantage

The G/R&D Population Office and USAID bilateral programs have provided technical assistance and financial support for the promotion of African urban family planning programs through a number of cooperating agencies (e.g. Population Council, John Snow Incorporated, Pathfinder International). Building on these earlier country-specific initiatives, the Africa Bureau and HHRRA Project staff can conduct cross-country comparative analyses, promote economies of scale in analyzing urban family planning problems common to several African countries, and take advantage of new linkages to regional institutions to collect data and disseminate results.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

The R&D/POP Office, through agreements with a number of cooperating agencies, supports projects that work to expand and improve urban family planning services:

- The Population Council has conducted situational analyses in family planning clinics in several African countries and are eager to have this assessment framework expanded and applied to a variety of settings for multiple purposes.
- John Snow Incorporated manages the SEATS Project which currently works throughout Africa to develop innovative approaches to large scale family planning program expansion. Technical staff are based in two regional offices – Harare and Dakar.
- Pathfinder activities include supporting community-based distribution programs, professional and para-professional training, clinical services, and institutional development efforts.

H. INTEGRATED AND VERTICAL FAMILY PLANNING PROGRAM APPROACHES

Linkages to the objective tree

Assessing the effects of program structure on program performance could have an impact on two population targets: improving family planning service delivery and increasing demand generation.

Regional Significance

Analyzing the performance of vertically organized family planning service delivery systems with that of integrated or various linked alternative networks is important for the subregion. Currently, experience with different kinds of delivery systems is new and relatively limited. If one approach or combination proves to be markedly superior in terms of service outputs, utilization, and cost-effectiveness, then this approach should be considered when new family planning programs are created or old ones expanded. Selecting the appropriate system is particularly relevant in designing delivery strategies for urban and rural settings or for countries with low-to-moderate levels of family planning demand, where population density and existing demand could significantly influence the cost-effectiveness of a delivery approach.

USAID/Africa Bureau's Comparative Advantage

USAID's experience in designing and implementing vertical and integrated program structures in a variety of settings (public/private, low vs. moderate demand, etc.) provides an excellent basis for a more rigorous analysis. Assessing the relative contributions of different program components will help establish a rationale for African program design based on not only how integration in program structure and operations affects performance, but which components are important and under what conditions.

Complementarity with Ongoing USAID Programs and the Activities of Other Donors/Institutions

- The Futures Group recently compiled a summary of family planning program structures with examples from each region.
- IPPF has extensive experience in using the "stand-alone" family planning clinic model associated with their private sector Family Planning Affiliates in several sub-Saharan Africa countries.

VI. FRAMEWORK RATIONALE: INFORMATION NEEDS AND GAPS

For the purposes of this framework, information needs and gaps are grouped into one of three broad categories:

- A. **Policy** — Which policies are most important in addressing population issues and reaching family planning service objectives in Africa? How can existing policies be improved? What are the necessary steps for turning population policies into concerted actions?
- B. **Demand for and Supply of Services** — How can services be delivered and expanded to maximize efficiency, equity, and quality? Which factors influence behavior and practice, and what are the real constraints to change?
- C. **Costs and Financing** — How can governments meet the growing family planning demand when donor aid is likely to have difficulty keeping up with expanding services, and national budgets are under increasing stress? What are the best mechanisms for building consensus among policymakers regarding resource allocation issues?

A. Policy

This section focuses on two levels of policies that influence population growth and, specifically, family planning programs: (1) explicit national population policies; and (2) key sectoral-level policies. A national population policy is generally a statement or document by a national government announcing its intention or plan to affect the country's population growth and perhaps population distribution and/or composition (Isaacs, 1991). Although they may vary with respect to particular provisions, national policies usually contain a number of related elements including a rationale, goals and objectives, targets, program measures, and an outline of implementation and institutional arrangements.

Sectoral-level policies refer to sets of regulations or program protocols within one sector (e.g. health/family planning) that dictate courses of action for institutions and individuals. Throughout the issues identification process, experts underscored the importance of focusing on policies that directly affect access to reproductive health services. Although access can be hampered by a number of political, sociocultural, economic, religious, medical, or legal impediments, medical barriers were consistently ranked as one of the top five most important issues requiring attention. Therefore, most of the analysis presented in this section is focused on barriers with a medical rationale.

1. National Population Policies

At the Third African Population Conference in Dakar (1992), leaders from the African region gathered to assess the implementation of the Kilimanjaro Plan of Action –a product of the 1984 Arusha Conference. It was clear that the spirit of Arusha has carried through the last decade, helping to keep population issues and policies at the forefront of development concerns. In 1980, only nine countries had policies aimed at lowering fertility. Today, 33 sub-Saharan African countries believe their fertility rates are too high. Eighteen have formulated and officially adopted explicit national population policies. Many of the remaining countries have either begun policy formulation or stated their intentions to do so.

Conference participants agreed that that same spirit must now be harnessed to focus greater attention on the critical actions necessary for policy implementation. Despite the increasing number of explicit population policies, implementation has not evolved systematically. Most countries still indicate a pressing need for more data, and many problems persist in achieving desired program objectives. Frequently cited constraints include:

- a lack of quantifiable and realistic targets for resource planning;
- inadequate institutional infrastructure and coordinating mechanisms for implementing and monitoring policies and programs;
- weak political interest and commitment;
- low availability and use of reliable information for developing strategies;
- infrequent and low quality program evaluations;
- low levels of participation by communities and local managers in policy and program design; and
- lack of national, subregional, and regional focal points for the collation and dissemination of population information.

No one is sure of the amount of resources that has been and currently is being devoted to the establishment of population policies in sub-Saharan Africa. What is evident, however, is that UNFPA and USAID have spent more than a decade providing technical assistance and financial resources for the establishment of national population commissions, population planning units, and national population policies. These efforts have been supported by extensive documentation on the population policy formulation process.

Unfortunately, very little has been documented or disseminated regarding the essential actions necessary for policy implementation. The result is a dearth of knowledge about the steps beyond policy adoption. For example, in a recent national population policy implementation workshop held in Niger, the Director of the National Population Directorate was unaware of steps any other country had taken to develop action plans or to sustain interest in population issues at the national and subnational levels. This is particularly disturbing since countries like Ghana, Nigeria, Zaire, and the Zambia have extensive experience in consensus building and the development of implementation frameworks. A few countries have even managed to increase national resource allocations to family planning programs owing to the policy implementation process. These and other country examples need to be documented and communicated to policymakers throughout the region.

2. Sectoral Policies: Reducing Medical and Other Barriers to Family Planning Access

Medical barriers, which constitute a significant limitation to contraceptive access in Africa, are defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton, 1992). Major barriers include inappropriate eligibility criteria; process hurdles such as excessive laboratory testing; restrictions on who may provide contraceptives; provider bias; and lack of knowledge and counseling skills.

Currently, G/R&D/Pop, working with USAID missions, USAID/W Bureaus, cooperating agencies, and other international organizations, is spearheading a global effort to reduce medical barriers through organized educational events, the development of medical barriers guidelines, and country-level analyses. One activity was the development of a Medical Barrier Survey instrument. Surveys were sent to USAID Health and Population Officers requesting that they provide an initial assessment of the situation in-country and suggestions for specific actions. The results of these surveys and the experiences of other experts currently working in Africa indicate a number of areas where lack of appropriate scientific information and gaps in documentation are impeding progress.

One of the most critical needs is the updating of service delivery protocols. In the majority of countries surveyed, providers require unnecessary medical tests and overly rigid follow-up schedules. For example, unwarranted "contraindications" to use of hormonal methods may be based on studies of high dose estrogen oral contraceptives (OC), and may not be necessary for low dose OCs. For continuing OC users, most countries still require follow-up visits for resupply purposes on a quarterly basis. In Tanzania, only one cycle is provided during each resupply visit. Stringent protocols also prevent women of certain age, parity, marital status and spousal consent status from receiving contraceptive services, although there is no specific documentation indicating which criteria apply to each contraceptive method at the

country level. Unnecessary age and parity restrictions are frequently found throughout the region. In general, inappropriate client eligibility requirements discriminate against groups that already face significant health or economic risks associated with pregnancy, e.g. adolescents and unmarried women. Overall, the surveys found that public sector services are more restrictive in nature than NGO services.

Other key areas requiring analytic activities are as follows:

- **Improving service quality**

Many medical barriers are constructed around life situations, notably age, parity, and marital status. Some counseling experts believe that providers, who are accustomed to focusing on these concepts, should be encouraged to continue doing so but for an entirely different purpose. Traditionally, providers are trained to offer family planning services based on a contraceptive-oriented approach. However, studies in Latin America show that providers can significantly enhance the quality of services by using a situation-specific approach to contraceptive distribution. This approach focuses on the reproductive life cycle of a woman and takes into consideration a number of factors such as age, marital status, health status, and the advantages and disadvantages of various contraceptives given a woman's particular life situation.

- **Fostering policy and program level change**

Currently, **no comprehensive documentation** exists regarding country-specific practices that affect access to family planning. The Medical Barriers Survey was meant to gather an initial range of opinions offered by regional counterparts. Although an important first step, it is not a comprehensive assessment at the country-level. Moreover, to encourage medical professionals and leaders to advocate change at the policy and service delivery levels, more efforts need to be directed at documenting the positive outcomes resulting from the reduction of medical barriers. The wide dissemination and discussion of lessons learned could play an important role in fostering commitment to change.

- **Strategic approaches to reducing barriers**

Once a needs assessment is completed, a systematic, integrated strategy for each country should be developed. According to one African family planning manager, " we need an affirmative program for what is an acceptable level of quality care [so that we can] then focus on removing barriers which clearly impede this program. Otherwise, we risk a piecemeal approach." Experiences from other regions indicate that organized educational events, such as regional workshops, can help initiate strategic planning processes.

B. Demand for and Supply of Services

Over the last decade, researchers have conducted a large number of studies and surveys focusing on service provision and demand generation. The HHRAA Project undertook an extensive literature review of key population/family planning topics in this category to determine the availability of information, as well as the gaps. The topics were also reviewed by staff from various donors, cooperating agencies, and African institutions who have experience in these areas. The issues addressed in this section do not represent an exhaustive description of all potential research, analysis, and dissemination needs, but rather those that are most frequently cited as priority issues for sub-Saharan Africa.

1. Adolescent Reproductive Health

There is growing concern about the reproductive health problems facing adolescents in sub-Saharan Africa. At the 1992 African Population Conference, the majority of country delegates expressed the need to focus on youth and to establish or expand adolescent and youth programs. Problems most frequently cited are both social and medical: the breakdown of traditional support structures, an early active sexual life, inadequate knowledge of reproductive biology, and limited awareness of and access to reproductive health services.

Owing to the Demographic and Health Surveys (DHS), we now have an unprecedented body of data documenting adolescent sexuality throughout the region. DHS data show that in the vast majority of countries surveyed, at least one out of every five young women, ages 15-19, had one child or more, or was currently pregnant at the time of the interview (PRB, 1992). Liberia, Mali, and Uganda are at the high end: in these countries, 45, 51, and 37 percent of teenage women had given birth or were pregnant at the time of the survey. Unmet need for family planning among currently married adolescents ranges from 16 percent in Nigeria to 48 percent in Ghana, with the need in most countries falling above 30 percent. In Botswana, Ghana, Kenya, and Zimbabwe, more than half of the unmarried, sexually experienced teenagers can be defined as having an unmet need for family planning.

Unwanted adolescent pregnancies often lead to unsafe, induced abortions (see page 30). Studies in Kenya, Mali, Nigeria, and Zaire have indicated that between 38 and 68 percent of women hospitalized for induced abortions are aged 19 or less (International Center for Research on Women, 1989). In a survey of young, unmarried Ibadan women, nearly all who became pregnant underwent voluntary, induced abortions. Among these women, only half were using contraception when they were subsequently surveyed.

In addition to DHS, which include some knowledge, attitude and behavior questions, an estimated 10 sub-Saharan countries have conducted special KAP

surveys for adolescents and youth. In general, attitudes vary widely and surveys often indicate a gap between knowledge and behavior. Despite widespread knowledge, only a small proportion of adolescents report ever having used a modern contraceptive. Many youth find it difficult or uncomfortable to talk about sexuality with their parents, family members, or other adults in general. Often the main sources of information are peers and the media.

What is needed now are wider, deliberate actions to address the issues, however complicated and politically sensitive they may be. Key information gaps and needed program actions are summarized below:

- **Increased understanding of adolescent knowledge, perceptions and behavior**

Few of the existing KAP studies include questions on STD/HIV/AIDS knowledge, perceptions or behaviors. Moreover, the existing DHS data on adolescents do not include data on males, and several country surveys include only limited data on unmarried adolescents and youth. Thus, there is a need to obtain data on adolescents and young adults – both male and female, married and unmarried – that more accurately reflect the range of issues that programs must address in responding to the needs of these target groups. One example of an excellent, comprehensive survey designed uniquely for adolescents and youth is the Young Adult Reproductive Health Surveys. These surveys have been conducted since 1985 by family planning and youth organizations in Latin America, with technical assistance and coordination provided by the Division of Reproductive Health of the Centers for Disease Control. They focus on a wide range of reproductive health issues and represent an excellent tool for potential application in the Africa region.

- **Identification of impediments to serving youth**

In addition to gaining a better perspective on adolescent perceptions and needs, planners are beginning to look beyond youth to identify impediments to program implementation. Many African family planning experts now believe that the next step to gaining acceptance of adolescent programs is to explore attitudes of parents, church leaders, service providers, and teachers toward sexuality education and reproductive health services. To date, there is very little documentation on how the roles, attitudes and behavior of these target group members impact on adolescent programs and contraceptive access in Africa.

- **Documentation and dissemination of successful programs**

Programs focusing on adolescent reproductive health are fairly new in Africa; most are less than 10 years old. Nonetheless, there are a number of innovative and apparently successful programs in existence, most notably in Nigeria, Sierra Leone,

Tanzania, Kenya, and Ethiopia (Barker, 1992). Since these experiences have not been sufficiently documented and disseminated, it would be valuable to take a comprehensive look with the aim of better understanding the context and the "recipe" for their success, and to identify potential models for replication or future operations research studies.

- **Widening the range of youth interventions**

According to a 1985 CPO survey, youth programs leaned toward multi-service centers and peer outreach, with 19 of 36 programs reporting that they promoted peer education. A survey taken in 1991 found that about half of programs in Latin America and Asia featured peer education, and an estimated 13 percent promoted peer distribution of contraceptives. Moreover, many countries are becoming more creative in designing programs to reach youth. Nearly all emphasize the fact that youth are best reached where they already congregate: in schools; on the street, in universities, in youth clubs, or at work-sites. Operations research is needed to investigate strategies for effectively reaching a variety of target audiences in this age group: hard-to-reach out-of-school, school leavers, and street youth; rural vs. urban youth; males vs. females; and youth from different socioeconomic backgrounds.

- **Improving the delivery of sex/fertility education**

Family life education (FLE) programs have become the *sina qua non* for addressing adolescent problems in the region. Unfortunately, the content and methodologies used vary significantly. An International Center on Adolescent and Fertility Survey found that many FLE programs focus more on population education than on issues relating directly to family planning and sexuality (Barker, 1990). Given the heavy reliance on FLE as a source of information for African youth and the shortcomings expressed, efforts should be initiated to experiment with a broader range of activities and to consider more innovative presentations. For example, in Latin America, programs are moving toward experiential educational methods and away from didactic teaching methods. Programs in Asia tend to rely more on IEC materials, mass media, and libraries for passing information to teens instead of the classroom setting. Reaching youth on their own turf by peers may be the most effective way to encourage teens to adopt responsible behavior.

- **Increased advocacy efforts regarding adolescent fertility**

Today, many countries have a strong, vocal and well-funded organized opposition to family planning for adolescents. Efforts to organize effective advocacy groups have not been as successful. Given communication difficulties in Africa, service providers and researchers throughout the region often work in isolation rather than joining forces. Support is needed to promote the establishment of networks and joint advocacy organizations comprised of professionals, family planning leaders, and

donors. This effort could include research into different advocacy strategies, organizational models, and dissemination mechanisms to be used at regional and subregional levels. Advocacy efforts could be further strengthened by research showing the cost to African governments of the common sequence of school expulsion of pregnant schoolgirls, early childbearing, high parity and subsequent maternal and child health problems (burden of illness), long-term productivity loss, and costs associated with abortion-related morbidity and mortality.

2. Gender Issues in Family Planning

Traditionally, family planning programs in Africa have largely targeted women. With the current interest in exploring male attitudes, needs, and concerns, and the expansion of delivery approaches (employment-based distribution, contraceptive social marketing) that have a greater potential for reaching men, the emphasis appears to be changing. However, African experts caution against the inherent risks of reversing the focus and failing to recognize the importance of addressing the underlying, and often more critical, gender issues that influence family planning practices, such as the sociocultural environments that dictate gender behavior and couple interactions.

Currently, there are representative studies of adult men available from 13 sub-Saharan countries. Key findings are that men are usually in favor of family planning, desire more information, are frequently unaware of how to obtain services, and rarely discuss family planning with their partners. APAC has also recently conducted research through the group's Agenda for Action initiatives. These studies reveal that men are generally more interested in the relationship between family size and socioeconomic issues such as educational opportunities and jobs for their children, than in health issues. Men perceive health issues as women's concerns.

Based on limited program experience in Africa to date, four strategies have the potential to promote greater male involvement in family planning: (1) subsidized retail sales; (2) work-site programs; (3) mass media campaigns directed specifically at males; and (4) community-based male distributors. However, few male programs have been systematically evaluated to determine their impact, and little is known about the relative cost-effectiveness of alternative interventions.

According to the literature review and discussions with key African family planning informants, more research and analysis is needed to understand the male/female dynamics of decision-making and the kinds of male involvement that would result in the greatest benefits, e.g. increasing the availability of male methods, expanding the number of sites where men can receive counseling and services, promoting joint decision-making. Would greater male involvement yield a significant payoff in increased contraceptive prevalence as opposed to targeting females or couples?

Another crucial factor influencing family planning practices in Africa for which little is known is the African male proclivity to have multiple partners. Research is needed to examine the underlying cultural and social factors that dictate male behavior. Knowledge gaps also exist regarding the reasons some men feel responsible for family planning while other men don't, and the attitudes and practices of men who have relationships outside of marriage.

Furthermore, little attention has been directed to the social underpinnings of lineage systems and the various cultural associations that affect family size. Gaining a stronger understanding of the institutions that govern high fertility norms may be important in understanding decision-making processes and in developing more effective and responsive programs. These assessments should also include an examination of the roles of traditional leaders and opinionmakers, and should identify mechanisms for mobilizing traditional channels for disseminating information.

3. Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs

For many years there has been considerable discussion and literature devoted to prospects for integrating family planning efforts into programs for the prevention and control of reproductive tract infections (RTIs)¹, including AIDS. The debate has often proceeded on ideological grounds, and has been marked with a paucity of data reflecting actual experiences of field-based programs. Furthermore, focusing on how existing vertical programs for family planning and STD control can be formally integrated is often a "non-starter" because of the enormous difficulties encountered in Africa in combining budgets and bureaucracies (Elias,1993). In many countries, these two programs fall under different lines of administrative authority.

One approach is to simply respond to the problems of reproductive tract infections within the context of existing family planning programs. RTIs are of primary concern to family planning providers, as these infections influence the safety and quality of services, the prevalence of infertility, the demand for fertility regulation, and the utilization of contraceptive methods. Therefore, the key research and analysis questions should not focus on how to integrate two separate government departments, but rather how to expand existing family planning services to more adequately meet the reproductive health needs of the clients (Elias, 1993).

¹ Reproductive Tract Infections are of three general types: sexually-transmitted diseases, endogenous infections caused by overgrowth of organisms normally present; and iatrogenic infections that are associated with medical procedures.

The extremely scant literature on incorporating RTIs, STDs, or AIDS efforts into family planning programs in Africa reflects not so much a lack of experience as a lack of effort to date to examine experiences, constraints, and impacts of integrated activities. For example, an estimated 22 sub-Saharan countries have established condom social marketing programs that effectively integrate family planning and STD prevention activities. JHPIEGO, in collaboration with the World Health Organization (WHO), has worked to adapt simplified problem-oriented approaches to managing sexually transmitted genital tract infections for primary, secondary and tertiary levels in several African countries. The Population Council OR/TA Project has completed projects dealing with diagnostic studies or technical assistance related to STDs or AIDS – notably in Burkina Faso, Gambia, Nigeria, Senegal and Zambia (Population Council OR Conference, October, 1993).

Given that literature reviews revealed very few case study examples, there appears to be a need for a "census" assessment of integrated programs that highlights lessons learned. This assessment could include examples outside of the region as well. The Population Council has demonstrated through operations research projects in Latin America that AIDS prevention activities could be successfully incorporated into the services offered by national family planning programs. A lessons-learned summary could also allay some of the concerns listed below that have been identified by family planning program managers, policymakers, and donors in Africa:

- attention to STDs and AIDS will stigmatize family planning and harm program performance;
- comprehensive reproductive health services are simply too expensive to even consider in resource-poor environments;
- family planning services are already overburdened and cannot accommodate expanded service obligations; and
- family planning clients are healthy people who will not appreciate being asked about or screened for diseases, such as STDs or AIDS (Elias, 1993).

The large number of vertical, donor-driven programs, each with specific objectives and funding mechanisms, constitutes a major impediment to program integration. There is a need to prepare guidelines to clarify how donor organizations can coordinate family planning and STD/HIV/AIDS programs within the context of funding, strategic prioritization, management considerations, and limitations of present cost-effectiveness studies (Bair, 1993). According to discussions and the literature, one critical area requiring additional research and analysis is the development of methods for measuring program success. What would constitute effective

performance indicators for integrated programs? The reliance on current indicators such as "births averted" and "couple years of protection" does not adequately capture other important dimensions in the broader reproductive health area, e.g. client satisfaction, STD prevention (Shelton, 1993).

Information is also needed regarding the costs associated with different service delivery approaches. Little is known about the relative cost-effectiveness of vertical vs. integrated approaches, the costs of providing condoms for the primary prevention of RTIs, or how the inclusion of screening and referral for RTIs affect cost. Operations research projects to determine the cost-effectiveness of syndromic management of RTIs (the stratagem of diagnosis and treating clients on the basis of groups of symptoms rather than specific laboratory diagnoses – especially in women) would be very useful in designing service delivery strategies. Syndromic validation studies are already in progress by the AIDSCAP Project (in Tanzania, Malawi and Mali) and more studies are planned. WHO is also planning to compare the cost-effectiveness of syndromic diagnosis with laboratory and clinical diagnosis.

A final important area of research for Africa concerns the feasibility of clients adopting and using dual protection – condoms to prevent infection plus a "more effective" contraceptive method to prevent unwanted pregnancy. No documentation is available on the implications of this strategy in terms of counseling, acceptability, compliance, or effectiveness. Similarly, more research is needed to explore the dimensions of acceptability and efficacy of female-controlled contraceptive methods to prevent RTIs, such as the female condom and a variety of vaginal spermicides. A related issue involves determining how existing family planning services can more effectively promote condoms for the primary prevention of RTIs – especially among men and youth. Given the number of condom social marketing projects in Africa, at least some answers to this question may exist, but data have not been analyzed or adequately disseminated.

4. Post-Abortion Management and Family Planning Service Provision

The World Health Organization estimates that 99 percent of the 500,000 maternal deaths that occur worldwide annually take place in developing countries; of these, an estimated 200,000 result from complications of illegal abortions performed by unqualified practitioners. In Africa, complications of unsafe abortion may be responsible for as much as 50 percent of maternal deaths.

Since abortion is a leading cause of disease and death among women of reproductive age in Africa, post-abortion management, counseling, and family planning service provision is a high-impact, focus area of concern. Evidence indicates that, in general, the potential target group – women who have had abortions – is not receiving effective contraceptive information or post-abortion family planning services.

Studies in Ghana revealed that 60 to 80 percent of minor operations performed at Korle–Bu Teaching Hospital were to treat abortion complications (Ladipo, 1989). Among women giving birth at this hospital, 25 percent reported at least one induced abortion prior to the current hospitalization; the incidence was even higher among women with only one previous pregnancy (Lamptey, 1985). These results indicate that induced abortion is often used to delay a first birth. Unfortunately, adolescents are increasingly becoming disproportionately represented among women seeking abortions. Data from 13 countries show that girls aged 11 to 19 represented between 39 and 72 percent of all hospital admissions for abortion–related complications (IPPF, 1993). It has been widely recognized that the old tradition of family based education – grandmothers talking about sex and reproduction with young girls in the family – has broken down. In most cases, parents and teachers have failed to fill this knowledge gap.

Research on the topic has been rather limited due to a reliance on hospital records and/or interviews with hospital patients. These data provide limited information on the epidemiology or incidence of abortion outside of those seeking treatment. Another gap observed in the literature is the relatively small number of recent publications. Following the Mexico City Population Conference in 1984, where a U.S. policy barring assistance to groups providing any type of abortion–related services was announced, the number of published studies dropped dramatically.

There are, however, several African countries where medical personnel have continued to gather data and have a significant amount of experience and knowledge on abortion–related mortality and morbidity (Ghana, Kenya, Nigeria, Tanzania, Zimbabwe). Much of this information has not been captured in existing data banks.

Abortion is an acute public–health problem in sub–Saharan Africa that absorbs a large share of medical resources. There is an urgent need for information concerning all aspects of abortion–related issues: both primary data collection and secondary data analysis of the magnitude of the problem; costs associated with treatment of abortion complications; post–abortion care and management needs; experiences with the provision of post–abortion family planning services; and information relating to the cultural and socioeconomic dimensions of individual abortion behavior.

5. Accelerating Urban Family Planning Programs

Africa needs more highly visible family planning successes beyond Botswana, Kenya, and Zimbabwe. The Population Council recently conducted family planning clinic situational analyses in several sub–Saharan countries including Kenya, Tanzania, Zimbabwe, Nigeria and Zaire. The analyses revealed that an estimated 15 percent of service delivery points provide 40 percent of services; another 20 percent

provide 25 percent of services; and the remaining 65 percent provide 35 percent of services (Fisher, 1992). Increasing the productivity of clinics in the second highest 20 percent tier could prove to be a promising strategy. Preliminary analyses of potential causal factors from this study suggest that the more successful clinics are likely to have a larger proportion of staff trained in family planning, a wider array of available contraceptives (especially progesterone-only pills), IUD services, a clean examination area, and a source of potable water.

There were also a number of inconsistent findings among countries; for example, supervisory visits appear to be related to clinic productivity in Zimbabwe but not in Nigeria or Tanzania. In order to serve a larger number of family planning clients, more research is needed to identify the factors associated with success within a variety of environments.

Population experts contributed the following suggestions for conducting a comprehensive urban study:

- Identify countries where Population Council has already conducted situational analysis studies to explore the possibility of building off existing urban analyses.
- Investigate first-tier (high-impact) as well as second-tier facilities. The first tier could also be expanded in terms of numbers served or types of services offered, such as voluntary surgical contraception.
- Assess the location of clinics with regard to public and private services. Public facilities may be underutilized or unnecessary in wealthy neighborhoods.
- Examine both supply- and demand-side reasons for underutilization.
- Assess the role of public provider salaries.
- Investigate the relationship between unmet need and low urban contraceptive prevalence.

6. Integrated and Vertical Family Planning Program Approaches

Traditionally, family planning service delivery strategies have been categorized as either vertical or integrated structures. Debate in the past has centered on which approach is more effective. Vertical approaches were popular in the late 1960s and early 1970s when advocates of this structure felt that resources for family planning

programs should be channeled into single-purpose organizations and that family planning clients' needs would not be lost in broader programs. This structure was also considered most effective in densely settled areas, e.g., urban areas, where there was a strong pre-existing demand for family planning. Proponents of the vertical approach have been concerned that family planning might lose its identity, as well as earmarked funds, if services were incorporated into a broader program (Gillespie, 1985).

The concept of an integrated program structure may refer to either management or service delivery or both. Characteristically, vertical programs are managed by an institutional structure with a single purpose, in this case providing family planning. The services may be offered at a single-purpose site and/or by single-purpose workers. Integrated management structures, on the other hand, describe an administrative hierarchy that performs a variety of functions in various fields. Family planning offered with an integrated approach typically means that these services are combined with maternal and child health (MCH), broader primary health care, or often wider development activities such as education or agriculture.

By the mid-1970s, it became obvious that the vertical approach was not consistently suitable for all regions. The integrated structure solved the problem of duplication of efforts and allowed for the incorporation of family planning into existing management and health service networks. In addition, it helped to resolve friction between well-endowed family planning programs and the usually deprived, government-funded MCH programs. Integrated structures typically involve multiple institutions, inter-sectoral coordination, and joint use of resources. This approach proved to be more effective in low density populations where it is more cost-efficient to deliver a variety of services at the same time. Furthermore, integrated programs are often more appropriate among populations with a low demand for or knowledge of family planning. The integrated approach allows family planning to be introduced in the context of broader health or development services.

Although most of the literature categorizes all program approaches as one of these two structures, one approach particularly relevant to Africa, albeit not widely incorporated into the theory, is the linkaged structure (Ickis, 1987). Linkaged programs, which can be either vertical or integrated in nature, describe services that are delivered by employing pre-existing infrastructures in the program design. For example, community-based distribution projects take advantage of community networks and leaders; social marketing builds on the existing commercial market system in a community.

This background suggests that in order to optimally organize family planning services in Africa, one must explore the relative advantages and disadvantages of the different approaches within a given context. It also suggests that it would be equally useful to disaggregate the components of program structure, determine if each component is itself vertically organized or integrated, and assess its influence on

program outputs and service utilization. Additional information needs concerning program structure and performance include: assessing the degree of integration within each program component – particularly looking at variables of both organizational structure and operations; assessing the degree of component-specific integration and program outputs and service utilization; and examining the interaction between family planning demand, population density, and organizational program approach.

C. Costs and Financing

Family planning cost and financing issues are important in the African context. Justifications for focusing efforts in these areas include (1) stagnating or declining donor aid when demand is likely to grow; (2) avoiding the same problems encountered in the health sector where implementation of programs was impeded due to lack of adequate resources and understanding of cost and financial implications; and (3) developing the means to build consensus among policymakers regarding key resource allocation issues.

1. Cost Recovery

Cost recovery refers to charging users of a family planning service part or all of the costs associated with providing that service. Establishing cost recovery mechanisms requires a detailed knowledge of both the total costs associated with providing the service (including capital, operating, and indirect costs) and the range of prices that can be charged to the users of the service (what clients are able and willing to pay).

Cost recovery can simultaneously increase both efficiency and equity of service delivery in developing countries. But whether these benefits are manifested in family planning programs that institute user fees depends on the overall health financing context, the mix of public and private sector services, the characteristics and demand patterns of the population served, the clarity of objectives and the guidelines for use of revenue generated (Foreit, 1993; Day, 1993). As more African countries initiate national user fee strategies within their overall health care system, it will become increasingly important to examine the effects of user fees on family planning services in particular.

Although there are few examples of successful, broad-based community financing schemes, some innovative programs exist. Under the Bamako Initiative, several operations research studies were conducted to assess the potential for community financing of contraceptives. Currently, community financing projects are underway in Kenya, Cote d'Ivoire, and Cameroon.

Another means of recovering costs is through cross-subsidization – using funds generated from one service to cover part of the cost of another service. For example, in Colombia, a large family planning program (PROFAMILIA) raised about 30 percent of its income from fees for gynecological and urological services, treatment of infertility and sexually transmitted diseases, prenatal care, and general medical care. In Brazil, the private hospital Sofia Feldman pays part of family planning costs with revenues from laboratory analyses. In 1988, with support from the Enterprise Program, the hospital bought equipment to conduct parasitology studies, immunology analyses, and urinalyses. By mid-1989, laboratory revenues covered 45 percent of the hospital's family planning costs (Lande, 1991). More efforts are needed to assess the scope of cross-subsidization of services in Africa either by unit, service, level of income, or region. Family planning programs can draw from the wealth of research on cross-subsidization that has already been done in the health field. Producing an essay on cross-subsidization, similar to available user-fee manuals, would also be useful.

2. Public/Private Sector Collaboration

In sub-Saharan Africa, many questions exist regarding the role and functions of the private sector in family planning. There has been limited documentation of the scope, scale, location, and number of clients served through private services. The Health Financing and Sustainability Project is beginning to study these questions for health services and could include family planning services. In general, these studies look at for-profit and non-profit sectors, employer-based services, private insurance, and questions concerning public/private relationships (e.g. are private services being crowded out by subsidized public sector services)? The Futures Group, under the OPTIONS II Project, is examining laws, regulations, and operational policies which increase the cost of commodities, training and equipment to levels that make the cost of family planning services prohibitively expensive for private providers (Kenney, 1993). OPTIONS undertakes special studies to promote policies in favor of expanding private services. These studies include legal and regulatory analyses of the private sector, market segmentation surveys, and price sensitivity of demand analyses to project the potential impact of introducing new brands and products at a range of prices (Bennet, 1993).

Another important question is how to convince policymakers to provide subsidies and grants to non-governmental organizations (NGOs). This effort requires sensitizing policymakers to the benefits of shifting activities to the private sector. Target audiences should include Ministers of Finance and Plan, and not just representatives of Health and Family Planning Departments. Employer-based strategies, particularly the Enterprise and TIPPS Project experiences, should be widely disseminated. Moreover, with over 22 sub-Saharan African countries now implementing contraceptive social marketing programs, there is a need to analyze cost implications and to disseminate results (PSI and SOMARC).

3. Costing Methodologies

A critical problem in determining overall family planning costs is that many different methodologies are currently in use. Economists suggest selecting and supporting one methodology and disseminating it widely. An associated problem is the use of macro-level costing methodologies versus those used at the service delivery level. Information is needed to determine how well economic costs can be calculated at the local level.

Project designs should incorporate specific sections devoted to family planning costs. Programs should clearly define objectives at the onset and give an indication of where resources should flow and in what quantities. To assist with this exercise, more emphasis should be devoted to gathering and analyzing cost data from different countries at different levels of family planning program development. Cost data can then be plugged into existing models to improve planning processes. Currently, there are cost information gaps for a number of variables including different modes of service delivery, integrated vs. vertical settings, urban vs. rural, low vs. high income levels, and low vs. high contraceptive prevalence.

Project designs must also consider demand- as well as supply-side variables. How important are total private costs to individuals? Can they act as barriers? Before proposing specific delivery modes, such as community-based distribution, there is a need to study fixed clinic vs. CBD/mobile units or social marketing strategies to determine which has resulted in reduced private costs to users.

4. Resource Allocation, Use, and Management

Increasing numbers of African countries are working to decentralize health and family planning services. Thus, more emphasis should be placed on examining the impacts and benefits of decentralization, including the retention of user-fee revenues and the authority to allocate local-level resources.

Program managers also need to be reminded of the importance of costs and financing in determining long-term program success. Disseminating financial management tools (manuals, handbooks) to program managers, and involving them in the budgeting process, may help raise awareness and interest in family planning resource management.

D. Cross-Cutting Issues

The following issues cross-cut several sectors, but are included for consideration under this framework because they contain elements that are important

for achieving population and family planning objectives: (1) program decentralization; and (2) assessing manpower deficits.

1. Decentralization

Decentralization in the African context has been defined as "a transfer of decision-making and executive power from the central level to the local or peripheral level, with the central level maintaining a guiding role" (Vriesendorp, 1992). This transfer results in total autonomy. In this system, the central body does not concentrate on the process, but on what the local level must produce. In order to function independently, the decentralized unit must become a legal entity.

The essential goal of decentralization is to streamline the tasks involved in serving the needs of the client population. Commonly stated prerequisites for decentralized management include the political will to decentralize, competent personnel at all levels, implementing mechanisms, a legal-administrative framework, resources, and the involvement of local leaders. Advantages of decentralization include the following:

- enhanced satisfaction of the population's needs
- increased accountability of personnel
- improved resource management
- efficient resource distribution
- rapid decision making closer to the level of implementation
- reduction of central level's workload
- improved integration of activities
- program expansion and sustainability

Currently, decentralization is a priority issue in most sub-Saharan African countries. Since total decentralization is difficult to accomplish, some countries are beginning through deconcentration – the partial transfer of decision-making and executive power, which results in conditional autonomy. Family planning experts believe that family planning could be the motor that drives changes in the current management systems, particularly in the health sector. For example, action plans in a number of countries include activities designed to decentralize selected activities: in Rwanda, 50 percent of the training program has been decentralized; Togo has adopted a decentralized management system with seven branch offices; and Morocco

is in the process of decentralizing supervision with the establishment of integrated teams at the regional and provincial levels (Vriesendorp, 1992).

More support is needed to document, monitor, and disseminate the implications and consequences of decentralization within family planning programs. In the larger context of national decentralization efforts, are there lessons in family planning programs that could be generalized to other sectors? Are there experiences in other ministries/sectors that could be useful for population programs? Since decentralization affects several management areas, most notably human and material resources, finances, data use, and organizational structures, are there overlapping program elements where intra- or intersectoral efforts could be initiated?

2. Human Resources: Assessing Manpower Deficits

Recent interviews during visits to Botswana, Malawi, Uganda, and Zambia, and discussions with USAID staff from Zimbabwe have highlighted the issue of a severe physician shortage. Over the past few years, this situation has been exacerbated as more and more physicians migrate to South Africa where salaries and professional opportunities are strikingly better. Illustrative of this shortage is the fact that in Malawi, all or almost all of the approximately 20 medical officers are expatriates. Comparable evidence exists in Botswana where expatriate district medical officers are the norm, not the exception. In Zambia, public sector clinics frequently function without physicians.

There is no short-term solution to correcting this shortage of physicians. If it is ever resolved, it will only occur after training sufficient numbers of physicians to saturate the market, and the currently attractive alternative of migration no longer exists. In the meantime, however, governments need to consider alternative health manpower strategies to ensure continuing access to quality primary health care services. One alternative is to adjust current policies, as well as pre- and in-service training curricula, so that nurses and paraprofessionals can assume more of the responsibilities currently carried out by physicians.

Information gaps and needs in this critical area include (1) documenting the extent of the physician shortage and its impact on health care; (2) determining what changes in policies, regulations, and practices would have to be instituted to fully implement a "nurse-based" health delivery system; and (3) promoting advocacy efforts to remove potential barriers. Examples of overcoming barriers include authorizing non-physicians to carry out certain procedures and prescribe medications, allowing nurses to insert IUDs and NORPLANT or provide injectable contraceptives, and permitting non-physicians to occupy management positions at all levels of the health care system.

VII. POTENTIAL APPROACHES TO ADDRESS PRIORITY NEEDS

Based on USAID/W's population and family planning focus, relevant literature reviews, priorities specified by African and international experts, and issues identified by participants at various workshops and recent conferences, the following activities are presented as potential approaches to address the needs and information gaps listed in the previous sections.

A. Adolescent Reproductive Health

- Conduct additional studies to assess the attitudes, knowledge and practices of both married and unmarried, male and female adolescents and youth in the areas of sexuality and reproductive health needs, including STD/HIV/AIDS information and services. Studies could be conducted with the assistance of CDC, utilizing the Young Adult Reproductive Health Surveys.
- Identify impediments to the establishment and expansion of programs by assessing the attitudes of parents, church leaders, service providers, and teachers toward sexuality, education, and reproductive health services for youth.
- Document, analyze and disseminate successful adolescent/youth programs to develop a better understanding of "recipes" for success and to share lessons learned.
- Conduct operations research projects aimed at identifying different approaches to reaching youth (e.g. out-of-school programs; in-school programs; social marketing; media).
- Support the development and utilization of an Adolescent Advocacy Training Module designed to help program managers and interested advocates "sell their issues" to policy audiences and the media. The Center for Population Options (CPO) is in the early stages of designing the module in collaboration with members of the Nairobi Centre for Adolescents.
- The Center for Population Options has a generic set of Family Life Education modules which they have adapted to a variety of settings and target audiences (e.g.in-school youth, out-of-school youth) in Latin America. These modules could be tested and culturally adapted within the African context.

- Support networks and joint advocacy groups by implementing conferences and workshops that provide forums for the presentation of research and analysis results, and the promotion of region-wide strategies for affecting policies and programs. CPO is requesting assistance in supporting the African Association for the Promotion of Adolescent Health – a network comprised of leaders devoted to the establishment and expansion of adolescent programs. Activities could include the following: (1) support for the reproduction and dissemination of a videotape produced during the First Inter-Africa Conference on Adolescent Health (Nairobi, March 1992); (2) assistance with the organization of a regional steering committee meeting; (3) support for regional or subregional adolescent conferences.
- Examine national costs associated with (1) adolescent abortion-related mortality; (2) the sequence of early school dropout due to pregnancy, early childbearing, high parity, and subsequent maternal and child health problems; (3) loss of productivity; and (4) the burden of illness. Disseminate these data to high-level policymakers, community leaders, donors, and representatives of advocacy networks.

B. Reducing Medical and Other Barriers to Family Planning Access

- Assist with conducting country-level assessments (situational analyses; review of current guidelines) and develop a typology of barriers by country (de facto and de jure). Assessments can be carried out in conjunction with subregional medical barriers conferences (JHPIEGO, FHI, INTRAH) and disseminated to policymakers, medical association leaders, family planning trainers, program planners, and donors. Final document could also include case studies (see below).
- Document and disseminate case studies that depict positive changes resulting from the reduction of medical barriers. Studies should highlight improvements in service quality and client satisfaction.
- Support workshops and conferences that provide scientific information, promote exchange, foster ownership, and encourage the development of systematic, integrated action plans. Follow-up on conferences to assess country-specific program impacts. Activities should be carried out through the R&D/POP working group responsible for Organized Education Events.
- Develop situation-specific decision trees to improve provider counseling and quality of care:

- Develop family planning algorithms for doctors and nurses based on client-oriented, rather than commodity-oriented, approaches.
- Field test prototype manual.
- Produce and distribute pocket-size algorithms for providers

JHPIEGO is currently implementing this activity in Latin America and could assist in developing similar algorithms within the African context.

- Document the extent of the physician shortage and its consequences. Examine alternative health manpower models focusing on nurses and paraprofessionals, and outline a strategic approach for executing policy and curricula changes, which will permit maximum use of nurses, midwives, paraprofessionals and auxiliary workers.

C. Gender Issues in Family Planning

- Conduct impact assessments on existing projects and programs that target male involvement.
- Analyze existing studies and conduct additional research as necessary to identify sociocultural factors influencing gender behavior, couple interactions, and decision-making processes. Apply findings to IE&C and service delivery approaches.
- Conduct a secondary analysis on KAP-related variables for husbands and wives for those surveys carried out during the DHS-I and DHS-II in which couple records can be linked. Prepare and disseminate a comparative study of husband and wife attitudes under the DHS Comparative Working Paper Series.
- Support local costs and provide technical assistance to in-country DHS teams to conduct a more detailed analysis of DHS III male modules. This activity would use the new model developed by Macro designed to assist local researchers in further analysis of male survey data. Training and analysis could be implemented through subregional research institutions like CERPOD.
- Support operations research projects to identify (a) payoffs of investing in activities targeting males versus females or couples; (b) types of male involvement approaches that are the most effective: male method promotion versus couple (spousal) communication promotion, etc.; and

(c) the most effective delivery sites for men, e.g. work sites, men's groups, traditional and nontraditional commercial outlets.

D. Strengthening Reproductive Health Services: Integrating FP and STD/HIV/AIDS Programs

- Conduct an assessment of existing integrated family planning and STD/HIV/AIDS programs in Africa with examples from other regions, highlighting experiences, impacts and lessons learned. Prepare a summary booklet for African policymakers, family planning managers, and donors.
- Support workshops/seminars designed to examine donor implications regarding the integration of family planning and STD programs. One potential forum might be the annual USAID/W conference sponsored by the Africa Bureau (last year's topic: Population and the Environment). The workshops should address the following questions:
 - How can donors overcome population vs. health polarity regarding funding sources and objectives?
 - What would be the program performance indicators of an integrated program? What are the trade-offs between family planning and health objectives?
 - What major criteria should be used in determining relative funding levels among elements of a comprehensive reproductive health program?
- Support analytic activities and research efforts to determine the costs associated with different service delivery approaches – integrated versus vertical, primary RTI prevention, and RTI screening and referral. Examine the cost-effectiveness of various integrated service models, and syndromic diagnosis of RTIs versus laboratory diagnosis.
- Assist with studies to determine the feasibility of "dual protection" among family planning clients. These studies should address the implications of this strategy in terms of counseling, acceptability, compliance, and measurements of effectiveness. This effort could also involve studies to learn more about female-controlled methods and their acceptability and efficacy in preventing RTIs – such as the female condom and various vaginal spermicides.

E. Post Abortion Management and Family Planning Service Provision

- Conduct secondary analysis of existing data, and primary research in selected countries related to the number of incomplete abortions (urban, periurban, rural); post-abortion family planning services; costs related to abortion morbidity and mortality with a special emphasis on adolescents and youth; attitudes and perceptions from both health care providers and clients; and policy and program implications. Research and analytic activities should be carried out in both Anglophone and Francophone Africa.
- Prepare technical reports and policy booklets designed for African policymakers, family planning managers, health providers and donors. Consider producing a computerized, storyboard presentation of the morbidity and mortality data; cost data, impacts and policy implications. This type of presentation would benefit from The Futures Group experience in RAPID-type computer models.
- Examine the sociocultural dimensions related to abortion behavior. Questions requiring additional study include the following:
 - How does a woman make the decision to end her pregnancy? What and who (enablers) influences her?
 - Are women who turn to abortion former users of contraceptive? If yes – why did they discontinue contraceptive use?
 - What do women know about the potential health and psychological risks associated with abortion?
 - What could have helped prevent an unwanted pregnancy? Are women aware of alternatives to abortion? What are the barriers to obtaining contraceptive information and services?

The results of this type of data collection could be used to develop more appropriate education, counseling, and family planning programs for this important target group.

F. National Population Policies

- Support seminars aimed at (1) reviewing experiences to date regarding national population policy implementation, (2) developing more comprehensive strategic planning approaches, and (3) disseminating existing "instruments" and computer models that can be used for data collection and analysis and for integrating population data into development plans. CERPOD is planning to facilitate a Francophone seminar in FY94. The Futures Group is prepared to provide technical assistance and partial seminar funding.

G. Accelerating Urban Family Planning Programs

- Conduct an assessment of 4–6 urban family planning service delivery programs to determine their: (1) adequacy in terms of coverage and capacity to meet demand; (2) absorptive capacity; (3) reasons for success with regard to contraceptive prevalence; and (4) quality of services provided (e.g. are they offering a full spectrum of contraceptive technologies and appropriate client counseling?)

H. Vertical and Integrated Family Planning Approaches

- Compare the performance of vertically organized family planning delivery systems with integrated approaches within a variety of environmental contexts (e.g. low demand vs. high demand, low vs. high population densities).

I. Cost Recovery

- Assess the scope for community financing of contraceptives by analyzing projects carried out under the Bamako Initiative.
- Assess the scope for cross-subsidization of family planning services either by region, income, or type of service. Produce a handbook for family planning managers similar to the recent manual produced by John Snow, Inc. on user-fees.
- Study the influences of prices on contraceptive utilization within different modes of delivery.

J. Public/Private Collaboration

- Assess the scope, scale, and location of clients served by private providers.

- Sensitize policymakers to the benefits of subsidies to NGOs to expand service delivery.
- Analyze the lessons learned in social marketing public/private collaboration (e.g., PSI and SOMARC) and disseminate the results to a broad range of policymakers and opinion leaders.

K. Costing Methodologies

- Establish a standard definition and methodology for calculating the cost of providing family planning services, then promote it. One suggestion for a standard approach is a handbook currently being developed by Barbara Janowitz of Family Health International.
- Use this approach to carry out thorough costing exercises in several countries, which would include countries at different levels of family planning program development and with various delivery modes.
- Plug empirical cost data into existing models (e.g., Target-Cost) to improve the accuracy of strategic planning throughout the region.
- Assess and synthesize the existing cost-effectiveness literature, particularly to highlight the cost implications of (1) demedicalizing services; (2) integrated vs. vertical services; (3) different method mixes; and (4) urban vs. rural strategies.
- Help enhance policymakers' understanding of the importance of cost recovery as a means to expand access to low-cost, high-quality services.
- Sensitize policymakers to the importance of including costs in strategic planning, even in cases where most funds come from donors. Morocco is currently shifting contraceptive costs from donors to the government. Morocco's efforts provide an excellent case study.
- Develop a better understanding of the full range of costs to individuals of accessing family planning services; Information could be gathered through a special DHS module on private costs and household expenditures.
- Carry out a thorough cost comparison of family planning service delivery in the public and private sectors.

L. Decentralization

- Examine the benefits of decentralization, including retention of fee revenues and power to allocate resources.
- Support national decentralized data analysis and application. CERPOD is currently working on the development of a module designed to teach data management, analysis, and use to local-level statisticians.

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ANNEX

At the recent Population Council Operations Research End-of-Project Conference in Nairobi (October 4-7, 1993), HHRAA Project staff administered a questionnaire asking selected conference participants to rank order (1-10) the following potential research, analysis, and dissemination topics. The following results include a listing of the topics from most to least important, other topics suggested by the respondents, and additional comments.

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
<p>1. Adolescents and youth. Many African countries are expressing the need to establish or expand adolescent and youth programs. Examples of specific needs include expanding and improving Family Life Education (FLE) programs and exploring attitudes of adolescents, parents, service providers, and teachers towards sexuality and adolescent reproductive health services.</p>	<ul style="list-style-type: none"> ● Church leaders need to be addressed fast and foremost. ● Need to address service delivery needs of youth beyond FLE, and look beyond youth-only models which may not be sustainable. ● No donors want to help. ● Must look into peer group education strategies, too. ● What about improving girls' self esteem, empowering them so they can make informed choices about their sexuality and reproduction.
<p>2. Medical barriers to increased family planning acceptance. Barriers are practices that result in an unjustifiable impediment to, or denial of, contraception. Major barriers that continue to limit family planning expansion include unnecessary restrictions on eligibility criteria or on who can distribute contraceptives and perform procedures, quality of care issues, and lack of knowledge and counselling skills.</p>	<ul style="list-style-type: none"> ● Service provider skills and attitudes are coming out as important factors influencing acceptance and continuation. ● Some of the barriers are legal. The rules need to be changed. ● Need an affirmative program for what is an acceptable level of quality care: then focus on removing barriers which clearly impede this program. Otherwise, risk piecemeal approach. ● Include political and religious barriers - particularly for the benefit of adolescents.
<p>3. Male involvement in family planning. How can we better address male attitudes, needs, and concerns about family planning? Research and analysis activities could include increasing our understanding of male/female decision-making and determining what type of male involvement would result in the greatest benefits.</p>	<ul style="list-style-type: none"> ● General gender bias of FP programs should also be looked into. ● The current failure to reach and convert women is because of fear of men and failure to educate men to be involved in FP. ● More anthropology and ethnic skills are needed in this research area. ● Problem here is partly education and partly programmatic. ● What are the community factors that influence male dominance? ● FP information gap among males. Expand to include general gender issues.

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
<p>4. Integrating family planning and STD/HIV/AIDS programs. Currently, there are a number of projects within countries aimed at integrating services, although few integrated programs exist on a national level. How can we facilitate program integration and donor project coordination when it is appropriate?</p>	<ul style="list-style-type: none"> ● Note that ZNFPC in Zimbabwe is just beginning a national-level STD/FP integration program. ● The issue is not the integration of two programs, but making FP relevant to the sexual lives of people, their concerns and sexual interactions. This will impact safe sex and sexual health in general as well as covering gender issues. ● What about integrating FP with child care services as well? There are more natural links here! ● Add RTIs!
<p>5. Incomplete abortion management/post-abortion contraception. As a leading cause of disease and death among women of reproductive age in Africa, abortion and related services such as post-abortion management, counseling, and family planning are becoming focus areas of concern. Topics requiring further research, analysis, and dissemination include collecting data related to incomplete abortions; post-abortion services; costs related to abortion morbidity and mortality; and policy implications.</p>	<ul style="list-style-type: none"> ● Prevention of unwanted post-abortion pregnancy cannot be overemphasized. ● Policy issues are the most important concerning abortion. Unless governments facilitate access to safe abortion, it will cause great damage to FP programs in Africa. ● Abortion is a problem, but should be covered when barriers are removed. Post-abortion services are already available in many countries. ● Very important. What about caring for complications of incomplete abortion?
<p>6. Decentralization. Decentralization is a process in which the central level transfers decision-making authority to the local or peripheral level. The essential goal is to streamline the tasks involved in serving the needs of the client population. Since this process can affect several management elements, most notably human and material resources, finances, information, and organizational structures, what are the implications for family planning services? How can countries better serve dispersed populations?</p>	<ul style="list-style-type: none"> ● It's obvious that central authority is unable to manage development programs. Authority and resources should be decentralized. Field people must be empowered to carry out their activities. ● Need to help decentralized managers better analyze existing data. ● Delegating power in a paternalistic country is a very difficult (delicate) task that requires urgent attention from officials and African researchers.
<p>7. Strategic planning for family planning resources. Family planning programs should clearly define objectives at the outset and give an indication of where resources should flow and in what quantities. Existing models (for example, Target-Cost) could be tested for their usefulness for strategic planning.</p>	<ul style="list-style-type: none"> ● More needs to be done to tap local non-health resources, i.e., agriculture, livestock projects. ● So much of this has been done in Zimbabwe (for example) it's not a pressing area. ● Also a need to define boundaries of program activity. ● As much as possible, the outcomes should be impact rather than/not only process indicators. ● Models are not only useful for strategic planning but effectiveness or impact outcomes

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
<p>8. Contraceptive discontinuation. Discontinuation plays a significant role in the number of clients lost from family planning services each year. How can service providers help ensure client satisfaction and lower discontinuation rates? What is responsible for the wide gap between ever use and current use of contraceptives?</p>	<ul style="list-style-type: none"> ● This is a big problem with insufficient attention. ● Need update/refresher courses with emphasis on counselling skills. ● If proper counseling is done, this will not be an issue. ● To diminish discontinuation, need to improve management of side effects.
<p>9. Family planning program costing methodologies. An accurate assessment of the costs of different types of service delivery approaches in different settings (for example, private vs public) is crucial to designing an effective family planning program; yet there is no standardized, user-friendly costing methodology currently available. Such an approach could be developed and widely disseminated.</p>	<ul style="list-style-type: none"> ● There is too much stress on "costs" in Africa FP programs. ● Will this include cost-effectiveness? It should. ● Assess how fee-for-services is or is not a barrier to FP services in poor-income population groups. ● Zimbabwe is doing this now. I'm sure other African countries will follow suit soon. ● In most countries, the political arena needs to be looked at if this area is to succeed. ● In general, FP programs don't plan costs. This is the reason they are so unlikely to be sustainable
<p>10. Cost recovery. There are a variety of approaches that family planning organizations can use to recover some of their costs, many of which have been successfully used for health services. Research and analysis activities could be undertaken to study different approaches and to determine which would be most appropriate in different African settings.</p>	<ul style="list-style-type: none"> ● It's time countries begin to show FP is in relation to socioeconomic development. It should be paid for like other services, e.g. education, curative treatments, etc. ● Is cost-recovery the answer under high levels of poverty? The issue first is to provide acceptable FP, then people will "buy" it. Don't cost-recover what is embryonic because it may abort! ● The Bamako Initiative is a real strategy, presented within the context of community health. It is important to use this channel. ● I don't know of many successful health service cost-recovery efforts. ● Goes hand-in-hand with cost methodologies. How do you know how much you need to recover, if you don't know how much it costs in the first place?.
<p>11. Public and private sector collaboration. In Asia and Latin America, the private sector has played a pivotal, cost-effective role in family planning service delivery. An assessment could be undertaken to examine the potential for the private sector in Africa, and to identify ways in which private and governmental organizations could collaborate.</p>	

POTENTIAL RESEARCH, ANALYSIS, AND INFORMATION DISSEMINATION TOPICS	RESPONDENT COMMENTS
<p>12. Resource allocation, use and management: Many African countries are working to decentralize the delivery of health and family planning services. What are the effects of decentralization on the cost of family planning services, the retention of user-fee revenues, and on the authority to allocate resources?</p>	

Other topics listed by respondents in order of ranking:

- Community perspectives of the design and implementation of FP programs. (1)
- Does Non-Project Assistance (NPA) work? Several African countries receive NPA on population policy change. How does NPA affect policy, government financing, dependency on donors? What modalities and conditionalities do other donors use? (1)
- Problems of KAP/GAP. (2)
- Service delivery strategies, i.e. how to ensure service delivery availability to prospective users in a manner that is acceptable to the user. (3)
- Interaction between child survival, family planning, and safe motherhood. (4)
- Social, economic, and health benefits of family planning (with an emphasis on documenting and disseminating information). (5)
- Service Quality: Control of RTIs to assure women and protect them from existing and perceived health risks. (10)

Other non-ranked topics listed by respondents:

- Targeting the politicians to educate them on family planning issues, particularly relating to adolescents.
- Impact of social changes (democratization, decentralization, privatization, etc.) on FP programs.
- How to expand long-term/permanent methods?
- More qualitative studies on users, non-users, and potential users, beliefs, attitudes beyond knowledge and practices. What are people's concerns about FP and modern contraception?
- What parts of program failures are related to donor pressures and requirements for immediate outputs?
- Methods of training staff about sexuality, allowing them to review own attitudes and beliefs, and become comfortable in discussing sexuality.
- Strengthen CBD programs at the grass roots level.

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**STRATEGIC FRAMEWORK FOR RESEARCH, ANALYSIS, AND DISSEMINATION
FOR SAFE MOTHERHOOD AND REPRODUCTIVE HEALTH IN AFRICA.**

USAID/AFR/ARTS/HHR

**DRAFT
07/94**

TOURE-POST-DUALE.

TABLE OF CONTENTS:

- i EXECUTIVE SUMMARY
- ii LIST OF ABBREVIATIONS

- I. INTRODUCTION
 - 1.1 Background
 - 1.2 Purpose and objectives of the strategic framework
 - 1.3 Process of developing the strategic framework

- II. SUMMARY OF RESEARCH AND DISSEMINATION PRIORITIES

- III. REVIEW OF INFORMATION NEEDS AND GAPS
 - 3.1 Major reproductive health issues
 - 3.1.1. Pregnancy-related Mortality and Morbidity
 - 3.1.2. Unsafe Abortions
 - 3.1.3. HIV/AIDS
 - 3.1.4. Reproductive Tract Infections
 - 3.1.5. Maternal Nutrition
 - 3.2 Sociocultural and economic factors affecting women's health
 - 3.2.1. Adolescent Reproductive Health
 - 3.2.2. Unregulated reproductive patterns
 - 3.2.3. Female genital mutilation and other harmful practices
 - 3.2.4. Girls and women education

3.3 Organization and efficacy of interventions and services

3.3.1. Efficacy of reproductive health interventions

3.3.2. Expanding essential reproductive health services

3.3.3. Community participation

3.3.4. Monitoring and evaluation

IV. Research, Analysis, and Dissemination Approaches

V. References

i. EXECUTIVE SUMMARY

A woman's ill health not only affects her own opportunities and her potential for contribution towards development but those of her family, particularly her children. Thus, it is appropriate that policies and programs continue to place principal emphasis on pregnancy, childbirth and reproductive health in developing countries. Research, analysis, and information dissemination activities are needed to guide the development of strategies and programs, and the allocation of appropriate resources for safe motherhood and improved reproductive health in Africa. At the same time it should be recognized that these activities need to be increasingly complemented over the longer-term by efforts to improve women's health and status more broadly, particularly before pregnancy occurs.

The purpose of this strategic framework is to assist the Office of Analysis, Research, and Technical Support of the USAID's Bureau for Africa, under its Health and Human Resource Analysis for Africa (HHRAA) project identify key research, analysis and dissemination issues on safe motherhood and reproductive health in Africa.

The strategic framework draws from previous consultations with African program managers and researchers, a review of the literature, and the products of international bodies convened to set women's health agenda and research priorities. It assesses, analyzes and prioritizes the information gaps and needs on the following subjects:

I. INTRODUCTION

1.1 BACKGROUND

Since the 1960s, several initiatives have influenced women's health status in developing countries. First, the family planning movement, which increasingly expanded its focus from a demographic rationale to one based on providing women with reproductive choice and the ability to avoid unwanted and poorly timed pregnancies, as well as protection from sexually transmitted diseases. Over the last decade, the child survival program brought greater recognition of the significant impact of maternal health and nutritional status on infant outcome, reflected by the inclusion of maternal mortality goals at the World Summit for Children in 1990.

The Safe Motherhood Initiative, launched in Nairobi in 1987, focussed world attention on the magnitude of maternal mortality, morbidity, and disability in the developing countries and the inadequacy of related health care. It also emphasized measures to improve women's health status, access to family planning, and access to quality maternity care. A consensus was developed that programmatic emphasis on specific, integrated maternal health and nutrition measures, in addition to satisfying unmet demand for family planning, will have the greatest impact on reducing maternal mortality and should receive short-run priority.

Although increased attention has been paid to maternal health since the Initiative, the transition from advocacy to implementation has been a slow one and a great deal more still needs to be done. Women's health should be recognized as an important health sector priority in its own right. This is due to a number of factors. First is the knowledge that 500,000 women die each year from pregnancy-related causes and some eight million suffer serious complications--mortality and morbidity that are largely preventable and/or manageable. This high toll of death and disability reflects the failure of health programs to meet the needs of the over one billion women of reproductive age in the developing world. Second is the growing recognition of both the social and economic dimensions of women's contribution to development.

A significant obstacle that prevents women from fulfilling their productive potential is poor health. This has adverse consequences on the well-being of households and on the formal economy. One-third of poor families in much of Africa are headed by women. In rural Namibia, for example, some 40 percent of households are headed by women. In Tanzania, women constitute 75 percent of the total population engaged in agriculture, many of whom bear full responsibility for feeding their families. Data on women's contribution to development, while still weak, indicate that women are responsible for up to three quarters of the food and cash crops produced annually in the developing world. Understanding the important but previously largely invisible, productive role of women has increased greatly during the past

fifteen years, stimulated in large part by the United Nations Decade for Women which ended in 1985.

A woman's ill health not only affects her own opportunities and her potential for contribution towards development but those of her family, particularly her children. The problem is, therefore, not confined to the health of women and mothers but has a major impact on the survival and quality of lives of babies and children. WHO estimates that about 7 million perinatal deaths each year in developing countries are associated with complications of pregnancy, labor and delivery, and the woman's general health and nutritional status before and during pregnancy. Thus, it is appropriate that policies and programs continue to place principal emphasis on pregnancy, childbirth and reproductive health in developing countries.

Research, analysis, and information dissemination activities are needed to guide the development of strategies and programs, and the allocation of appropriate resources for safe motherhood and improved reproductive health in Africa. At the same time it should be recognized that these activities need to be increasingly complemented over the longer-term by efforts to improve women's health and status more broadly, particularly before pregnancy occurs.

1.2. PURPOSE AND OBJECTIVES OF THE STRATEGIC FRAMEWORK

The purpose of this strategic framework is to assist the Office of Analysis, Research, and Technical Support of the USAID's Bureau for Africa, under its Health and Human Resource Analysis for Africa (HHRAA) project identify key research, analysis and dissemination issues on safe motherhood and reproductive health in Africa. Interventions to reduce maternal morbidity and mortality in Africa are available, but it is unclear if any of these have been effectively used or whether the relative effectiveness of different interventions has been studied. Any effort in this area should begin with an analysis of past projects and studies.

A number of elements may have contributed to the success or failure of safe motherhood and reproductive health programs, particularly program support components including advocacy, policy dialogue, human resource development (specifically training) financing of services, management, supervision, logistics, quality assurance, the use of information and communications, marketing, evaluation, private sector involvement, and most of all community support and participation. Expert analyses from previous efforts in these areas will be instrumental to developing a new generation of cost-effective maternal and reproductive health projects and programs.

The strategic framework presents a synthesis of existing knowledge and information gaps and set research priorities relevant to decision-making toward reaching the following objectives:

- To expand and strengthen the analytical base for reproductive health policy and program implementation by identifying, discussing and prioritizing knowledge

gaps and information needs in the following areas:

- * the extent, causes and distribution of women's morbidity and mortality;
 - * the relative effectiveness, efficiency, impacts, and costs of alternative safe motherhood and reproductive health strategies;
 - * the economic, social, medical and legal constraints to safe motherhood and improved reproductive health;
- To identify approaches for increasing policy and program support, community participation and individual empowerment for safe motherhood and improved reproductive health.

1.3 THE PROCESS OF DEVELOPING THE STRATEGIC FRAMEWORK

The process of developing the strategic framework involved: (1) consultations with African researchers and program managers in the field; (2) consultations with USAID and other development agencies's field staff; and (3) desk and case study analyses of relevant literature.

The SARA took the opportunity of its staff participation in a number of international meetings organized in 1993 on safe motherhood and reproductive health to consult with experts and decision makers and to identify a preliminary list issues to be addressed through research and analysis. A first issues identification exercise consisted of consultation and discussion with African experts attending the World Bank and the WHO sponsored meeting of experts on safe motherhood in Francophone Africa

II. SUMMARY OF RESEARCH AND DISSEMINATION PRIORITIES

A safe motherhood experts working group was conveyed on June 15 to look at research issues raised in this paper and try to come up with a list of priorities relevant to the African setting. The international community already agreed on mortality data. Although the levels may change from one setting to another one, the five leading causes are already known. What is really needed is how to reduce the level; or in a more practical way: **what can be done to reduce maternal mortality and morbidity?** Discussions indicate the need for more information on factors contributing to higher pregnancy-related morbidity and mortality in Africa, and the need for more intervention-oriented type of research. A consensus was to focus on three major areas:

- socio cultural issues
- interventions and services
- monitoring and evaluation of interventions

A. Socio cultural issues

- * Identify through community surveys and through existing studies and literature reviews, cultural and traditional barriers that affect motivation to seek or not seek appropriate care and utilization of maternity services. Findings can be used to develop specific approaches to address these barriers. A special attention should be given to adolescents and women in rural, isolated settings where the majority are illiterate with little access to information. Find out what is the community point of view of quality of care.
- * There is a need to evaluate the effectiveness of social support networks, their different approaches and their impact on improved women's reproductive health. Also research can be focussed on how community-based support networks might be formed and/or used to help provide women with better health information and better access to health facilities through the establishment, for example, of cooperative transportation arrangements. Best practices and lessons learned from the research can be disseminated and utilized to develop and /or strengthen community-based networks, based on specific socio-cultural settings.
- * Community involvement is crucial to the success of any safe motherhood intervention. Therefore, there is a need to support information dissemination and research studies on innovative community interventions which have the potential for expansion and replication to support safe motherhood and improved reproductive health in Africa.
- * How can we increase awareness about risk factors not only to the pregnant women but in the community as a whole to prompt their support when need arises.
- * Given the role TBAs play in the community, mechanisms for integrating trained TBAs in the modern health care system need to be determined, specifically in areas with very limited access to modern medical care. Mechanisms to link traditional and modern care systems for efficient and effective maternity care should be explored.
- * Female genital mutilation (FGM) should have a special attention. There is a need for social science research to learn more about the attitudes of community members toward female circumcision in order that strategies to reduce the incidence of the practice be identified. Analysis and information dissemination on the devastating consequences of FGM on women's reproductive health and the social and psychological impact should be carried out. Disseminating the initiative and action agenda of the organizations involved in the fight against FGM to sensitize policy makers and stimulating the creation of a joint advocacy group should be considered. Involve young people themselves, and look at the potential role of youth organizations in the fight to eradicate female genital mutilation.

B. Interventions and Services

What are the most important, easy and practical interventions (in terms of: drugs, equipment, supply; personnel: curriculum revision, refresher courses, supervision; and service delivery: services for adolescents, integrated services, prenatal contacts) that will increase safe motherhood in typically poor and undeserved areas? During the discussions special attention was given to:

- situation analysis of services
- prenatal care leading to intrapartum and postpartum care
- risk assessment
- emergency referral systems
- first referral facilities
- abortion issues
- family planning and its integration with other services

A consensus was made on the following:

- * There is a need to carry out **situation analysis of services** to define real problems. Use the results to determine how infrastructure and services can be made friendly and convenient to patients; based on a synthesis for different countries, design an optimum service package, an African standard approach for pregnancy management and patient care practice and norms to include into training curriculums.
- * What components of **prenatal care** are most useful in reducing maternal mortality? What should be optimum prenatal care. Research design to be done in the field to come up with appropriate standards and methodologies for urban as well as for rural areas. Percentage of women coming for prenatal care is increasing while percentage coming to delivery in health facilities is not. What concrete actions should be taken to have women at the delivery site: health education, husbands' involvement, increasing health care providers' awareness about socio cultural factors against hospital delivery?
- * It is a priority to carry out further research on **risk assessment** in the African environment in order to develop guidelines for health providers to screen women for the most important complications. Screening should not be limited to the prenatal period but should be continuous during intrapartum and postpartum period. How can we concentrate attention to the most likely to need specific care.
- * What can be done to **bring high risk women into first referral facilities** by involving the community in: (1) emergency transportation system through social support network (saving groups and village cooperative transportation systems), (2) in the conception and building of maternity waiting homes to increase their acceptance.
- * Once high risk women are at the **first referral level facility**, what can be done to shorten the waiting time before intervention: increase provider competence through revised

curriculums or put emphasis on Life Saving Skills (LSS) training, need for role models, incentives to increase morale? What can be done to ensure quality care at that level?

- * There is a critical need to raise awareness of policy makers on the magnitude of **unsafe abortion** by doing epidemiological studies specifically focused on high risk groups: adolescents, single or divorced women; and looking at the effectiveness and impact of different treatment techniques.
- * Review experiences to date regarding **integration of family planning** with maternal and child health services. What is the most effective and efficient way to change reproductive behavior and to increase access to contraceptive information and supplies? What can be done at policy level to delay birth of first child? When are women most receptive to family planning counseling and services (during prenatal care, postnatal care or post-abortion care)? Which degree of integration is more effective: should we only integrate family planning counseling in all maternity services with a strong referral system to family planning services, or should we offer both family planning counselling and services on site at contact points? Conduct studies on the effectiveness of targeting family planning activities on postpartum and post-abortion patients.

B. Monitoring and Evaluation

Monitoring and evaluation should be an important component of each safe motherhood program. Community should be involved in the process and be kept informed about progress. Policy makers also should be informed. UNICEF has planned to do an evaluation of essential obstetric functions in several countries, followed by policy recommendation. A document on guidelines for monitoring progress in the reduction of maternal mortality has been developed for the purpose, raising methodological issues in measuring maternal mortality and giving indicators of efforts to reduce it. If widely disseminated, that document can be a useful tool for monitoring and evaluation in safe motherhood.

III. REVIEW OF INFORMATION NEEDS AND GAPS

3.1 MAJOR REPRODUCTIVE HEALTH PROBLEMS

3.1.1 Pregnancy-related mortality and morbidity

Every minute of every day, a woman dies from complications related to pregnancy or childbirth (Safe Motherhood Initiative, 1987). On the approximately 500,000 women who lose their lives each year from complications of pregnancy and labor, more than 99 percent occur in developing countries (Winikoff 1991). The majority occurs in Africa and South Asia, where maternal mortality ratios may be about 200 times higher than those in industrialized countries (Tinker, Koblinsky et al 1993).

Because of poor access to safe, hygienic deliveries attended by trained attendants, WHO estimates that the majority (80 percent) of maternal deaths are **direct obstetric deaths** due to obstetric emergencies such as hemorrhage, unsafe abortion, hypertensive disorders, sepsis and obstructed labor. The remaining are estimated to be **indirect obstetric deaths** due to existing illnesses aggravated by pregnancy. In developing countries, indirect obstetric deaths have mainly been associated with illnesses such as hepatitis, malaria, anemia and diabetes (Lettenmaier et al. 1988.) The presence of one of these conditions may put women at higher risk of dying from one of the direct complications of pregnancy. Malaria, for example, not only may be more severe in pregnant women, it may also contribute to anemia, which in turn may decrease a woman's chance of surviving a hemorrhage.

High fertility rates in Africa remain an enormous constraint to both the improvement of maternal health and child survival. The average total fertility rate is 6.5 children per woman compared to 3.9 in Asia and 1.9 in industrial countries. The maternal mortality ratios (the number of women dying from causes related to pregnancy and childbirth per 100,000 live births) are 630, 380, 23 and 12 respectively for Africa, Asia, Europe and North America. Given the current fertility rates, if the rates of maternal mortality in the developing world remain unchanged, by year 2000 there will be 650,000 maternal deaths by year (PRB 1991).

In addition, long after delivery, a large number of women suffer from pregnancy and labor-related **maternal morbidities and disabilities**. For example, a community-based study in a rural area in Egypt found over half of the women suffered from uterine prolapse, although many cases were unrecognized by the women themselves (Zurayk 1991). A study at the Gondar hospital in Ethiopia found that more than one-half of the patients with obstetric fistulae, a disability caused by prolonged labor, had been divorced by their husbands and one-third had resorted to begging (Royston and Armstrong 1989). In Zaria, Nigeria, where the social consequences of fistulae had been the subject of a detailed study, 77 percent of long-term fistulae patients were living apart from their husbands, while none from the control group was divorced or living apart. Childlessness as a sequela of the fistulae was found to be an important factor in the marital breakdown (WHO/MCH/MSM/91.5). Data from the World Bank *World Development Report 1993* indicates that although males generally have higher rates of premature mortality, women have higher rates of disability during their reproductive years and in old age (60 and older), much of which can be attributed to pregnancy, childbirth and sexually transmitted diseases (STDs).

Basic epidemiological data on maternal mortality and morbidity is essential to examine the efficacy of many established maternity care practices. Without adequate, reliable information on levels and patterns of maternal mortality and morbidity, it will be difficult to decide on future directions, services and priorities. Discussions with concerned professionals in the field indicate the need for more information on factors contributing to higher pregnancy-related morbidity and mortality in Africa. Data on pregnancy-related deaths are usually not accurate for most African countries, because the majority of deliveries in rural areas are still domiciliary and often deaths are not reported as related to pregnancy and delivery. Furthermore, deaths and complications

from miscarriages or ectopic pregnancies are often ignored and unreported. Therefore,

There is a need to develop rapid assessment methodologies and to conduct community-based studies on the levels and patterns on pregnancy- and delivery-related morbidity and mortality.

In community-based studies, a variety of sources have been used: ranging from physicians, midwives and health care providers to religious leaders and graveyard attendants. A community-based study on maternal mortality is being conducted by the Zimbabwe Medical School (Tinker, Koblinsky et al. 1993). Maternal mortality studies supported by WHO's Maternal Health and Safe Motherhood Program, are also being conducted in Cote d'Ivoire, Mali, Mozambique, Tunisia and Northern Ghana. Regarding maternal morbidities, the Family Health International Maternal and Neonatal Health Center is coordinating a five-country survey in Egypt, Ghana, Indonesia, India, and Bangladesh. The London School of Hygiene and Tropical Medicine is coordinating a project on methods for measuring maternal health. WHO's guidelines on measuring reproductive morbidity (using combinations of direct questioning, clinical examinations and laboratory testing) also exist.

These modules/studies could be analyzed and utilized as models to design similar mortality and morbidity surveys adapted to specific African country settings.

3.1.2 Unwanted Pregnancy and Unsafe Abortion.

Incomplete abortion is a serious health problem in the developing world. As a leading cause of disease and death among women of reproductive age in Africa, post abortion management, counseling and family planning service provision should be a high impact, focus area of concern.

Worldwide, an estimated 40 and 60 million abortions take place each year, and it is estimated that the majority are performed under unsafe conditions, (WHO 1992 Women's Health: Across Age and Frontier), resulting in significant social and psychological costs to the women as well as economic costs to the health system. WHO studies in various settings indicate that the share of maternal deaths caused by induced abortion ranges from seven percent to more than 50 percent (Tinker and Post 1991). And for every woman who dies, one study in India documented that 30-40 more suffer serious, often lifelong health problems (Jacobson 1990). At Jomo Kenyatta Hospital in Nairobi, Kenya, 50-60 women are treated for abortion complications per day, accounting for 40% of all admissions (Henshaw 1990).

The wantedness of a pregnancy is also important especially since women who have an unwanted or unplanned pregnancy are more likely to seek an abortion. It has been documented that women resort to abortions even if the only procedures available are unsafe illicit abortions that greatly increase the risk of death and disability. In most developing countries, about 20 to 30 percent of married women wish to avoid pregnancy but are not using contraception (Westoff and Ochoa 1991), with the result that one in five births in these countries is unwanted.

In most Sub-Saharan African countries, access to safe abortion is legally and/or logistically restricted. Health services are deficient in the provision of medically safe termination of pregnancy as well as in the management of complications of unsafe abortions. Family planning programs are often targeted to married couples. Adolescents, singles, divorcees or women after an abortion have usually little access to contraceptives.

It is estimated that between 30 and 40 percent of the very high maternal mortality in sub-Saharan Africa is due to unsafe abortion. Limited available hospital data indicate that abortion accounts for one in three pregnancy-related deaths in sub-Saharan Africa (Dixon-Mueller 1990).

Unsafe abortion is one of the major causes of mortality as well as morbidity. The cost of treating complications is considerable--many times greater than that of offering medically safe abortion services--and places a heavy financial burden on health systems in developing countries where this may consume as much as 50% of hospital budgets (Coeytaux et al. 1993).

Reducing the number of unsafe abortions should be one of the top priorities in the region. But it is not getting adequate attention. Thus, areas for research, analysis and information dissemination could include:

Raising Awareness of Policy Makers.

Although limited, the available hospital data indicate that unsafe abortion is major cause of mortality in Africa. Because of the legal restriction to safe abortion, women with unwanted pregnancies usually seek unsafe abortions performed by untrained persons in unhygienic conditions. Therefore it is still difficult to document precisely the extent of abortion-related morbidity and mortality or the underlying factors that contribute to unsafe abortion.

Data from selected urban hospital such the Kenyatta Hospital in Nairobi indicate that the number of women admitted for complications of abortion is on the rise and put a strain on the limited resources available at the hospital (Tinker, Koblinski, 1993). In that hospital, about 10,000 women are treated each year for complications of illicit induced abortion. This represent a fivefold increase over a decade (Deborah Maine). A community survey of maternal mortality in Addis Ababa found that illicit abortion was the leading cause of maternal death (Deborah Maine). In Nigeria and Ghana, one out of every five women interviewed in maternity centers said they had an illicit abortion. A hospital survey in Tanzania showed that illicit abortion was the leading cause of maternal death. The average age of women died was 19 (Deborah Maine).

Therefore, raising awareness of policy makers regarding the extent and dimensions of abortion as a health issue should be a high priority. Epidemiological, social (qualitative and quantitative) and economic research and analyses of the problem are needed to guide policy dialogue and to develop programs to reduce abortion-related mortality and morbidity.

There is a critical need to initiate studies on the epidemiology of abortion,

specifically focused on those at highest risk of abortion: adolescents, single or divorced women, women after induced abortion and women with STDs. Women's resorting to unsafe abortions is determined by many interacting factors (socioeconomic, education, availability of family planning information and services, etc.).

3.1.3. HIV/AIDS¹.

As of mid-1993, of the 8 million adults infected with HIV in sub-Saharan Africa, over 4 million are women. Heterosexual transmission has been the overwhelmingly predominant mode of spread since the pandemic began, and as a result, AIDS has struck men and women in this region in an almost even ratio. Infection rates in women aged 15-49 have reached as high as 25% in some urban areas and high risk groups (WHO/GPA/DIR/89.12 Rev.1), and AIDS is already the leading cause of death among urban women aged 20-40 years (World Bank WID Fact Sheet, 1992). Since most of the infected women are of childbearing age, many infants are also at risk, as a result of HIV transmission from the infected mother to the fetus. Of the 1.1 million estimated pediatric HIV infections worldwide, the vast majority (90 percent) occurred in sub-Saharan Africa and WHO estimates that some 900,000 HIV-infected infants have already been born in Africa (WHO Press Release WHO/54 1991).

The decision regarding whether or not to bear children is highly complex. The presence of HIV infection is likely to complicate this decision even further. Infected women should be fully informed regarding the health risks of pregnancy in the presence of HIV and should also have access to a full range of effective methods of contraception to prevent pregnancy. In addition, condoms should be used consistently and correctly to minimize the risk of transmission.

HIV-infected women or women at high risk who do become pregnant should be advised about the risks of having an infected child. Studies have suggested that the transmission rate of HIV infection from mother to fetus/infant during pregnancy and at the time of delivery is between 15% and 40%.

Some groups are advocating that a woman who decides not to continue the pregnancy should have access to safe abortion services where legal, but the final decision must be made by the woman herself. In particular, where termination of pregnancy is not against the law, they should receive adequate counseling and support to enable them to make an informed choice. In this connection, there is a need for strengthening the training of health care providers at all levels to enable them to provide on-going support, counseling and care. **The training of health care providers in HIV counselling and care, the cost-effectiveness and the impact of such training on patient care quality would need further analysis**

¹ Women and HIV/AIDS also discussed in the HIV/AIDS strategic framework.

Research is still needed on a number of priority topics in this area including:

The impact of pregnancy on the health of HIV-infected women.

The impact of HIV infection on pregnancy and pregnancy outcome.

Cost and impact of HIV counseling and testing of HIV-infected women and their partners. (Additional research topics on counseling and testing discussed in the HIV/AIDS, STDs and Tuberculosis strategic framework.)

The behavioral determinants of consistent and correct condom use for prevention of both pregnancy and HIV transmission.

Breastfeeding and HIV Transmission.

The role of breastfeeding in HIV transmission also has to be clarified. In August 1991, the results of a study in Rwanda were published in the Lancet, reporting on HIV transmission through breastfeeding among a group of women who were infected with HIV after delivery. Individual cases of transmission through breastfeeding have also been documented (for instance, where women have been infected postpartum through a transfusion of HIV-contaminated blood). However, the magnitude of the risk of HIV transmission through breast-feeding, especially among women already infected during pregnancy is not known as yet--randomized controlled studies are underway in Kenya, Rwanda and Haiti to determine the actual risk. Recent studies suggest however, that the risk was substantial (about 30%) among the small numbers of mothers who developed an HIV infection while the infant was nursing.

More research is needed regarding the risks and benefits of breastfeeding by HIV-infected women in different cultural settings. This information will be important to policy makers and health professionals in the formulation of policies related to breastfeeding by HIV-infected mothers.

3.1.4. Reproductive Tract Infections.

Reproductive tract infections (RTIs) go largely undiagnosed and untreated among women in developing countries in part because many are asymptomatic, and in part because of the "culture of silence" surrounding these infections. The majority of RTIs are sexually transmitted and carry serious consequences for the pregnant woman and her fetus as well as for the non-pregnant woman. In many cultures, women accept vaginal discharges or the chronic abdominal pain which accompanies some RTIs as part of their womanhood. Existing prevalence data on RTIs are limited both in quality and in scope, but Table 1 presents figures derived from community and country level studies in Africa, Asia and Latin America.

Table 1. Median Prevalence of RTIs in Third World.

Disease	Population	
	High Risk ²	Low Risk ³
Chlamydia	14%	8%
Gonorrhea	24%	6%
Trichomoniasis	17%	12%
Syphilis	15%	8%
Chancroid	9%	Not available

Source: Wasserheit and Holmes (1992).

Consequences in Pregnant Women. In pregnant women, RTIs are responsible for ectopic pregnancy as well as for adverse outcomes of pregnancy. Population-based incidence rates for ectopic pregnancy are rarely available for developing countries, but data from selected countries suggest that post-infectious ectopic pregnancy following RTIs is not uncommon. For example in Gabon, 1 in 62 pregnancies was ectopic; in Benin, 1 in 88; in Uganda 1 in 91 pregnancies was ectopic compared to 1 in 133 in Sweden (Meheus and Wasserheit 1991). These studies revealed that both gonorrhea and chlamydia played an important role in the development of ectopic pregnancy.

RTIs also play a significant role in adverse pregnancy outcomes, such as fetal wastage (both spontaneous abortion and stillbirth), low birth weight (due to prematurity, intrauterine growth retardation IUGR or both) and congenital infection. Table 2 presents rates of adverse pregnancy outcomes associated with RTIs.

Table 2 : Rates of Adverse Pregnancy Outcomes associated with RTIs.

²Commercial sex workers; STD clinic patients; men in occupations involving extended or recurrent separations from family (truck drivers, military personnel).

³ Antenatal, abortion and family planning clients; participants in community surveys.

Maternal Diagnosis	Fetal Wastage	LBW	Congenital infection
Chlamydia	?rare	10-30%	40-70%
Gonorrhea	?rare	11-25%	30-68%
Early syphilis	20-25%	15-50%	40-70%
Bacterial vaginosis	?rare	10-25%	rare
Trichomoniasis	?rare	11-15%	rare
No RTI	4-10%	2-12%	NA

Source: Wasserheit and Hitchcock 1992.

Consequences in Non-Pregnant Women. If untreated or inappropriately treated, RTIs spread spontaneously from the lower reproductive tract to the upper reproductive tract resulting in pelvic inflammatory disease (PID), a major cause of maternal morbidity and mortality in women. As many as 10-20% of women with untreated gonorrhea or chlamydia develop PID (Hamers and Wasserheit 1993). In some countries, PID is the most common diagnosis among women attending STD clinics. In Zimbabwe for example, 47% of women attending an STD clinic had PID (Latif 1985). Women with a history of PID have a higher risk of having an ectopic pregnancy. For example, Westrom and Mardh reported from data collected in Sweden that ectopic pregnancy is 6 to 10 times more common among women with a PID history compared to those who have never had an upper tract infection. The same data also indicated that recurrent PID occurs in 20 to 25 percent of women with a PID history, and that 15 to 18 percent experienced chronic, disabling pelvic pain (Westrom and Mardh 1990).

infertility. Delay in PID treatment is a critical risk factor for impaired fertility. Women with PID who delay seeking health care for more than two days after onset of symptoms have a threefold increase in risk for infertility or ectopic pregnancy compared with those who seek care promptly (Hamers and Wasserheit 1993). This risk is highest for women with chlamydia infection: 17.8% of those who delayed seeking health care developed impaired fertility compared with none who sought prompt treatment (Hillis et al. 1993).

15 to 25 percent of women with PID in developing countries become infertile (Wasserheit 1990). The risk of infertility also increases significantly with the number of episodes of PID--occurring in as high as 50 percent of women after a third episode (Westrom and Mardh 1990). The link between infection associated with PID and infertility has been well documented. In a standardized clinical investigation of over 10,000 infertile couples in 25 countries by WHO's

Special Program of Research, Development and Research Training in Human Reproduction, infections accounted for infertility in 36% of the cases in developed countries compared to 85% in Africa, 39% in Asia and 44% in Latin America (WHO 1987). The study also found that a history of STD in the male partner increased the risk of an infection-related infertility diagnosis in the female partner, regardless of whether she had a history of infection.

Post-partum infection and post-abortal infection are also important causes of acquired infertility. Women are at greater risk of infection leading to secondary infertility if they give birth in unsanitary conditions or without trained attendance and some traditional childbirth practices may also promote infection. The 1987 WHO infertility review also noted that the risk of secondary infertility in one African country was twice as high among women delivered by an untrained attendant as among those delivered by a trained attendant. Post-abortal infection is another important cause of infertility in some countries. Abortions performed by untrained practitioners are often unsanitary with a high risk of infection. In a Nigerian study, it was found that the relative risk of secondary infertility occurring in women with previous abortions was 3.6 times higher than in those without previous abortions (Osinusi 1986). These findings suggest the wide prevalence of acquired infertility of infectious origin.

The majority of reproductive tract infections (RTIs) are sexually transmitted. WHO estimates that worldwide, about 250 million new infections are sexually transmitted annually. Compared with men, women are more susceptible to acquiring infection and are also more likely to experience complications from the primary infection: in part, because these infections are often asymptomatic in women and thus go untreated. Non-sexually transmitted infections such as those due to an overgrowth of organisms normally present in the reproductive tract (bacterial vaginosis, candidiasis) are also RTIs and are equally as important. For example, bacterial vaginosis (BV) is notable for its potential role in pelvic inflammatory disease, infertility and premature births.

In its approach to controlling RTIs in women, USAID is supporting a spectrum of activities. For example, in Nairobi, Kenya, a demonstration project aimed at maternal syphilis control was implemented in urban prenatal clinics by MotherCare. Although the impact, effectiveness, cost and feasibility of the demonstration project has not yet been evaluated, the project demonstrated the feasibility of an integrated reproductive health service package by decentralizing screening facilities to a primary health level. In Mali, 1,000 women were educated about condoms through STD clinics. Sentinel surveillance systems have been established to track and monitor STDs in several developing countries including Burundi and Uganda. As part of its STD Diagnostics Initiative, USAID is funding research and development of field diagnostic technologies. And through its HIV/AIDS prevention programs to reduce sexual transmission of HIV, STDs are being addressed through behavioral interventions, condom promotion and STD control through provision of diagnosis and treatment at existing service delivery systems such as prenatal clinics and family planning clinics.

Much is being done, but more still need to be done. Priorities for the future include the

following:

Assessing on-going prenatal screening and treatment demonstration projects and studies (some examples, maternal syphilis control demonstration projects in Kenya and Jamaica, a study on prevention of premature births by treating pregnant women infected with bacterial vaginosis in Indonesia) to determine: (a) program cost-effectiveness; (b) the potential for improving pregnancy outcomes through STD control; and (c) opportunities for replication and expansion.

Collaborating with HIV/AIDS prevention programs, continue research on: (a) behavioral factors and interventions; (b) condom promotion and use; (c) STD control activities such as counseling, diagnosis and treatment, partner notification and referral. (Research topics discussed in detail in the HIV/AIDS, STDs and Tuberculosis strategic framework.)

Collaborating with family planning programs: (a) assess how key reproductive health interventions can complement and reinforce family planning; (b) compare the feasibility, acceptability, quality and cost-effectiveness of integrated FP and STD programs with vertical programs; and (c) evaluate the use-effectiveness and acceptability of simultaneous use of two contraceptive methods, since the most effective choices to prevent pregnancy are not necessarily the most effective for preventing RTI

Existing prevalence data on RTIs among third world women are limited both in quality and in scope. In most countries, studies have focused on commercial sex workers (CSWs) because they are more readily accessible through government-sponsored screening programs; likewise, studies involving non-CSW populations usually draw on antenatal and family planning clinics and so are rarely population-based. There is a need to undertake population-based studies through local institutions to assess the prevalence of RTIs/STDs among women in the general population.

Help specialized institutions in the design of feasible means of data collection for monitoring the prevalence of RTIs/STDs and the patterns of sexual behavior.

Analyze currently available data on integrated services and disseminate results on the most effective ways to integrate information, screening, and services for STDs/HIV/AIDS /RTIs into ongoing health and FP programs.

INFERTILITY

Infertility frequently results from complications of lower genital tract infections and pelvic inflammatory disease. Although experts generally agree that STDs are the major preventable causes of infertility, poor obstetric and gynecological practices (including unsafe abortions) also result in infections leading to infertility. Little research is available, however, on the relative importance of these two leading causes of infertility.

Estimated primary infertility rates are 10.1 percent in Africa and secondary infertility rates are very high in many of the countries: e.g. 33% in Cameroon, 25% in Tanzania (Rooney 1992). Among infertile women in Africa, a study found that infertility was due to infection in 85% of the cases reviewed (Rooney 1992). In addition infection-related infertility has been found to be positively correlated with the frequency of asymptomatic infections in women, unavailability of diagnosis capability, unavailability of treatment capability as well as low efficacy of treatment and frequency of unsafe abortion.

Infertility has consequences of particular concern for women in Africa where a woman's value and status are closely tied to her ability to bear children. Women who are unable to bear children are divorced by their husbands and socially ostracized, therefore turning to prostitution to survive.

The crucial role family planning programs play in infertility prevention should also be recognized. By promoting barrier contraceptives and spermicides, family planning programs can help interrupt transmission of STDs and reduce infection-related infertility; in addition, by making contraceptives available to women who want to prevent unplanned pregnancies, family planning programs can reduce the incidence of illegal abortions, long term consequences of which can lead to infertility.

Research is essential to establish the extent of the problem of infertility, the contributing factors and their prevention, the management of the problem in affected couples, and the social, psychological and economical consequences.

3.1.5 Maternal Nutrition.

Women's reproductive role is intimately related to nutritional needs and resulting vulnerabilities. Frequent reproductive cycling, where a woman is pregnant and/or lactating, increases the body's need for **iron, Vitamin A, and iodine**, the micronutrient for which deficiencies are most common. By the same token, poor nutritional status contributes to some of the major causes of maternal mortality. WHO estimates that half of non-pregnant and two-thirds of pregnant women in the developing world are anemic (WHO Progress 1990). **Anemia** has the effect of both reducing immunocompetence and of increasing the risk of death due to hemorrhage during labor. 450 million adult women in developing countries are also estimated to be stunted as a result of childhood **protein-energy malnutrition** (World Bank Effective Family Planning Programs 1993), and the highest levels of malnutrition among women are found in South Asia and sub-

Saharan Africa (World Bank Women's Health and Nutrition Draft 1994). Women who are stunted are at higher risk of obstructed labor, which is associated not only with higher maternal mortality but with fetal asphyxia leading to brain damage or death of the fetus. Another indicator of maternal malnutrition is low birth weight (LBW) of the infant. LBW is a major problem in developing countries and a WHO study in selected countries in seven regions estimated that 22 million LBW babies are born each year and that 21 million are in developing countries (Williams, Baumslag and Jelliffe 1985).

The high prevalence of protein-energy malnutrition, iron deficiency anemia, iodine and vitamin A deficiency disorders among women in developing countries is well documented. Based on an extensive 1991 literature review of women and nutrition, conservative estimates suggest that among the 1.1 billion women 15 years and older living in developing countries, over 500 million women were stunted as a result of childhood protein-energy malnutrition, about 250 million suffered effects of iodine deficiency, and almost 2 million were blind due to Vitamin A deficiency (Leslie 1991). The magnitude of these serious problems argue for giving high priority to efforts to improve the nutrition status of women. When mothers are undernourished, their children are born with low birth weights and suboptimal nutrients stores, and they face a higher risk of morbidity, growth faltering, and premature death.

Causes of maternal undernutrition are varied. They include inadequate dietary intake (often commencing in infancy and early childhood), frequent and repeated infections (particularly hookworm, malaria), and the increased nutrient requirements that accompany frequent and closely spaced pregnancies. Consistent with this, strategies to improve maternal nutrition include improving girls and women's dietary intake and micronutrient status (through nutrition education, food and/or micronutrient supplementation, or broadly targeted food fortification programs), prevention and treatment of malaria and other parasitic infections, and child spacing.

Low-cost methods to improve women's dietary intake through nutrition education (example: ICDS Program in India...?), or to improve their micronutrient status through direct supplementation have been introduced in many countries, but these activities have not been fully integrated nor received the attention they deserve.

Further research and analysis are required to assess 1) the efficacy of integrating nutrition services into family planning and women's reproductive health programs, 2) the effectiveness of specific interventions and delivery mechanisms for improving specific deficiencies (such iron, vitamin A, iodine, etc.), and 3) cultural and economic barriers to sustainability of these efforts.

Supplementation Programs

Targeted supplementation programs deliver food and/or capsules (micronutrient), but they must be supported by an effective delivery system. For example, although provision of iron is the

most common feature of a nutrition program for pregnant women, many supplementation programs have failed because the tablets did not reach the women or the women did not take them. The success of the World Bank-supported Tamil Nadu Integrated Nutrition project was in large part due to highly motivated community nutrition workers.

While reasonably good information exists on the prevalence, causes and treatment of iron deficiency anemia, research is needed to find better ways of distributing iron to women and ensuring that they consume it appropriately. Therefore, it might be useful, using existing data, to assess and disseminate information on supplementation programs. And identify effective delivery systems supporting the programs and factors associated with their success.

Food Fortification.

Fortification is another key approach although the gains can be maintained only through sustained intervention over the years supported by effective delivery systems. Examples of fortified food have included bread, sugar (Guatemala), curry powder (India), fish sauce (Thailand), milk powder and cookies (Chile) as vehicles, and various micronutrient as fortificants. Fortification programs are clearly important because they offer the best way to ensure that women enter pregnancy with sufficient nutrient reserves to cope with the extra requirements of pregnancy.

Conduct research and analysis to identify successful models of food fortification (lessons learned, cost-effectiveness, impact on nutritional deficiencies in women). How do fortification programs compare with supplementation programs in terms of cost-effectiveness, acceptability and impact?

Innovative Nutrition Programs.

Several small-scale, innovative nutrition projects exist. Some well-known examples include: the community kitchens organized by women's groups in Lima, Peru; a nutrition program organized by refugees in a refugee camp in Thailand; and the Tamil Nadu Integrated Nutrition project in India. All these programs illustrate the importance of community participation in the design and management of nutritional interventions in order to ensure cultural appropriateness and commitment of the beneficiaries. For example, in the Peruvian kitchens, women's groups pooled together to prepare and distribute food which may be donated, subsidized or purchased; in the Thai model, husbands played a strong, positive role in the nutrition of their wives; and in the Tamil Nadu project, the community nutrition worker played a key role in educating and mobilizing women to participate in the program. The Iringa Nutrition Program in Tanzania provided small hand-operated maize grinders (for women to grind their own maize at home), improved stoves to conserve fuel wood and reduce wood hauling, and hand carts for the

transport of agricultural produce and water, to reduce women's caloric expenditure and to compensate for time consuming nutrition-related activities. A future research priority could be to

Assess and disseminate information on innovative nutrition programs, focusing on their sustainability and their impact on improved nutrition and how the success of these programs can be replicated in the African context.

Program Participation and Cultural Beliefs

The goal of improving women's nutrition will only be accomplished by working with the beneficiaries (women) to define and act upon their nutritional needs. More research effort should be invested in understanding the beneficiaries' anticipation of a program's "benefit" to them, relative to its "cost", such as work constraints, time, accessibility, income and/or value and quality of services, etc. For example, in Colombia, child care services for participating mothers are part of the Nutrition and Child Care project and are perceived by the participants as a "benefit".

Research and analysis of "costs" and "benefits" as perceived by the intended beneficiaries could be carried out for already existing programs. Information gained could be utilized in future program designs by reducing identified "costs" and increasing identified "benefits" to enhance demand and program participation.

Overcoming cultural constraints to women's participation in nutrition programs requires an understanding of the extent of the problem as well as the causative factors.

There is a need to identify cultural constraints (socio-cultural dietary practices and taboos) to women's improved nutrition and disseminate information to IEC planners.

Anemia in pregnancy and Malaria.

In areas where malaria is endemic, such as most of sub-Saharan Africa, malaria is an important contributor to severe anemia in pregnancy as a result of hemolysis. A study of anemia etiology in pregnant women in Zambia by Fleming et al found *Falciparum* malaria to be the commonest cause of the anemia. Studies have also shown that pregnant women regularly protected with antimalarial do not become severely anemic provided the prophylaxis is not started too late in pregnancy. What then are the reasons for the lack of policy in many countries for the delivery of malaria chemoprophylaxis to pregnant women?

There is a need to analyze and disseminate information on malaria

chemoprophylaxis in pregnancy focusing on: (1) effects of malaria in pregnancy; (2) evidence for the benefits of chemoprophylaxis; (3) different approaches used for delivery of malaria chemoprophylaxis; (4) constraints and obstacles faced, such as the spread of the chloroquine resistance; and (5) Treatment of malaria-associated anemia in pregnancy; (6) national policy for malaria chemoprophylaxis.

3.2 SOCIOCULTURAL AND ECONOMIC FACTORS AFFECTING WOMEN'S HEALTH

3.2.1 Adolescent Reproductive Health.

Sexual activity - which can lead to early childbearing, unplanned pregnancy with unsafe abortion and exposure to STDs (including AIDS)- poses the greatest health risk for adolescent women. In addition to the health risk, teenage unplanned pregnancy also leads to school drop-out (e.g. 8,000 teenage girls in 1988 in Kenya, 18,766 in 1984 in Tanzania), loss of career opportunities, and sometimes devastating psychosocial consequences ("moral persecution", disowning by the family, child abandonment, prostitution).

Early childbearing. Early childbearing rates are among the highest in the world. On average more than 50 percent of African women have given birth by age 20, and in some African countries, as many as 40 percent of women have their first child before age 18. Given that 31 percent of Africa's population was between the age of 10 and 24 in 1990, controlling births to adolescent mothers can have a tremendous impact on safe motherhood programs. Births to adolescents currently represent between 15 and 20 percent of all births for 11 African countries for which current data are available (CPO 1992). Although adolescent fertility rates vary greatly within and among countries, early childbearing is generally associated with rural residence, low education, low income and early age of sexual initiation (UN 1989).

The medical consequences of early childbearing both on the mother and the child have been well documented by WHO and others. Women under age 20 suffer more pregnancy and delivery complications, such as toxemia, anemia, premature delivery, prolonged labor, vesico vaginal fistulae, cervical trauma, and death than do women over age 20. A recent survey from Northern Nigeria found that nearly 60 percent of 241 recent VVF cases were to women under age 18. In another Nigerian study, 17 percent of 14-year-olds developed hypertensive disease of pregnancy as compared to 3 percent of women aged 20 to 34 (WHO 1989). Infants born to adolescent mothers also have a higher risk of dying. In Burundi, Ghana, Kenya, Liberia, Mali, Nigeria, Senegal and Zimbabwe, infants born to mothers aged 15 to 19 face a 20 to 60 percent higher risk of dying before their first birthday than those born to women aged 20 to 29 (PRB 1992). (See also section Effects of Reproductive Patterns.)

Abortion. Where abortion is legal, roughly one-fourth of abortions are to teenagers (Singh and Wulf 1990). Where abortion is restricted, teenagers often resort to clandestine abortion and

account for between 1 to 4.4 million abortions annually (Center for Population Options 1992). Studies in Kenya, Mali, Nigeria, and Zaire have indicated that between one- and two-thirds of women hospitalized for induced abortion are aged 19 or less (ICRW 1989).

Sexually Transmitted Diseases and HIV/AIDS. Research suggests that adolescent girls may be biologically more vulnerable to sexually transmitted diseases (STDs) and HIV infection than older women who have completed their physical development. For example, data from Rwanda documented that the younger the age of first pregnancy or first sexual intercourse, the higher the incidence of HIV infection: in the study, of the young women pregnant at age 17 or younger, over 25 percent were HIV-infected; and of the young women 17 or younger at first sexual intercourse, 17 percent were HIV-infected (Chao 1991). Infection rates declined sharply in both categories in later age groups.

In addition to biological vulnerability, economic dependence forces some adolescent girls into providing sexual favors to older partners. Studies in Ethiopia and Zimbabwe reveal that while the ratio of AIDS infection is equal among men and women 20 to 29 years old, adolescent girls aged 15 to 19 are three to five times more likely than boys to be infected ((Werk-Zewdie 1993).

Sexual activity - which can lead to early childbearing, unplanned pregnancy with unsafe abortion and exposure to STDs (including HIV/AIDS)- poses the greatest health risk for adolescents.

These problems are both social and medical, and are related not only to early sexual activity but also to inadequate knowledge of reproductive biology, and limited knowledge of and access to information, counseling and services dealing with early sexual activity.

Raising Awareness and Advocacy.

There is a need to raise awareness among policy makers about the cost and benefits of adolescent pregnancy prevention, sex education and family planning.

Examine national costs associated with: (1) adolescent abortion-related mortality/morbidity; (2) the consequences of early school drop-out due to pregnancy, early marriage and early childbearing, high parity, and subsequent maternal and child health problems; (3) loss of productivity due to reproductive health problems; and (4) the burden of illness. Disseminate data to high-level policy makers/community leaders and donors.

Many countries have a strong, vocal, and well-funded organized opposition to family planning for adolescents. On the other hand, there are few organized or effective advocacy groups to counter the opposition.

A priority approach could be to consider supporting the establishment of joint advocacy groups comprised of professionals and leaders of family planning, population, youth services, community development and women's organizations to focus attention on adolescent reproductive health issues. This effort could include research into different advocacy strategies and organizational models to be used at regional and sub-regional levels.

Conduct research on community mobilization strategies to address adolescent needs and help develop a community consensus (example from Uganda-use of community meetings to discuss adolescent needs).

Adolescent Health Needs.

A clear understanding of adolescents' health needs and how to address them should be a public health priority in Sub-Saharan Africa. For example, existing data on the use of health services indicate that adolescents use health services less than either children or adults (WHO 1986).

More information is needed on how to increase use of reproductive health services, including STD prevention and family planning by adolescents.

The USAID supported MNHC (Maternal Nutrition and Health Care) Program conducted two studies that provided information on prenatal care use by adolescents and the factors that affected their care decision. The studies investigated the knowledge, attitudes and practices of adolescents regarding pregnancy and prenatal care in Mexico City and in Guatemala. Similar studies adapted to the African context need to be conducted focusing not only on pregnancy and utilization of prenatal services, but on KAP of adolescents regarding sexuality and use of health and family planning services as well.

3.2.2 Effects of Unregulated Reproductive Patterns.

The number of pregnancies and deliveries that a woman goes through also determines her lifetime risk of maternal death. It has been estimated that in sub-Saharan Africa, a woman runs a one in 21 lifetime risk of dying from pregnancy-related causes; in South Asia, it is one in 34 - compared to one in 10,000 in Northern Europe and one in 2,700 in North America (Rochat 1987; World Bank Women's Health and Nutrition Draft 1994).

The relationship between maternal mortality and reproductive characteristics such as **age, pregnancy order, birth interval**, are among the best documented in the literature. Higher parities as well as births at younger and older ages carry high risks of mortality for the mother. For example, in the absence of obstetric care, women who have a birth before age 18 are three times as likely to die in childbirth as those who have a birth between ages 20 and 29; and for

women over 34, the risk of maternal mortality is five times as high (World Development Report 1993). Parity is also a strong determinant. For example, three population-based studies carried out in Bangladesh, Ethiopia and the Gambia documented that women of parity 5 or more have about 1.5 to 3 times the risk of maternal death than women at lowest risk parities such as parity 2 or 3 (National Research Council 1989).

In addition, births to very young women elevate health risks not only to the mother but to the child as well. Data from Demographic and Health Surveys documented, that in Mali where 51% of the teenagers were pregnant with first child or having one or more children, the infant mortality rate was 164/1000 live births, compared to Zimbabwe where the percent of teenagers pregnant or having one or more children was 21% and the infant mortality rate was 60/1000 live births (USAID Sixth Report to Congress 1991).

Shorter birth interval contributes to maternal depletion and increases infant mortality rate. By spacing pregnancies leading to longer birth intervals family planning indirectly reduces maternal and childhood morbidity and mortality. Family planning alone could prevent between 25 and 40 percent of maternal deaths (Daly, Azefer 1993). One of the eleven points in the call to action adopted at the 1987 International Safe Motherhood Conference says: "we need to expand family planning and family life education programs, particularly for young people, and make services for planning families socially, culturally, financially and geographically accessible". But the challenge lies in the low level of contraceptive prevalence in Sub-Saharan Africa: 14 percent of married women for total contraception and only 10 percent for modern contraceptive methods. These figures are as low as 7 and 3 percent for Western Africa (PRB World Population Data Sheet, 1993), showing the urgent need to focus research and analysis on factors susceptible to increase family planning acceptance, and what are the best alternatives to target high risk women.

3.3 ORGANIZATION AND EFFICACY OF REPRODUCTIVE HEALTH INTERVENTIONS.

Even the most common, accepted and established interventions need to be re-examined for their impact on safe motherhood and improved reproductive health in Africa. Information on efficacy of interventions is crucial for decision making about strategies and resource allocation. WHO has been promoting well-equipped first referral centres with strong connection with the community level maternity centres to deal with obstetric emergencies in several African countries. The following interventions are examined in this section:

- Prenatal, intrapartum and postpartum care
- The use of risk assessment/approach
- Upgrading first referral level facilities
- Referral system

3.3.1 EFFICACY OF REPRODUCTIVE HEALTH INTERVENTIONS

a). FAMILY PLANNING.

Family planning has always been an important component of safe motherhood. Family planning allows women to delay motherhood, space births and avoid unwanted, unplanned pregnancies; and reducing the number of pregnancies also means fewer pregnancy-related morbidity and mortality. By satisfying "unmet needs" for family planning, maternal deaths could be reduced by 17 percent in Africa (Maine 1991). The World Bank *World Development Report 1993* ranks family planning among the most cost-effective interventions to improve maternal and child health.

In addition to research topics discussed in the population and family planning strategic framework, some other considerations under safe motherhood could include unmet need and missed opportunities:

Unmet Need.

Studies of the potential market for contraception show that substantial proportions of women want to space or limit future pregnancies, yet are not using any contraceptive method. Studies also document that at least a fourth of all maternal deaths could be prevented if women who said they want no more children were able to avoid future pregnancies. By satisfying these "unmet needs" for family planning, maternal deaths could be reduced considerably, and specifically for Africa, it is estimated that 17 percent of maternal mortality could be reduced (Deborah Maine 1991).

"Unmet need" constitutes at least 10 percent of reproductive age women and as much as 40 percent in such countries as Kenya and Togo (Effective Family Planning Programs 1993). Recent DHS surveys found that among 10 sub-Saharan countries, more than 20 percent of married women indicate that they would like to limit their family size or space the birth of their children, but many of them are not using family planning. In Nigeria, 21 percent of married women who want to limit or space are not using any contraceptive method. In Ghana and Kenya, the levels of unmet need reach almost 40 percent (APAC Status Report). These surveys do not include unmarried women. Figures for induced abortion provide another indication of the level of unmet need for family planning. Since the current definition of "unmet need" includes only married women, the percentage of women with unmet need would undoubtedly be substantially higher if it were to include all women who want to space or limit future births but are not using any contraception.

What different approaches can be used or are there some approaches that programs should be emphasizing which are better than others to reduce unmet need?

Making Best Use of "Contact Points".

Providing family planning services at each point of contact by women with the health system can ultimately increase women's access to contraception. Some successful contraception programs have been linked to health services most often used by women: examples include the Sfax Tunisia post-partum program and the Matlab Bangladesh program. In the Matlab program where family planning was linked to a community-based service that also provided basic maternal and child health care, contraceptive prevalence rate in the intervention area increased from 8 percent in 1977 to 56 percent in 1989, compared to the comparison area where the prevalence rate remained at less than 20 percent. In the Tunisia program, family planning was integrated with post-partum care. A post-abortion family planning program exists in Cotonou, Benin and was evaluated by WHO. An evaluation of a community-based program to provide family planning services to women at high risk of unwanted pregnancy was also done by WHO in San Borja, Peru (WHO 1990-1991 Progress Report). It might be useful to:

Review experiences to date regarding integration of family planning with maternal and child health services. What is the most effective and efficient way to change reproductive behavior and to increase access to contraceptive information and supplies? When are women most receptive to family planning counseling and services (during prenatal care, postnatal care or post-abortion care)? Which degree of integration is more effective: should we only integrate family planning counseling in all maternity services with a strong referral system to family planning services, or should we offer both family planning counselling and services on site at contact points? Conduct studies on the effectiveness of targeting family planning activities on postpartum and post-abortion patients.

- Quality assurance of maternity care

a). Prenatal, Intrapartum and Postpartum Care.

Basic research on established interventions such as prenatal, intrapartum and postpartum care and its efficacy is essential to rational planning of effective health services to reduce maternal mortality and morbidity.

Studies should be designed to provide answers to questions such as: What conditions can benefit most from early prenatal care? What conditions can benefit most from postpartum care? What components of prenatal and postpartum care are most useful in reducing maternal morbidity; are these different from those components most likely to reduce mortality? Do these components of care contribute to measurable improvements in maternal mortality and morbidity? How much do

these interventions cost?

The use of Risk Assessment/Approach

For women in sub-Saharan Africa, the risks of complications in pregnancy are much higher than the rest of the world. It has been estimated that in sub-Saharan Africa, a woman runs a one in 21 lifetime risk of dying from pregnancy-related causes, compared to one in 34 in South Asia, one in 73 in Latin America, one in 10,000 in Northern Europe and one in 2,700 in North America. All antenatal care programs throughout the world are based to some extent on risk assessment. This risk approach requires that all pregnant women be screened for risk factors during the prenatal, intrapartum and postpartum periods, and that those identified as being at high risk receive special surveillance and treatment from a suitable level of care, with the objective of concentrating attention on those most likely to need such care.

However, recent studies in developing countries have suggested that most of the women who are identified as having "risk factors" may not develop life-threatening complications, since most of the major problems which can lead to maternal mortality cannot be predicted with sufficient accuracy, except in the case of obstructed or prolonged labor (Winikoff 1991; Maine 1990). The largest number of maternal deaths come from those women who are identified as "low risk". For example, analysis of data from Kasongo, Zaire, show that of 100 women who were labeled "high risk" for obstructed labor because of bad history, only 10 percent developed obstructed labor. Conversely, of all obstructed labors, only 29 percent were predicted. Thus, the poor predictive power of screening was challenged by some people. The rationale was that using the risk approach may overload an already over-stretched maternity unit; and that women may lose confidence in the system because they were designed high risk but delivered without problem (Kwast 1993). Improving the medical care system, including early identification and treatment of complications for every woman, plus adequate referral system, to deal with obstetric emergencies seems to be the proposed option of this advocacy group.

In fact, screening programs face a problem sometimes referred to as the "inverse care law." It is often those at highest risk of adverse outcome (very young age, lack of education, poverty) who are least likely to use and have access to health services. And for many women in developing countries (especially those in rural areas) it is not possible to follow the advice they are given during screening. For example a study in Kenya found that the women who intended to deliver in the hospital, only about one-third did so. The reason for this was not that the women changed their minds, but that practical difficulties, such as lack of transportation, arose (Maine 1991).

One problem may be the use of the terminology "high risk" and "low risk"; and the fact that once categorized, all our efforts are focused on high risk women. But, Cameroon has adopted the risk approach in Yaounde for several years and concluded that the program has succeeded in bringing about significant reductions in maternal mortality.

Clearly, there is a controversy about the effectiveness of the risk approach. During a meeting held in April 1993 in Bujumbura, Burundi, the Francophone African Resource Group for Safe Motherhood (a group of African experts) agreed on the following: A significant number of African women possess one or more of the broad characteristics which are frequently used to define maternal risk, such as pregnancy under age 15 or over age 40, multiple pregnancies or previous complications, or other associated health problems such as malaria, hypertension, stunted growth or malnourishment. But there are not enough studies to conclude on the predictive value of "risk factors" for maternal mortality in developing countries. And, because of the issues of access and availability to health services in Africa, some African health and family planning professionals still see the risk approach as an evolving process and have identified it as an important area for continued research in Africa. The socioeconomic status of most women in Africa and the barriers to access to care create an environment in which it is important to screen women for early indications of complications and to refer them to trained health providers. The group concluded that:

It is a priority to carry out further research on risk assessment in the African environment in order to develop guidelines for health providers to screen women for the most common and important complications (Daly, Azefor and Nasah 1993).

3.3.2 EXPANDING ESSENTIAL REPRODUCTIVE HEALTH SERVICES

a). Upgrading First Referral Level Facilities.

Equally important is the role of first referral level facilities (upgraded health centers, rural hospitals) in providing the essential elements of obstetric care. Identifying risk will not help women if essential obstetric care to prevent or treat problems are not available or are inaccessible. For example, in Senegal's Kaolak hospital, transfusion was not available for 80% of women referred in labor needing transfusion, nor was anaesthesia for 64% of those needing it (Region medicale de Kaolak 1988). It is widely accepted by international expert bodies that the route to safer motherhood lies not through expensive technologies but through strengthening and upgrading existing health centers and district hospitals to provide essential elements of obstetric care to all those in need. But, what has been learned so far about first referral level facilities? How efficient are they? How can quality care be ensured at first referral facilities? Lack of infrastructure, an insufficient number of personnel (and in some muslim cultures, lack of female health workers specifically), inadequate training, shortage of supplies and equipment, and inadequate monitoring and supervision all contribute to inefficient, poor quality services (Starrs 1993).

Future research should focus on evaluating existing first referral level facilities to: assess their efficiency and sustainability as well as their impact on safe motherhood;

and to identify the best approaches to ensure key quality care at the facilities. Studies should be designed to provide answers to questions such as: What has been learned so far about the efficiency of first referral level facilities? Which services when provided at first referral level facilities most effectively reduce maternal mortality and morbidity? What are the most practical, cost-effective approaches to ensure provider competence at referral facilities, especially in remote areas?

The Referral System.

Getting women to the nearest first referral level facility when complications arise still presents formidable problems in many developing countries. Many women die while waiting for transportation or during transportation. For example, in Addis Ababa, 13% of maternal deaths recorded over a two-year period occurred on the way to the hospital. Between 1975 and 1983, 8% of maternal deaths recorded in two rural areas in Turkey took place on the way to the hospital. In rural China, a maternal mortality survey revealed 15 percent of maternal deaths occurred on the way to the hospital. This problem is being tackled in a variety of approaches: by bringing services closer to the people and by bringing people closer to the services. Information about the effectiveness and impact on maternal mortality and morbidity of these various approaches (maternity waiting homes, mobile teams, village cooperative transportation systems, etc.) is generally incomplete and often unavailable.

In some countries such as Malawi, Ethiopia, Zaire, maternity waiting homes are being used. The positive impact of the "tukul" or maternity waiting home in reducing maternal mortality as well as morbidity at the Attat Hospital in Central Ethiopia is well-documented. In Cuba, government supported maternity waiting homes were part of Cuba's successful program to reduce maternal mortality. And in Zimbabwe, maternity villages were an integral part of the maternity services offered by four rural missionary hospitals. Conversely, experience in Zaire showed that maternity waiting homes in Karawa were under-utilized due primarily to a lack of community involvement in designing and building the homes and consequent lack of consideration for community concerns, particularly related to patient's food preparation. Other approaches such as village cooperative transportation systems, obstetric emergency flying squads, mobile teams for primary health care and family planning who can identify high risk women in the community are also being tried. In Southern Ethiopia, maternal messengers who will run and walk for up to three hours from a village to alert the midwife at the health center are being used. In some parts of Africa, women's groups pool funds and lend them to various members in turn. This custom could be adapted to provide funds for obstetric emergencies.

There is a need for analysis and information dissemination on the effectiveness, costs, sustainability and impact on maternal mortality and morbidity of the various approaches being used to improve referral for emergency maternity care: maternity waiting homes, village cooperative transportation systems, savings groups, obstetric emergency flying squad, and mobile teams.

Quality Assurance of Maternity Care

There is significant concern by African health professionals about the quality of health services for women in Africa. Even where health services are readily available and affordable, women may not use them because of their poor quality (Parker et al. 1990). Therefore, efforts to improve the quality of services are crucial. Lack of infrastructure, an insufficient number of personnel (and in some muslim cultures, lack of female health workers specifically), inadequate training, shortage of supplies and equipment, and inadequate monitoring and supervision all contribute to poor quality services (Starrs 1993). Researchers should focus on finding the best ways to ensure the key quality of care factors in service delivery points: provider competence, appropriate physical infrastructures and management system, adequate supplies and equipment, good information to patients and strong follow-up system.

One component of high quality of care is the presence of qualified personnel. shortage of physicians, nurses and trained midwives in developing countries - particularly in rural areas - contributes to maternal deaths (Maine 1991). Also, most of the nurses, midwives and physicians in Africa, once in the field, do not have any opportunity for additional update and training. Moreover, no evaluation is carried out about their ability in rural clinics to diagnose, treat or refer clients to the closest hospital. A MotherCare project has provided annual continuing education to some midwives in Uganda and Nigeria to upgrade their midwifery skills and develop proficiency in life saving skills (LSS), including risk assessment, use of partograph for monitoring labor, use of written protocols for referrals, and problem solving. This LSS is a program developed by American College for Nurses and Midwives (ACNM) and has been offered in various countries by different donors (MotherCare in Nigeria and Uganda, Carnegie Corporation in Ghana, and Population Council in Vietnam). The effectiveness of such projects should be evaluated and documented.

As a basis for effective intervention, evaluate existing services providing care to women, focusing exclusively on factors that create a negative perception of quality including:

- * **provider competence (training curricula, refresher training, conformity to guidelines, supervision)**
- * **client-oriented physical infrastructures and services (convenient service hours, privacy, special needs of adolescents, availability of counseling and a range of treatment and diagnostic options)**
- * **adequate equipment and supplies**
- * **adequate staffing (female health care providers)**
- * **provider sensitivity**
- * **information flow between clients and providers**
- * **continuity of care and follow-up**

*** monitoring and supervision**

and identify ways to improve quality care.

Determine how infrastructure and services can be made friendly and convenient to patients in terms of space (adequate for counselling, treatment and diagnosis), in terms of timing (availability of services at time when demand is highest, not when it is convenient to providers), and in terms of treatment options (for example a range of contraceptive options).

Determine how can a constant provision of supplies and equipment be ensured in quantities sufficient to meet needs? Should the "Bamako Initiative" be expanded everywhere or do we need some improvement? What are the best re-supply systems?

b). increasing maternity care coverage and maximizing access.

In most African countries, the number of physicians is very low and the number of physicians trained in obstetric care is even lower, and almost all of them are in big cities. Moreover, in most countries midwives are reluctant to work in rural areas, and TBAs are the only alternative to pregnant women. This presents a major problem since complications leading to maternal death are often not predictable and require immediate action by those nearby. Given the realities of transportation, communication, availability of health services, and cultural practices and preferences of clients, nurse-midwives, midwives and TBAs at the most peripheral level of the health care system are in an excellent position to provide women's health services, after adequate training. However, problems of legislation and licensure prevent this option in many countries.

Some approaches to increase maternity care coverage and maximizing access comprise: (1) including community obstetrics in the training of physicians; (2) upgrading the skills of non physician personnel (nurse-midwives and midwives) in management of obstetric emergencies and delegating responsibility to them; (3) increasing the supply of trained female health care providers; (4) influencing national policy in the practice and quality of maternal care including delegation of responsibility; (5) increasing outreach services; and (6) community involvement. For example, a 1989 World Bank economic and social strategy study in Pakistan suggests that more efforts should be focused on outreach and community based delivery systems to overcome the lack of facility-based services for women.

An analysis and evaluation of the above approaches should be considered a priority for generating information needed to develop strategies to increase coverage of maternity care.

Responsibility Delegation.

In most African countries, the number of physicians is very low and the number of physicians trained in obstetric care is even lower. Almost all of them are in big cities while 80 percent of the population is in rural areas. Example, of the 200 obstetricians in Nigeria in 1980, more than 90 percent were located in the national and state capitals. By contrast, the proportion of the population living in urban areas was estimated at 11 percent (Deborah Maine 1991). A study in East Africa in 1979-81 found that only an estimated one in 10 women who needed an emergency cesarean section obtained one (Deborah Maine 1991).

Obviously, the responsibility for performing life saving tasks, such as symphysiotomy, cesarean section, or manual removal of a retained placenta, is typically in the hands of a few who work far from where the women actually deliver. This can be overcome by coordinating communication and transport between levels and/or to delegate specific life saving functions to non-physician personnel after special training. However, problems of legislation and licensure prevent this option in some countries.

But, in many countries, midwives already perform essential functions such as manual removal of placenta, vacuum-assisted deliveries, etc. In Zaire, selected obstetric nurses are trained to perform emergency surgery, including cesarean section, symphysiotomy, repair of ruptured uterus, and hysterectomy. (White et al. 1987). This is also being done in the Gambia, where selected nurse-midwives are trained in "high-risk" obstetrics and are posted to upgraded health facilities. In Uganda and Nigeria, MotherCare demonstration projects are designed to improve the quality of maternal care by strengthening the knowledge and skills of midwives through training focusing on management of obstetrical emergencies.

Analysis and evaluation of existing and ongoing field works regarding responsibility delegation, focusing on impact and lessons learned (including acceptability of greater responsibility of MCH care by non physicians and approaches used to influence national policy in responsibility delegation) should be considered among the research priorities.

APPROPRIATE TECHNOLOGY

Manual Vacuum Aspiration.

For several years, the International Projects Assistance Services (IPAS) has been conducting studies and supporting services (e.g., training and equipment) related to the use of manual vacuum aspiration (MVA). MVA is a simple procedure using a hand-held syringe that can be used safely by all levels of health staff including trained paramedical personnel in the management of complications of unsafe abortions. The manual kit for MVA marketed by IPAS is inexpensive, easy to use and appropriate to a wide range of settings. In Kenyatta National Hospital, Nairobi, substantial health care resources were being used to manage incomplete abortions. After the introduction of manual vacuum aspiration technique, clients and providers

have benefited from shorter hospital stays, better results, and cost that have been reduced by 23 to 66 percent (Tinker, Koblinsky).

A group of health professionals (in Nigeria, Kenya, Zimbabwe, Ghana, Ethiopia, Zambia, etc.) exist, who have worked closely with IPAS and who could serve as resources. The knowledge and experiences of these health professionals should be capitalized not only to further extend MVA training but also to study the cost-effectiveness and impact of manual vacuum aspiration in the treatment of incomplete abortion in African countries where it has already been adopted.

d). Services Catering to Adolescents.

A number of successful adolescent programs exist, although these experiences have not been sufficiently documented and disseminated. Given the increasing priority of meeting adolescent needs, it may be valuable to take a comprehensive look at existing teen services with the aim of better understanding the context and the "recipe" for their success. For example, the Youth Counseling Project in Ethiopia, housed in its own center, provides counseling, nonprescription contraceptives and referrals for clinical services. The project which plans to open its own clinic reports that its condom distribution has been very successful; in one year it registered nearly 2000 condom clients (CIE 1992). In Botswana, the YWCA's Educational Center for Adolescent Women serves adolescent mothers and pregnant teens through basic schooling, child care, parenting classes, sex education and counseling. The Center reports there have been no dropouts and few repeat pregnancies in three years (IYF 1992). In Mexico, Guatemala, Costa Rica and other Central American countries, Family Planning Associations train adolescent counselors to promote family planning among their peers, and multi-service youth centers offer family planning information and service along with job-related and recreational activities (Harper, nd).

It might be useful to identify and analyze successful regional adolescent/youth services to develop a better understanding of "recipes" for success. How can existing family planning services be redressed to make them more accessible to adolescents? What adaptations are needed to better serve adolescents? What strategies must be used to integrate FP and STD/AIDS services in family life education or youth programs? What approaches are required to enhance the ability and freedom of adolescents to make informed choices about health and contraception?

3.3.3 Community participation

a). Community Involvement.

Community involvement is felt to be very important in Africa. Knowledge of the danger signs of pregnancy, labor and delivery period and where to go for appropriate services is essential to reducing maternal and neonatal mortality. In order to improve timely and appropriate use of services, these signs must not only be recognized by the woman, but also by those who are in the community and are in the decision making position during the time she may be disabled (MotherCare Lessons Learned 1989-1993). And mobilizing resources to transport the woman to health services once complications are identified may require a community-wide effort, which in itself needs a convincing push (MotherCare). Therefore community involvement should be a high priority of safe motherhood programs in Africa in order to increase maternity care coverage. MotherCare carried out a three-year community-based project in Bolivia (Inquisivi), based on "autodiagnosis" of health problems through the community women's group. The project also promoted income generating activities (including the production and sale of safe birth kits) that would provide emergency funds for transport of obstetric complications. If effective, such project could be a model for community participation to disseminate for replication in African settings.

There is a need to support information dissemination and research studies on the evaluation of innovative community interventions which have the potential for expansion and replication (approaches used, costs, impact on women and sustainability) to support safe motherhood and improved reproductive health in Africa.

b). Training Traditional Birth Attendants.

WHO estimates that in developing countries, some 60 to 80 percent of births are still delivered at home by traditional birth attendants (TBAs). Furthermore, results from the Maternal Nutrition and Health Care (MNHC) Program, a USAID-funded 13-country research program indicated that surprisingly large numbers of women selected traditional birth attendants as their care providers. Accessibility of the TBAs was the one factor consistently identified as a key determinant of use. Investing in TBA training has been the focus of a number of national and international organizations, and many countries now offer some form of training program for TBAs. Training programs have already brought benefits--for example, a World Bank-supported evaluation in the Gambia documented that trained TBAs demonstrated significantly greater knowledge of risk factors and referred more pregnant women with complications than did untrained TBAs (Post et al. 1990).

One barrier to successful TBA training programs is the lack of collaboration between the formal health system and the TBAs. The PROAIS project in Fortaleza, Brazil, is an example of successful collaboration. The project trains TBAs and also serves as a base for professors and health science students from the Fortaleza University to meet their rural community work requirement. The program not only succeeded in providing rural areas with modern medical care but students have also benefitted from the opportunity to combine their formal training with

beneficial traditional practices (Bomfin 1991). The success of the project has prompted similar efforts elsewhere in Brazil. The Karawa Health Zone Project in Zaire and the project in Zimbabwe in which community midwives are trained to improve coverage of antenatal, delivery and postnatal services are other examples (Tinker, Koblinsky et al. 1993).

Given the role TBAs play in the community, mechanisms for integrating trained TBAs in the modern health care system need to be determined, specifically in areas with very limited access to modern medical care. Mechanisms to link traditional and modern care systems for efficient and effective maternity care should be explored; and the impact on maternal mortality and morbidity of training TBAs should be assessed.

c). **Education.**

Formal education affects health behavior, which in turn affects health status. Illiteracy and low levels of educational attainment deprive women of both the knowledge of health problems and the will to seek care. For example, it is widely believed that pregnancy is not a condition that requires medical care, which is sought only in cases of complications (United Nations 1986). Similarly, a study in Zimbabwe found that the main reason why women with cervical cancer delayed seeking care was that they did not recognize the seriousness of the problem.

Greater educational achievement is associated with an increased likelihood to use health services and seek health care. A multivariate analysis of household data from Jamaica (Strauss et al. 1992) showed education to be an important determinant of the health status of adults. The World Bank's Agenda for Action to achieve greater advancements in health places "providing solid primary schooling to all children, especially girls" as crucial to foster an enabling environment for households to improve health (World Development Report 1993 - Investing in Health). The Report cited Kenya as an example, where rapid and sustained increase in female enrollment was achieved by a combination of high-level political commitment to universal primary schooling, strong demand creation through information and support from the international community. Another example is Bangladesh, where girls' education in rural areas is now cost free up to the eighth grade and all new recruitment as primary level teachers will be females (UNICEF 1991).

It might be useful to analyze different approaches to increase women's literacy rates especially among less favored populations. Assess and disseminate information on innovative programs to increase female enrollment (such as Kenya, Bangladesh), focusing on the constraints faced and the approaches used by the programs to overcome the obstacles, and the correlation between health improvement and the investment in female schooling.

Lack of Autonomy and self-esteem.

Maternal autonomy and self-esteem exert powerful influences on a wide range of maternal care choices and behaviors such as utilization of health services. Women lack legal titles to land and are less likely to obtain credit, despite contributing the majority of labor to food production. While men receive the income from cash crops for export, women rarely do. For example, Ghanaian women farm but do not have the right to sell their farm crops and, despite the "significant contribution" that women in Lesotho make to household income, expenditure decisions are dominated by men (Rahman 1992). A number of examples correlate women's inadequate access to health services because of income constraints.

In Senegal, a study found that decreased utilization of health services by women, particularly poor women, was in response to rising user fees (Timyan 1993). Educational attainment and financial accessibility through involvement in income generating positions can contribute greatly to female autonomy and self-esteem and in turn impact on women's health. For example, the Country Women's Association of Nigeria (COWAN) uses a traditional credit system as the vehicle for assuring adequate health care for its members, through a membership card that entitles them to medical attention at the referral hospital (Timyan 1993).

There is a need to conduct research on the impact of female autonomy and self-esteem on women's reproductive health behaviors. Assess and disseminate information on innovative programs to promote female autonomy (educational attainment, financial accessibility through involvement in income generating activities), focusing on approaches used, lessons learned, impact on health and potential for replication.

Impact of Culture and Tradition.

a. Barriers to utilization of Services.

Culture and tradition have great influence on women's reproductive behavior and, therefore, on maternal morbidity and mortality. For example in many African settings women are reluctant to use maternity centers. Women's use of health facilities may be restricted by the necessity for privacy and/or the custom that a male relative must give permission or accompany them while travelling. For Saudi Arabian women for example, the requirement that care must be given by a woman has hindered the use of MCH services. Women in sub-Saharan Africa, particularly rural places, depend upon older women in the household or in the community for advice about their health, but older women are typically traditionalists with limited formal education and with little knowledge of modern medicine.

WHO conducted a study in Nigeria on "The TBA and The Hospital System" to review factors

contributing to choices pregnant women make in the utilization of obstetric services. Another WHO study of cultural factors influencing use of maternal services was conducted in rural Kenya in 1990 (WHO 1987-1990 Progress Report). Also a team from Center for Population and Family Health, Columbia University, has worked with West African institutions to form a network of multidisciplinary research teams known as the Prevention of Maternal Mortality (PMM) Network in nine universities located in Benin, Nigeria and Ghana. The focus is on understanding the many interacting factors - cultural, social, economic, geographic, and others - that act as barriers to prompt emergency treatment of obstetric complications through focus group discussions; and to identify potentially effective interventions. It might be useful to:

Identify through community surveys and through existing studies and literature reviews (such as the Nigerian study, the Kenyan study, and the PMM findings), barriers (including cultural and traditional) that affect motivation to seek or not seek appropriate care and utilization of maternity services, specifically in settings where TBAs are preferred to trained health personnel. Findings can be used to develop specific approaches to address these barriers. (Give special attention to adolescents and women in rural, isolated settings where the majority are illiterate with little access to information.)

b. Female Genital Mutilation.

Another example of culture and tradition influencing maternal morbidity and mortality is female genital mutilation (FGM) which is still practiced in many African countries. Major health problems are associated with FGM - particularly with the more severe forms such as clitoridectomy and infibulation. In addition to the immediate medical problems (e.g. hemorrhage, septicemia, shock, etc.) female circumcision significantly contributes to chronic health problems. A higher proportion of circumcised women are infertile, and many experience complications due to painful and difficult childbirth leading to longer expulsion phase, perineal lacerations and urinary fistulae.

The practice of such traditions, which are deeply rooted in cultural and religious beliefs, is clearly a major health concern in Africa. The estimated total number of mutilated women and girls in East, West and Central Africa is about 110.529 millions which is more than half of the female population (Hosken 1992). IPPF is organizing campaigns to eradicate the practice. In 1989 IPPF sent a questionnaire to all 48 African and Arab World national family planning associations to gauge the extent of female genital mutilation and the work being done to overcome it. IPPF's International Medical Advisory Panel has now drawn up a draft statement on female genital mutilation, which is being circulated internationally before being finalized (IPPF 1991). But there is a need for more organizations to try together to bring female genital mutilation into the broader programs aimed at improving the reproductive health of women. Priority areas for future research include:

- (a) Analysis and information dissemination on the devastating consequences of FGM on women's reproductive health and the social and psychological impact.**
- (b) Social science research to learn more about the attitudes of community members toward female circumcision in order that strategies to reduce the incidence of the practice be identified.**
- (c) Several organizations including WHO, United Nations Children's Fund, IPPF, the Population Crisis Committee and Women's International Network have joined the fight against FGM. Analyzing and disseminating their initiative and action agenda to sensitize policy makers and stimulate the creation of a joint advocacy group should be considered. But perhaps the greatest opportunity for long-term change is involving young people themselves. Therefore it might be useful to look at the potential role of youth organizations in the fight to eradicate female genital mutilation.**

c. Social Support Networks.

Social support systems such as the presence, guidance, and assistance of a wide network of family, extended family and community members are crucial factors influencing maternal care choices throughout all phases of the reproductive process. Appropriate social support can also provide a means to reinforce desired maternal health practices and health care seeking behavior. In some parts of Sub-Saharan Africa these traditional systems appear to be eroding. In areas where these networks, particularly women's groups and associations, have been successful in providing health information and drawing on local women to promote their own health, there has been no evaluation on their effectiveness and their impact on improved women's reproductive health, to date.

There is a need to evaluate the effectiveness of social support networks, their different approaches and their impact on improved women's reproductive health. Also research can be focussed on how community-based support networks might be formed and/or used to help provide women with better health information and better access to health facilities through the establishment, for example, of cooperative transportation arrangements. Best practices and lessons learned from the research can be disseminated and utilized to develop and /or strengthen community-based networks, based on specific socio-cultural settings.

3.3.4 Monitoring and evaluation

IV. RESEARCH, ANALYSIS, AND DISSEMINATION APPROACHES

Because research, analysis, and dissemination activities need to be demand driven, the AFR/ARTS will revise and update this framework as new information and requests are presented by African decision-makers and experts in reproductive health, and USAID Mission and field staff.

The research, analysis, and dissemination activities will be implemented through a range of approaches. These approaches may be thought of as falling along a continuum involving different levels of methodological sophistication and input. At the one end of the continuum is literature review and synthesis of existing information, especially lessons learned from previous or ongoing studies and programs. An approach might involve a literature review and synthesis followed by short-term field work to verify conclusions or test hypotheses. At an other end of the continuum is long-term , multi-country research with primary data collection.

An effective dissemination of information generated will be essential to achieving the purpose of improving policies, strategies, and programs of reproductive health in Africa. The dissemination activities should support advocacy efforts for an improved reproductive health in Africa.

Research priorities and approaches to implementing analytical activities should be tied to field programs which offer the potential for an effective African participation during all the phases of implementing the analytical activities, including assessment of impact of the activities on decision-making related to reproductive health in Africa.

USAID has addressed maternal health and nutrition as part of its overall health strategy. AID's experience in maternal health and reproductive health in Africa has been through a variety of bilateral and centrally funded child survival, population and family planning projects. These programs should facilitate the implementation of a broader approach to reducing maternal mortality and morbidity, and to improve reproductive health services.

USAID plays a major leadership role in population and family planning that strongly influences actions and priorities throughout the world. One of the principal objectives of the Agency' population, health, and nutrition strategy is to improve individual reproductive health, with special attention to the needs of women and adolescents. USAID Bureau for Africa interest in improving reproductive health in Africa will help to draw more attention and resources to this important public health area.

A number of USAID cooperating agencies active in the family planning arena could also contribute to addressing the broader issue of safe motherhood and improved reproductive health. For example, in its approach to controlling RTIs in women, USAID is supporting a spectrum of activities through various cooperating agencies. In Nairobi, Kenya, a demonstration project

aimed at maternal syphilis control was implemented in urban prenatal clinics by the MotherCare project. Although the impact, effectiveness, cost and feasibility of the demonstration project has not yet been evaluated, the project demonstrated the feasibility of an integrated reproductive health service package by decentralizing screening facilities to a primary health level.

In Mali, 1,000 women were educated about condoms through STD clinics. Sentinel surveillance systems have been established to track and monitor STDs in several developing countries including Burundi and Uganda. As part of its STD Diagnostics Initiative, USAID is funding research and development of field diagnostic technologies. And through its HIV/AIDS prevention programs to reduce sexual transmission of HIV, STDs are being addressed through behavioral interventions, condom promotion and STD control through provision of diagnosis and treatment at existing service delivery systems such as prenatal clinics and family planning clinics.

During each analytical agenda setting cycle, AFR/ARTS will use the strategic framework to select priority issues. The analytical activities would be implemented based on their likelihood to provide information for better decision on strategies and programs to improve reproductive health in Africa.

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**ANALYTIC ACTIVITY SUMMARY:
OPERATIONS RESEARCH ON SOCIAL MARKETING OF REPRODUCTIVE
HEALTH SERVICES TO ADOLESCENTS**

THEME: ADOLESCENT REPRODUCTIVE HEALTH SERVICES (IF21)

QUESTION: Is social marketing an effective approach to reach in-school and out-of-school adolescents with information and services to prevent unwanted pregnancies, HIV and other STDs?

WHY IS THIS QUESTION IMPORTANT?: One of the four USAID priority areas, Population and Health, has as one of its objectives the improvement of the reproductive health of adolescents. The process of developing the AFR/ARTS/HHR draft strategic framework for population and family planning also identified adolescent reproductive health as an important need which was incorporated as the following objective: "To increase demand generation by promoting policies and program approaches that encourage contraceptive use by special groups: adolescents and youth;...." Programs in adolescent reproductive health are fairly new in Africa and there is a need to identify potential models for replication, which the current project will attempt to do. Some projects in Africa have offered education and services to adolescents, but the number of those actually reached has been small. Social marketing techniques have the potential for reaching larger target audiences.

RESEARCH DESIGN: Building on an existing condom social marketing program, the project will add a specific focus on adolescents through mass media communications targeted at this audience and teen-to-teen workshops. Mass media alone versus the combined strategy will be implemented in different locations and compared through baseline and final surveys.

WHO IS GOING TO DO IT?: Population Services International

ACTIVITY MANAGER: Phyllis Gestrin

EXPECTED OUTPUTS: Country monographs on the outcome of OR and a document summarizing the results in the two countries.

EXPECTED ACTIONS: Other countries in Africa would add a focus on adolescents to their contraceptive social marketing programs, particularly as it relates to service delivery.

PRIMARY AUDIENCES: Because contraceptive services for adolescents is still a sensitive issue, the primary target would be African policy-makers in relevant ministries. Other important audiences include health and family planning personnel, USAID missions, and other donors.

DISSEMINATION STRATEGIES: Publications, distribution of reports to host government personnel, international agencies, and others involved in the provision of reproductive health services.

FUNDING SOURCES: HHRAA -- \$300,000 for the addition of an adolescent focus in Botswana and Benin. This will be added to basic support for PSI's contraceptive social marketing program which comes from USAID bilateral funds and other donors. Contracting mechanism for Botswana will be an OYB transfer to the bilateral project. Contract mechanism for Benin is under discussion.

STARTING AND COMPLETION DATES: Start: upon receipt of funds, approximately September 1994.
End: September 1996.

ANALYTICAL ACTIVITY SUMMARY
ANALYSIS OF VERTICAL AND INTEGRATED FAMILY PLANNING
SERVICE DELIVERY (1F17)

THEME: Improving Family Planning Service Delivery

QUESTION: Which approach to delivering family planning services is more effective: a "vertically" organized, exclusive family planning (FP) service, or one that is integrated with other maternal-child health functions?

ACTIVITY: Compare the performance of "vertically" organized FP service delivery systems with integrated programs.

WHY IS THIS QUESTION IMPORTANT?: If one approach proves itself to be markedly superior (in terms of volume, quality of services, and cost effectiveness), then this should be considered as new FP programs are started or old ones are expanded.

RESEARCH DESIGN: Compare and analyze the performance of two "vertically" organized FP service delivery systems (Ivory Coast and the "Chogoria" region in Kenya) with three integrated programs (Botswana, Cameroon, and Senegal). This is a "natural" experiment with activities already underway; consequently, there are no design or implementation costs.

WHO IS GOING TO DO IT?: The Academy for Educational Development and its subcontractor, Tulane University School of Public Health, and African subcontractors.

ACTIVITY MANAGER: Robert Haladay.

EXPECTED OUTPUTS: An evaluation of two contrasting approaches to providing contraceptive services will reveal the strengths and weaknesses in each. This analysis will be of value to program managers and donors as they design new or expanded family planning service delivery programs in Africa.

PRIMARY AUDIENCES: The primary audiences will be African public health and family planning officials, NGO managers, and the international donor community.

WHAT ARE THE RESOURCE COSTS? FY 1993: \$146,000; LOP: \$322,000.

FUNDING SOURCE: DFA/HHRAA Project funds.

STARTING AND COMPLETION DATES: July 1993 through December 1996.

ANALYTICAL ACTIVITY SUMMARY

COMPARATIVE ANALYSIS OF URBAN POPULATION PROGRAMS (1F16)

THEME: Reducing Rapid Urban Population Growth

QUESTION: Should more vigorous family planning and fertility control programs be mounted in urban areas?

ACTIVITY: Assess six urban family planning programs to determine their: (1) adequacy of coverage and capacity to meet demand; (2) absorptive capacity; (3) success in increasing contraceptive prevalence, and (4) quality of services.

WHY IS THIS QUESTION IMPORTANT?: Family planning acceptance spreads from cities to the countryside. Therefore, it is important that urban family planning programs be maximally effective so that they will serve as models for replication.

RESEARCH DESIGN?: The hypothesis is that urban men and women of reproductive age remain underserved in terms of their contraceptive needs. A corollary hypothesis is that the service delivery system is overwhelmed and unable to satisfy expressed or latent demand for services.

WHO IS GOING TO DO IT?: An Office of Population Cooperating Agency.

ACTIVITY MANAGER: Lenni Kangas, Robert Haladay.

EXPECTED OUTPUTS?: (1) A report on the status of six major urban family planning programs in Africa, including their accomplishments, shortcomings, needs, and opportunities for improvement; (2) the basis for new bilateral projects to substantially upgrade urban family planning services.

PRIMARY AUDIENCES?: (1) Health, family planning, and political leaders in urban/municipal areas; (2) the donor community.

WHAT ARE THE RESOURCE COSTS?: Assessments will be conducted in six cities by two-person teams of African and U.S.-based principals. Staff from CERPOD and CAFS will be funded to participate. Salaries, travel, per diem, subcontracts: \$250,000.

WHAT IS THE FUNDING SOURCE?: HHRAA Project Funds.

STARTING AND COMPLETION DATES: August 1993 through March 1994.

HHRAA Project

Population/Family Planning

Subsector Results Report

Period ending May 1994

1. Major Achievements

It has been recognized for each sub-sector of the HRD Division that an assessment to measure the policy impact of the division's activities is premature, given the nature of the research and analysis (R&A) activities that have been undertaken. This judgment applies as well to the population/family planning sub-sector. On the other hand, there are indicators that the process being utilized to develop R&A activities in this subsector is on the correct track.

In the initial two years of activities, from mid-1992 to mid-1994, approximately 33% of the financial resources obligated through the prime contractor of the HHRAA project were expended in the population sub-sector. A significant achievement resulting has been the development of a Population Strategic Framework that both is consistent with the Agency's evolving overall strategy and has served as the de facto strategy for the Africa Bureau.

Furthermore, as the analytic agenda in this area has been formulated, with much interaction and participation from field missions and Africans, expressions of interest from these quarters in the eventual results have surfaced. Included in this category are the on-going studies of the assessment of urban family planning services, the vertical/integrated organization comparative study, various efforts centering on adolescent fertility and the nascent examination of how HIV/AIDS prevention measures can best be integrated with conventional family planning programs.

2. Key Outputs

- A. A report on partial results of the assessment of urban population programs is ahead of the original schedule and will be completed by October 1994, in time for presentation to and discussion by health officials from East and Southern Africa.
- B. The comparative study of integrated and vertically organized family planning programs is on schedule, with field sites being selected and local analysts contracted.
- C. Two new studies on adolescent fertility have been initiated, the first focusing on data analysis of the Demographic Health Surveys of 4 countries in West Africa and the second testing various social marketing approaches to reach youth with advice and services in Botswana and South Africa.

D. A monograph on the prevalence and consequences of septic (unsafe) abortion is in development, based on hospital admission records and interview material in 12 countries in E/S Africa.

E. Workshops

- A "mini" seminar was held in Washington in June 1994, as a follow-up to the Population Council/Operations Research Conference convened in Nairobi.
- Johns Hopkins, a subcontractor in the HHRAA project, organized a gender workshop focusing on the involvement of men in the dynamic of family planning decision making (6/94, Washington).
- In January 1994 a medical barriers workshop (more recently termed "maximizing access to quality") was carried out in Harare for medical practitioners of the subregion.

F. Reports/Dissemination

- A synthesis was commissioned and financed by the HHRAA project of the National Academy of Sciences (NAS) report on Population Dynamics of Sub-Saharan Africa. Copies of the main body of work were purchased and distributed to USAID Missions in the region.
- Four current issues, on new contraceptive technologies, of the popular "Population Reports" produced by the Population Communications Services project of JHU were translated into French and 10,000 copies distributed in Francophone West Africa.

G. Technical Assistance

Considerable "internal" technical assistance was provided on a continuing basis to the Bureau in reviews of Country Program Strategy Plans, Project Papers, budgets and other documents by the core staff of the Population/Family Planning sub-sector. In addition, technical assistance in the form of TDYs has been performed at the request of field Missions and other collaborating agencies, such as:

- Project Paper design for family planning/HIV prevention in Uganda; design work on the continuation of REDSO/ESA support to the Center for African Family Studies (CAFS); participation in site selection for the Urban FP Study. (Michigan Senior Population Fellow)
- Project Paper design work, Social Soundness Analysis, Eritrea; expert meeting on Integrated Management of the Sick Child Initiative, CDC, Atlanta; chairing

of workshop on priority setting for HIV/STD/TB initiatives as part of the Annual Conference on AIDS, Marrakech. (RTA/Public Health Adviser, Office of International Health)

- Resource person at Regional Population Conference, Dakar; review of Ghana Project Paper; member of PP team for Zambia, designing social marketing component; extended TDY in Uganda, replacing Mission HPN Officer during HL. (DH Senior Population/Health Officer)

3. Relevance

Throughout the Analytical Agenda setting process, there have been built-in a series of "reality checks" to ensure that topics selected for study and analysis are relevant to USAID's work in the developing world. To define a tentative agenda, two major Consultative Groups were convened (Dec. 1992, May 1993) which produced a listing of possible research areas for investigation. These topics were vetted with field personnel and African nationals for priority ranking based on relevance and importance at the Regional Population Conference in Senegal (12/93) and at a Population Council-sponsored meeting in Kenya (10/93).

The Population Strategic Framework, referred to in Section 1, was reviewed by the Office of Population key personnel and distributed in May 1994 to USAID Mission HPN Officers for comments and feedback. A further reality check in developing the Framework was afforded by the timely publication of six studies on "Population dynamics in Sub-Saharan Africa" by the National Academy of Sciences which was fortuitously produced and reviewed in conference during the early stages of strategy formulation and from which the strategy benefitted greatly.

4. Research

The positive reaction of potential clients (Mission staff, African managers, NGO Directors, etc.) is a favorable indicator that the quality and utility, at least of the sub-sector research agenda, is valued and responding concretely to the needs of Africans in this developmental field. The interest expressed in a number of on-going studies, mentioned above (Section 1), is a promising sign that research findings may be used.

5. African Participation

The emphasis on maximizing the involvement of Africans in the identification of issues in the sub-sector has been manifested both through membership in the Consultative Groups and active engagement in the vetting process reviewing the priority rankings of issues.

The activities identified have been linked with indigenous research or consulting institutions to the maximum extent feasible. For example, the urban family planning program study has been under the coordinating guidance of CAFS located in Nairobi. CERPOD, the research center in Bamako, Mali, has provided the principal investigators for the study on adolescent fertility in

Francophone Africa. The research to develop the monograph on the consequences of unsafe abortion is being conducted by the Commonwealth Regional Health Community Secretariat (CRHCS) based in Arusha, Tanzania.

Furthermore, the sub-sector activities have intentionally been designed to engage African researchers as the key resource and analytical personnel. The vertical/integrated organizational model, for example, will process Demographic Health Survey (DHS) data through the work of a series of subcontractors hired locally in the countries where case studies are being drafted. In this same study, the principal investigator is a Nigerian demographer.

6. Dissemination

Beyond the description provided in 2.F. regarding the NAS study and "Population Reports", a dissemination strategy has been designed directed towards program implementers and policy makers, consistent with the general thrust of the HHRAA project. USAID Mission staff, Cooperating Agency personnel, national program directors and the African research community are the main targets of dissemination efforts. In addition, discussions are on-going concerning the development of a new population information initiative involving African journalists, as an attempt to replicate the positive results of the Population Reference Bureau's (PRB) earlier projects focused on Women's Rights.

Funding of printing costs was provided for the distribution of the African Population Advisory Committee's (APAC) publication of its consciousness-raising community programs designed to promote responsible parenthood.

Finally, the proceedings of a landmark workshop (5/93) for Africa Bureau senior management focusing on the population-environment nexus were published and distributed in USAID/Washington and to field Missions.

7. Issues

It is obvious that for research results to be utilized by field practitioners there must be a sense of shared proprietorship in the development of the work itself. Generic to the entire HRD portfolio of R&A agenda items has been a resistance by many USAIDs to grant concurrence for proposed activities based on the fear that they would impose additional management burdens on already understaffed Missions. This seems to be the principal issue that has surfaced in the population/family planning sub-sector.

8. Recommendations

Emphasis should remain on the need to (a) disseminate the products of the R&A work and (b) maximize the involvement of African researchers at all stages in the process, for legitimacy of research results and to enhance the potential utilization of findings.

June 15, 1994

HHRAA RTA QUARTERLY WORKPLAN REPORTS

NAME: Lenni W. KANGAS

SUBSECTOR: POPULATION/FAMILY PLANNING

QUARTER: JANUARY 1 - MAY 31, 1994

A. OUTPUTS

1. TDY'S (Objectives and accomplishments)

TDY at the request of REDSO/ESA, Nairobi, to be a member of a Project Paper design team for a new project with the Center for African Family Studies (CAFS), Jan. 23- Feb. 7, 1994. CAFS is a major regional family planning training and research center jointly funded by the International Planned Parenthood Federation and USAID REDSO/ESA.

Project Paper has been completed; REDSO approval expected 6/94; obligation anticipated 9/94.

2. Technical Assistance to Africa Bureau (e.g. report/document reviews, analytical analysis, presentations, evaluations)

-Wrote concept paper on operations research and program surveillance of ongoing efforts to integrate HIV/AIDS prevention, STD diagnosis and treatment with family planning and MCH programs in Africa. REDSO/ESA has agreed to be full partner in advocating this analysis activity to regional USAID missions and host country governments. Funding will be provided by the HAPA Project in FY 1994.

Collaboration with the Population Council Operations Research-Technical Assistance Project in Africa and with Pathfinder International in Africa is under consideration.

3. Research/ Dissemination/ Management (Reports on Progress/Performance of Research/Dissemination Activities)

-Actively involved in research management of assessment of family planning services in four African cities, i.e. Mombasa, Kenya; Blantyre, Malawi; Bulawayo, Zimbabwe, and; Dakar, Senegal. Project on schedule with assessments completed in Mombasa and Bulawayo, Blantyre will be done by July 15, and Dakar by October 15, 1994. Supplementary funding of \$310,000 in FY '94 arranged for JSI/SEATS via OYB transfer to Office of Population.

-Conceived one day presentation of operations research results in African family planning for Washington audience by the Population Council. (Held June 14, 1994 after snowstorm forced cancellation in February.)

-Invited to participate as member of National Academy of Sciences panel preparing to conduct research on behavioral aspects of AIDS in Africa.

-Conceptualized and designed, with Phyllis Gestrin, a multi-country operations research effort to provide adolescents with information and contraceptives to prevent unwanted pregnancy and avoid contracting STDs including HIV/AIDS. Project approved and will be conducted in Botswana and South Africa

4. Collaboration with African individuals and institutions

-Selected CAFS as principal African collaborator in assessment of urban family planning services in four large African cities. Served as technical advisor and liaison with CAFS research staff and actively worked with them in February, 1994 in Nairobi.

-With Bob Haladay, maintained frequent contact with the secretary of the African Population Action Committee (APAC) and arranged assistance to APAC for their annual meeting in Kenya in May, 1994.

-Visited and recommended collaborative relationship with the Social Research Center, University of Malawi, in Zomba for urban family planning assessment in Blantyre, Malawi's principal city. This recommendation was accepted and a contract between JSI/SEATS and the Social Research Center was executed in May, 1994.

-Recommended Eastern and Southern Africa Consortium for Reproductive Health, based in Arusha, Tanzania, as principal collaborator for three country study of the incidence of abortion and post abortion contraception. Conferred with Consortium director, Dr. Stephen Kinoti, in Africa and U.S. Contract signed in Spring, 1994.

5. Other (publications, meetings, representations)

-Prepared responses to Congressional inquiries from Cong. Obey, Cong. Johnston, and Senator Simon and testimony on population, family planning, and HIV/AIDS for AA/AFR John Hicks.

-Held two briefings for Japanese foreign assistance official, Mr. Yuichi Sasaoka, on population and family planning in Africa with specific reference to Kenya. (Japan and the U.S. are planning to jointly support health and population activities in Kenya and Ghana.)

-Submitted abstract for 1994 African Studies Association annual meeting entitled, "Demographic Dimensions of African Development" which was accepted for presentation at November, 1994 conference in Toronto.

-Drafted conceptual HPN project for South Africa in March (prior the election) and subsequently became lead person in HHR Division for coordinating HPN assistance by USAID Washington and Cooperating Agencies to South Africa.

-Represented Africa Bureau on Population Sector Council and, at times, the combined Health-Population Sector Council. Provided extensive technical comments on proposed policies and implementation guidelines.

-Attended country program review and technical issues meetings too numerous to recall.

-Covered the HIV/AIDS area during periods when Bill Lyerly was absent or on extended TDY by representing the Bureau at the monthly AIDS management meeting, responding to Congressional inquiries, and preparing written statements for Congressional testimony.

B. IMPACT

Because the results of the several analyses will not be available for another six months or so, it is not possible to attribute to them any significant contributions to policy change or revised project design and implementation.

I am optimistic, however, that the implications of the urban assessment will have an impact both on the municipalities where these analyses have been carried out and on international donor reaction which we expect will be positive in terms of additional funding for urban services.

Similarly, the series of technical exchanges envisioned in the integration study should result in mid-course corrections and revisions in the ways integrated and combined programs are implemented and/or designed. The first of such exchanges tentatively will occur in January or February, 1995 after surveillance activities have been in place for at least four months.

Date: June 15, 1994: Signature



Comments By Supervisor Mr. Kangas continues to
do an excellent job for the Africa
Bureau.

Date: Signature

R.H. Haladay

DRAFT

RESIDENT TECHNICAL ADVISOR REPORT

TO: Robert Haladay
CC: Hope Sukin, Subhi Mehdi, USAID/AFR/SD/HRD
FROM: Phyllis Gestrin, Population/Family Planning and Child Survival
PERIOD: June 15 to October 1, 1994
DATE SUBMITTED: draft submitted October 4, 1994

The following presents my activities for the above-referenced time period. I have used the format previously suggested by the Education Sector because it would seem to be easier to incorporate my individual data into sub-sector and project reports.

Because R. Haladay is on TDY at the time of this report, a draft is being submitted at this time. The final version will be completed upon his return.

Activity/Output	Description	Result/Impact	Collaborators/Audience	Products
PART A - OUTPUTS				
1. TDYs:				
No TDYs. TDY to Eritrea in June included in last report.				
2. TECHNICAL ASSISTANCE				
Abortion Indicators Working Group. Continuing involvement from 7/19/94 to present.	Preparing a set of indicators for evaluating projects which include abortion related activities.	<ul style="list-style-type: none"> . uniformity in evaluating projects . greater precision in eval . more comparability in eval. across projects 	<ul style="list-style-type: none"> . USAID cooperating agencies . USAID staff . African govns. . donors 	. set of eval. indicators
G/PHN/POP Abortion Working Group. Ongoing participation	Inter-office working group whose aim is to promote quality post abortion care through dissemination of information, policy changes, review of project proposals, etc.	Group just formulated its objectives and deliverables for the next 12 months.	<ul style="list-style-type: none"> . USAID CAs . USAID W and Missions . donors 	. document listing objectives and 12-month deliverables
G/PHN/POP Review Committee for the new Adolescent Reproductive Health Project. Participation from beginning of report period to present.	Preparing a new \$125,000,000, five-year project in the Global Bureau that will focus on adolescent reproductive health	<ul style="list-style-type: none"> . greater attention to adolescent RH . development of new, more effective approaches for reaching adolescents with RH education & services. 	<ul style="list-style-type: none"> . African govns. . USAID cooperating agencies . USAID W. and missions . donors 	. NAD, logframe, new project paper, and an RFP for a new adolescent RH project.
G/PHN/POP Adolescent Working Group. Ongoing participation	Inter-office AID working group whose aim is to improve adolescent reproductive health through information dissemination, improvements and expansion of USAID's programs and coordinating with other donors and orgs.	Group just formulated its objectives and deliverables for the next 12 months.	<ul style="list-style-type: none"> . USAID Cas . USAID W and Missions . donors 	. document listing objectives and 12-month deliverables
Review panel for G/PHN/POP New Centrally Funded Worldwide Project	Reviewing proposals submitted in response to the RFP	nature of matter under review is confidential	<ul style="list-style-type: none"> . African govns. . USAID cooperating agencies . USAID W and missions . donors 	. decision on award of contract
AFR/SD/HRD Child Survival	Ongoing review of Bureau child survival activities			
3. RESEARCH AND ANALYSIS MANAGEMENT AND DISSEMINATION				

<i>a. Management</i>				
Post Abortion Complications Research (JHPIEGO)	Ongoing management			
CERPOD Study on Adolescent Reproductive Health in the Sahel (PRB)	Ongoing management			
Adolescent Reproductive Health Services in Botswana and South Africa (PSI)	Ongoing management			
CDC Integrated Case Management Study in Kenya	Ongoing management			
Activity/Output	Description	Result/Impact	Collaborators/Audience	Products
<i>b. Dissemination</i>				
Annual Conference of the American Public Health Association	. Draft presentation on HHRAA, focussing on tying research to decision-making and African participation	. greater knowledge of the HHRAA Project and its mode of operation	. draft reviewed by HHRAA and AFR/SD/HRD staff	draft presentation
Meeting organized by P. Gestrin on HHRAA-supported CDC Sick Child Research in Kenya. 8/19/94	. Presentation by Joe Naimoli of status of project and initial results . Discussion of future research needs in some key areas related to the sick child initiative	. dissemination of results of CDC research . identification of overlapping research priorities . new HHRAA research activities being planned for 1995 . new research collaborations	. USAID cooperating agencies . CDC . USAID/G/HN	. 1995 research projects for the sick child
See section e. grp membership				
Meeting organized by P. Gestrin on HHRAA-supported CDC Sick Child Research in Kenya. 9/14/94	. Presentation by Lisa Lee of status of project and initial results, as well as prospects for utilization of results by Kenyan gov.	. dissemination of results of CDC research.	USAID cooperating agencies . CDC	. preliminary results

<i>c. Planning - Strategic Frameworks</i>				
New Journalists Project	Reviewed and discussed with PRB new dissemination project to focus on senior level African journalists and NGOs	Eventual impact of activ. <ul style="list-style-type: none"> . greatly expanded dissemination of information on population matters, including HHRAA research results . NGOs that know how to work with the press . Journalists who know how to write about population issues 	<ul style="list-style-type: none"> . African public that reads newspapers . African policy makers 	<ul style="list-style-type: none"> . Outlines of a new HHRAA activity in FY95
New Project on training for Integrated Case Management of the Sick Child	Reviewed proposal from QA Project and Jim Heiby (G/PHN/HN) to collaborate on computer-based training.	Eventual impact of activity <ul style="list-style-type: none"> . ADD 	<ul style="list-style-type: none"> . African health personnel . USAID W and missions . donors 	<ul style="list-style-type: none"> . Concept paper for a new HHRAA activity in FY95
New Project on Monitoring for Integrated Case Management of the Sick Child	Reviewed proposal from WHO/Jennifer Bryce to develop tools and a methodology for monitoring.	Eventual impact of activity <ul style="list-style-type: none"> . ADD 	<ul style="list-style-type: none"> . African health personnel . USAID W and missions . donors 	<ul style="list-style-type: none"> . Proposal for a new HHRAA activity in FY95
AFR/SD/HRD Strategic Framework on AIDS/STDs/TB . literature review to identify priority areas for research and analysis	Reviewed and proposed revisions in current draft.	<ul style="list-style-type: none"> . articulation of rationale for research, analysis, and information dissemination 	<ul style="list-style-type: none"> . African govns. . USAID cooperating agencies . USAID W. and field staff 	<ul style="list-style-type: none"> . final draft of strategic framework
Participated in meeting organized by BASICS and G/PHN/HN on integrated case management of the sick child	Reviewed current knowledge and gaps in knowledge	<ul style="list-style-type: none"> . define future research needs 	<ul style="list-style-type: none"> . USAID . Cas . CDC 	<ul style="list-style-type: none"> . better collaboration among USAID, CDC, and Cas
CDC Proposal for "bridge funding" for several activities, including sick child	Reviewed proposal and suggested revisions.	<ul style="list-style-type: none"> . action eventually delayed until FY95. 		
<i>d. Collaboration with African Individuals and Institutions</i>				
See attached written paragraph				

Activity/Output	Description	Result/Impact	Collaborators/Audience	Products
<i>e1. Other - Monitoring and Evaluation</i>				
Rapid evaluation of the CDC sick child research	<ul style="list-style-type: none"> . Developed procedures for a rapid evaluation of the activity to be used for the mid-term HHRAA evaluation. 	<ul style="list-style-type: none"> . more well-designed research in future . indication of impact research is having on African health staff 	<ul style="list-style-type: none"> . AFR/SD/HRD . CDC . mid-term evaluation team 	<ul style="list-style-type: none"> . questionnaire . schedule for eval.
<i>e2. Other - Group Membership/Representation of USAID/AFR/ARTS</i>				
see Technical Assistance above				
Population Reports upcoming monograph on Adolescents	<ul style="list-style-type: none"> . Met with the editor of the monograph to suggest directions for the presentation and discussed HHRAA adolescent research projects . Reviewed and commented on the outline for the monograph 	<ul style="list-style-type: none"> . dissemination of information on HHRAA projects . more comprehensive presentation of adolescent issues 	<ul style="list-style-type: none"> . African population experts . Cas . USAID . donors 	<ul style="list-style-type: none"> . suggestions for revisions
Population Reports upcoming monograph on Abortion	<ul style="list-style-type: none"> . Reviewed and commented on the outline for the monograph 	<ul style="list-style-type: none"> . dissemination of information on HHRAA projects . more comprehensive presentation of abortion issues 	<ul style="list-style-type: none"> . African population experts . Cas . USAID . donors 	<ul style="list-style-type: none"> . suggestions for revisions
Meeting with New USAID/Zambia Country Director Paul Hartenberger CK SP	<ul style="list-style-type: none"> . Described HHRAA activities and integrated case management of the sick child 	<ul style="list-style-type: none"> . dissemination of information on HHRAA projects 		
<i>e3. Other - Professional/Personal Development/Conferences</i>				
APHA--See Dissemination above				
National Council for Intl. Health Governing Board	<ul style="list-style-type: none"> Serve as Chair of Membership/Governance Committee. Currently organizing elections for new Governing Board. 			

Activity/Output	Description	Result/Impact	Collaborators/Audience	Products
<i>e4. Other - Inter-office and Inter-agency Communication</i>				
In absence from W. of liaison, have served as liaison between OIH and HHRAA.				
<i>PART B - IMPACT</i>				
See attached written material				
<i>PART C - MID-TERM WORKPLAN UPDATE</i>				
See attached written material				

3d. Collaboration with African individuals and institutions

The description is the same as in the RTA report for the previous period. Significant increase in African participation and collaboration is anticipated for the next period, when the RTA participates in the meeting of the Ministers of Health from the East and Southern Africa region where the results of the study on abortion complications will be presented and discussed.

PART B - IMPACT

Because the results of several of the research and analysis activities which I manage will not be available for at least a month, it is not yet possible to attribute to them any significant contributions to policy change or revised project design and implementation. For further details see previous RTA report.

The first direct measurement of impact will come during October and November when the rapid evaluation of the CDC sick child activity in Kenya is implemented and the report written. The second indication of impact will come at the above-mentioned meeting of the Ministers of Health in November.

PART C - MID-TERM WORKPLAN UPDATE

Progress or final accomplishment of all plans listed in the six-month workplan established in the last RTA report has been achieved with two exceptions. Due to the pressure of work in Washington and the absence of the Population Sector staff on TDYs, this RTA was unable to participate in the project paper team for the new West African Regional Health and Family Planning Project. In addition, work on developing a new HHRAA research activity with the Mothercare Project was put on hold, for reasons internal to that project.

During the next four months (through the end of the next RTA reporting period), I plan to focus on the following activities, most of which were anticipated in the work plan established in the previous RTA report:

- Oversee completion of the CDC Sick Child Study in Kenya and preparation of the study reports
- Collaborate with Global Bureau, BASICS, CDC, and WHO in defining important next steps in implementing the integrated care of the sick child strategy.
- Explore need for additional HHRAA activities on integrated care and develop new proposals.
- Work with the Quality Assurance Project and G/PHN/HN to develop a new computer-based project for training in integrated case management.
- Work with WHO to develop a tools and a methodology for monitoring integrated case management activities.
- Finalize the strategic framework on behavior change.
- Oversee implementation of the PSI operations research in Botswana and South Africa
- Oversee implementation of the CERPOD adolescent RH study
- Explore possibility of and need for additional HHRAA activities related to adolescent reproductive health and develop proposals
- Explore possibility of and need for additional HHRAA activities related to gender issues in family planning and develop proposals
- Oversee the implementation and finalization of the post abortion CRHCS study. Participate in the Ministers of Health meeting in Malawi in November. Develop a policy document based on study results
- Collaborate with the Office of Population in developing the new adolescent reproductive health project and continue working with the adolescent working group
- Collaborate with the Office of Population's Abortion Working Group
- Work with the Mothercare Project to develop a new HHRAA research activity on abortion complications
- Continue work with the Female Genital Mutilation Task Force and explore possibilities for funding of new HHRAA activities in this area
- Maintain relations with donors (WHO, UNICEF, WHO, World Bank), foundations, NGOs/PVOs, and intra-USAID and inter-US government agencies. Look for opportunities for collaboration

Name: Phyllis Gestrin, PhD, MPH
Population/Family Planning
Child Survival

Reporting Period: FY 1994 - October 1, 1993 to June 15, 1994

Date Submitted: June 24, 1994

Submitted to: Marion Warren, USAID/AFR/HHR
Hope Sukin, USAID/AFR/HHR
Robert Haladay, USAID/AFR/HHR
Subhi Mehdi, USAID/AFR/HHR

cc: Roscoe Moore, USPHS/OIH

PART A - OUTPUTS

A. TDYS

1. American Society for Tropical Medicine and American Society of Parasitology Conference, Atlanta, Georgia, November 1-5, 1993

- Participated in one day meeting of international experts to discuss the status and future directions of Integrated Case Management of the Sick Child Initiative. Meeting resulted in agreement to widen approach to include home based care.
- Meeting with Centers for Disease Control and Prevention (CDC) staff involved with research projects for the HHRAA Project. This first face-to-face discussions resulted in useful suggestions as to ways to facilitate the implementation of HHRAA sponsored research.
- Facilitated meeting of African health professionals and CDC staff to discuss the draft of the strategic framework on Integrated Care of the Sick Child, which resulted in the addition of some important research and analysis topics to the framework.

Products: Revised strategic framework; new directions for possible HHRAA research.

2. VIIIth Annual Conference on HIV/AIDS in Africa, Marrakech, Morocco, December 6-17, 1993

Designed, managed implementation, chaired, and evaluated a two-day satellite workshop in which USAID Mission representatives and host country counterparts identified and ranked research, analysis and dissemination priorities for HIV, STDs, and TB. The workshop also provided information to workshop and conference participants on the Analytic Agenda, the HHRAA Project, and the HHRAA portfolio. Participated in sessions of the concurrent AIDSCAP

workshop and coordinated participation of AIDSCAP staff in the USAID meetings. Attended the week-long African HIV/AIDS Conference. After the workshop, collaborated in drafting and revising the workshop report and made a presentation to USAID staff on the research priorities defined during the workshop.

Products: Workshop report, Revised Draft Strategic Framework for HIV, STDs, and TB.

3. Project Plan team -- USAID/Eritrea, June 3-16, 1994

Served as part of a four-member team that drafted a Project Plan (PP) for the new, \$15 million Eritrea Health and Population Project. As a result of my participation, several crucial parts were added to the PP, including a major emphasis on Integrated Management of the Sick Child, as well as training and supervision to support health education, and education to stop the practice of female genital mutilation.

Consequent to a meeting with the head of the Primary Health Care Division of the Ministry of Health (MOH) in Eritrea, gave a workshop for MOH staff on Integrated Care of the Sick Child.

Products: A project plan for the new EHP Project and, as a result of the workshop, increased understanding among MOH personnel of the integrated approach and its importance and relevance to the Eritrean situation.

B. TECHNICAL ASSISTANCE TO BUREAU

1. REDSO/WCA Regional HIV/AIDS, FP, and Child Survival Project. April 1994

Participated in review of proposed regional project on HIV/AIDS, family planning, and child survival to replace individual HPN projects in close-out USAID countries.

2. Eritrea Issues Meeting and ECPR for the PID Review of the new Health and Population Project. May 1994. Reviewed the PID, participated in the meetings, and drafted an issues paper and a chart representing the different PID versions, the latter serving as the basis for discussions at the ECPR. My participation was significant in obtaining approval for a more integrated approach with system strengthening components.

3. Botswana Closeout Plan Review. May 1994. Reviewed document and participated in closeout meeting. Supported eventual decision to continue population/family planning/AIDS project until end FY96.

4. Meeting with Kaiser Foundation. Participated in meeting with Kaiser Foundation Vice President in charge of South Africa to review Kaiser supported current and future Kaiser supported activities and possible USAID projects.

5. UNICEF Meeting with USAID/AFR. Purpose of meeting between UNICEF (Special Assistant to the Director, Africa Section staff, and Program Financing staff) and USAID AFR and Global Bureau staff was to review possible areas of joint interest, including Child Survival and Nutrition, in order to stimulate further collaboration between UNICEF and USAID. Prepared summary

documents on USAID country programs, participated in meeting, and collaborated in the preparation of a cable to Missions summarizing the results of the meeting.

6. **"Policy Formulation" Document.** Reviewed the document prepared by SARA contractor Porter/Novelli and participated in the meeting to advise on revision of the document.
7. **"Human Resources Development" Document.** Reviewed the document prepared by SARA contractor and participated in the meeting to decide on possible HHRAA funded activities in this area.
8. **Backstop Robert Haladay.** Share back-stopping duties when Mr. Haladay, the direct-hire staff member responsible for population programs in AFR/ARTS/HHR, is on TDY. Participate in agency meetings, respond to Mission inquiries, and oversee the preparation of documents.

C. RESEARCH AND ANALYSIS MANAGEMENT AND DISSEMINATION

1. Management

As Dr. Clark noted in his RTA report, "The roles of activity manager are many and varied, key responsibilities include: acting as a liaison between USAID bureaus and Missions, the cooperating agency/subcontractor, and the investigators; assisting the cooperating agency and investigators to overcome impediments to implementation whilst maintaining the scientific integrity of the activity; insuring that the activities involve African collaborators to the extent possible and contribute to the strengthening of African institutions; in some cases, direct technical assistance to the cooperating agency and hands on involvement in the conduct of the activities, and; insuring that the research products of the activity are technically correct, of high quality and linked to a dissemination plan.

In this regard, I serve as the Primary Activity Manager for:

- The Centers for Disease Control Study, "Defining Issues and Solutions in the Integrated Case Management of Sick Children in Health Facilities", which is being implemented in Kenya. Funding totals \$200,000.
- The Center for Applied Research on Population and Development (CERPOD) Study, "Tendencies and Determinants of Modern Contraception and Reproductive Health Behavior in Adolescents in the Sahel" which is focussing on four West African countries (Burkina Faso, Senegal, Niger, and Mali). Funding totals \$214,000.
- Study being conducted by Commonwealth Regional Health Community Secretariat (CRHCS based in Arusha, Tanzania with technical advice from JHPIEGO and IPAS), "Monograph and Policy Document on the Consequences of Unsafe Abortion and Strategies for Integrating FP and Abortion Services" which will focus on the 12 countries in East and Southern Africa that are part of the Secretariat. Funding totals \$149,000.
- The Population Services International (PSI) Study, "Operations Research on Social Marketing of Reproductive Health Services to Adolescents" which will add a specific focus on

adolescents to existing condom social marketing programs in Botswana and South Africa. Funding totals \$300,000 in FY94, with an additional \$50,000 expected in FY95.

My role in the PSI study was central to its existence in that I initiated the idea and, along with PSI, conceptualized and designed the multi-country operations research effort to provide adolescents with information and contraceptives to prevent unwanted pregnancies and avoid contracting STDs, including HIV/AIDS.

2. Dissemination

a. Used Marrakech Workshop on HIV/AIDS (see TDY section) to disseminate information on the AFR Analytic Agenda, the HHRAA Project, and the HHRAA Portfolio.

- The research priorities and the process used to identify them were presented in a Round Table Discussion at the VIIIth International Conference on HIV/AIDS in Africa.
- The workshop report has been reviewed by participants and is now being sent to other relevant people.

b. E-mail notes

AFR/ARTS/HHR is using E-mail to USAID mission staff as an important vehicle for keeping them up-to-date on HHRAA activities and results. Wrote two of the first E-mail notes to the field on Integrated Management of the Sick Child and on the two adolescent reproductive health activities described above.

c. Abstract to American Public Health Association (APHA)

Took the initiative in drafting and submitting to APHA an abstract for a panel discussion on the HHRAA Project research, analysis, and information dissemination activities which was accepted for presentation at the next annual convention in October 1994.

d. Prepare and circulate trip reports.

e. The draft Strategic Framework for Integrated Management of the Sick Child was sent to USAID HPN Officers and a large group of African professionals to obtain their input on the HHRAA priorities for research, analysis, and information dissemination in this area.

f. Two of the activities I manage, the CERPOD study on adolescent reproductive health and the CRHCS study on the consequences of abortion have dissemination components built into the plans. The CRHCS study will culminate later this year in the presentation of the study results and policy options to a meeting of Ministers of Health from the relevant countries.

3. Planning - Strategic Frameworks

Overseen the development of two HHRAA Strategic Frameworks: Integrated Care of the Sick Child, and Behavior Change and Maintenance for Child Survival. The final draft of the former was recently completed after it had been circulated to the field for comment. The first draft of the latter, having just been completed and reviewed by staff from the BASICS Project, will now

be circulated to Mission staff and African professionals for review. It should be influential, not only in determining HHRAA activities, but also in the design of a wide range of projects in that it focusses on a forgotten part of Child Survival interventions, the need to create ways in which behavior change will be maintained after the life of a project.

In addition to the above, have also reviewed drafts and participated in discussions of the Strategic Frameworks for Child Survival and for Population.

D. COLLABORATION WITH AFRICAN INDIVIDUALS AND INSTITUTIONS

Two of the research and analysis activities I oversee are being managed and implemented by African institutions with the participation of African professionals in the study countries. Both activities also involve some technical assistance which will build research and analysis capacity. CERPOD is managing a study on adolescent reproductive health in four West African countries. To prepare for key components of the study which will use focus groups and key informant interviews, researchers from the four countries were brought to Bamako for a one week workshop (conducted by a leading anthropologist from Tulane University) in which they were taught how to use these techniques and analyze the data. They also collaborated in the design of the research protocols.

At the beginning of the 12 country study in East and Southern Africa on the complications of abortion which is managed by an African institution, CRHCS, researchers from several countries were brought to Nairobi to collaborate in the development of research protocols.

In all the other field studies and TDYs, African individuals and institutions have participated and collaborated to a significant degree. For example, the Marrakech workshop was facilitated by an African based consulting firm. In the PSI operations research in South Africa, a host country national will be coordinating the implementation of peer education.

E. OTHER

1. Monitoring and Evaluation

Worked with research study managers to develop indicators for measuring the progress and success of the activities and to complete the Activity Description Sheets.

2. Group Membership/Representation of USAID/AFR/ARTS

- G/R&D/Pop Working Group on Adolescent Reproductive Health (RH). As part of this group, assisting in development of the proposed centrally-funded project on adolescent RH.
- Agency-wide Task Force on Female Genital Mutilation. Also appointed to serve on a sub-committee that will review grant proposals.
- Participated in the one week Cooperating Agency Meeting sponsored by G/R&D/Pop in February to review agency policy and priorities in population and reproductive health. Also

participated in the one day meeting for HPN Officers which followed.

- Serve as backup representative to Health Sector Council, Population Sector Council, and Nutrition Sector Council.
- Participated in some activities of the G/R&D/Pop AFR/OR TAG.
- Invited to participate in WHO Working Group on integrated management of the sick child. Unable to participate due to trip to Africa, but expect to participate in future meetings.

3. Professional/Personnel Development/Conferences

- Serve as an elected member of the Board of Governors of the National Council for International Health and the Chair of the standing committee on Membership and Governance.
- Participated in a one week workshop on Facilitation and Training which was run by the Training Resources Group in Alexandria, VA.

4. Inter-office and Inter-agency Communication

Played a significant role in facilitating communications between offices within USAID (AFR/ARTS and G/R&D/Pop), between USAID and collaborating agencies including OIH and CDC, and between OIH and other PHS agencies, such as CDC. This communications and liaison function is strengthened by my dual association with USAID and the PHS, and has proved useful in activity management and problem solving, coordinating efforts that would otherwise be duplicative, and establishing processes and contacts for project development and project monitoring. Among my major activities in this area have been:

- Reviewed and rewrote parts of the USPHS Office of International Health (OIH) annual report to USAID on the HHRAA project.
- Attended OIH staff meetings and additional meetings with Dr. Moore to discuss issues.
- Assisted CDC in locating a country in which to conduct its study.

PART B - IMPACT

Because the results of several of the research and analysis activities which I manage will not be available for several months, it is not yet possible to attribute to them any significant contributions to policy change or revised project design and implementation.

The indications are that the study on abortion complications will quickly have an impact on policy decisions of the Ministers of Health in the 12 African study countries. Technical Directors for the countries, who will be meeting in August, will review initial study results and prepare a policy paper for discussion at the meeting of the Ministers of Health in November.

At the time when I began work at USAID in May 1993, abortion and adolescent reproductive health were two areas in which Washington and field staff, reflecting an earlier policy environment, were reluctant to engage in even research and analysis, although acknowledging the crucial need for more information on these topics. In part through my advocacy, these very important issues are now getting the more serious attention they deserve. For example, the CTO of one centrally-funded G Bureau project gave up opposition to collaboration on an post-abortion study following my advocacy of an appropriate approach.

Another area in which my input has been important is integrated management of the sick child. As a result of my participation in the project paper development in Eritrea, this important focus will be included in the new project.

Finally, female genital mutilation is slowly being accepted within the Africa Bureau and by Mission staff as an important topic which needs to be addressed, in part through my participation in the agency-wide task force. In addition, the Eritrea Project Paper will contain a specific mention of this topic in the section on health education development.

PART C - MID-TERM WORKPLAN UPDATE

With two small exceptions, all aspects of my 1994 Work Plan were accomplished as scheduled. The two exceptions were that the sick child activities took place at a somewhat later date than expected and no new sick child projects were initiated in this project cycle.

During the next six months, I plan to focus on the following activities (most of which were anticipated in the original work plan):

- Oversee implementation of the CDC Sick Child Study in Kenya
- Collaborate with Global Bureau, BASICS, CDC, and WHO in defining important next steps in implementing the integrated care of the sick child strategy.
- Explore need for additional HHRAA activities on integrated care.
- Finalize the strategic framework on behavior change and begin implementing some of its recommendations
- Oversee implementation of the PSI operations research in Botswana and South Africa
- Oversee implementation of the CERPOD adolescent RH study
- Explore possibility of and need for additional HHRAA activities related to adolescent reproductive health
- Explore possibility of and need for additional HHRAA activities related to gender issues in family planning
- Oversee the implementation and finalization of the post abortion CRHCS study. Participate in the Ministers of Health meeting in Malawi in November. Develop a policy document based on study results
- Collaborate with the Office of Population in developing the new adolescent reproductive health project and continue working with the adolescent working group
- Participate, if possible, in the project paper team for the new West African Regional Health and Family Planning Project
- Work with the Mothercare Project to develop a new HHRAA research activity on abortion complications
- Continue work with the Female Genital Mutilation Task Force and explore possibilities for

funding of new HHRAA activities in this area

- Maintain relations with donors (WHO, UNICEF, WHO, World Bank), foundations, NGOs/PVOs, and intra-USAID and inter-US government agencies. Look for opportunities for collaboration

**Population/Family Planning Sub-Sector
Publications List
10/28/94**

Assessment of Urban Population Program Report

Gender Workshop Report

Medical Barriers Workshop Report

Synthesis of NAS Report of Population Dynamics

French Version of Population Report

Population Strategic Framework

Proceedings of Landmark Workshop (5/93) for African Bureau Senior Management

Concept Paper "Proposed Adolescent Reproductive Health Initiative

U.S. Public Health Service (PHS) quarterly progress report (April -June, 1994).