

**OPERATIONS
RESEARCH**
TECHNICAL ASSISTANCE

AFRICA PROJECT II

THE POPULATION COUNCIL



**AFRICA
OPERATIONS RESEARCH
AND TECHNICAL
ASSISTANCE PROJECT II:**

ANNUAL REPORT

OCTOBER 1996 - SEPTEMBER 1997

**USAID Contract No. CCP-C-00-3008-00
Project No. 936-3030**

The Population Council

The Population Council seeks to help improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council analyzes population issues and trends; conducts biomedical research to develop new contraceptives; works with public and private agencies to improve the quality and outreach of family planning and reproductive health services; helps governments to influence demographic behavior; communicates the results of research in the population field to appropriate audiences; and helps build research capacities in developing countries. The Council, a nonprofit, nongovernmental research organization established in 1952, has a multinational Board of Trustees; its New York headquarters supports a global network of regional and country offices.

Africa OR/TA Project II

The overall objective of the Africa OR/TA Project II is to broaden understanding of how to improve family planning services in Sub-Saharan Africa, and to apply operations research and technical assistance to improve services by:

- increasing access to a full range of family planning services and methods;
- developing service delivery strategies that are client-oriented and acceptable to various population groups;
- improving the operations of programs to make them more efficient and financially sustainable;
- improving the quality of services;
- strengthening the capabilities of family planning program managers to use operations research to diagnose and solve service delivery problems.

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I. Introduction

This report describes activities undertaken during the fourth year of the five-year (October 1993 - September 1998) Africa Operations Research and Technical Assistance (OR/TA) Project II. The Project is implemented by the Population Council through a subcontract with USAID. Project staff are based in offices in Africa and at the Council's New York office (see Appendix One). The overall objective of the Project is to broaden understanding of how to improve family planning and other reproductive health services in Sub-Saharan Africa, through applying operations research and technical assistance to family planning and other reproductive health services in Sub-Saharan Africa by:

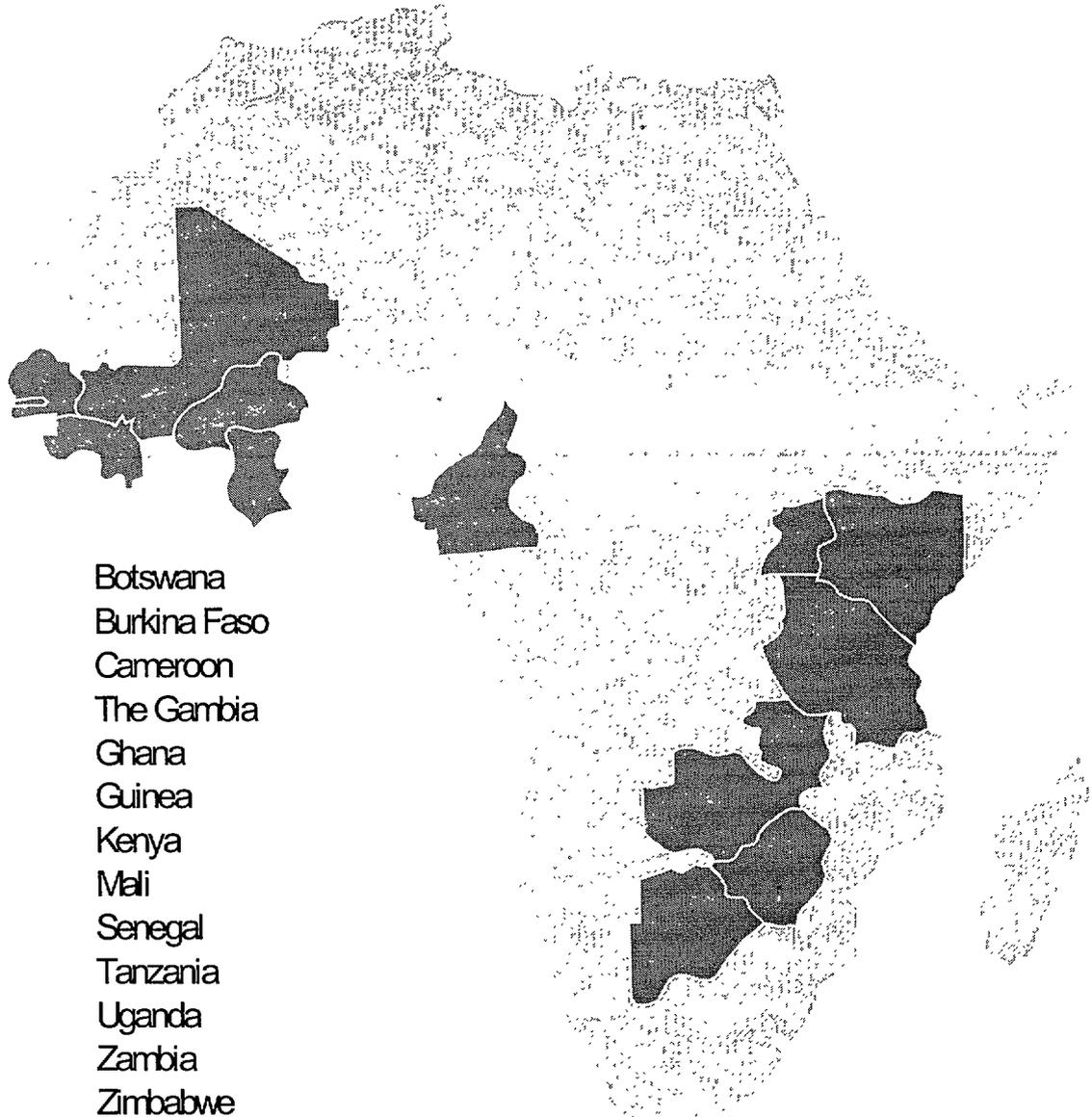
- increasing access to a full range of family planning services and methods;
- developing service delivery strategies that are client-oriented and acceptable to various special population groups;
- improving the operations of programs to make them more efficient and financially sustainable;
- improving the quality of existing services;
- strengthening the capabilities of family planning program managers to use operations research to diagnose and solve service delivery problems.

Many studies have now been completed, and so over the past year much attention has been paid to disseminating study results as they have been produced, both within the country itself and internationally. Project staff have also spent much time assisting service delivery organizations, USAID Missions and other technical assistance organizations to maximize the utilization of these results when making decisions about ways of improving access to and quality of reproductive health services. This Annual Report will highlight several of the key results produced so far and will give examples of how these results have been utilized by program managers and policymakers.

Country strategic workplans for all of the Project's focus countries have now been developed, approved and are being implemented (see section III). The Project also undertakes some limited activities in a few non-focus countries. The map overleaf identifies the countries in which the Project is active.

The Africa OR/TA Project II plans and reports its activities in relation to USAID's Strategic Objectives and Results and so the format of this report follows this framework. The Project was designed originally to focus on strengthening *family planning* service delivery, and activities related to improving access to and quality of family planning services have remained the primary focus of the Project. Most activities contribute, therefore, to USAID's Strategic Objective #1, that is, "achieving a sustainable reduction in unintended pregnancies through an increased use by women and men of voluntary practices that contribute to reduced fertility". Half way through the Project's first year and following the 1994 ICPD Conference, USAID requested that the Project increase attention to strengthening other reproductive health services. In response to this request, the proportion of activities contributing towards USAID's other Strategic Objectives increased. In particular, activities were developed for "increasing the use of key reproductive health interventions" (Objective #2), and "increased use of interventions to reduce STI/HIV transmission" (Objective #4).

Africa OR/TA Project Countries



The Project now receives approximately half of its funds through “core support” from the Population, Health and Nutrition Center at USAID/Washington, and half through “field support” from USAID country and regional Missions. The Project is also implementing three ‘buy-ins’ in Senegal, Zambia and Zimbabwe, having already completed buy-ins from the Missions in Burkina Faso and Botswana. Core Support is used to fund research and technical assistance activities that address region-wide issues and concerns, whereas Field Support funds country- or region-specific activities that assist a USAID Mission to address its own strategic objectives.

The Project implements activities through two broad types of activity: research subprojects and technical assistance (TA) activities:

- A subproject can be implemented through either a subcontract with another organization or directly by Project staff as an in-house subproject.
- A technical assistance activity is one that takes five person-days or more and has a clearly defined objective and scope of work.

By the end of September 1997, the Project had initiated 47 subprojects and 38 technical assistance activities as described in the table below.

<i>Country</i>	<i>Subprojects</i>	<i>Technical assistance</i>	<i>Total Subprojects and TA</i>
Botswana	8	-	8
Burkina Faso	4	7	11
Gambia	1	-	1
Ghana	4	2	6
Kenya	5	5	10
Mali	1	2	3
Senegal	5	8	13
Tanzania	5	3	8
Zambia	5	1	6
Zimbabwe	2	0	2
Regional	6	9	15
Interregional	1	1	2
Total	47	38	85

By its very nature, operations research cannot be successfully undertaken without close collaboration with other organizations that support the work of national service delivery organizations. The Africa OR/TA Project II has worked with over 40 technical assistance and donor organizations on country-specific, regional or international activities. A list of these organizations and the locations of the collaborative activities are given in Appendix Two.

In September 1997 a four person team from POPTECH undertook the Project's Year Four evaluation on behalf of USAID. The team concluded that "the Africa OR/TA Project II has responded to USAID/Washington's request to diversify the project research portfolio to encompass a broad reproductive health research agenda. Project research corresponds with USAID's strategic objectives. Project work is being carried out in a mix of countries across the continent, reflecting both USAID mission priorities and the willingness of the Population Council to optimize "windows of opportunity" as they present themselves." The team also provided numerous recommendations for how best the Project could complete its activities so as to maximize the dissemination and utilization of results.

II. Overview of Project Activities and Key Results

1) Increased use of voluntary practices that contribute to reduced fertility

1.1 New and improved service delivery strategies developed and evaluated

The USAID-supported OR program has traditionally focused on developing and evaluating innovative strategies, and on improving existing strategies, for delivering family planning services. This focus continues to represent the major proportion of the Africa OR/TA Project II's work. Small-scale experimental studies are implemented which enable program managers to test, on a pilot basis, alternate ways of increasing access to and quality of family planning services. Four strategies are currently being explored: community-based approaches for increasing access in rural areas; innovative approaches to improving quality in clinics; providing family planning services to reduce the likelihood of repeat abortions; and reaching under-served populations, such as adolescents and men.

A) TESTING COMMUNITY-BASED APPROACHES TO INCREASING ACCESS TO FAMILY PLANNING INFORMATION AND SERVICES

During Year Four the Project continued to support two major activities that seek to develop and test approaches for increasing access to family planning and other reproductive health services in rural areas of Ghana and Burkina Faso in west Africa. Both activities are being implemented at field stations in remote areas where demand for family planning is very low and where the population has limited access to static clinics. The objective of both studies is to assist the Ministries of Health (MOH) to develop cost-effective, sustainable and culturally appropriate service delivery strategies that reach the majority of the rural population.

The MOH's Navrongo Health Research Centre (NHRC) in northern **Ghana** is prospectively testing two service delivery mechanisms through the Community Health and Family Planning (CHFP) Project: relocation of nurses from clinics to community health compounds, linked with delivery of health and family planning services through compound visits; and recruitment and support, by communities, of volunteers called *Yezura Zenna* (YZs) for health promotion and basic service delivery.

Initially three nurses, termed Community Health Officers (CHOs), were relocated to villages for a trial period of 18 months to assess the feasibility and acceptability of this approach to service delivery. The communities built the nurses what is known as a Community Health Compound where they live and work. The MOH has provided the nurses with motorbikes which they use daily to make visits to all compounds in the village.

The approach was fine-tuned through applying the lessons learned through the pilot phase, and since October 1996 the full complement of 16 community-based nurses has been operational, covering approximately half of the Kassena-Nankana District. Data collected

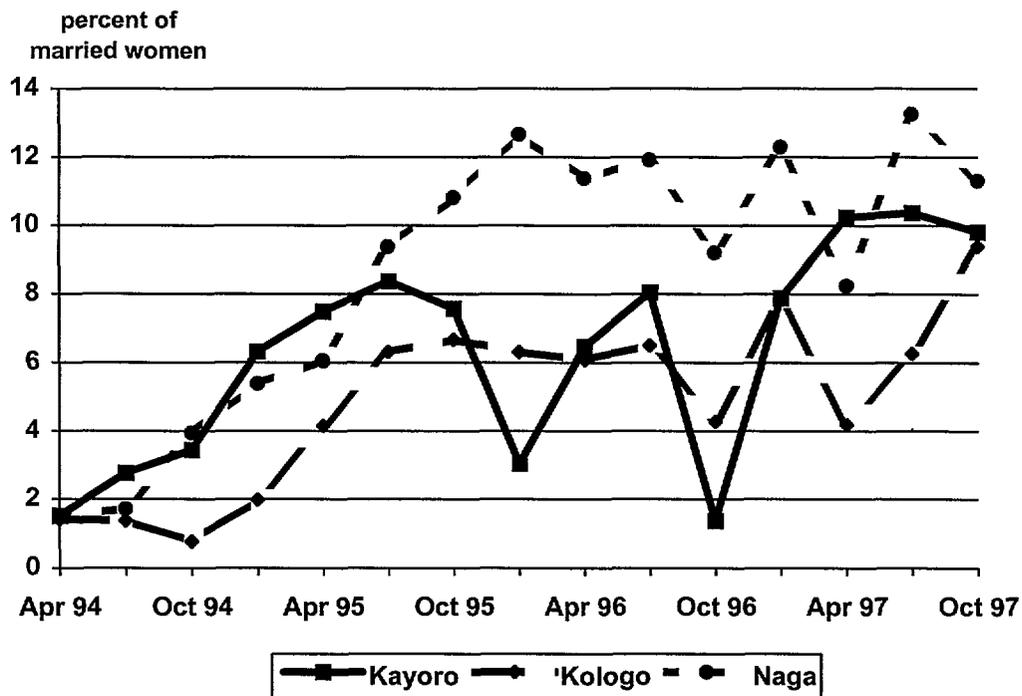
from the record books of the three nurses working since the trial phase in the villages of Kayoro, Kologo and Naga show that, over the first year, they had an immediate impact on the proportion of married women using family planning (Box 1). This is probably because the nurses' visit to the compounds overcomes problems of the women's restricted mobility and the difficulty of access to static facilities in this remote rural area. It should be noted also that almost all women starting to use family planning chose the injectable, most likely because it allows them to practise family planning without their husband's knowledge.

This intervention will be tested for four years altogether to allow for a longer-term assessment of its effectiveness. These data suggest that although providing contraceptives to women within their compounds meets an immediate need among those who strongly want to use an effective method, the challenge facing the program is whether further demand can be created through this approach.

BOX 1

Household delivery of contraceptives by nurses in areas with poor access to static facilities quickly meets an immediate need for family planning services, but appears to be limited in creating further demand

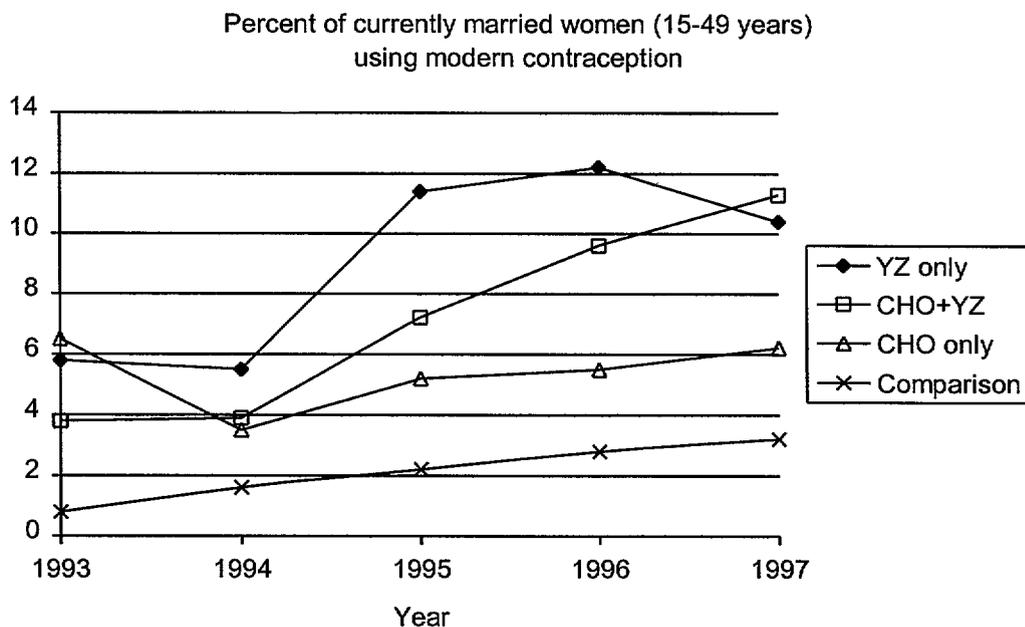
Proportion of married women using family planning in three villages served by community-based nurses



The CHFP Project has been organized so that the impact of these two interventions can be tested independently and together through a four-cell design covering the whole of the Kassena-Nankana District (i.e. CHOs only; YZs only; CHOs + YZs; and normal services). Annual panel surveys are being undertaken to measure the impact of these two service delivery interventions on the family planning and fertility behavior of the population in each cell. Box 2 indicates that over the four year period there has been an increase in contraceptive use for the District as a whole (from 3.4 percent to 7.9 percent). This increase is most marked, however, in the two cells where the YZs have been introduced, either by themselves or in conjunction with a CHO. This suggests that community volunteers play an essential role when introducing family planning services in environments where existing utilization is almost non-existent.

Box 2

Preliminary results from Navrongo suggest that community agents are essential for increasing the acceptability and use of modern contraceptives in communities with a constrained demand for family planning



Full-scale implementation of the community-based intervention being tested by the MOH of **Burkina Faso** at the *Laboratoire de la Santé Communautaire* (LSC) in Bazèga began in December 1996. A population of about 30,000 persons is served by 84 volunteer agents (giving a coverage of approximately 110 women of reproductive age per agent). The agents promote family planning generally, provide pills (without prescription), condoms and spermicides to clients requiring them, and refer clients interested in other methods to one of the clinics in the study area. The implementation of the intervention is being monitored through service statistics collected by the agents using record cards designed specially for use by non-literates. Its effect on the population as a whole is being assessed through a bi-annual panel survey, the baseline for which was collected in April 1996 and the first round will be collected in April 1998.

For the first 11 months of the intervention, the agents held 230 group health talks and made 517 home visits within the 44 villages and 550 compounds in the study area. Over 8,300 people attended these health talks and 2,365 persons were visited at their homes (of which 43 per cent were men). The agents appear to be acceptable sources of family planning methods - contraceptive methods were provided to 1,615 new family planning acceptors and the agents re-supplied 1,381 continuing clients. Interestingly, over half of these were condom users and the rest were mainly pill users with a few accepting spermicides. Nine clients were referred for other contraceptive methods, all wanting to use the injectable. Further analysis is being undertaken to try to determine the sex of the new condom users.

Although this may not seem to be a large number of clients per agent (19 new clients in 11 months), this level of productivity needs to be put in perspective. The baseline survey revealed a contraceptive prevalence rate for modern methods of only three per cent among all women. Moreover, the six clinics located in the agents' catchment area served only 70 new clients and 490 continuing clients over the same period. Thus the community-based program is currently outperforming the clinic-based program as a source of pills and condoms in this area.

B) TESTING INNOVATIVE APPROACHES TO IMPROVING SERVICE QUALITY IN MCH/FP CLINICS

Situation Analysis studies have shown that the quality of family planning services is generally poor throughout sub-Saharan Africa. Improving the quality of services may enhance the image of clinics as service delivery points (thereby increasing the number of clients served). It may also ensure that service users receive appropriate and sufficient information (thereby reducing early discontinuation and encouraging method switching if a client has a problem). Three studies to test strategies for improving service quality were undertaken during Year Four.

At the LSC in Bazèga, **Burkina Faso**, a clinic-strengthening intervention is being evaluated in terms of its effect on the readiness of clinics to offer quality services, the quality of services provided, and on the number of family planning clients served. The impact of this intervention on the use of family planning services in the clinic catchment areas is being

evaluated with and without the community-based intervention described above through population surveys. The intervention consisted of:

- an assessment of training needs (undertaken by INTRAH);
- training clinic staff in family planning and other reproductive health issues;
- equipping clinics with a minimum package needed to offer the pill, condoms, spermicides, and injectables, and to undertake pelvic exams;
- establishing a functioning service statistics system.

The immediate output of this intervention is an expected increase in the readiness of clinics offer quality services. This is being measured using a quasi-experimental research design, by comparing the readiness of 13 experimental clinics (which received the strengthening activities) before and after the intervention with eight control clinics. Data were collected on 15 indicators describing clinic readiness using a clinic inventory and staff interviews adapted from the Situation Analysis approach: data analysis is on-going.

Increasing clinic readiness is expected to strengthen the quality of services provided to clients. Service quality was measured by observing client-provider interactions. Unfortunately, because contraceptive use is so low in the clinic catchment areas (around three percent) it was possible to observe only 13 new and 53 revisit clients for all 21 experimental and control sites during the data collection period, despite the researchers spending five days at each clinic (i.e. a total of 105 days fieldwork). This sample size is clearly insufficient to measure quality at the clinic level and highlights one of the methodological problems of trying to measure service quality in low-prevalence settings.

The impact of the intervention will be measured at two levels: the number of family planning clients served by the clinics (tracked through the clinic service statistics); and the number of family planning users in the clinic catchment areas (measured through bi-annual panel surveys).

In **Zambia**, technical assistance is being provided for a study, implemented by the MOH and CARE/Zambia (with funding from USAID through the Council's Expanding Contraceptive Choice Program and from WHO), to increase the number of contraceptive users served by the clinics through enhance contraceptive choice and quality of care. This intervention is being implemented through an integrated package of:

- training health personnel in the provision of a full range of contraceptive methods and support services;
- the introduction of new or underutilized contraceptive methods (including the injectable, IUD, emergency contraception and the female condom);
- the development and field testing of models to introduce such contraceptives within the context of broad method choice.

The first phase, which ended in April 1997, documented the experience of strengthening service delivery and introducing new and underutilized contraceptive methods, particularly the injectable, in 26 health facilities in peri-urban Lusaka and Livingstone. A package of staff training, IEC and related materials was developed to expand client contraceptive options. The

second phase is currently field testing this introductory package at 11 rural health centers in Ndola with a long-term view of replicating it on a nationwide basis.

A major achievement has been the development of strategies to mobilize and sensitize communities to quality reproductive health services. Project staff are working with secondary school teachers, neighborhood health committees and village chiefs to orient community members to new family planning methods as the injectable, emergency contraception, and the female condom. Quantitative and qualitative research methods are being used to examine women's motives for method choice, continuation, and discontinuation, and providers' perspectives on family planning methods and the service delivery system in general. The study is also investigating the technical and managerial actions necessary to improve quality of care in the public sector.

Phase Two has already attracted national attention because the integrated package of clinic strengthening, expanded choice and community outreach appears to have had an immediate effect on overall contraceptive use at the experimental clinics. Although use of all methods has increased, the proportion of clients using the injectable has grown from about one per cent to over 20 per cent, demonstrating its strong appeal once it is made available. The results of this study are contributing to efforts to register Depo Provera→ in Zambia.

In **Senegal**, the *Programme National de Planification Familiale* (PNPF) is strengthening 14 clinics in all ten regions to serve as centers of excellence or "Reference Centers", for the provision of family planning and other reproductive health services. Method continuation rates are known to be low, and so the PNPF is interested in finding out whether improving the quality of service at clinics will increase the likelihood of women continuing to practice family planning, using either the method originally chosen or through switching to another method. In collaboration with the Council's Expanding Contraceptive Choice program, the quality of care provided is being measured at a sample of five Reference Centers and at five matched, comparison clinics (i.e. those which have not been strengthened but have similar characteristics). To measure the effect of improved quality, cohorts of women have been recruited from both Reference and comparison clinics and are being followed over time to find out whether their reproductive and contraceptive behavior differs depending on the quality of service received at the clinic. Funding has been leveraged from the Rockefeller Foundation to continue following these cohorts beyond the end-date of this study.

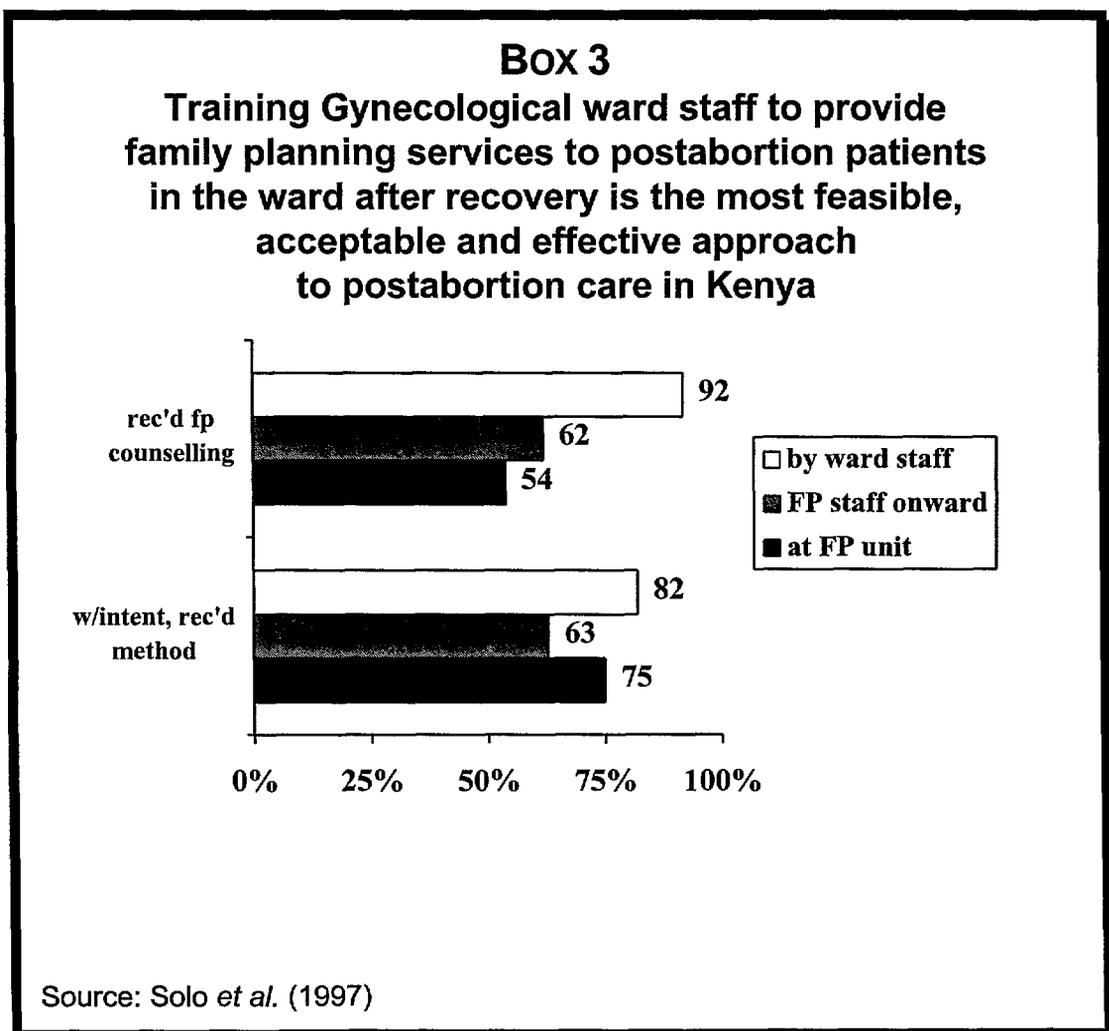
C) TESTING INNOVATIVE APPROACHES TO LINKING FAMILY PLANNING SERVICES WITH THE TREATMENT OF INCOMPLETE ABORTION

Many women suffering from an incomplete abortion, whether it was spontaneous or induced, have a real need for information and possibly contraceptive services to help them avoid becoming pregnant following treatment for this obstetrical emergency. Three studies are being undertaken by the Africa OR/TA Project II (in Kenya, Burkina Faso and Senegal) to test innovative approaches to linking family planning information and services directly with improved treatment of incomplete abortions (through MVA) in hospitals.

The study in **Kenya**, implemented by the MOH and with additional assistance from Ipas, compared three models for providing family planning services to women who had been treated for an incomplete abortion, with each model being tested in two hospitals:

1. training gynecological ward staff to provide family planning information and services to women while they recover in the ward;
2. bringing staff from the hospital's family planning clinic to the gynecological ward to provide family planning information and services;
3. after recovery and immediately prior to discharge, escorting women from the gynecological ward to the hospital's family planning clinic for counseling and services.

The key results from the study are presented in Box 3. The three models were compared in terms of their acceptability to clients and staff, the feasibility of implementation, and their effectiveness in delivering family planning counseling and services. The comparison revealed that training the gynecological ward staff in post-abortion family planning counseling and requiring them to provide counseling (and services if required) to the women while they recovered on the ward was the most effective model - the



proportion of women receiving counseling and the percentage of those deciding to use family planning who left the hospital with a method were the highest for this model. This model was also found to be the most acceptable to both hospital staff and women because it allowed a relationship to be established between them, as well as the most feasible to implement because it caused the least disruption to existing services. As a consequence of this study, the Kenyan MOH has decided to promote this approach to providing postabortion care as a key component of its recently revised reproductive health program.

Baseline data for similar studies have been collected at hospitals in Ouagadougou and Bobo-Dioulasso in **Burkina Faso**, and at three hospitals in Dakar, **Senegal**. Services for treatment of incomplete abortion using MVA linked with counseling for family planning have now been introduced; both studies are being implemented jointly with JHPIEGO. At all five sites, family planning information and services are being provided on the gynecological ward. Baseline data from Burkina Faso indicate that most (62 per cent) of the postabortion patients are married, their mean age is 27 years, on average the women already had 2.4 children (although 29 percent had no children), and one third of them wanted another child within 12 months. Eleven per cent said that they were using a method of family planning at the time of pregnancy (7 per cent modern, 4 per cent natural). Thirty per cent of the women received family planning counseling prior to the introduction of the intervention. Almost all of these were at the Bobo-Dioulasso hospital because the staff started providing counseling immediately the project began. Of these women, 56 per cent also received a contraceptive method.

D) TESTING INNOVATIVE APPROACHES FOR REACHING ADOLESCENTS

Family planning and other reproductive health services have been developed primarily to meet the needs of married women of reproductive age. Adolescents, both male and female, and men in general, are currently under-served by reproductive health programs throughout the region. One of the key functions of the Africa OR/TA Project II is to develop and test innovative approaches to providing services which can reach these two under-served groups. During Year Four, two studies were on-going which test approaches to meeting the needs of adolescents.

An experimental study in **Zambia** is testing and comparing two different approaches to achieving the same objective - encouraging out-of-school youth to avoid unprotected and unwanted intercourse in order to reduce the likelihood of having an unwanted pregnancy or contracting a sexually transmitted infection. The strategies were described in last year's Annual Report. The study is being implemented by CARE/Zambia in collaboration with two national NGOs: the Planned Parenthood Association of Zambia (PPAZ) and the Makeni Ecumenical Center. Baseline data have been collected from the four study sites using Participatory Learning and Action (PLA) methods, including a questionnaire survey that provides quantitative data of some key indicators.

Both approaches are fully implemented, with 100 adolescent community counselors and nine credit groups, with 221 adolescents participating, all of who have received credit. The adolescent community counselors have linked up with other youth groups including the credit groups and their local clinics to offer peer education. A major challenge facing the peer counselors approach is considerable resistance from parents, teachers, elders, as well as some of the adolescents themselves, to the promotion and selling of condoms to adolescents on the grounds of immorality and that it encourages promiscuity. In one site the adolescents have abandoned selling condoms in favor of free distribution; sales would have meant competing with free condoms already being distributed in the community and also marketing the product required a greater level of condom promotion than most of the youth felt comfortable with. Efforts are being made to counter this opposition, through trying to find parents willing to advocate condom use, involving health personnel and peer group discussions.

In **Ghana**, Project staff are providing technical assistance to PPAG (the IPPF-affiliate) in the implementation of an IPPF-funded project which seeks to test different approaches to providing reproductive health services to adolescents in the Volta Region. The project will compare the effectiveness of using peer counselors linked with youth centers and peer counselors linked with 'youth-friendly' MOH clinics as alternate means for communicating reproductive health messages and for providing appropriate services. The completion of the needs assessment/baseline survey (see section 1.2.B) has guided the design of the interventions that are currently being implemented.

Publications and presentations on new and improved service delivery strategies

Community-based strategies

Binka, Fred, Alex Nazzar, and James Phillips. 1995. The Navrongo community health and family planning project. *Studies in Family Planning* 26(3): 121-139.

Binka, Fred, Alex Nazzar, and James Phillips. 1994. The Navrongo Community Health and Family Planning Project. Paper presented at the 122nd annual meeting of the American Public Health Association, Washington, D.C., 30 October-3 November.

Gouédé, Nicholas. 1997. On the road to reproductive health: A day in the life of a community health worker. *Populi* 24(2):8-10.

Luck, Margaret, Diane Nell, Ebrima Jarjou and Marc Michaelson. 1996. *Contributions of demand mobilization and contraceptive availability to increased contraceptive prevalence: Issues for replication*. Save the Children Federation, The Gambia Field Office, Banjul, The Gambia. September.

Linking family planning services with the treatment of incomplete abortions

Askew, Ian. 1998. Measuring the quality of postabortion care. Paper presented at the "Global Meeting on Postabortion Care: Advances and Challenges in Operations Research," Population Council, New York, 29-21 January.

Ghosh, Anita, Bibiane Kone, Jean Lankoande and Placide Tapsoba. 1997. Introducing improved postabortion care into maternity services in Burkina Faso. Paper presented at the "Global Meeting on Postabortion Care: Advances and Challenges in Operations Research," Population Council, New York, 29-21 January.

Huntington, Dale, Barbara Mensch, and Vincent C. Miller. 1996. Survey questions for the measurement of induced abortion. *Studies in Family Planning* 27(3):155-161.

Ominde, Achola, Margaret Makumi, Deborah Billings, and Julie Solo. 1997. *Postabortion care services in Kenya: Baseline findings from an operations research study*. The Africa OR/TA Project II, Nairobi, Kenya, March.

Solo, Julie, Achola Ominde, Margaret Makumi, Deborah Billings and Colette Aloo-Obunga. 1998. *Creating linkages between incomplete abortion treatment and family planning services in Kenya: What works best?* The Division of Primary Health Care, MOH, Ipas and the Africa OR/TA Project II, Nairobi, Kenya, January.

Solo, Julie, Achola Ominde, Margaret Makumi, Deborah Billings and Colette Aloo-Obunga. 1998. *Creating linkages between incomplete abortion treatment and family planning services in Kenya: What works best?* Paper presented at the "Global Meeting on Postabortion Care: Advances and Challenges in Operations Research," Population Council, New York, 19-21 January.

Solo, Julie and Deborah Billings. 1997. An analysis of the resources needed to create linkages between incomplete abortion treatment and family planning services in Kenya. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Solo, Julie, Deborah Billings and Achola Ominde. 1997. Improving postabortion care services in Kenya: what works best? Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Solo, Julie. 1997. Findings. Presentation at the Kenya Postabortion Care Study Dissemination Workshop, Nairobi, Kenya, 9-10 June.

Solo, Julie and Deborah Billings. 1996. Testing alternative approaches to providing integrated treatment of abortion complications and family planning in Kenya. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Solo, Julie, Esther Muia, and Khama Rogo. 1995. *Testing alternative approaches to providing integrated treatment of abortion complications and family planning in Kenya: findings from phase I.* The Africa OR/TA Project II, Nairobi, Kenya, August.

Approaches for reaching adolescents and males

Fetters, Tamara and Gladys Nkhama. 1997. Using peer support to encourage contraceptive method use and continuation in Zambia. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Muhondwa, Eustace and Naomi Rutenberg. 1997. *Effects of the vasectomy promotion project on knowledge, attitudes, and behaviour among men in Dar es Salaam, Tanzania.* Population Council's Africa OR/TA Project II, September.

Muhondwa, Eustace, Naomi Rutenberg, and Grace Lusiola. 1996. The effects of a vasectomy promotion project on knowledge, attitudes, and behavior among men in Dar-es-salaam. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Ndeti, Cecilia, Gilbert Magiri, Jacqueline Mundy, *et al.* 1995. Increasing male involvement in a CBD program in Kenya. Paper presented at the annual meeting of the American Public Health Association, San Diego, CA, 29 October-2 November.

Sanogo, Diouratié. 1995. Rôle des leaders d'opinion (LO) dans la promotion et la prestation des services de santé et de planification familiale en milieu rural au Cameroun. Paper presented at the Conférence Régionale Francophone sur l'Amélioration de l'Accessibilité et la Qualité des Services de Santé de la Reproduction et de Planification Familiale. Ouagadougou, Burkina Faso, 12-18 March.

1.2 New and improved methodologies for data collection and evaluation developed and tested

A) STRENGTHENING THE SITUATION ANALYSIS METHODOLOGY

The Africa OR/TA Project was responsible for the initial development of the Situation Analysis approach to assessing facility-level service delivery, and has continued to play the leading role in further developing and refining the methodology. During the last year the Population Council published "The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook". This handbook contains an introduction to the methodology, the core data collection instruments, guidelines for training, question-by-question guides, and an analysis plan. It is intended to be used by program managers and researchers wishing to carry out a standard Situation Analysis study. About 2,400 copies of the handbook have been distributed in over 25 countries, and translations are underway to make the handbook available in French and Spanish (in collaboration with the INOPAL III Project).

Work began on a monograph which will describe and analyze the provision of clinical family planning services in Sub-Saharan Africa through synthesizing and preparing comparative analyses of data collected through Situation Analysis Studies in over eight African countries. The monograph will be targeted for program managers, donors, technical assistance organizations and researchers concerned with strengthening reproductive health services in the region. Publication is planned for mid-1998.

An international conference for Francophone program managers on the analysis and utilization of data from Situation Analysis studies was held in Dakar, Senegal in June 1997. The conference drew about 90 program managers, donors, and researchers from ten countries, and addressed the methodological approach of Situation Analysis, the treatment and analysis of data, dissemination of results, and ways to increase their utilization. The conference allowed for useful region-wide discussions and resulted in several plans to carry out such studies in numerous countries. A report of the meeting is pending.

A number of analyses of Situation Analysis data were undertaken concerning various reproductive health issues and the results disseminated through publications and presentations. The African Journal of Fertility and Sexuality (Vol. 1, No. 2, Dec. 96) contains several articles based on these analyses authored by Project staff. A paper was presented at the EVALUATION Project/IUSSP conference in Costa Rica on "Methods for the Evaluation of Family Planning Program Impact". In addition, a paper on the relationship between client load at clinics and the readiness to offer quality services was presented at APHA.

The database of Situation Analysis studies in sub-Saharan Africa was maintained and enlarged during this period. It now holds hard copy and computer file versions of the data, questionnaires, and reports from about twenty studies. To ensure that the data can be used by non-specialists, significant cleaning and indexing were undertaken.

USAID has allocated resources for all future facility-based surveys to the newly initiated "DHS+ Project" as part of its MEASURE Results Package. Staff from the Africa OR/TA Project II have already begun to collaborate with staff working on MEASURE, through sharing instruments and advising on the development of revised approaches to collecting data on a range of reproductive health services.

B) APPLYING PARTICIPATORY RESEARCH METHODS TO DESIGNING AND EVALUATING REPRODUCTIVE HEALTH PROGRAMS

Operations research studies which test interventions with quasi-experimental designs have conventionally relied on questionnaire surveys to provide quantitative measures of the effect of interventions on the population receiving the services. Diagnostic studies have also relied heavily on questionnaire surveys. Although there has been an increasing use of qualitative methods (especially focus group discussions, in-depth interviews and observations) to collect information, it is only recently that use has been made of methods undertaken with the participation of those for whom the services are intended to benefit.

The two large-scale community-based projects being implemented in Navrongo, **Ghana**, and, **Burkina Faso** have both used participatory methods to collect information and design their interventions so that they are acceptable to the communities, and so that communities are motivated to participate in their implementation. For a fuller description of the participatory design process followed in Navrongo see Nazzar *et al.* (1995), and in Bazèga see LSC (1997). Another forthcoming study in Bazèga to design a community-based intervention for countering the practice of female circumcision will also use participatory methods to better understand the community's beliefs and feelings towards the practice and to elicit their suggestions for how best to motivate people to stop the practice.

The intervention study to test approaches to reaching out-of-school youth in **Zambia** is using Participatory Learning and Action (PLA) methods to understand and develop its interventions based on adolescents' perceptions of sexual and reproductive health concepts and practices. A workshop has already been held to train managers and researchers in PLA methods, and the skills learned through this training have been applied in collecting the study's baseline data. These methods include area mapping, social mapping, body mapping, transect walks, ranking and scoring, diagrams, wealth/well-being ranking, sketch stories (drawing picture stories), focus group discussions and sex census by secret ballots.

One of the strengths of this approach is that it enhances the community's sense of ownership and support of the interventions being tested as they have been involved in their design. For example, the report of the baseline survey indicated that "Mr. X, one of the participants, told that they [the community] saw and knew the problems that they had and so were the best people to choose ways which would help them overcome their problems." The PLA approach has led to a high level of community participation in implementation; for example, a number of parents voluntarily put up the collateral for their children's participation in the micro-credit program.

Participatory methods have been used frequently for designing community-based programs but the study in Zambia is the one of the few occasions on which they are being used to measure the effectiveness of the interventions over time. A similar approach was taken earlier when the Africa OR/TA Project II provided technical assistance to IPPF in applying participatory evaluation methods for designing and assessing sexual health interventions with its affiliate organizations in **Ghana, Tanzania, the Gambia and Burkina Faso**. Unfortunately, funding for this initiative was prematurely ended by the donor before the interventions could be evaluated and so it has not been possible to apply lessons learned from this experience.

C) REFINING EXISTING METHODS TO BETTER MEASURE THE COST-EFFECTIVENESS OF REPRODUCTIVE HEALTH PROGRAMS

Through a partnership with FHI, the Africa OR/TA Project II has been adopting existing resource analysis methods for measuring the cost-effectiveness of strengthening reproductive health service programs. Two studies are currently being undertaken. Working with the ZNFPC in **Zimbabwe**, the cost of adding STI detection and management procedures to routine consultations for family planning clients is being measured. This includes the way in which family planning providers use their time and other associated costs of providing an integrated service. A similar study is being undertaken with the Nakuru Municipal Council in **Kenya**, where the cost of adding STI detection and treatment to services for antenatal and family planning clients is being measured.

In **Tanzania**, the Africa OR/TA Project II has just completed a study to compare the cost-effectiveness of three community based distribution (CBD) programs with different schemes for remunerating field agents. This study, which tested the hypothesis that CBD agents who are salaried perform more cost-effectively than volunteers, adapted cost analysis methods used elsewhere (in Kenya and Bangladesh) for assessing how to cost and compare the work done by non-salaried and salaried workers. For each program the cost per agent visit and the cost per CYP per agent was calculated. The results are presented in section 1.6B.

D) DEVELOPING A RAPID ASSESSMENT MECHANISM FOR MONITORING THE QUALITY OF INTEGRATED REPRODUCTIVE HEALTH SERVICES

The Africa OR/TA Project II worked with the Division of Family Health in Botswana to develop and test a rapid assessment mechanism for monitoring routinely the quality of services provided through its integrated MCH/FP and STI/HIV program. The mechanism collects data from a representative sample of clinics through a checklist based on the Situation Analysis approach. Lot Quality Assurance Sampling (LQAS) is used to generate statistically valid measures for 50 key indicators from a small sample of observations of provider-client interactions. Many of the indicators measured through this mechanism (which were defined through a consultative process involving managers from all levels of the health care system) have now been incorporated by the MOH Information System for use at the national level.

The rapid assessment mechanism was found to be acceptable to staff and managers because it gave valid information on the readiness of health facilities to provide integrated family planning and STI services. This information has been used by the Central Training Section of the MCH/FP Unit to revise its curriculum for future courses, putting more emphasis on general and breast examination procedures, and on STI and HIV/AIDS risk assessment and counseling procedures. The MCH/FP Unit is also planning to revise its family planning client record forms to record and report routinely information which measures some of these key indicators.

A report describing the development and field-testing of the mechanism is available (Maribe *et al.*, 1997). A second rapid appraisal will be undertaken in the near future that will allow the sustainability of an integrated approach to service delivery to be measured.

E) DEVELOPING AND STRENGTHENING FIELD STATION RESEARCH CAPACITIES

The Population Council is supporting the development of two governmental health research field stations, one at Navrongo in northern **Ghana** and one in Bazɩga, central **Burkina Faso**. The Navrongo Health Research Centre has been established for almost ten years and most assistance is now directed towards assisting it to develop more fully the already impressive capacity that exists. The *Laboratoire de Santé Communautaire* (LSC) in Burkina Faso has only recently been established and so the Africa OR/TA Project II is helping the MOH to develop the capacity to organize the field station itself. An organizational structure has been created in which the MOH's *Direction de la Santé de la Famille* has established collaborative links with organizations which can contribute differently to the needs of the field station, namely, the Bazèga *Direction Regionale de la Santé*, with the University's *Unité d'Enseignement et de Recherche en Demographie*, with *Mwangaza*, an NGO specializing in community mobilization, and with the Population Council. This group meets routinely and all activities planned for the LSC are done so jointly.

The field station will be physically established within the district capital of Bazɩga in early 1998, for which the MOH will contribute a building and a vehicle and will second two senior staff. All MOH staff in the experimental area are about to be trained in interpreting and using data to enhance the immediate utilization of MIS data and study results. The LSC has also been able to attract funding from sources such as the Rockefeller Foundation and UNFPA, and is planning collaboration with Family Care International, and the USAID-funded FOCUS, HORIZONS and FRONTIERS Projects.

Publications and presentations on improved data collection and evaluation methodologies

Strengthening the Situation Analysis approach

Africa OR/TA Project II & Asia and the Near East OR/TA Project. 1996. *Strengthening Situation Analysis methodology: A coordinated interregional approach*. Population Council, New York, January.

Huntington, Dale, Kate Miller and Barbara Mensch. 1996. The reliability of the Situation Analysis observation guide. *Studies in Family Planning* 27(5):277-282.

Leonard, Ann (ed.) 1997. *Situation Analysis: How can we use it better?* Report of a workshop on strengthening the utilization of Situation Analysis for planning, managing, and evaluating reproductive health services, Nairobi, Kenya, May 29-31, 1996. Population Council, Nairobi, Kenya.

Miller, Kate, and Diouratié Sanogo. 1997. Analyse Secondaire: Développement des indicateurs pour les managers. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Miller, Kate, and Diouratié Sanogo. 1997. Méthodologie pour le développement des indicateurs. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

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Miller, Robert, Andrew Fisher, Kate Miller, et. al. 1997. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*. Population Council, New York.

Miller, Robert. 1996. Description and evolution of the Situation Analysis approach. Paper presented at a workshop on "Strengthening the Utilization of Situation Analysis for Planning, Managing and Evaluating Reproductive Health Services," Population Council, Nairobi, Kenya, 29-31 May.

Ndhlovu, Lewis. 1998. Lessons learned from Situation Analysis Studies in Zambia. Paper presented at the session "Facility Surveys in Developing Countries: Lessons Learned and New Directions," Annual Meeting of the Population Association of America April 2-4, Chicago, Illinois

Sanogo, Diouratié. 1997. Définition de l'Analyse Situationnelle. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Tapsoba, Placide. 1997. Evolution de l'Analyse Situationnelle. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Using Situation Analysis to assess program readiness and service quality

Askew, Ian, Barbara Mensch, and Alfred Adewuyi. 1994. Indicators for measuring the quality of family planning services in Nigeria. *Studies in Family Planning* 25(5): 268-283.

Askew, Ian, Kate Miller, and Barbara Mensch. 1995. Key indicators for measurement of quality of family planning services. Paper presented at The EVALUATION Project's Service Delivery Working Group meeting, Washington, D.C., 5 October.

Askew, Ian. 1994. Distinguishing between quality assurance mechanisms and quality assessment techniques. *Health Policy and Planning* 9(3): 274-277.

Fisher, Andrew, Kate Miller, and Robert Miller. 1997. Situation Analysis: Assessing the functioning and quality of the service delivery environment. Paper presented at the IUSSP/Evaluation Project Seminar on Methods for the Evaluation of Family Planning Program Impact, Jacó, Costa Rica 14-16 May.

Fisher, Andrew, Robert Miller, Ian Askew, Barbara Mensch, Anrudh Jain and Dale Huntington. 1996. The Situation Analysis approach to assessing the supply side of family planning programmes. *African Journal of Fertility, Sexuality and Reproductive Health*. 1(2):121-135.

Mensch, Barbara, Andrew Fisher, Ian Askew, et al. 1994. Using Situation Analysis data to assess the functioning of family planning clinics in Nigeria, Tanzania, and Zimbabwe. *Studies in Family Planning* 25(1): 18-31.

Applying participatory research methods to designing and evaluating programs

Fetters, Tamara and Kathleen Siachitema. 1997. "Reproduction health"; Adolescents appraise their own reproductive health problems in peri-urban Lusaka, Zambia. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Laboratoire de Santé Communautaire. 1997. Mobilisation sociale pour la mise en place d'un programme à base communautaire en matière de Santé de la Reproduction (S.R.) dans le Bazèga: Premiers éléments de bilan. Série Documentaire #5, Juillet.

Nazzar, Alex, Philip Adongo, Fred N. Binka, et al. 1994. The Navrongo Community Health and Family Planning Project phase I trial: Developing community participation in community health. Paper presented at the 122nd annual meeting of the American Public Health Association, Washington, D.C., 30 October-3 November.

Nazzar, Alex, Philip Adongo, Fred N. Binka, et al. 1995. Involving a traditional community in strategic planning: The Navrongo Community Health and Family Planning Project pilot study. Paper presented at the annual meeting of the Population Association of America, San Francisco, California, 6-8 April.

Nazzar, Alex, Philip Adongo, Fred Binka, James Phillips and Cornelius Debpuur. 1995. Developing a culturally appropriate family planning program for the Navrongo experiment. *Studies in Family Planning* 26(6): 307-324.

Rapid appraisal mechanism for assessing service quality

Maribe, Lucy Sejo, Baker Ndugga Maggwa, Ian Askew and Kate Miller. 1997. *Using a rapid assessment approach to evaluate the quality of care in an integrated program: The experience of the Family Health Division, Ministry of Health, Botswana*. Population Council, Nairobi, Kenya, November.

Maribe, Lucy and Baker Ndugga Maggwa. 1996. Using a modified Situation Analysis approach for routine monitoring of quality. Paper presented at a workshop on 'Strengthening the Utilization of Situation Analysis for Planning, Managing and Evaluating Reproductive Health Services,' Population Council, Nairobi, Kenya, 29-31 May.

1.3 Improved knowledge base for applying new or improved service delivery strategies or family planning technologies

A) INTRODUCING EMERGENCY CONTRACEPTION

A national assessment of the needs for expanding contraceptive options in **Zambia** (supported by WHO) recommended that emergency contraception (specifically the Yuzpe method of oral contraceptives) could play a critical role in limiting unwanted pregnancies. In Zambia, however, as in many countries where the introduction of emergency contraception is being considered or undertaken, there are many unknown issues.

The Africa OR/TA Project II is supporting a study (in collaboration with WHO and the Canadian Public Health Association) to improve what needs to be known about accessibility to the method, product administration and dispensing, managing side effects, encouraging users to make the transition to routine contraceptive use, and provider training. The study is being implemented by the University Teaching Hospital (UTH), the MOH, Planned Parenthood Association of Zambia, and the University of Zambia Health Services. The first exploratory phase of the study has been completed which collected data from 1,600 women seeking family planning service or information, 400 women seeking a termination of pregnancy, all women seeking emergency contraception, focus group discussions with students, and interviews with providers.

The key findings and programmatic recommendations from this exploratory phase are presented in Box 4. The second phase of this study will involve testing some of these recommendations through some small-scale OR studies which address specific issues. Two such studies have already been identified and are under development: a comparison of the acceptability of two different regimes of hormonal contraception: PC-4 and Postinor-2; and a comparison of prophylactic prescription with prophylactic distribution of emergency contraception to see which approach maximizes women's access to and use of the method.

Box 4

Lessons learned about emergency contraception from:

Women attending for termination of pregnancy

- the majority of women did not recognize the risks associated with individual instances of unprotected sex;
- most women did not suspect until at least one week after intercourse that they might be pregnant;
- method failure accounted for very few cases of unwanted pregnancy;
- only half the women said they would have tried emergency contraception immediately following the act of intercourse that led to the unwanted pregnancy;
- of those who would have tried, less than 20 percent had contraceptive pills available;
- virtually all women who suspected within three days of intercourse that they may be pregnant, consulted someone - typically their partner;
- of those who would have sought more information on emergency contraception, almost 80 per cent would have consulted a provider.

Family planning clients

- almost half believe there are ways to avoid becoming pregnant even after unprotected sex;
- over one quarter of the methods identified to avoid pregnancy involve use of contraceptive pills;
- accuracy of knowledge on the appropriate regimen for using emergency contraception declines rapidly after instruction;
- women under 20 years seem more open than older women to obtaining emergency contraception through non-traditional outlets.

Programmatic recommendations

- health education messages should communicate an accurate sense of the risks of even a single act of unprotected sex;
- the time intercourse occurred, rather than the time of a woman's menses, must be promoted as the critical marker in the monthly cycle;
- providers are an acceptable means for reaching a large sector of the population in need;
- the prophylactic distribution of a dedicated emergency contraceptive product should be explored.

Source: Skibiak *et al.* (1997)

B) DEVELOPING APPROPRIATE AND ACCEPTABLE REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS

Over the past year, the Africa OR/TA Project II has supported two diagnostic studies, one in **Zambia** implemented with CARE/Zambia, and one in **Ghana**, implemented with PPAG, the IPPF-affiliate. These studies have explored in depth the issues surrounding adolescent sexual behavior and their service needs for preventing unwanted pregnancies and sexually transmitted infections. The purpose of these studies was to guide the design and implementation of new service delivery strategies aimed specifically at youth (see section 1.1.E). Both studies used different research methods: the study in Zambia used the Participatory Learning Approach (PLA) (see section 1.2.B), whereas the Ghanaian study used a questionnaire survey. The key findings from the Zambian study are given in Box 5 and for the Ghanaian study in Box 6. In addition to guiding the design of service delivery interventions, the results of both studies have been widely disseminated within each country and internationally.

C) UNDERSTANDING HOW TO ORGANIZE MALE-ORIENTED REPRODUCTIVE HEALTH SERVICES

For men to be more actively involved as partners in reproductive health care, existing approaches to providing reproductive health care services will need to be re-organized. The use of MCH/FP clinics, while an appropriate strategy for providing services directly to women, is fraught with difficulties when trying to meet the needs of couples and of men individually. Little is known, however, about how best to organize reproductive health services (within both clinics and community-based programs) so that they can be male-oriented.

A study in **Kenya**, undertaken in collaboration with the Africa Population Policy Research Centre and the Family Planning Association of Kenya (FPAK), seeks to increase program managers' understanding of two aspects of service delivery related to male involvement: 1) men's and women's attitudes about men's role in their own and their partner's reproductive health, and 2) the type of family planning services, and services for the treatment and prevention of STIs, which men and women would like to see offered to men.

A community survey has recently been completed in three communities of Kakamega District in western Kenya. This survey employed a variety of qualitative data collection methods to elicit from men and women their perceptions and preferences regarding men's roles. The study's second phase will use a participatory research approach, specifically an adaptation of the COPE method developed by AVSCI, to obtain health providers' perspectives on the provision of services to men in their clinics. The results will be used by the FPAK to develop criteria for evaluating their current models of service provision for men (male-friendly clinics and male CBD and workplace distributors), as well as for planning the expansion of their program.

Box 5

A study using PLA methods with adolescents in Lusaka, Zambia showed that:

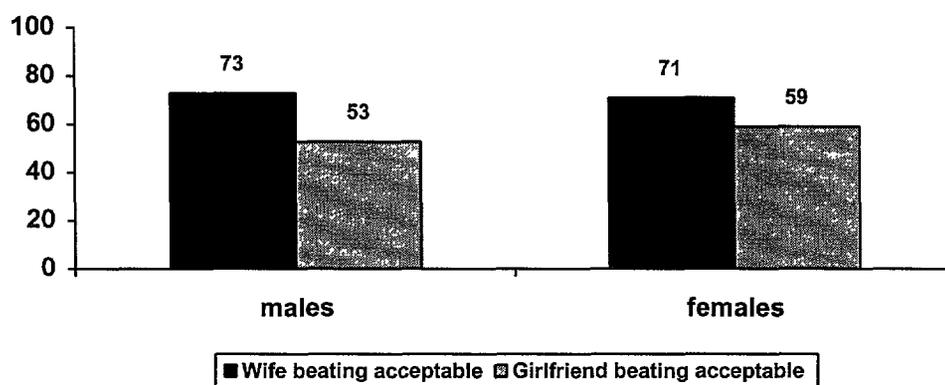
- There appear to be high levels of sexual activity pre-puberty, less activity between the ages 13-16 as pregnancy and disease become a concern, rising again around age 17-18 as adolescents find a regular partner.
- Peer pressure to engage in sex, particularly among boys, is strong. Many girls engage in sex out of curiosity and exchange sex for help with school work or pocket money. Preferred sexual partners are age-mates, the exception being out-of-school girls.
- Adolescents are less likely to be sexually active when they live with parents than with other relatives. Girls worry that if they have sex they will get pregnant and be thrown out of school. Many adolescents noted abortion and death as a consequence of pregnancy.
- Adolescents are highly knowledgeable of STIs, condoms, and condom availability. Young boys complain that condoms are too large and may slip off, and older boys complain of a reduction in pleasure. Some girls are able to negotiate condom use despite the fact that payment is higher for "live" sex.
- Little use is made of contraceptives other than condoms. Many believe that contraceptives are for adults, and that young boys cannot impregnate girls (their sperm is not strong enough).
- Adolescents know many facts about sex and reproduction but very little about sexuality. They cite a lack of reliable sources of information about sexual health. The main sources are grandparents, friends, and video shows, but NOT parents.

Source: Feters *et al.* 1997

BOX 6

A survey of 750 urban youth in three regions of Ghana showed that:

- Lack of jobs and high clothing prices were paramount concerns, especially for males. A lack of recreational facilities, one reason for the youth center initiative, was of least concern to the respondents.
- Both sexes approve traditional values which maintain a gender imbalance, with no significant differences by religion, age, or education. Particularly worrying was the high proportion of both boys and girls approving of beating a girlfriend / wife.



- Less than 10 per cent of youth aged 12 to 15 have ever had sex, while about 40 per cent of those aged 16 to 17, and almost 75 per cent aged 18 and over have ever had sex.
- Less than one in five could correctly indicate when pregnancy is most likely to occur during the monthly cycle. One third of never-married females who have ever had sex have experienced a pregnancy; 91 per cent of these say they did not want to be pregnant at the time; 89 per cent of them had or attempted an abortion.
- Almost all respondents claim knowledge of ways to avoid pregnancy. Methods mentioned most frequently are full abstinence, condoms, and oral contraceptives. Virtually all claim to have "heard of condoms," but less than half mentions each specific step of correct condom use.
- Virtually all know of diseases which can be contracted through sexual intercourse. Ninety-seven per cent mention HIV/AIDS; 81 per cent mention syphilis. Almost all indicate that HIV is transmitted through sexual intercourse; only 11 per cent incorrectly indicate that casual contact or insect bites are a source of HIV.

Source: Glover *et al.* (1997)

Publications and presentations on improving the knowledge base for introducing new family planning technologies and strategies

Introducing emergency contraception

Ahmed, Yusuf, M. Ketata and J. Skibiak. 1998. *Emergency Contraception in Zambia: Setting a new agenda for research and Action*. Africa OR/TA Project II and Expanding Contraceptive Choice Program, Population Council, Nairobi, Kenya, April.

Skibiak, John, Yusuf Ahmed, Davy Chikamata and Peter Hall. 1997. Emergency contraception: searching for new solutions. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Developing appropriate and acceptable services for adolescents

Glover, Evam Kofi, Angela Bannerman, Robert Miller, Heidi Jones, Eugene Weiss and Joanna Nerquaye-Tetteh. 1997. Adapting Reproductive Health Strategies to Adolescent Needs: Findings from Three Ghanaian Towns. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Ouédraogo, Boukary, Inoussa Kaboré, Youssouf Ouédraogo, and Idrissa Ouédraogo. 1996. *Identification des besoins spécifiques des jeunes dans le domaine de la santé sexuelle*. A report of Technical Assistance provided by the Africa OR/TA Project II to the Association Burkinabè pour le Bien-Etre Familial (ABBEF), CFDS/GTZ Projet, Formation et Recherche Action. Ouagadougou, Burkina Faso, August.

Improving existing community-based services

Askew, Ian and Jane N. Chege. 1996. Impact and effectiveness of CBD models in Kenya: what factors account for variance in program achievements? Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Bamba, Azara, Jeanne Nougara, Jean-Baptiste Koama, and Youssouf Oujdraogo. 1996. *Etude pour tester l'expansion de l'utilisation des Accoucheuses Villageoises pour les prestations de services de SMI/PF/NUT dans cinq provinces du Burkina Faso: Enquête de base*. A report of Technical Assistance provided by the Africa OR/TA Project II to the Ministère de la Santé, de l'Action Sociale et de la Famille and UNFPA / Burkina Faso, Ouagadougou, Burkina Faso, May.

Chege, Jane Njeri and Ian Askew. 1997. *An assessment of community-based family planning programmes in Kenya*. Africa OR/TA Project II, Nairobi, Kenya, January.

Mundy, Jacqueline, and Ian Askew. 1994. *Current experiences with community-based distribution of family planning in Kenya: A review prepared for USAID/Kenya*. A report of Technical Assistance provided by the Africa OR/TA Project II to USAID/Kenya. The Africa OR/TA Project II, Nairobi, Kenya, September. [In English and French]

1.4 Knowledge transferred through training, dissemination and utilization

A) TRAINING IN OPERATIONS RESEARCH, PLANNING AND MANAGEMENT

Training in operations research, and in program planning and management, is a major component of the Project's efforts to transfer knowledge to strengthen host-country organizations capacity to plan and manage their service delivery programs. A full listing of all training workshops held to date is given in Appendix Three. In addition to being a means for transferring knowledge to host-country organizations, training is frequently used as an element of capacity-building strategies. The Project's capacity-building activities are described in section 1.5.a.

B) DISSEMINATION OF RESEARCH RESULTS

a) Nationally

For all subprojects and some technical assistance activities that test interventions, a report is produced which is distributed in-country to all appropriate organizations and individuals. Approximately 300 organizations and individuals worldwide also receive copies of all Project reports and communications materials. The results of most studies are presented at in-country dissemination seminars, during which the programmatic implications and policy recommendations arising from the study findings are normally identified and agreed upon by the seminar participants.

i) Dissemination of OR results through national seminars

All OR studies include a national dissemination seminar as one of their principal mechanisms for disseminating results to key policymakers, program managers and donors within a country. These seminars are normally hosted by the service organization that implements the study, and/or which can most directly utilize the results. In addition to presenting the study itself and the key findings, these seminars are used as opportunities for planning for the use of some or all of the results. Every effort is made to ensure that participants are able to either disseminate the results more widely within their own region or district, or have authority to implement any recommendations which have proved feasible and effective. To date, more than 30 national seminars have been held.

ii) Sub-national analysis and dissemination of results from Situation Analysis studies

Whereas the early Situation Analysis studies provided data primarily for national level decision-makers only, Situation Analysis studies are now designed to collect data representative at the sub-national level also (e.g. for provinces and/or for administratively separate programs). Consequently, almost all studies now include not only a sub-nationally

representative sampling plan, but also build in sub-national analyses of the data and dissemination of these results to regional, provincial district and program-specific audiences.

The Situation Analysis study undertaken in **Senegal** in 1994 included all clinics in the country. A substantial and decentralized dissemination process was undertaken with the results being analyzed separately for all ten regions of the country. Over the past year, lessons have been learned about this decentralized approach which could be utilized by the MEASURE Project and others supporting national Situation Analysis studies (see Box 7).

Box 7

A decentralized approach to disseminating the results of a Situation Analysis study should bear in mind that:

- **Early involvement of district level staff in program decision-making favors the understanding and implementation of the national policy.** For example, equipment for child survival services purchased by the nutritional rehabilitation unit had been distributed to 300 clinics without their involvement in the planning process; consequently the equipment stayed in warehouses and has never been used.
- **Implementation of action plans takes longer at the central level than the district level.** Sub-national dissemination of the Situation Analysis results facilitated the identification and prompt resolution of problems specific to the local levels.
- **Full involvement of central level staff in sub-national dissemination activities improves communication between the national and district levels and a better understanding of each other's expectations.**

Source: Diop *et al.* (1997)

In **Kenya**, the MOH requested that the national data be re-analyzed and presented to Provincial and district level staff. Consequently, three workshops (each comprising representatives from two provinces) were held at which the data for each province were presented and discussed. These workshops proved extremely popular as for many it was the first time they had received data that was directly relevant to their daily activities. Several managers were able to plan immediate solutions to specific problems which did not require external resources beyond those within their authority. These included: making sure that all providers were aware of the new service delivery guidelines that no longer included age and marital restrictions on contraceptive use; and linking with other local government agencies to

bring in running water where it was currently missing. Data were also analyzed and reported separately for program managers of the Nairobi City Council program and their counterparts at Pathfinder International (see Ndhlovu and Chege, 1997) and for Marie Stopes International. The datasets have also been provided to AVSCI and JHPIEGO to assist in planning for their technical assistance activities.

iii) Dissemination of results from Field Stations

The Navrongo Health Research Centre (NHRC) in **Ghana** puts much emphasis on disseminating the results of their research nationally and internationally. For example, staff at the NHRC regularly produce “Working Papers” which analyze various aspects of the data collected. Many of these working papers are of sufficient quality to be presented at international conferences and/or published in peer reviewed journals, giving the results a high profile internationally.

The lessons being learned through the NHRC’s CHFP Project are seen by the MOH as crucial to guiding the operationalization and implementation of community participation in Primary Health Care. Now that the community-based intervention is fully operational, the NHRC is actively seeking to disseminate the preliminary results throughout the health care system within Ghana. This is being undertaken through a combination of presentations at national and regional level workshops, meetings with key senior policymakers and program managers and, perhaps most importantly, visits to the Project site in rural northern Ghana. Individual visitors have included the President of Ghana, the Minister of Health, and the Director of Medical Services.

In addition, the NHRC has hosted a number of extended visits by program managers and others who want to learn more about the way in which the services are being offered. For example:

- representatives from the Upper West, the Upper East, the Northern and the Volta Regions of Ghana have visited the project and are now looking for ways in which many of the innovative approaches being tested could be adopted for use in their own districts.
- Representatives from DANIDA visited the project to learn how the community health nurses had been trained in midwifery, and as a result DANIDA supported a change in the training syllabus of all community health nurse training schools so that it incorporates midwifery.
- In collaboration with the Division of Manpower and Human Resources, the NHRC is developing an in-service training scheme whereby all District Directors of Health Services will visit the project to gain exposure to the procedures being implemented.
- Following a visit by the Dean of the University of Ghana School of Public Health, all graduate students on the public health program are now required to spend time at the NHRC; one student subsequently returned for a four month attachment.

- The Community Health Nurse training school in Tamale now sends all its final year students to spend one week in the field with the community-based nurses, and plans are underway for the other three nurse training schools to do the same.
- The MOH Health Research Unit has sent two senior researchers to document the experiences to date so that they can be disseminated widely within the Ministry.

b) Internationally

Staff at the New York office disseminate key results from Project studies to an international audience through a variety of communications channels including:

- requests for materials from the Project's publication list;
- the OR Home Page on the World Wide Web;
- an e-mail listserve for over 200 individuals;
- announcements to USAID's Assistant Administrator;
- the *Update* series of two-page research summaries sent to 2,500 recipients worldwide.

As of the end of Year Four, the Project had produced 43 subproject and TA final and interim reports, 8 *Updates*, 22 papers published in journals, and 62 papers presented at conferences. All publications are available upon demand in the New York Office, and limited supplies are also in the Project's offices in Africa.

Discussions held with USAID and with the OR/TA Projects for Asia/Near East and for Latin America have led to the production of two new global communications channels: a bi-annual newsletter which reports on findings on common topics from all three regions; and a series of two-page '*OR Summaries*' of key research results (similar to the *Updates*), also from all three regions. These global materials are now available from the New York office.

c) UTILIZATION OF OR FINDINGS AND TECHNICAL ASSISTANCE

a) Using OR findings to strengthen services

The ways in which results from OR and technical assistance activities are used to strengthen service delivery programs can vary depending on the nature of the research or technical assistance activity undertaken. Consequently, the process used to by the Africa OR/TA Project II to maximize the likelihood that results will be used is determined largely by the type of OR activity being undertaken.

For example, if the *experimental testing of a new service delivery intervention* demonstrates that it is feasible and effective, emphasis is placed on facilitating the intervention becoming part of the routine procedures of the service delivery program. Box 8 describes the process being followed in Kenya to assist the MOH in utilizing the results of the study (reported earlier in section 1.1.B) which demonstrated how best to link family planning counseling with treatment for an incomplete abortion.

The results from *diagnostic and/or evaluative research studies* tend to be used directly and immediately by program managers. Consequently, they may require less on-going assistance from Project staff after completion to ensure their utilization. Such studies are normally requested by program managers themselves to answer a specific problem, whether it is diagnosing a particular situation or evaluating the effectiveness of an on-going intervention. The design, implementation and dissemination of Situation Analysis studies, for example, appears to be well suited to ensuring that managers can use the results to identify not only their priority problems but also the most immediate solutions (as shown in Box 9 below).

BOX 8

SCALING-UP THE RESULTS OF AN EXPERIMENTAL POST-ABORTION INTERVENTION STUDY

Following the study's national dissemination seminar, Project staff facilitated a series of collaborative meetings between the MOH and technical assistance and donor organizations working in Kenya, including AVSCI, JHPIEGO, Pathfinder International, Ipas, USAID, SIDA, and DfID. These meetings have enabled joint plans to be drawn up by the MOH and the organizations so that the training and infrastructure strengthening activities on a national scale are coordinated, duplication of effort is avoided, and the MOH is efficiently supported in achieving its goal of providing postabortion care services at all MOH hospitals. The MOH is also using the study results to substantiate the recommendations for implementing postabortion care in its revised national reproductive health policy guidelines and standards. This process for maximizing utilization of an intervention study is successful because of:

- extensive involvement of relevant parties, including services providers, at all points of the study, from planning to dissemination
- clear presentation of findings
- development of clear and detailed plans for expansion, including specific responsibilities, persons responsible and timelines, at the dissemination workshop
- strong ownership taken by the MOH at all points of the study
- continued support and technical assistance for the MOH from Africa OR/TA Project II staff beyond the completion of the research activities.

Box 9

UTILIZATION OF RESULTS FROM SITUATION ANALYSIS STUDIES

Country	Date	Utilization of results
Botswana	1995	<ul style="list-style-type: none"> • formulation of reproductive health section of Government of Botswana's five-year National Development Plan • development of indicators for monitoring integrated reproductive health services • Task Force established to review client record forms, service provider guidelines and IEC materials after weaknesses identified by study • training course developed in logistics management • supervisory checklist developed for integrated services - will be tested on a pilot-basis as an OR study • data used by USAID as baseline measures for evaluating its bilateral BOTSPA integrated services project • development of UNFPA's five year Project Review and Strategy Development Plan
Burkina Faso	1991, 1995	<ul style="list-style-type: none"> • MOH developed new training curricula and materials for training providers in counseling • "Reference guide" on contraceptive methods developed to improve information given • GTZ analyzed data to strengthen services at those clinics which it supports • UNFPA funded a comparative analysis of results from 1991 and 1995 studies, and a regional level analysis of the 1995 data to guide joint planning with the MOH • MOH used results to guide World Bank funded decentralization process
Ghana	1993, 1997	<ul style="list-style-type: none"> • MOH evaluated effect of some management decisions taken after 1993 study • JHPIEGO used results of items on training to monitor implementation of revised curriculum
Kenya	1990, 1995	<ul style="list-style-type: none"> • FHI used results to assess adherence by providers to new standards and guidelines • development of MOH Reproductive Health Strategy • development of National Implementation Plan for Family Planning Program (1995-2000) • Nairobi City Council and Pathfinder use results to assess and strengthen infection control, counseling and IEC activities • Marie Stopes International use data to develop proposals for the World Bank • Results disseminated to six provinces and used by managers to plan improvements at sub-province level
Senegal	1994, 1996	<ul style="list-style-type: none"> • decentralized dissemination lead to rapid training sessions for improving providers attitudes and beliefs about contraception • development of 1996 National Action Plan • Fees policy reviewed and standardized • IPPF-affiliate begins to provide injectables • data used as baseline for USAID bilateral child health / family planning project implemented by MSH
Zambia	1997	<ul style="list-style-type: none"> • data used as baseline for evaluating: <ul style="list-style-type: none"> - USAID bilateral clinic-strengthening project implemented by JSI - USAID Child Health Project - UNFPA reproductive health care project in 10 districts - MOH Lusaka health program
Zanzibar	1994	<ul style="list-style-type: none"> • MOH purchased equipment found missing at specific facilities • development of next five-year program • management and supervision courses added to program
Zimbabwe	1991, 1996	<ul style="list-style-type: none"> • development of 1997-2001 national reproductive health program • assessment of changes in program since 1991.

The Africa OR/TA Project II has been conducting a series of case studies to assess the extent to which the results from completed OR studies have been utilized, and to identify the key factors determining whether or not the studies were useful to service delivery and donor organizations. The final report is currently being completed, but the preliminary conclusions are given in Box 10.

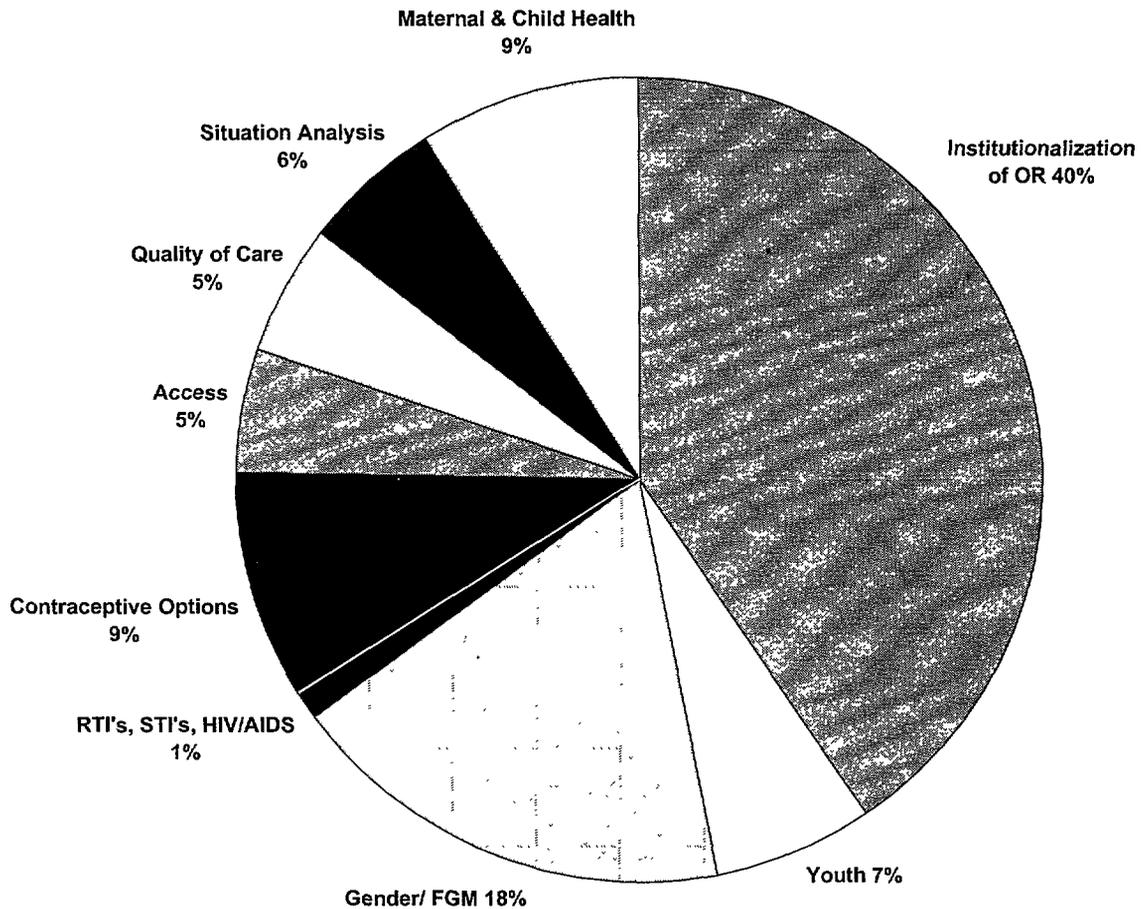
Box 10

To maximize the utilization of results, those implementing an OR study should:

- develop OR agendas in coordination with local counterparts to address their expressed needs and problems;
- focus on building and maintaining close relationships with collaborators through frequent interactions in all phases of research;
- minimize duplication of effort and maximize potential interrelations among studies by identifying other projects that are being conducted concurrently;
- focus on the quality of research at all stages;
- disseminate findings to central level policymakers as well as regional and implementation levels, including service providers;
- mutually develop clear, concrete, and detailed recommendations with the implementing organization for using findings, outlining actions to be taken, person(s) responsible for these activities, and timelines for activities;
- include in research budgets staff time to promote utilization of findings, including assistance in writing proposals and obtaining funding;
- from the beginning with potential users, and include in proposals, explicit details on the possible ways information will be used;
- strengthen the focus on sustainability, including cost recovery efforts and collaboration with other organizations, that could assist in making interventions sustainable.

Source: Solo *et al.* (forthcoming)

b) Providing technical assistance to strengthen programs



The Africa OR/TA Project II commits a substantial proportion of its human (and financial) resources to providing *technical assistance* to many service delivery, technical support and donor organizations on a variety of research, training, service delivery and policy-related issues. Technical assistance, by its very nature, is the activity most likely to result in direct utilization by the recipient organization. The impact on policy and programmatic decision-making is variable, however, depending on the nature of the assistance provided. The graph above describes the types of technical assistance provided by Africa OR/TA Project II staff, and gives the distribution of time spent on each category.

Publications and presentations on knowledge transfer through dissemination and utilization

Diop, Nafissatou, Annamaria Cerulli, and Diouratié Sanogo. 1996. Regional dissemination of Senegal's Situation Analysis study results: A promising way to maximize operations research utilization. *African Journal of Fertility, Sexuality and Reproductive Health* 1(2):169-173.

Diop, Nafissatou and Diouratié Sanogo. 1997 Dissemination from top to bottom: a promising way to maximize the utilization of Operations Research findings in Senegal. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Diop, Nafissatou. 1997. Rôle de la dissémination dans l'utilisation des résultats. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Diop, Nafissatou. 1997. Pour une optimisation de l'utilisation de l'AS au Sénégal. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Gouédé, Nicholas. 1998. Population Council Operations Research and Technical Assistance Home page. A demonstration presented at the Second Internet Meeting of USAID-Population and Health Materials Working Group (PHMWG) at Johns Hopkins University's Center for Communication Programs, Baltimore, Maryland, 21-22 January.

Gouédé, Nicholas. 1997. Availability of Operations Research findings in reproductive health on the Internet. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Gouédé, Nicholas. 1997. Communication Strategy of the Africa OR/TA Project II: A round-up of Situation Analyses studies and communication channels. Slide show presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

Ndhlovu, Lewis and Jane Chege. 1997. *Family planning services in Nairobi: Report of a workshop for strengthening the utilization of findings from research studies of clinic and community based family planning services of the Nairobi City Council.* The Africa OR/TA Project II, Nairobi, Kenya, September.

Solo, Julie, Annamaria Cerulli, Robert Miller and Ian Askew. 1998. *Strengthening the Utilization of Family Planning Operations Research: Findings from Case Studies in Africa.* The Africa OR/TA Project II, Nairobi, Kenya.

Tapsoba, Placide. 1997. Facteurs de maximisation de l'utilisation des EAS. Presentation at francophone Africa program managers' workshop on "Analysis and Utilization of Situation Analysis studies," Population Council, Dakar, Senegal, 9-14 June.

1.5 Enhanced capacity for organizations to design, implement, evaluate and finance reproductive health programs

A) STRENGTHENING STRATEGIC PLANNING, MANAGEMENT AND EVALUATION CAPACITIES OF KEY SERVICE DELIVERY ORGANIZATIONS

During Year Four, activities were focused primarily on building capacity in the Evaluation and Research Units (ERU) of the **Zimbabwe** National Family Planning Council (ZNFPC) and the Planned Parenthood Association of **Ghana** (PPAG). At ZNFPC, a number of short training workshops on specific research and computing topics have been completed, and assistance provided for the development of the Unit's next five year strategy. With PPAG, the approach has been to build capacity through a combination of staff training, joint development and implementation of research studies, collaborative authoring of papers, and supplying essential computer equipment.

Additional capacity-building activities have included:

- In **Burkina Faso**, Project staff provide extensive technical assistance to the MOH in designing the structure and functioning of the Bazèga field station, developing its research agenda, and facilitating linkages with donor and technical support organizations.
- In **Senegal**, Project staff provides substantial technical assistance to the USAID Mission in enabling it to develop and use evaluation indicators for monitoring and reporting its Strategic Objectives
- In **Tanzania**, occasional assistance is being provided to both the MOH Reproductive Health Unit and UMATI (the IPPF-affiliate) to prepare research protocols. Assistance was also provided to UMATI with developing indicators for their strategic plan.

B) ENHANCE THE FINANCIAL SUSTAINABILITY OF REPRODUCTIVE HEALTH CARE PROGRAMS

As part of the community-based service delivery projects being implemented at Navrongo in **Ghana** and at Bazèga in **Burkina Faso**, cost-recovery mechanisms are being tested. At both sites, the community-based volunteer agents are selling health care and contraceptive commodities. The income generated from these sales are used both to motivate the agent and to provide some measure of cost-recovery for the programs. At Navrongo, the scheme is managed primarily by the community health committees who have decision-making authority over how any 'profits' are spent after passing on the cost of the commodities to the District Health Management Team. Data on both approaches are currently being collected and results will be available by the end of the studies.

The USAID Mission in **Tanzania** requested the Africa OR/TA Project II to assess the three CBD programs which it supports, with a particular focus on whether remunerating CBD agents affects their performance. This study was undertaken through the Project's sub-contract with FHI to undertake cost analyses of service delivery interventions. Box 11 summarizes the key findings from the study.

Box 11

A study of the costs and effectiveness of CBD programs in Tanzania concluded that:

- **Programs having frequent supervision, strong community support, and the opportunity to undertake income generating activities performed better than those without these characteristics.**
- **Whether agents operate in urban or rural-based communities or whether they operate in high or low contraceptive prevalence rate sites does not seem to influence CBD agent outputs.**
- **CBD agents provided with monetary remuneration see more clients and generate more Couple Years of Protection (CYP) than those provided with non-monetary incentives, and agents given non-monetary incentives have higher outputs than agents who are not provided any incentives.**
- **Monetary remuneration, while important for motivating agents to produce more outputs, does not necessarily guarantee job satisfaction.** Agents provided with monetary remuneration complained about inadequate remuneration more than agents provided with non-monetary remuneration.
- **There are significant variations in each program's cost structure which affect their cost-effectiveness.** For example, one program spends a large proportion of its budget on remuneration, another on supervision and training, and the third on training.
- **The program that provides non-monetary incentives is the most cost-effective program.** However, the programs' variation in cost-effectiveness ratio's cannot be attributed solely to variations in remuneration strategies.
- **Rather than focusing narrowly on compensation policies, program managers should consider how best to allocate the budget between compensation and other support services for agents that contribute to their productivity.** A broad focus on ascertaining the cost-effectiveness of remuneration enables program managers to consider that improved cost-effectiveness may be attained by increasing some costs while decreasing others.

Source: Chege *et al.* (forthcoming)

Publications and presentations on enhancing organizations' planning, implementation and evaluation capacities

Chege, Jane, Naomi Rutenberg, Andrew Thompson and Barbara Janowitz. *Factors affecting the outputs and costs of Community Based Distribution of family planning services in Tanzania*. Population Council, Nairobi, Kenya. Forthcoming

Montsi, Mercy Rapelesega and Naomi Rutenberg. 1997. *The Youth Empowerment Project: Strengthening NGO management, research and service delivery capabilities in Botswana*. Population Council, Nairobi, Kenya, June.

Pakes, Bernard. 1996. *Strengthening NGOs management and service delivery capabilities: Management component of the YEP project*. Botswana National Productivity Centre, Gaborone, Botswana, November.

Khulumani, Pilate and Bernard Pakes. 1996. *Strengthening NGOs management and service delivery capabilities: Research component of the YEP project*. Health Research Unit, Ministry of Health, and the Botswana National Productivity Centre, Gaborone, Botswana, November.

Maribe, Lucy and Scott Stewart. 1995. Botswana's national program of integrated services - what are the costs: A case study. Paper presented at the annual meeting of the American Public Health Association, San Diego, CA, 29 October-2 November.

Tapsoba, Placide, Alex Nazzar, Olivia Aglah, and Robert Alirigia. 1996. Making the Bamako Initiative work: The Navrongo experience. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Twahir, Amina and Baker Ndugga Maggwa. 1995. Mkomani Clinics' integration of MCH/FP with STD/HIV services - what are the costs: A case study. Paper presented at the annual meeting of the American Public Health Association, San Diego, CA, 29 October-2 November.

1.6 Increased access to and quality of family planning services

Several countries in the region have undertaken a second Situation Analysis study. This allows program managers and donors to learn whether their health facilities have improved their readiness to offer family planning services, and whether this has resulted in improved quality of service provided. This application of the Situation Analysis approach is particularly useful for evaluating the effectiveness of overall program strengthening interventions, including programs of bilateral assistance. This evaluation approach is being used, or has been used, in Burkina Faso, Ghana, Kenya (including Nairobi city), Senegal, Zimbabwe, and Zambia¹.

Box 12 illustrates how two Situation Analysis studies have been used by the **Nairobi** City Council and Pathfinder International to diagnose the problems in their urban services program, and then evaluate the effectiveness of the resultant improvements.

Likewise, after the 1991 national Situation Analysis study in **Zimbabwe**, several interventions were introduced (e.g. providers were trained in counseling skills and STI management; promotional materials were printed and distributed, and training manuals were reviewed) to rectify some of the weaknesses identified. The second Situation Analysis study, completed in 1996, was used to evaluate these interventions and identify how the program could be strengthened further. Preliminary results suggest that:

- the proportion of clients being told about condoms decreased;
- with the re-introduction of the injectable, it has rapidly become the method most frequently discussed during consultations;
- long term and permanent methods are still infrequently discussed;
- although a far higher proportion of women were asked about their reproductive goals, fewer women were asked if they were breast feeding;
- fewer women were told about side effects and their management;
- procedures for assessing STIs and the risk of cancer continue to be done infrequently.
- the proportion of women receiving medical and pelvic examinations decreased.

¹ In Zambia there has only been sufficient time within the Africa OR/TA Project II to undertake the baseline Situation Analysis study. A similar approach was planned for Botswana, but after the baseline Situation Analysis study was completed, the withdrawal of USAID support for the national reproductive health program meant that the second Situation Analysis study could not be undertaken with USAID funding.

Box 12

Based on results from the 1991 Situation Analysis study the Nairobi City Council (NCC), with support from Pathfinder International, introduced the following improvements:

- extensive basic and refresher training in family planning for providers
- development and distribution of print and audio materials at health facilities and in some communities within Nairobi
- purchase and distribution of equipment necessary for adequate provision of clinical family planning services (e.g. sterilizers, uterine sounds, instrument trays, forceps and blood pressure machines)
- training in management information systems to orient staff, discuss feedback and utilization of information for decision making.

Four years later the second Situation Analysis study showed the NCC that there had been:

- an increase of 29% in the proportion of health facilities with visual materials such as brochures, posters and flip charts;
- an overall improvement in the availability of equipment for family planning services;
- a higher proportion of providers reporting that they were sufficiently trained in providing family planning services;
- a higher proportion of providers telling new clients how to use the method chosen, its advantages and disadvantages, and what to do if side effects are experienced.

These results confirmed to the NCC that it has succeeded in improving service quality. Provider-imposed restrictions for many contraceptive methods however (based on spousal consent, marital status, and number of children) still exist and are being addressed through disseminating and enforcing the new policy guidelines and standards. With the increased focus on improving the quality of care provided, the NCC, again with assistance from Pathfinder International, is developing three 'model' clinics that will be used to explore the effect of improving service quality on client behavior (satisfaction and method continuation).

Source: Ndhlovu and Chege (1997)

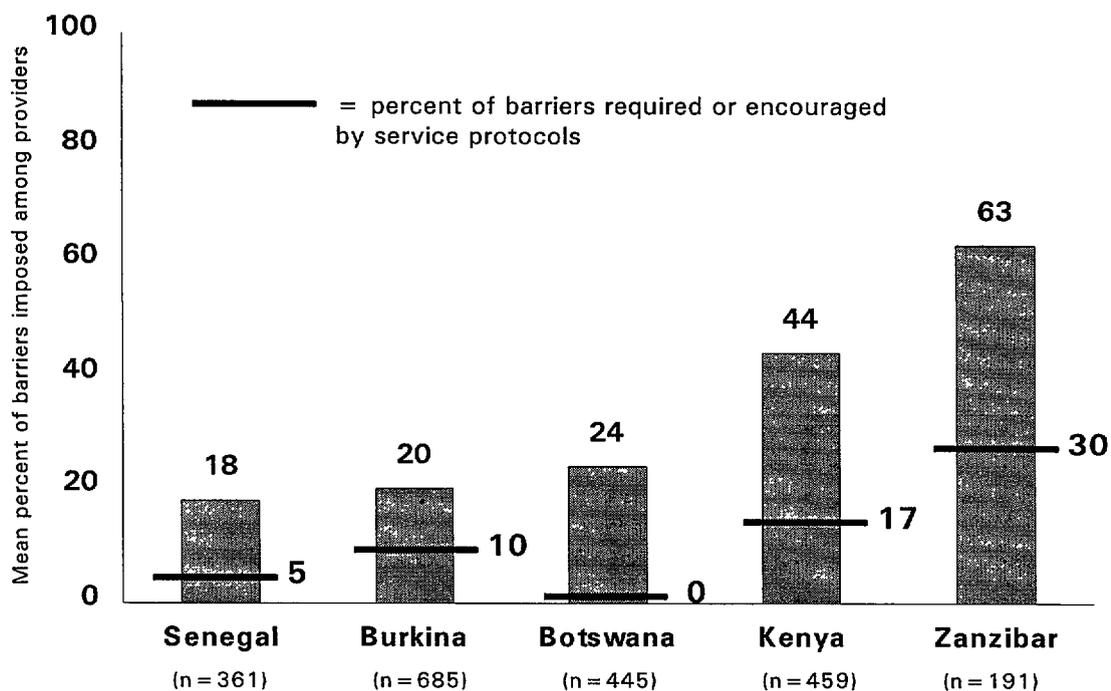
Policy or provider-imposed limitations based on a client's age, parity, and marital status can constitute barriers to some women's access to family planning services, and may inhibit the quality of service provided. Using data from five Situation Analysis studies, a comparison was made of the limitations imposed by policy guidelines with how many are actually applied by providers. Five potential barriers (minimum and maximum age, parity, marital status, and spousal consent) were measured for six methods (pills, condoms, IUDs, injectables, Norplant® implants, and tubal ligation). As seen in Box 13, policy guidelines are not particularly restrictive, except in Zanzibar. Sterilization is the most restricted method, mainly by age, parity, and spousal consent, and condoms the least restricted. IUDs are frequently restricted by parity, and pills by maximum age.

When interviewed, however, many providers indicate that they impose their own restrictions over and above what is required in the policy guidelines. These data suggest that in addition to working to reduce restrictive guidelines, efforts are necessary to encourage providers not to impose their own, additional requirements if access to contraceptive methods is not to be unnecessarily restricted.

Box 13

Many providers impose requirements beyond those in national policies and guidelines which act as barriers to women who may want use these methods

Percent of barriers required by guidelines compared to those imposed by staff



Publications and presentations on access to and quality of reproductive health services

Situation Analysis studies

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Maggwa, Baker N., Ityai Muvandi, Martin Gorosh, et al. 1995. *Findings from the sub-Saharan Africa urban family planning study: Mombasa City report*. Report of Technical Assistance provided by the Africa OR/TA Project II to the SEATS Project. John Snow Inc., Washington, D.C., March.

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Miller, Robert, Kate Miller, Lewis Ndhlovu, Julie Solo, and Ominde Achola. 1996. A comparison of the 1995 and 1989 Kenya Situation Analysis study findings. *African Journal of Fertility, Sexuality, and Reproductive Health* 1(2):162-168.

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Ndhlovu, Lewis, Julie Solo, Robert Miller, Kate Miller and Achola Ominde. 1997. *An assessment of clinic-based family planning services in Kenya: Results from the 1995 Situation Analysis study*. The Africa OR/TA Project II, Nairobi, Kenya, January.

Quality of care

Fisher, Andrew and Kate Miller. 1996. Conditions required at SDPs to deliver quality family planning services: Why so many do so little. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

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2) Increased use of client-centered reproductive health interventions

2.1) Reduction in the practice of Female Genital Mutilation

The Africa OR/TA Project II is supporting several activities with the ultimate aim of reducing the practice of female circumcision (also known as female genital cutting or more frequently as female genital mutilation (FGM)). In **Mali** a strategy has been developed with the Government's Commissariat à la Promotion Feminine (CPF) to address both the *policy* and *research* needs of those seeking to reduce the practice.

To aid the Government's efforts in developing and implementing appropriate policies and programs, Project staff assisted the CPF to organize a national seminar. This seminar created a high-profile forum at which the issues surrounding FGM could be debated publicly. The major outcome of the seminar was a national action plan for numerous community-based and educational anti-FGM activities, including research. The Africa OR/TA Project II produced two key background documents for the seminar: a review of the literature on FGM in Mali and of activities undertaken to date, and a re-analysis of data from the FGM module of the DHS. Box 14 describes the key outcomes of the seminar.

In January 1997, Project staff collaborated with the international organization RainBE to organize and implement a **regional** workshop in Ouagadougou, Burkina Faso, on research and advocacy activities in the region. The workshop was attended by participants from countries throughout the Sahelian region. The key points emerging from this four-day workshop include:

1. the need for an assessment of the reliability of available statistics on the practice of FGM in the region;
2. a strong commitment by all participants to combating any kind or type of FGM;
3. the desire of all participants to develop a "concerted strategy" for eradicating FGM;
4. the need to develop a manual on women's rights regarding such harmful practices;
5. a strong interest in creating a "bulletin" to link those working within the region.

Priority was given to a request for a regional training workshop on operations research as applied to FGM for staff from the participating institutions. A need was also expressed to encourage more research on evaluating the impact of interventions conducted for behavior change.

In **Mali, Burkina Faso, Ghana** and other countries of the region, there are a number of organizations already exploring different approaches to reducing the practice. Little is known about the appropriateness, acceptability and effect of these interventions, however. Research is essential to further *diagnose* the socio-cultural context and suggest possible interventions, to *evaluate* the effectiveness of on-going interventions, and to develop and test new *interventions*. The Project is supporting the following activities which address these three research needs.

Box 14

National Action plan supported by Government pledges eradication of FGM in Mali

“The Commissariat à la Promotion de la Femme (CPF) has pledged today to take the fight for the sexual and reproductive health of women in Mali forward by working alongside parliamentarians and non-governmental organizations (NGOs). The widespread violation of women’s bodily integrity, especially female genital mutilation (FGM), is a compelling cause for immediate and bold action.”

This statement - part of a national action plan endorsed by the Government of Mali - was the result of a three-day seminar held in Bamako. The workshop brought together 85 participants, including the Minister of Health, Solidarity, and the Elderly, the Minister of Justice, the Minister of Education, representatives of the Islamic and Christian religions, and multi-disciplinary experts in reproductive health.

The participants agreed to undertake collaborative efforts to fight FGM because of its serious health consequences. Some participants called on the Government to ensure that sexual and reproductive rights form part of the legal and policy frameworks within the country. Other recommendations adopted included setting up a follow-up mechanism for various interventions, continuing to raise awareness of FGM among the wider community and operations research on anti-FGM strategies.

In conclusion, the Head of the CPF stated that while the Government could not, overnight, eliminate millennia of prejudice and discrimination against Malian women, particularly regarding their sexual behavior, it surely could help them to stop this harmful traditional practice “but only by means of a national strategy based on an interactive approach that takes into account the country’s social and cultural patterns.” Furthermore, the Minister of Health, Solidarity, and the Elderly stated that “the challenge is right there, but to overcome these constraints we must examine all past mistakes and come up with a sustainable strategy for the total eradication of FGM in the country.”

Source: Gouédé (1998)

Diagnostic research on FGM:

- The 1996 panel surveys at the Bazèga LSC in **Burkina Faso** and the Navrongo Health Research Centre (NHRC) in neighboring northern **Ghana** included a module on FGM. Both surveys sampled people from similar ethnic groups and found comparable levels of practice (79 per cent in Bazèga and 77 per cent in Navrongo). Data analysis is currently on-going.
- The LSC is about to undertake a survey at the 21 clinics in the Bazèga area among women attending who have a pelvic examination, the intention being to observe the prevalence and type of female circumcision and any associated complications. A similar survey was undertaken last year by the NHRC in the four clinics in its district; the results are currently being analyzed.
- The NHRC has also recently completed a study that explored the perceptions of adolescent girls towards FGM through asking them to write essays describing their feelings towards the practice; results are currently being analyzed.
- A collaboration is about to begin between the local NGO, *Mwangaza*, the **Burkina Faso** MOH, and the Comité National de Lutte Contre les Pratiques de l'Excision (CNLPE). This study will use the Participatory Learning Approach (PLA) to gain knowledge which can be used for: improving staff knowledge of community perceptions and understanding of FGM and of the main reasons for continuing the practice; engage communities in discussions on the health and other related problems associated with FGM; facilitate a process whereby the value of female circumcision is questioned by community leaders and representatives; and to work with communities in developing potential interventions.

Evaluative research on FGM:

- A study is about to be initiated in **Mali** with *the Centre Nationale de Recherche Scientifique et Technique* (CNRST) to evaluate the effectiveness of approaches to “converting” those persons who have traditionally carried out circumcisions. Several NGOs have tried different strategies for motivating traditional circumcisors to not only stop practising but also to become advocates against the practice. To date, however, none of these approaches have been evaluated.

Intervention research on FGM:

- The CBD agents in Bazèga, **Burkina Faso**, have, for the past year, been expected to provide information and education on the drawbacks of FGM through group talks and when meeting individually with their clients. A rapid assessment of their activities conducted in May 1997 indicated some problems with this intervention, however. Many of the agents themselves approve of female circumcision and so are not comfortable with this role, particularly when their clientele also approves of the practice. The intervention will be continued until the end of the study period to assess whether this problem can be overcome through increasing their exposure to the anti-FGM messages.

- The Association de Soutien au Développement des Activités de Population (ASDAP), in collaboration with the **Mali** MOH, is about to implement an intervention study among clinic health workers. The intervention will include training staff in identifying health-related complications of circumcision and their management, introducing educational activities into group health talks and individual consultations, and staff supervision. The effect of this intervention will be evaluated in terms of changes in clinic staff communicating anti-circumcision messages and in their ability to identify and manage circumcision-related complications.

Publications and presentations on Female Genital Mutilation

Diallo, Assitan. 1997. Présentation de la revue de la littérature pour les MGF au Mali. Presentation at FGM workshop, Programme de l'Atelier National pour la Definition de Strategies d'Eradication des MGF au Mali," Commissariat à la Promotion des Femmes, Bamako, Mali, 17-19 June.

Diop, Nafissatou J., Annamaria Cerulli, and Diouratié Sanogo. 1996. Female circumcision in West Africa: A socio-cultural dilemma revolving around health, religion, culture and women's perceptions. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Kaboré, Inoussa, Placide Tapsoba, Diouratié Sanogo, Paul Nebié, Ernest Dabiré, Baya Banza, Georges Gueilla, Téléphore Kaboré, and Clotilde Ky. An innovative community based approach to eradicate female genital mutilation in West Africa, Burkina Faso. 1997. Paper presented at the 125th Annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Ouédraogo, Ousmane, Boubacar Héma, Denis Zongo, Batébié Zio, Soahibou Danté and Youssouf Ouédraogo. 1996. *La pratique de l'excision: Données qualitatives collectées dans 19 provinces sur 15 groupes ethniques auprès de clientes et prestataires de services des formations sanitaires*. Prepared by the Africa OR/TA Project II in cooperation with the Ministère de la Santé, de l'Action Sociale et de la Famille, Ouagadougou, Burkina Faso, May.

Sanogo, Diouratié. 1997. Présentation du module MGF de l'Enquête Démographique et de Santé (EDS II). Presentation at FGM workshop, "Programme de l'Atelier National pour la Definition de Strategies d'Eradication des MGF au Mali," Commissariat à la Promotion des Femmes, Bamako, Mali, 17-19 June.

Tapsoba, Placide, Youssouf Ouédraogo, and Miriam Lamizana. 1996. Liberating African women from female genital mutilation: Results from an action research project in Burkina Faso. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

2.2) Improved quality of post-abortion treatment

An integral component of the postabortion care interventions tested in Kenya, Burkina Faso and Senegal (described in section 1.1.C) has been the introduction of Manual Vacuum Aspiration (MVA) as the preferred means for improving clinical evacuation of an incomplete spontaneous or induced abortion. In the **Kenya** study, three of the six hospitals selected were already using MVA (the method has been available in the country for several years); the proportion of evacuations using MVA undertaken at all six hospitals increased from 63 per cent to 95 per cent after introduction of the intervention. None of the hospitals have switched to making the treatment an out-patient service (as is happening in other countries), but the mean duration of patient stay did reduce significantly in four of the six sites. A wide range in duration of stay was observed between the hospitals, however, suggesting that most hospitals could look for ways of better organizing the overall procedure so that duration of stay could be reduced further.

Although the successful introduction of MVA to new sites in Kenya is encouraging, not all procedures associated with using MVA improved. As is shown in Box 15, some improvements in staff attitudes were noticed, but clients received only marginally more information about what might happen after the procedure, and, most seriously, there was no improvement in pain control procedures. These are serious issues which suggest that although the introduction of a new technology through training and supplies of equipment is quite feasible and acceptable, other components that ensure quality treatment are not so easily implemented without strong supervision and support.

MVA had never been used in any Francophone west African country prior to last year. The pioneering studies currently being implemented in **Burkina Faso** and **Senegal** are being monitored very closely by the Africa OR/TA Project II and JHPIEGO to ensure that the results can demonstrate the method's safety and effectiveness to others in the region.

Box 15

Introduction of MVA and provider training in Kenya led to moderate changes in the quality of post-abortion treatment:

No change in pain control:

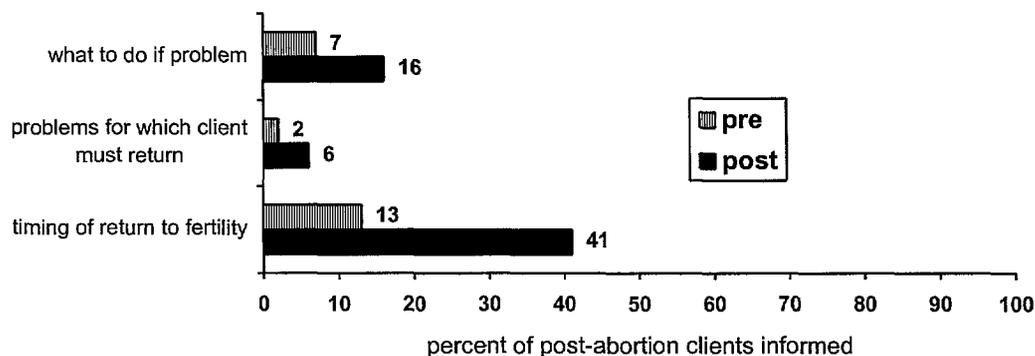
- There was no increase in the use of pain control medication with MVA. Only three per cent of patients before and after the intervention received analgesia and/or a paracervical block, despite this being recommended in training and available at all sites.
- Observers noted that, after training, providers were more likely to reassure patients orally and to hold their hand during the procedure.
- Consequently, there was no significant difference in the level of pain reported by patients before and after the procedure - approximately 60 per cent described it as extreme, 30 per cent as moderate, and 10 per cent as minimal.

Improved provider attitudes:

- Provider attitudes improved significantly. Those describing relations with clients as poor reduced from 46 to 31 per cent, while those describing attitudes as good increased from 36 to 55 per cent. Many providers attributed this change to the training received.
- The proportion of clients complaining about poor staff attitudes reduced from 25 to 10 per cent after the intervention.

Information provided to patients increased, but not sufficiently well:

- There was some improvement in information given to clients about the procedure, this aspect of service provision needs much more attention.



- The increase in information given concerning return to fertility may be linked with improved understanding by providers of a woman's fertility - the proportion of providers knowing that a woman can use contraception immediately after evacuation increased from 62 to 87 per cent after training.

Source: Solo *et al.* (1998)

3) Increased use of key child health and nutrition interventions

The introduction of selected child health and nutrition services provided by community-based agents are being tested in Navrongo, **Ghana** and Bazèga, **Burkina Faso**. In Navrongo, these services are provided through a combination of the community-based nurses and community volunteers and include immunization, nutrition advice, and treatment for diarrhea, malaria and ARI. In Bazèga, attention is focused specifically on managing diarrhea and malaria. Both studies have collected data on a range of population-based infant and child health indicators through their panel surveys, and on service utilization through the agents' and clinics' service statistics. Over the coming year, the effect of these interventions will be assessed in terms of increased awareness of symptoms of sickness, improved health-seeking behavior, and increased use of curative and referral services.

For the first time, two Situation Analysis studies have collected data on the quality of child health services provided at MCH/FP clinics². In **Senegal**, the Situation Analysis study was used to assess the degree to which the national guidelines for case management of diarrhea are being followed. Observations of 48 consultations revealed that, on average, only three out of eleven recommended questions are being asked by service providers of the child's caretaker (child's age, episode frequency and stool characteristics), and that three out of six recommended medical guidelines are being followed by service providers (measuring the level of dehydration, checking mucus for signs of anemia, and taking weight).

Over half the clinics visited had experienced stockouts of ORS packages in the previous six months. Following the presentation of this result, the Senegal Applied Food and Nutrition Service (SANAS) decided to officially include ORS packages in the country's Bamako Initiative program and to disseminate the treatment guidelines nationally.

In **Zambia**, 1,697 interactions with sick children were observed. Preliminary results show that many service providers lack skills to provide proper and adequate care to sick children. Although most providers had attended training courses on the management of diarrheal diseases and immunization, less than half had been trained in the management of malaria, ARI and integrated management of childhood diseases. Training was found to significantly increase the information given to the child's caretaker, and led to providers undertaking a more rigorous risk assessment for childhood diseases. Providers were observed to not gather enough information about the child's illness to fully assess their danger signs.

Moreover, the location and type of health facility appear to influence the quality of care received. For example, children attending rural facilities are far less likely to be assessed for all danger and dehydration signs, and children attending health centers are less likely to have an adequate assessment compared to those visiting hospitals.

² Situation Analysis studies about to begin in Cameroon, Guinea and Senegal will also include modules on child health services.

4) Increased use of interventions to reduce HIV transmission and mitigate the impact of the HIV/AIDS pandemic

4.1) Enhanced quality, availability and demand for STI prevention and management services

A) LESSONS LEARNED FROM INTEGRATING STI/HIV MANAGEMENT SERVICES INTO ON-GOING MCH/FP PROGRAMS

The Africa OR/TA Project II has completed four case studies (in **Kenya, Uganda** and **Botswana**) of programs which have sought to integrate STI/HIV services into their existing MCH/FP services, both in clinics and community-based settings. The case studies have already proved to be extremely useful to the programs themselves, in that they documented empirically the strengths and weaknesses of each program so that program managers have been able to take immediate action to rectify most of these problems.

During the past year the results from these case studies were synthesized. It was found that, although implemented by different types of organizations, in different situations and at different scales, there were a number of similarities in the way in which an integrated approach was being addressed (see Box 16).

All four programs have made efforts to include four components in their integrated approach to providing services to family planning and antenatal clients, although with differing degrees of success. The key lessons learned through this synthesis have been disseminated widely to audiences throughout Africa, the U.S. and elsewhere, and are given in Box 17 below.

Drawing from these findings, the Africa OR/TA Project II has already begun to undertake a number of OR studies to address some of the key questions which remain. These include improving the effectiveness of the syndromic approach (through on-going studies in **Kenya** and **Zimbabwe**), and understanding clients' and providers' perceptions of reproductive tract morbidity and concomitant health-seeking behavior (through studies in Navrongo, **Ghana** and Bazèga, **Burkina Faso**).

Box 16

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

- For MCH/FP clinics with no or limited access to laboratory facilities
- Package of services offered to new family planning and antenatal clients during a single visit

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

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

Source: Maggwa and Askew (1997)

Box 17

Lessons learned from case studies of programs which have sought to integrate ST/HIV services into existing MCH/FP services:

- Risk assessment and clinical history taking, essential for finding potential STI cases among mainly asymptomatic MCH/FP clients, are not performed consistently or according to guidelines. Many factors contribute to this including: providers' poor counseling skills; misperceptions of clients' needs; absence of appropriate guidelines and check lists; inadequate client record cards; and insufficient privacy during consultations.
- A thorough general clinical examination and a pelvic examination, essential for detecting signs and symptoms associated with STIs, are not always undertaken. Little emphasis on clinical examinations within STI management algorithms; client record forms that do not record STI information; and missing basic equipment and supplies were common.
- Although staff had been trained in syndromic management, many had problems completing the algorithms due to drug shortages or bureaucratic barriers that required referral to another provider or facility for treatment.
- Requesting clients to notify their partners orally is ineffective and remains a major problem if successful treatment of the woman is not to be undermined through re-infection by her untreated partner.
- HIV testing and counseling is an essential component of any integrated approach, but because of the resource-poor context all programs refer clients elsewhere.
- In line with national policy guidelines, all four programs are expected to offer syphilis screening for pregnant women but this service is not effectively implemented. Clients have to return later to obtain the results, or go elsewhere for the test, and normally have to pay for the tests. No attention was paid to screening other STIs associated with adverse obstetric outcomes.
- Information and education activities to encourage preventive behavior and improve health seeking behavior are essential components and could be improved greatly with minimal additional resources. Daily group health talks are mandated but are held infrequently, and information on STIs and HIV/AIDS is only given occasionally in both group talks and individual consultations.
- Condom promotion is undertaken to differing extents by each program but needs to be strengthened in all cases.
- Community-based workers raise awareness about STIs and facilitating access to information and services, but need to be more thoroughly integrated with the clinic-based services.

B) TESTING THE INTEGRATION OF STI/HIV INFORMATION AND SERVICES INTO COMMUNITY-BASED MCH/FP PROGRAMS

From its inception in September 1996, the community-based reproductive health program being tested at Bazèga, **Burkina Faso** has included training the volunteer agents to communicate information on STI signs and symptoms, and to refer potential cases to clinics for diagnosis and management. The effect of this intervention on increasing access to and demand for such services is being measured through the collection of service statistics from the agents and through the second round of the panel survey to be completed in 1998.

During the past year the CHFP Project in Navrongo, **Ghana** has trained its volunteer community agents in STI/HIV information and education services through a course provided by CEDPA. To ensure that those referred to a clinic could receive appropriate services, training in syndromic management and infection prevention were provided to all staff working in the Project's five clinics by JHPIEGO. The testing of this intervention in the controlled environment of the Navrongo field station is seen by the Ghana MOH as an important complement to its on-going pilot integration program (supported also by JHPIEGO) in the country's Eastern Region. Its effectiveness will be assessed over the course of the coming year.

4.2) Improved capacity to monitor and evaluate program impacts

The development and testing in **Botswana** of a rapid assessment tool for routinely monitoring the quality of STI/HIV services provided through the national MCH/FP program was described in section 1.2.D above. This tool will be applied for a second time in Botswana in 1998 through the FRONTIERS Project, and opportunities will be explored for applying it to similar programs in other countries of the region.

As described above, the CHFP Project at Navrongo, **Ghana** and the CHL at Bazèga, **Burkina Faso**, have integrated STI/HIV services into their community-based MCH/FP services. Monitoring the implementation of these new services and evaluating their impact on the general population is essential. Working with their District Health Management Teams, the NHRC and CHL have amended the clinic and community-based MIS so that they can record and report the provision of these services. In addition, a module was added to the panel survey instruments to collect data on the general population's exposure to these new interventions to measure their coverage and utilization.

4.3) Approaches that address key contextual constraints and opportunities for prevention and care developed

There are many unanswered questions about how infection with, or the perceived risk of infection with HIV/AIDS affects couple's and individual's decisions about childbearing and contraceptive use in sub-Saharan Africa. The Africa OR/TA Project II is currently supporting a study in **Zambia** on reproductive decisionmaking in the context of HIV/AIDS. The objective is to examine women's and men's perceptions of their risk of acquiring HIV/AIDS in a high HIV prevalence setting and how these perceptions are related to decisions about childbearing and contraceptive use. This study is based on qualitative data collected through focus group discussions and in-depth interviews with married men and women of reproductive-age. The preliminary results (presented at the 1997 PAA conference) are given in Box 18 below. One key recommendation for family planning programs is that they should consider promoting and possibly offering voluntary HIV testing and counseling to all women. Women can then establish the risk of a pregnancy for themselves as well as the future child.

Box 18

Focus group discussions with women and men in Zambia indicate that:

- Most respondents believe that a pregnancy should be avoided by women with HIV. Pregnancy in a woman who has the HIV virus is associated with a serious deterioration in her health and the onset of the symptoms of AIDS or full blown AIDS, even though these women appeared healthy prior to or during that pregnancy.
- In response to the question: "do couples want to continue having children before they are too ill?", one female focus group participant responded *"that is a long time ago when people used to say that, nowadays you can conceive and die with the pregnancy."*
- In another focus group, a woman elaborated: *"you may decide to have children before they confirm that you have the virus. Suppose you already have it and it manifests itself through the child, that is the end of you because they say that AIDS becomes more prevalent after you deliver and during pregnancy you will be in and out of hospital, and you see the symptoms like headache, abdominal pains and continuous diarrhea, and you realize that my health is at risk, had I known I would not have fallen pregnant."*

Source: Rutenberg *et al.* (1997)

4.4) Quality and timely assistance provided to partners to ensure effective and coordinated implementation of HIV/AIDS programs

The Project is a member of the USAID/REDSO-supported Regional Technical Group of partner CAs and managers of integrated programs that is addressing the feasibility and effectiveness of integrating STI/HIV/AIDS and MCH/FP services. In addition to its central function of evaluating and testing innovative integration strategies, the Project is also collaborating closely with its partners on some of the consortium's other activities. These include: studies of the cost of integration (REDSO); assembling a regional inventory of integration experiences (Pathfinder International); preparing a literature review of the syndromic approach (FHI); developing standardized recommended drug lists (Commonwealth Health Secretariat); and dissemination and sharing of lessons learned and best practices through workshops and papers (REDSO). This assistance will continue through Year Five.

The integration of STI and HIV/AIDS services into the existing MCH/FP program has been a priority concern for the **Kenya** USAID Mission and the national MOH. To consolidate and coordinate the efforts being made by the many CAs addressing this issue in Kenya, a CAs Integration Working Group has been established. The Group meets quarterly to review on-going activities and review experiences gained. Staff from the Africa OR/TA Project II continue to play an active role within the Group which will continue to function over the coming year.

Publications and presentations on interventions to reduce STI and HIV transmission

Askew, Ian, Baker Ndugga Maggwa and Lenni Kangas, 1998 Integrating STI/and HIV/AIDS Services Into MCH/FP Programs in East and Southern Africa, Paper Presented at meeting of the Population Association of America, Chicago, Illinois, USA, April 2-4, 1998.

Askew, Ian and Baker Ndugga Maggwa. 1996. Operations research on the integration of STI/AIDS services into MCH/FP programs in east and southern Africa: Findings from Situation Analyses and case studies in selected countries. Paper presented at a workshop on "The interface between family planning and HIV/STD prevention", co-sponsored by IUSSP, WHO, Wellcome Trust and The African Population Policy Research Centre, Nairobi, Kenya, 2-4 October.

Elias, Christopher and Adepeju Olukoya. 1996. Perceptions of reproductive tract morbidity among Nigerian women and men. *Reproductive Health Matters* 7:56-65.

Kariba, James, Bedan Kariuki and Baker Ndugga Maggwa. 1997. *Integration of STI and HIV/AIDS with MCH-FP Services: A case study of the Nakuru Municipal Council's Project on Strengthening STD/AIDS Control*. Nakuru Municipal Council and the Africa OR/TA Project II, Nairobi, Kenya, April.

Maggwa, Baker Ndugga and Ian Askew. 1997. *Integrating STI/HIV management strategies into existing MCH/FP programs: Lessons from case studies in East and Southern Africa*. Population Council, Nairobi, Kenya, July.

Maggwa, Baker Ndugga. 1996. Sexually transmitted infections, family planning, and maternal-child health: integrating services in sub-Saharan Africa. *Population Briefs* 2(4):4.

Maggwa, Baker Ndugga and Ian Askew. 1997. Integrating STI/HIV management strategies into existing MCH/FP programs: Lessons from case studies in East and Southern Africa. Paper presented at workshop on "Improved Reproductive Health: International Shared Experience" by the Population Council, Bogor-West Java, Indonesia 4-5 December.

Maggwa, Baker Ndugga and Ian Askew. 1997. Integrating STI/HIV management strategies into existing MCH/FP programs: Lessons from case studies in East and Southern Africa. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Maggwa, Baker Ndugga, Naomi Rutenberg and Ian Askew. 1997. A challenge to integrating STI/HIV management strategies into existing MCH/FP programs in East and Southern Africa: Talking about sex and sexually transmitted diseases. Paper presented at the 125th annual meeting of the American Public Health Association, Indianapolis, Indiana, 9-13 November.

Maggwa, Baker Ndugga. 1997. STD services and comprehensive primary health care: The practical implications. Paper presented at the Forum on Establishing Appropriate Services for the Management and Prevention of STDs, Department of Health, Johannesburg, South Africa, 25-26 September.

Maggwa, Baker Ndugga, Ian Askew, and Andy Fisher. 1995. Integration of STI and HIV/AIDS services with MCH-FP services: Experiences from four countries in sub-Saharan Africa. Paper presented at the annual meeting of the American Public Health Association, San Diego, CA, 29 October-2 November.

Mukaire, Joy, Florence Kalikwani, Baker Ndugga Maggwa and Wilson Kisubi. 1997. *Integration of STI and HIV/AIDS services with MCH-FP services: A case study of the Busoga Diocese Family Life Education Program, Uganda*, Busoga Diocese Family Life Education Program, the Africa OR/TA Project II and Pathfinder International, Nairobi, Kenya, January.

Rutenberg, Naomi, Ann Biddlecom, Fred Kaona and Kathleen Siachitema. 1997. Reproductive decision-making in the context of HIV/AIDS in Zambia. Paper presented at the annual Population Association of America Meeting, Washington, D.C., 27-29 March.

Rutenberg, Naomi, John Skibiak, and Baker N. Maggwa. 1996. The effect of HIV prevalence on the demand for family planning. Paper presented at the annual meeting of the American Public Health Association, New York, New York, 17-21 November.

Twahir, Amina, Baker Ndugga Maggwa and Ian Askew. 1996. *Integration of STI and HIV/AIDS services with MCH/FP services: a case study of the Mkomani Clinic Society in Mombasa, Kenya*. Mkomani Clinic Society and the Africa OR/TA Project II, Nairobi, Kenya, April.

Twahir, Amina and Baker Ndugga Maggwa. 1995. Mkomani Clinics' integration of MCH/FP with STD/HIV services - what are the costs: A case study. Paper presented at the annual meeting of the American Public Health Association, San Diego, CA, 29 October-2 November.

III. Subprojects and Technical Assistance Activities

Botswana

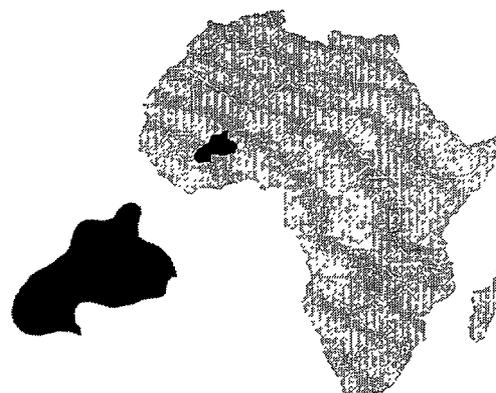


Subprojects

Duration / budget

Strengthening NGOs' management and service delivery capabilities to provide reproductive health services to adolescents	November 1995 - September 1996 <i>\$231,850</i>
Assessing the coverage and adequacy of services provided to care givers of HIV+ youth	June 1996 - September 1996 <i>\$5,935</i>
Evaluating the effectiveness of adolescent peer education training programs	June 1996 - September 1996 <i>\$5,994</i>
Utilization of IEC materials on HIV/AIDS by adolescents with disabilities	July 1996 - September 1996 <i>\$2,242</i>
Accessibility, availability and use of condoms among adolescents	July 1996 - September 1996 <i>\$10,125</i>
Creation of database and maps of all NGOs in Botswana	May 1996 - July 1996 <i>\$10,688</i>
Baseline study for evaluation of the effect on service quality of integrating STI/HIV/AIDS services into the national MCH/FP program	April 1995 - July 1996 <i>\$100,587</i>
Development and testing of rapid appraisal mechanism for assessing quality of integrated services in the national program	June 1996 - April 1997 <i>\$37,490</i>

Burkina Faso



Subprojects

Testing the introduction of MVA with family planning counseling and services for treating post-abortion complications in hospitals in Ouagadougou and Bobo-Dioulasso

Duration / budget

August 1996 -
September 1998
\$61,441

Testing a community-based reproductive health care program and cost-recovery scheme

June 1995 -
August 1998
\$356,519

An assessment of the current and potential actions taken by pregnant women, new mothers and their families in managing safe motherhood and child survival

February 1998 -
July 1998
\$15,200

Measuring the prevalence, typology and complications associated with female circumcision among clinic clients

February 1998 -
June 1998
\$9,155

Using a participatory approach to designing a community-based intervention to address female circumcision

February 1998 -
July 1998
\$20,644

Assessing the health-seeking behavior and perceptions of reproductive morbidity of communities and service providers

January 1998 -
August 1998
\$18,973

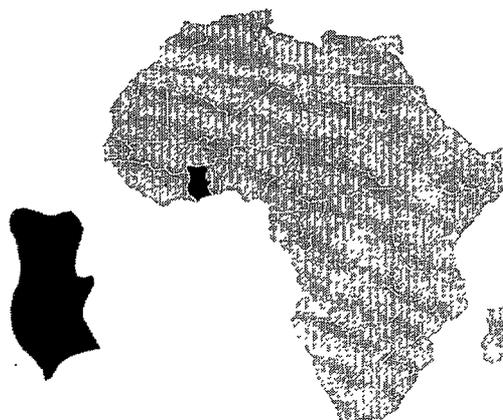
Situation Analysis study to assess changes in subsystem functioning and quality of care of national MOH program

March 1995 -
April 1996
\$103,800

Technical Assistance

Baseline survey in five provinces for MOH program to expand role of TBAs as family planning providers	August 1994 - March 1996 44 days
Training in Operations Research for NGO health managers from several Francophone countries	January 1995 - March 1996 12 days
Development of national five-year health research agenda	February 1995 5 days
Development of a Community Health Field Station	December 1995 - November 1996 110 days
Implementation of a sexual health project by IPPF-affiliate	December 1995 - July 1996 30 days
Design of OR study on FGM for National anti-FGM committee	December 1995 - December 1996 55 days
Assessment of IPPF-affiliate's Youth-to-Youth program	March - June 1996 15 days

Ghana



Subprojects

Duration / budget

Diagnosis of the demand for family planning services and micro-pilot testing community-based nurses and volunteers in Navrongo, northern Ghana	May 1994 - April 1995 \$244,624
Testing a community-based health care and family planning program and cost-recovery scheme at Navrongo	May 1995 - September 1998 \$802,899
Testing the effect of training community-based voluntary health workers in STD/HIV prevention at Navrongo	January - September 1998 \$13,800
Testing the effect of integrating STD/HIV services at MCH/FP clinics in Navrongo	January - June 1998 \$8,810
An assessment of current perceptions and practices for identifying and treating reproductive tract infections at Navrongo	July - October 1997 \$5,350
Testing the feasibility of using community-based volunteers as providers of oral contraceptives at Navrongo	February - July 1998 \$23,403
The characteristics of Norplant® implant users at Navrongo	January - July 1998 \$11,168
Strengthening the operations research and program evaluation capacity of PPAG, the IPPF-affiliate	May 1996 - September 1998 \$25,000
Situation Analysis study to assess program strengthening activities of the national MOH MCH/FP program	August 1996 - June 1998 \$211,211

Technical Assistance

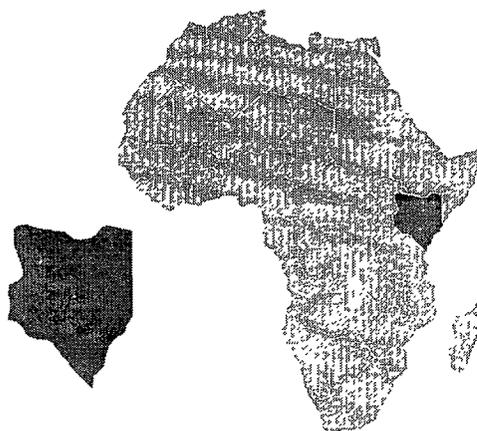
Designing a study to introduce the female condom at Navrongo

March 1996 -
June 1997
20 days

Workshop held at Navrongo to train journalists in reporting
reproductive health issues in the national media

December 1997
14 days

Kenya



Subprojects

Duration / budget

Testing alternative strategies for providing an integrated service for treating abortion complications and offering family planning counseling and services in hospitals

January 1995 -
June 1998
\$265,973

Assessing the role and impact of family planning CBD programs

March 1995 -
December 1996
\$148,885

National Situation Analysis study to assess changes over five years in subsystem functioning and quality of care of family planning services, and assessment of integration of FP and MCH services

March 1995
September 1997
\$195,181

Comparison of clients' and providers' perceptions of quality of care provided at public and private clinics

April 1994 -
September 1995
\$30,949

Testing an improved approach to managing STIs among MCH/FP clients at Nakuru Municipal Council clinics

October 1997 -
September 1998
\$80,043

Clients' and providers' perceptions of how best to integrate male-oriented services at MCH/FP clinics

September 1997 -
August 1998
\$32,254

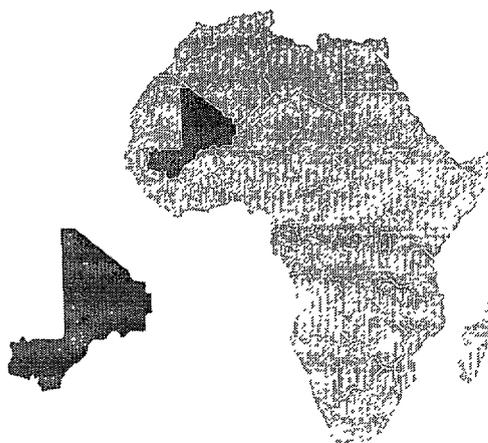
National workshop to launch the MOH's revised policy guidelines and standards for reproductive health and family planning services

February -
March 1998
\$11,350

Technical Assistance

Preparation of briefing paper on CBD programs for USAID/Kenya Mission	June - September 1994 35 days
Interpretation and utilization of data from Situation Analysis and CBD impact studies by Nairobi City Council	February - October 1996 14 days
Developing research designs for testing alternative models of providing reproductive health services to men	February 1995 - July 1998 45 days
Training NGO program managers in quality of care	December 1993 5 days
Developing a proposal for testing the feasibility and effect of CBD agents providing the injectable	February - July 1994 20 days

Mali



Subprojects

Duration / budget

National Seminar to develop a Plan of Action and Research Agenda on reducing FGM

May -
August 1997
\$15,049

Testing the effectiveness of training health facility staff in client education on FGM, and in the treatment of FGM complications

February -
September 1998
\$58,680

Evaluation of the strategy for “converting” traditional practitioners from circumcision to other activities

December 1997 -
July 1998
\$29,836

Technical Assistance

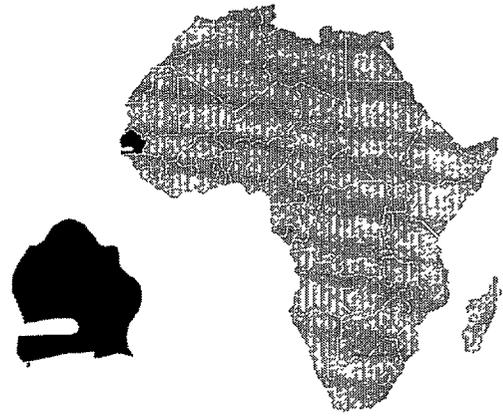
Comprehensive review of activities and literature on countering FGM in Mali

July 1996 -
March 1997
84 days

Implementation of a Situation Analysis study in two regions

April 1995 -
June 1996
25 days

Senegal



Subprojects

Duration / budget

Testing the effect of improving the quality of clinical services through model clinics on contraceptive use dynamics

February 1997 -
August 1998
\$92,600

Testing the introduction of MVA with family planning counseling and services for treating post-abortion complications in three hospitals in Dakar

April 1997 -
July 1998
\$64,000

Baseline Situation Analysis study to determine levels of subsystem functioning and quality of care in every family planning clinic in the country prior to introduction of USAID-supported program strengthening interventions

April 1994 -
December 1995
\$108,140

Mid-term Situation Analysis study to assess changes in subsystem functioning and quality of care in clinics receiving USAID-supported programmatic interventions after one year

January -
June 1997
\$59,800

End-term Situation Analysis study to assess changes in delivery of reproductive health services following USAID-supported interventions

March -
September 1998
\$200,555

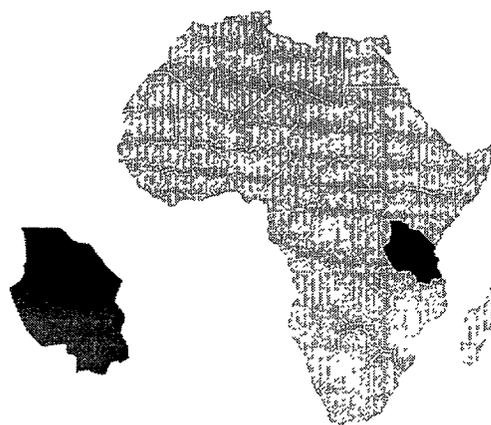
Training in OR and development of three OR proposals for the National Family Planning Program

March -
May 1996
\$14,705

Technical Assistance

Analysis and dissemination of national Situation Analysis study results at the regional and district levels	May - December 1995 173 days
Literature review on all family planning and child survival activities	November 1994 - February 1995 90 days
Development of evaluation indicators for USAID-supported Child Survival and Family Planning program	March - June 1995 27 days
Re-engineering of the USAID/Senegal strategic planning process	March - May 1996 12 days
Measure indicators for evaluating achievements under USAID/Senegal's Strategic Objective No. 1	February - July 1997 25 days
Development of policy guidelines on CBD for the National Family Planning Program	March 1996 - March 1997 41 days
Training of Regional Medical Officers in OR for developing malaria control interventions	June - October 1995 23 days
National workshop on IEC activities concerning integration of STD/HIV services at MOH clinics	May 1997 - June 1998 15 days

Tanzania



Subprojects

Duration / budget

An assessment of the cost-effectiveness of three alternative family planning CBD models

February 1997 -
March 1998
\$24,700

Evaluation of the effects of a vasectomy promotion campaign on the knowledge, attitudes and behavior of men in Dar es Salaam

January -
September 1996
\$13,783

Training workshop on OR and proposal writing for staff from the National Family Planning Program

December 1995 -
March 1996
\$16,006

Baseline Situation Analysis study to assess levels of subsystem functioning and quality of care in every family planning SDP in Zanzibar

October 1994 -
February 1996
\$45,166

Technical Assistance

Evaluation of UMATI's sexual health and other programs

January 1995 -
September 1998
45 days

Development and implementation of OR studies by the MOH Reproductive Health Unit

January 1995 -
September 1998
50 days

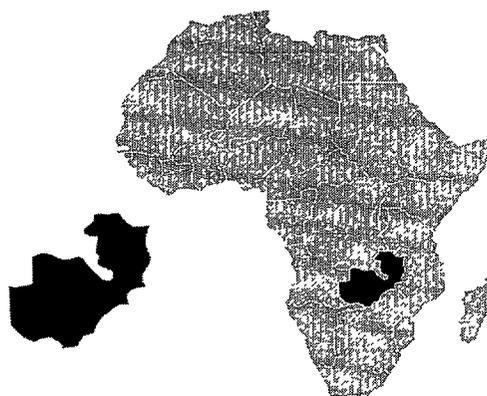
Implementation of a baseline Situation Analysis study to assess readiness of clinics in Mbeya Region to integrate STI/HIV services into existing MCH/FP services through an ODA-supported project

March -
September 1995
33 days

Development of an evaluation plan for the AVSCI Quality Management Approach

October 1993 -
August 1994
25 days

Zambia

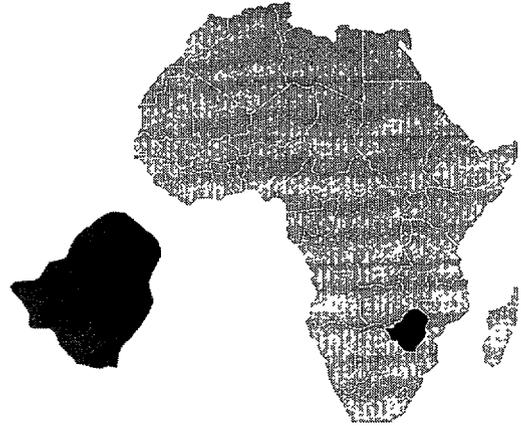


Subprojects

Duration / budget

Testing and comparing two community-based strategies for improving reproductive health amongst out-of-school youth in Lusaka	August 1996 - July 1998 \$156,957
Determining the most appropriate strategies for introducing emergency contraception in MOH and other clinics	September 1997 - September 1998 \$54,641
Comparing the acceptability and administration of two regimes of hormonal emergency contraception: PC-4 and Postinor-2	May 1998 - September 1998 \$13,520
A comparison of prophylactic distribution and prophylactic prescription strategies for increasing access to emergency contraception	May 1998 - September 1998 \$9,710
Training MOH and NGO staff in the Participatory Learning Approach	August 1996 - November 1996 \$19,756
National baseline Situation Analysis study to assess levels of subsystem functioning and quality of care in clinics receiving USAID-supported and UNFPA-supported interventions	February 1997 - February 1998 \$171,287
Revisit to a selection of clinics from the Situation Analysis study to obtain more in-depth information about delivery of reproductive health services	December 1997 - January 1998 \$3,400
Study of contraceptive decision-making behavior among couples with HIV/AIDS	March 1997 - September 1998 \$9,111
Technical Assistance	
Expanding contraceptive choice and improving the quality of services at rural MOH clinics	October 1996 - September 1998 85 days

Zimbabwe



Subprojects

Duration / budget

A national Situation Analysis study to assess changes since 1991 in subsystem functioning and quality of care in the national family planning program

June 1996 -
July 1998
\$116,201

Strengthening the research and research management capacity of the ZNFPC Evaluation and Research Unit

January 1996 -
July 1998
\$26,763

Assessing the potential demand for and effectiveness of integrating STI/HIV management services within ZNFPC's clinic-based family planning services

January -
September 1998
\$115,783

Measuring the cost of adding STI management services to the existing family planning services at ZNFPC clinics

March -
September 1998
\$12,500

Non-Focus Countries

Country	Duration / budget
The Gambia	
Evaluating the relative effects of community-based demand mobilization and service improvement strategies on contraceptive prevalence	April 1995 - September 1996 \$72,775
Cameroon	
Baseline Situation Analysis study to assess clinic-based reproductive health and family planning services	October 1997 - September 1998 \$145,382
Guinea	
Baseline Situation Analysis study to assess levels of subsystem functioning and quality of care in clinics	January - September \$148,529

Regional and Interregional Activities

Subprojects	Duration / budget
Technical assistance from FHI in costing analysis	February 1997 - September 1998 \$258,293
Documenting and strengthening the utilization of OR findings	March 1996 - May 1998 \$18,316
Strengthening the utilization of the Situation Analysis approach in sub-Saharan Africa	July 1995 - July 1998 \$239,686
Strengthening the Situation Analysis approach interregionally	March 1994 - July 1995 \$92,295
Case studies of programs which have integrated STI/HIV services into existing MCH/FP service programs	April 1995 - June 1997 \$53,699
Regional workshop on quality improvement for reproductive and child health services in east and southern Africa	April - May 1997 \$16,178
Regional workshop on developing and implementing standards and guidelines for reproductive health services in east and southern Africa	May - July 1998 \$40,000

Technical Assistance

Identifying and developing research studies on adolescent reproductive health in west Africa with the Pacific Institute for Women's Health	January 1997 - June 1998 25 days
Regional workshop on FGM for NGOs and researchers in west Africa with Rainbo	October 1996 - May 1997 31 days
Training materials and resource person at OR Regional Training Workshop for West and Central Africa with CERPOD and Tulane University	August - October 1996 20 days
Training materials and resource person for gender and OR at the UNFPA Anglophone Regional Training Workshop for Population Program Managers	March 1996 8 days
Analysis of services provided to breastfeeding clients attending for family planning at clinics in Senegal and Nigeria for the Wellstart Project	January - February 1996 12 days
Preparation of three background papers on measuring quality of family planning services for the UNPD Task Force on the Measurement of Quality	September - October 1995 32 days
Presentation of papers on OR studies at the USAID-supported Regional Conference on Maximizing Access and Quality of Services in Francophone Africa	February - March 1995 40 days
Developing study designs and research proposals on adolescent reproductive health services in Kenya and Zimbabwe for funding by the Rockefeller Foundation	November 1994 - December 1996 15 days
Advice and training on OR methods for the IPPF Sexual Health Project	January 1994 - March 1996 25 days
Design of study on the effectiveness of integrating LAM services into CBD programs in east Africa	January - September 1998 10 days
Implementation of three urban Situation Analysis studies by the SEATS Project	October 1993 - March 1995 41 days

Appendix One: Project Staff

Nairobi, Kenya

Ian Askew, Project Director
Naomi Rutenberg, Deputy Director, East / Southern Africa
Ndugga Maggwa, International Resident Advisor
Lewis Ndhlovu, International Resident Advisor
Julie Solo, International Resident Advisor
John Skibiak, Associate
Jane Chege, National Fellow (until September 1997)
Violet Bukusi, Administrative Assistant

Dakar, Senegal

Diouratié Sanogo, Deputy Director, West / Central Africa
Placide Tapsoba, International Resident Advisor
Nafissatou Diop, International Resident Advisor
Mounir Touré, Host Country Social Scientist (since September 1997)
Marthe Bruce Dieng, Administrative Assistant

Ouagadougou, Burkina Faso

Inoussa Kaboré, Host Country Social Scientist
Jeanne Marie Zongo, Administrative Assistant (until July 1997)
Pauline Zoundi, Administrative Assistant (since July 1997)

Lusaka, Zambia

Kathleen Siachitema, Host Country Social Scientist
Winnie Lubusi, Administrative Assistant (since September 1997)

Bamako, Mali

Assitan Diallo, National Fellow (until October 1997)

New York, USA

Robert Miller, Senior Research Associate
Joanne Gleason, Program Manager
Nicholas Gouédé, Communications Specialist
Katherine Miller, Staff Associate
Heidi Jones, Staff Assistant
Elizabeth Motyka, Staff Assistant (until September 1997)
Elizabeth Pearlman, Staff Assistant (from January 1998)

Appendix Two: Collaboration with other organizations

Collaborating organization	Location of collaboration
Africa Population Policy Research Centre	Kenya
AIDSCAP Project	East and Southern Africa
AVSCI	Ghana, Kenya, Senegal, Tanzania
BASICS Project	Guinea, Zambia, East and Southern Africa
British Council	Tanzania
CAFS	East and Southern Africa
Cambridge Consulting Corporation	Botswana
Canadian Public Health Association	Zambia
CARE International	Zambia, Regional
Commonwealth Health Secretariat	East and Southern Africa
CEDPA	Ghana, Kenya
CERPOD	West and Central Africa, Mali
CLUSA	Burkina Faso
Data for Decisionmaking Project	East and Southern Africa
EVALUATION Project	Regional
Family Health and AIDS Prevention Project	Burkina Faso, Cameroon, West and Central Africa
FHI / Population Program	Regional, East and Southern Africa
FINNIDA	Ghana
FPMD Project	Zimbabwe
GTZ	Burkina Faso, Kenya
INTRAH	West and Central Africa
IPAS	Kenya
IPPF	Ghana, Kenya, Regional
JHPIEGO	Burkina Faso, Ghana, Senegal
PCS/JHU	Kenya, Zambia, Regional
JSI	Zambia
Marie Stopes International	Kenya, Tanzania
Mellon Foundation	Ghana
MSH	Guinea, Senegal
DfID	Kenya, Tanzania, Zambia
Pacific Institute for Women's Health	Burkina Faso, West and Central Africa
Pathfinder International	East and Southern Africa, Kenya, Tanzania, Uganda
Population Council Policy Research Division	Ghana, Zambia
Population Council ECC Program	Burkina Faso, Kenya, Senegal, Zambia, Regional
PSI	Botswana, Zambia
Rain&	Burkina Faso, Senegal, Zambia
Rockefeller Foundation	Burkina Faso, Ghana, Kenya, Zimbabwe
SCF/USA	Gambia
SEATS Project	Senegal, Zambia, East and Southern Africa
UNFPA	Burkina Faso, Botswana, Kenya, Mali, Zanzibar, Zambia
UNPD	Regional
Wellstart International	Regional
WHO	Senegal, Zambia, International
World Bank	Regional

Appendix Three: Training workshops in operations research and program management

Location	Coverage	Dates	Topic	Participants
Nairobi, Kenya	National	Dec, 1993	Quality of care	NGO staff
Dakar, Senegal	Regional	July, 1994	Situation Analysis	Regional training team
Nairobi, Kenya	Regional	Aug, 1994	Situation Analysis	Regional training team
Ouagadougou, Burkina Faso	National	Oct, 1994	Computing training	MOH staff
Harare, Zimbabwe	National	Feb, 1995	Qualitative research	ZNFPC researchers
Ouagadougou, Burkina Faso	Regional	March, 1995; March, 1996	Operations research	NGO health managers
Dakar, Senegal	National	June, 1995	Operations research	Regional MOH staff
Dakar, Senegal	National	Sep, 1995	Proposal development	MOH staff
Arusha, Tanzania	National	Jan, 1996	Operations research; proposal development	MOH & NGO staff
Harare, Zimbabwe	National	Jan, 1996	Computing skills	ZNFPC staff
Gaborone, Botswana	National	Feb, 1996	Operations research; proposal development	NGO staff
Dakar, Senegal	National	March, 1996	Operations research; proposal development	PNPF and NGO staff
Harare, Zimbabwe	National	April, 1996	Strategic planning	ZNFPC staff
Gaborone, Botswana (5 x 3-day workshops)	National	April-August 1996	Strategic management	NGO staff
Livingstone, Zambia	National	August, 1996	Participatory Rapid Appraisal	MOH, NGO and University staff
Gaborone, Botswana	National	August, 1996	Data analysis	NGO staff
Nairobi, Kenya	Municipal	October, 1996	Data analysis	NCC staff
Mombasa, Kenya	Regional	April, 1997	Quality improvement	Program managers
Harare, Zimbabwe	National	October, 1997	Strategic planning	ZNFPC staff