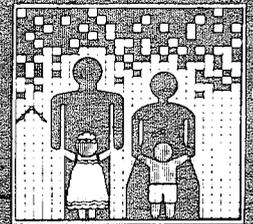


# Africa OR/TA Project

4-7 OCTOBER 1993  
NAIROBI • KENYA

## CONFERENCE PROCEEDINGS AND PAPERS



THE POPULATION  
COUNCIL

**THE POPULATION COUNCIL**

**AFRICA OPERATIONS RESEARCH AND  
TECHNICAL ASSISTANCE PROJECT**

**END-OF-PROJECT  
CONFERENCE**

**NAIROBI HILTON, KENYA**

**4-7 OCTOBER 1993**

**CONFERENCE PROCEEDINGS**

2

## TABLE OF CONTENTS

	<b>Page</b>
<b>ACKNOWLEDGEMENTS</b>	i
<b>INTRODUCTION</b>	ii
<b>A BACKGROUND</b>	
1. The Africa OR/TA Project	5
2. What Is Operations Research ?	9
3. What Is Situation Analysis ?	20
<b>B ESSENTIAL CONFERENCE PAPERS</b>	
1. <b>Family Planning in Africa</b>	
Overview of Population Council World Wide Activities and Focus on 21st century, Ms. Margaret Catley-Carlson	5
Family Planning in Africa and The Role of Operations Research/Technical Assistance, Dr. Fred Sai	9
Family Planning in Africa: A Summary of Recent Results from Operations Research Studies, Dr. Andrew Fisher	20
2. <b>Integrating and Expanding Family Planning with Other Service Delivery Programs</b>	
A Puzzle of Will: Responding to Reproductive Tract Infections in The Context of Family Planning Programs, Dr. Christopher Elias, Ann Leonard and Jessica Thompson	26
Perceptions of Reproductive Morbidity Among Nigerian Women and Men and Their Implication For Family Planning Services, Dr. Adepeju Olukoya	40
Combinaison de la Planification Familiale au Program Elargi de Vaccination au Togo, Dr. Aristide Aplogan	44

	<b>Page</b>
<b>3. Non-Clinical Delivery of Family Planning Services: The Role of Community Based Distribution in Africa and The Field Research Agenda for The Future</b>	
Community Based Distribution of Family Planning in Africa: Lessons From Operations Research, Dr. Jim Phillips and Wendy L. Greene	48
Les Programms de Distribution à Base Communautaire (DBC) comme Mode de Prestation de Services de Planning Familial en Milieu Rural: Expérience du Cameroun et du Mali, Dr. Diouratie Sanogo	54
<b>4. Situation Analysis Studies As a Means of Identifying and Solving Service Delivery Problems</b>	
Development and Evolution of the Family Planning Situation Analysis Methodology, Dr. Robert Miller, Dr. Ian Askew and Dr. Andrew Fisher	64
Using Situation Analysis Studies to Develop Quality of Care Indicators: Examples from Ghana, Nigeria and Tanzania, Dr. Barbara Mensch	83
<b>5. Barriers to Family Planning Services: Gender Issues, Medical Issues</b>	
Gender Barriers to Family Planning, Dr. Nahid Toubia	92
<b>C CONFERENCE OUTCOMES AND RECOMMENDATIONS</b>	
<b>1. Reports from working groups on using operations research to improve service delivery</b>	<b>98</b>
<b>2. Report from panel discussion on: The use of situation analysis findings to improve programs with representatives from Zimbabwe, Kenya, Tanzania, Burkina Faso.</b>	<b>103</b>
<b>3. Report from working groups on gender issues in family planning</b>	<b>110</b>
<b>4. Report from panel discussion on: The process of institutionalizing operations research, examples from Mali, Burkina Faso, Ghana, Nigeria and Kenya</b>	<b>112</b>

<b>APPENDICES</b>		<b>Page</b>
A	CONFERENCE SCHEDULE	114
B	POSTER SESSION	121
C	PARTICIPANTS	124
D	CONFERENCE EVALUATION	141

5

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The Population Council, an international, non profit organization established in 1952, undertakes social and health science programs and research relevant to developing countries and conducts biomedical research to develop and improve contraceptive technology. The Council provides advice and technical assistance to governments, international agencies, and non governmental organizations, and it disseminates information on population through publications, conferences, seminars and workshops.

## INTRODUCTION

The first regional meeting on operations research in family planning in Africa took place October, 4-7, 1993 in Nairobi, Kenya. The conference was sponsored by The Population Council's Africa Operations Research/Technical Assistance Project with financial support from the Office of Population, U.S. Agency for International Development (Contract Number DPE 3030-Z-00-8065, Strategies for Improving Family Planning Service Delivery).

Operations Research, as employed in the family planning field, is a problem solving process used to improve the accessibility, availability and quality of service delivery. An important objective of OR is to provide managers, administrators, and policymakers with the information they need to improve existing service delivery activities and to plan future ones. The conference represented one of a number of strategies employed by the Africa OR/TA Project for the dissemination of the results of specific OR projects in the region and the promotion of their utilization.

The specific objectives of the conference were: to promote the maximum utilization of Operations Research study findings for improving family planning service delivery in Africa; to disseminate the major findings from completed Africa Operations Research Project studies; to review operations research methods and procedures; to discuss future directions for Family Planning Operations Research in Africa.

In order to meet the objectives, the program included panel presentations and discussion, plenary presentations and working group sessions on using operations research to improve service delivery, gender issues in family planning and family planning issues facing Africa in the 1990s. There was also a poster session to display the methodology and results of specific OR projects. Research reports and population, family planning and health education materials were available on display.

The participants included operations research principal investigators and family planning administrators from the region as well as representatives from collaborating agencies and donor organizations in the family planning field. A full list of all participants, over 200, is attached as Appendix C.

## **A BACKGROUND**

### **1. The Africa OR/TA Project**

The Population Council's Africa Operations Research and Technical Assistance (OR/TA) Project completed five years of activity on August 31, 1993. Funded by the U.S. Agency for International Development through Contract DPE-3030-Z-00-8065-00, the Project is designed to improve the coverage, cost-effectiveness, and quality of health and Family Planning services.

The Project has a staff of eleven professionals in the Africa region -- five in Nairobi, four in Dakar, and one each in Bamako, Mali, and Ouagadougou, Burkina Faso. Administrative support is provided by two staff located at the Council's headquarters in New York.

Primary objectives of the Africa OR/TA Project are to:

1. Promote the development of Family Planning services;
2. Improve the quality of existing services;
3. Increase users' access to Family Planning services;
4. Increase the availability and use of underutilized contraceptive technologies;
5. Provide more acceptable services to special population groups; and
6. Improve the operations of services by making them more efficient and sustainable.

During the past five years, the OR/TA Project has supported 72 Operations Research activities in 19 countries. Out of this total, almost half (49 percent) were diagnostic or evaluation studies. Thirty-four percent were experimental studies, and 17 percent were classified as technical assistance activities.

The Africa OR/TA Project placed special attention on developing Family Planning in Francophone Africa. A total of 44 percent of all OR activities were implemented in Francophone countries. The Project also gave priority to activities in the private sector. Although most Family Planning programs in the region are governmental, the Project succeeded in working with private sector institutions (such as IPPF affiliates and NGOs) in 45 percent of its activities.

The breakdown of activities by theme reflects the Population Council's concern with quality of care and the needs in Africa such as new delivery systems and underutilized methods. Of note are the number of AIDS prevention activities undertaken by the Project. In addition, institution-building received considerable emphasis, notably in Nigeria, where technical assistance to reinforce an OR unit based at Obafemi Awolowo University in Ile-Ife was provided by Project staff.

## **2. What is Operations Research?**

Operations Research is a problem solving process used to improve the accessibility, availability, and quality of service delivery. The process has five steps:

1. Problem identification and diagnosis;
2. Strategy selection to overcome the problem;
3. Strategy experimentation and evaluation;
4. Dissemination of experimental test results;
5. Utilization of the results for service delivery improvement.

OR focusses on the day-to-day activities or "operations" of health and Family Planning programs. These operations are under the control of managers and administrators. They include activities such as training, logistics, information and education, clinic activities, and rural service delivery. OR looks at problems affecting the supply of services, not the demand for services. It examines current service delivery problems and searches for solutions. The attention of OR is on variables that can be manipulated through administrative action.

An important objective of Operations Research is to provide managers, administrators, and policymakers with the information they need to improve existing service delivery activities and to plan future ones. OR seeks practical solutions to problem situations and viable alternatives to unsatisfactory operating methods. It diagnoses and evaluates the problems of programs and compares one service delivery approach against another in terms of impact, cost effectiveness, and client acceptability.

### 3. What is Situation Analysis?

In 1989, a new Operations Research study methodology called a Situation Analysis was developed by the Population Council's Africa Operations Research and Technical Assistance Project.<sup>1</sup> There are three basic objectives for a Family Planning Situation Analysis study:

1. To describe the availability, functioning, and quality of health and Family Planning activities in a representative sample of (or in all) service delivery points (SDPs) in a geographic area.
2. To analyze the relationship between subsystem functioning and the quality of services provided and received.
3. To evaluate the programmatic impact the provision of quality services has on client satisfaction, contraceptive use dynamics, fulfillment of reproductive intentions, and ultimately, on fertility.

The SDPs examined by a Situation Analysis study might be fixed facilities such as Government clinics, Mission hospitals, or private clinics. They might be mobile units, or they might be community based distributors (CBDs) who provide services to couples at their home. Whatever the type of SDP, an SA study collects information through observation and interviewing techniques from service providers and clients on a few key indicators of each Family Planning subsystem. The subsystems are:

- Logistics/supplies
- Facilities
- Staffing
- Training
- Supervision
- Information, Education and Communication (IEC)
- Record Keeping

The indicators of these subsystems relate to the "supply" side of Family Planning.

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<sup>1</sup>. Miller, Robert A., Louis Ndhlovu, Margaret Gachara, and Andrew A. Fisher, "The Situation Analysis Study of the Family Planning Program in Kenya, Studies in Family Planning, Vol. 22, No. 3, May/June 1991.

The major users of the findings from a Situation Analysis study are policy makers, donor organizations, program administrators, and service providers at all levels. Typically and as a minimum, a situation analysis study will yield information on:

- Current equipment and contraceptive supplies at SDPs;
- Condition of physical facilities;
- Frequency of stock-outs;
- Staff available at SDPs;
- Training of service providers;
- Travel and waiting time of clients;
- Contact time with service providers;
- Services received by clients;
- Frequency of supervision and actions of supervisor during visits to the SDP;
- Number of new and continuing clients seen in past three months;
- IEC materials available at the SDP and actually used with clients;
- Type and maintenance of record keeping system;
- Information passed between provider and client during interactions;
- Quality of services provided and received in terms of the six quality of care elements;

This information can be used for a variety of purposes such as:

- Assess the quality of care provided to clients by public and private service clinics and by CBDs;
- Provide an estimate of the potential for expansion of services through the various SDPs such as clinics, hospitals, and CBD agents;
- Identify the referral mechanisms between CBDs and clinics;
- Refine the estimates of staff training needs (both initial and refresher);
- Examine the availability and use of information, education, and communication (IEC) materials;
- Highlight equipment requirements, particularly for clinical methods such as the IUD and sterilization;
- Guide the plans for facility renovation;
- Quantify the current contraceptive supply levels at all service delivery points;
- Assess the functioning of the management information and logistics system;
- Provide data for policy formulation or change;
- Identify areas for initiating Operations Research studies.

## **B ESSENTIAL CONFERENCE PAPERS**

### **1. Family Planning in Africa**

#### **Overview of Population Council World Wide Activities and Focus on 21st Century**

**Margaret Catley-Carlson  
President, The Population Council, New York**

Today is truly the first day in the rest of the life of this planet and its people. As of January 1993, there were 5.5 billion of us; we add over a quarter of a million people to the earth every day. Africa adds a million every three weeks. The population of young people coming into reproductive age will expand globally by 25% in the next decade, more in Africa.

It took 1 million years for humankind to reach one billion people on earth. We will now add a billion per decade for at least the next two decades, and maybe a third.

Of the increase of one billion births per decade 93% will be in the developing world. From an environmental standpoint, we could not tolerate the reverse. Every child born in the North consumes over a lifetime from 20 to 30 to 100 times the resources and accounts for 20 to 30 times the waste - year in and year out - of their counterparts in developing countries.

Current consumption and waste patterns of the North, if unchanged, probably pose a larger threat to our biosphere's continued survival in the near and medium future than population growth. But this rate of population growth is dangerous - for the planet, for the communities, for the stability and well being of families, in both the long and short term.

The current population growth rates pose an extraordinary challenge to school and educational systems. Africa's enormous efforts in the field of education have not yet resulted in 50% of its children continuing beyond 5 years of primary education. As the population doubles over the next 23 years it will take twice as many schools just to maintain that already inadequate level. Population growth rates complicate and slow the capacities of countries to promote development. It has great implications for human welfare.

This enormous growth is one of the characteristics of the Demographic Transition through which our global civilization is passing. It is unique. It never happened before. It will never happen again. It is a phenomenon of the past 200 years. And it will be finished in another 100 or 150 years. We are living in it.

In this transition every society on earth moves away from high birth rates and high death rates. In societies just beginning the transition a very high percentage of the population is dying before the normal life span. Most die in the first year or before 5 years - and thereafter probably of infectious disease. Societies evolve toward low birth

rates and low death rates; in post transition societies most of the death takes place in the last ten years of life expectancy. The cause of death tends to be chronic disease, genetic, diseases of lifestyle.

What we need to do is to hasten the transition, to move as quickly as possible to the year in which the planet will have its peak population, when our people live to their full life spans, when children do not die. The earlier this happens, the smaller the number will be. Nigeria, with just over 100 million people now, will have over 400 million if current level of fertility continue.

Can we hasten this transition? Yes.

The demographic imperative is threefold: First, we must meet the unmet demand for contraception that now exists. Second, we must know and address the conditions which promote demand for larger families. Third, we must slow demographic momentum. The categorical imperative is to take on these tasks in ways that are totally human, totally respectful of the lives we are touching, and in ways that themselves reflect the kind of world we want to create.

Operations research has a high level of relevance to the hastening of the demographic transition.

#### **On unmet need**

We know that millions of women who are not using contraceptives would prefer to space the next birth or have no more children. It is our collective task to serve these women with appropriate service, high levels of quality of care and the creation of supportive environments which will encourage their access. We must explore together Community based distribution models, and work through pricing issues, choice, availability questions.

We need new technologies, even though we all know that technology cannot be looked at in isolation. We must spend time and resources to make sure that the software of reproductive counselling, examination, follow through, choice, reversibility options, are appropriate to the hardware available. Most of the criticism about modern contraceptive systems is in fact criticism that this all important software is not given the importance the hardware gets.

But better hardware and new technology is needed. Norms and social practices are changing. We hope to develop contraceptives which will be used under the control of women, and by women when lactating. We need contraceptives to be used by men, post coital contraceptives, menses inducer or medical abortion, and - perhaps most important for the health of the women and men of the world - contraceptives under the control of women that would also offer protection against sexually transmitted diseases and infections - most particularly targeted at AIDS. This conference will be discussing these issues.

## Family size

Desired family size is still higher than two in virtually all countries of the developing world. In sub-Saharan Africa it is about six, with only Mauritius, South Africa, Lesotho, Botswana and Zimbabwe and now Kenya having less than 5.5 total fertility rates. In most of Latin America, Asia and North Africa, families want 3 to 4 children.

What are the real determinants of family size? Why is there a difference between these societies and the 2 child norm of the industrialized world? There are at least three key factors:

- Child survival - no country in the developing world has experienced a sustained fertility reduction under high child mortality conditions. Despite enormous progress in Africa, 5 African countries had a rise in under five mortality between 1980 and 1990. There is more than a demographic linkage here. The elements of child survival are also the elements that can be integrated into effective delivery systems: you will be looking at integrating EPI and family planning issues.
- Economic Development - there must be real economic advancement to raise the general level of prosperity and because it is this development which makes children more costly.
- Men must cooperate in fertility limitation because inequality is itself a direct cause of high fertility. Men and women have markedly different time and financial obligations to children. In many high fertility cultures, women often hold a clear self-interest in limiting their fertility -- which men may not share. When partners disagree over the terms of sexual relations, contraceptive or disease protection and numbers of children, the male is more likely to dominate.

Inequality among children also works to sustain high fertility. A family that under conditions of equality could afford four children, under conditions of **inequality** may easily have six or seven. Families that discriminate often don't educate their girls.

African countries will have to look long and seriously at these issues which are as important as contraceptive availability to the attainment of demographic goals.

## Population Momentum

Later marriage in African societies could have as significant a demographic effect as the introduction of new contraceptives. Teenage pregnancy has a demographic effect as well as an often devastating human effect. And there is a known answer here. Of all the social and economic forms of investment which affect fertility behavior, the level of education of women stands out as the most consistent.

## **Prescriptions**

We want African girls and women in school. We want it because it will enhance their lives in immeasurable ways, and because if all young girls were in school, it would dramatically bring down population growth rates in both the numbers of children wanted, and the age of first childbirth.

We want later babies - to have healthier babies and less infant mortality, to give girls a chance to be educated, to find values - and because this could cause a decline in the maximum population that Africa will reach.

We want infant mortality in Africa to decline; it is not acceptable that over 180 babies and young children per thousand die before the age of five. We want this improvement because it is wrong that babies and young children should die, that families should suffer - and because there is no country on earth where fertility has declined before infant mortality has fallen.

We want better quality of care because people should be well treated, given choices. This treats people with respect; it also promotes more contraceptive prevalence and therefore a better demographic outcome. Operations research is one of our major tools to improve programming.

We want to meet unmet demand because it is wrong that women should have fertility which they do not want, which impedes them and their families from living better lives.

I salute you for your interest - for your dedication, and I thank you for the partnership we share in this vital area.

## **Family Planning in Africa and The Role of OR/TA**

**Dr Fred Sai**

**President, International Planned Parenthood Federation**

Three decades have gone by since most Sub-Sahara African countries attained independence and gave hope to their populations for a brighter future. During the struggle for independence, the flag-waving slogan was: "Seek ye first the political kingdom and everything else will be added on to you". Africans believed this slogan and unfortunately, many thought that everything would be alright in the social and economic spheres as well as for human rights and dignity. For a while, it appeared as if some of these promises would be fulfilled. Many countries expanded their education intake. In many, economic development took off quite well. Unfortunately, after the first ten years or so, what set in was what has now been described as the development nightmare; with bad governments making poor policy choices, some of them opting for centrally planned economies; increasingly the people's needs were not being met, and many rulers resorted to more and more coercive government. By the mid eighties it had become clear that for any real development SSA countries should change to more sympathetic and responsive types of government. During all this period, Africa had been lagging behind all other major regions in practically every field of development.

Sub-Sahara Africa at present, has the dubious distinction of being the fastest growing region in the world. Currently the regional population growth rate of 3% per annum means the population will double in 23 years to something close to 1 billion persons. It also has some of the worst health statistics. The average infant mortality rate is about 100 per thousand live births. Such high rates reaching 250 or more per thousand live births in some poorer parts of the continent put a premium on high fertility. Maternal mortality is estimated at over 600 deaths per 100,000 live births, again with some poor countries experiencing double this number. The high population growth rate is maintained by a high total fertility rate of 6.5 per woman. And life expectancy of 50 to 52 years is the lowest in the world. Many of these figures are attributable to a very high load of infectious and communicable diseases, most of which have been controlled or even eradicated in the more advanced countries, and to conditions resulting from high and poorly managed fertility related problems. In the field of fertility management, Africa has the lowest contraceptive prevalence rate. The use of modern methods is estimated at about 10 %.

It is not surprising to learn that, as of now, Africa has the lowest GNP per capita (about US\$490). Among the 45 countries classified as the least developed in the world, Africa has the majority. Africa has been rightly described as a continent in crisis. A recent report of the Secretary General of the United Nations showed that in 1985, total government health expenditure was 6% and on education, 15%. Five years later, by 1990, total expenditures had dropped to 5% on health and 11% on education.

In this same period, the absolute number of illiterate people increased from about 134 million to 139 million.

Food production and nutritional standards also declined. By 1989 40% of Africa's pre-school children were suffering from acute protein-energy deficiency, up from 25% in 1985.

Equally devastating has been the rapid spread of Aids. By 1991 WHO estimated that 6 million persons in Africa were infected with the HIV virus, more than half of the world's total infections. Of the 6 million, about 3 million were women and about 900,000 were HIV-infected infants. In fact, one of the most rapidly growing problems of the region is, HIV infection and orphanhood due to deaths from AIDS and AIDS-related infections.

As if these were not enough problems in themselves, we add continually many man-made difficulties for our populations. At present Africa has more refugees per capita than any other major region. Many of these refugees are, due to bad governance, unnecessary strifes or wars that may have ethnic or other connotations. No African worth his salt feels happy looking at TV pictures these days. Hunger and malnutrition, man-made in most instances, are the lot of millions of our populations. The transition from peasant economies to market economies appears to be leaving many Africans with little or no employment. By 1990, it was estimated that open employment affected over 30 million Africans and severe underemployment, a further 90 million people. Partly for this reason, but also sometimes for economic and political reasons, between 1985 and 1990, an estimated 50,000 to 60,000 highly skilled mid-level and high-level management personnel left Africa to seek employment elsewhere. These of course, are precisely the people Africa needs to build its economies and develop its health systems. Even a small country like Ghana has probably more of its physicians outside the country than within the country.

It should come as no surprise that when we look at the population and family planning fields, some of the problems mentioned in the health and development fields generally, should also be present. By the end of the 1960's, only Ghana, Kenya and Mauritius had expressed concern about the impact of population growth on socio-economic development and produced some policies for them. Between the 60's and the Bucharest World Population Conference of 1974, only a very few African Governments would give any attention to population policy or family planning programs. Many of them felt that such programs were not necessary and that family planning was best left to be a result of comprehensive social and economic development. The majority of African countries, particularly the francophone areas, were the most vocal next to Latin America in stating that "Development is the best contraceptive."

During the following 10 years, however, things changed quite dramatically. Some of the change was probably due to the attention that family planning issues received from the Alma Ata Primary Health Care Conference 1978, when it was agreed by health authorities that family planning was a necessary part of healthy development for mother and child.

In 1984, African leaders met in Arusha and prepared for the 1984 International Conference on population. They produced the Kilimanjaro Program of Action for Population and Self-Reliant Development. This program, recommended that African

Governments should recognize the importance of family planning as a means of child spacing and safeguarding the health of mothers and children. The program also called for integrating family planning services, into maternal and child health services, and for ensuring the availability and accessibility of family planning services to all couples and individuals.

We can claim that 1984 was a turning point, at least in terms of a growing awareness of population and related problems, the need for development policies that considered population growth and the recognition that family planning programs could make a significant contribution to maternal and child health. Indeed, during the Mexico Conference in 1984, African governments also accepted that direct intervention in fertility management was an activity worth supporting.

Since 1984, many more African countries have either explicitly propounded family planning and population policies, or implicitly accepted them. Unfortunately, this acceptance has not been translated into widespread availability and accessibility of the information, education and services necessary for individuals to exercise their free choice to family planning.

At the Third African Population Conference held in Dakar, Senegal, December 1992, in the Dakar/Ngor Declaration on Population, Family and Sustainable Development, the governments of Africa were called upon to set quantifiable national objectives for the reduction of population growth, with a view to bringing down the regional natural growth rate from 3 to 2.5% by the year 2000 and to 2% by the year 2010. A corresponding objective stated that the regional contraceptive prevalence rate should be increased from approximately 10% to 20% by the year 2000 and to 40% by the year 2010. Now, these are tremendous advances from the position African governments held about population and family planning only 20 years ago and we must recognize what this means in terms of development thinking generally, and the concern for human resource development.

African governments have finally accepted that populations growing out of balance with the increase of their resources cannot make them attain the development aspirations they have for their people in terms of education, employment and health. The programs and services to translate these hopes into reality, are still very far from being on the ground and operational research of various kinds would be needed to help:

1. put proper programs on the ground, or
2. orient programs so that they can attain the ends and objectives for which they are designed.

But one should ask, whether in the 20, 30 or more years of family planning activities in the African continent, no successes have been attained. The news is not all bad. There are important success stories. The data emerging from recently completed Demographic and Health Surveys (DHS), point to major changes taking place throughout Africa. Total fertility rates remain still high, but the trend is downward. Kenya, Zimbabwe and Botswana are the countries which appear to have had the most startling

changes in total fertility, admittedly starting from very high points; Kenya from 8.3 to 6.6; Zimbabwe from 6.5 to 5.5; and Botswana from 6.5 to 5.0. These same countries have the highest contraceptive prevalence rates in Africa. 27% in Kenya, 43% in Zimbabwe; and 33% in Botswana. I have had the chance to see what is happening in South Africa recently and the contraceptive prevalence rate there is even higher; in the 50's, and the total fertility rate is about 4.5 per woman. Admittedly, much of this is because the sizeable section of the population which is highly developed also consumes a very large quantity of contraceptives. It was clear to me, however, that contraceptive uptake in South Africa among very poor and semi-literate people is much higher than the rest of Africa; much of this due to the widespread use of injectables.

Surveys show that African women want more children than women in other regions of the world on the whole. Yet, the African continent is not isolated from the new attitudes favoring smaller families that have spread through the rest of the world. Where infant and child mortality levels have fallen, where more women are educated, where economies are developed, where urbanization is proceeding rapidly and where family planning programs are more active, fertility levels do fall. Re-examination of some of the findings of the DHS's and world fertility survey data show that although the differences are still small, they do exist in many parts of Africa.

Once again, let me refer to Kenya. Kenya's fertility fell 22% during the 80's from a total fertility rate of 8.3 children per woman in 1977/78 to 6.5 in 1989. Desired family size fell 35% over the same period, from 7.2 to 4.7 children and contraceptive use rose more than threefold. Although traditional Kenyan values favored large families, recent trends have encouraged Kenyan couples to have smaller families.

Rapid population growth has put pressure on farming land in many areas, making it less advantageous to have large families. Higher female literacy, has helped promote new attitudes to family size. Increasingly, parents want to send their children to school and especially, to secondary school, recognizing what difference in possibility of employment secondary school attendance makes. But rising school fees have made it much more expensive to educate large families. The old extended family support systems seem to be breaking down too. These trends, among others, have fuelled a demand for family planning. A strong government commitment to provide a more effective family planning program has meant that more of the demand can be met. The demand is clear in other African countries as well. Recent field studies in Ghana and Nigeria have confirmed the economic rational as the major one for men supporting family planning.

One of the most important developments in Africa in the last 10 or so years, has been the acceptance by many countries, that family planning services, whilst they are to be integrated into health services as much as possible, do not have to be always entirely based within health clinics. There can be free standing family planning services, provided they are in a relationship of mutual reinforcement with clinic services providing comprehensive health care for populations. Thus some countries are rapidly introducing family planning services in rural areas, not only through the existing clinic structure of the ministries of health, but also, through community-based distributors. There are also, trials of social marketing programs in many of the big and small towns. Too many

countries, though still, hang on to the old idea that contraceptives, especially hormonal contraceptives, are dangerous medicines that should always be prescribed by the doctor.

### **The Demand for Services**

It is sometimes claimed, that in Africa, the low level of family planning use is not due to a lack of supplies or trained personnel but to a lack of demand for services.

From the recent Demographic and Health surveys conducted in Africa, we can conclude that this is unlikely to be the reason. In 11 countries where the studies have been completed, at least 47% of married women said they either wanted no more children or wanted to delay the birth of the next child, at least two years. Most of these women were unfortunately not using any contraceptive. These 11 countries represent a diverse group from north to south and east to west -- Botswana, Burundi, Ghana, Kenya, Liberia, Mali, Nigeria, Senegal, Togo, Uganda and Zimbabwe.

Ghana's findings show about 60% either wanting to postpone the next birth by two or more years or to have no more children. This compares very badly with the currently estimated contraceptive prevalence rate of around 15 to 17%, some 10% only being modern methods.

Another figure that should impress us is a demand for accessible abortion. Since abortions are illegal or restricted in most of Africa, there are no good figures of the rates of abortion anywhere. However, anecdotal reports make it clear that this is an increasing menace, at least in the major towns.

A small research by Lamptey and others from FHI showed that some 60% of women who were having their first full pregnancy in the Korle Bu Hospital in Accra had at least one abortion already; the highest rates being among those who have had 12 years of education or more. Indeed, admissions for complications of induced abortions are now very high in major African centers, making many concerned clinicians feel the time has come to revisit abortion legislations in the region.

If there is such a demand, then why is it that even where there are services, the people are not taking up contraception. The answer simply could be that the services are either too weak or not provided in a form that conforms with what the people would want. What the people would want to use could be described as quality services that are made accessible to them with very little discomfort and fitting within their environment and circumstances. These are services which are planned and executed with the full involvement of the people themselves. It is for the provision of such people-oriented quality services, that OR/TA projects help to identify what is needed and how the need is to be satisfied. Findings from OR show that if quality services are offered, they will be used.

In Tanzania, a community-based distribution program at the work site raised method use in one factory from 16% to 30% and in another from 20 to approximately 33%. In Western Kenya, within a 2-year period, modern method use in one

experimental area increased from 7% to 15% and in another area from 14% to 34%. In contrast, the use of modern methods in one of the control sites remained at 6% over the two years and the other control site increased only slightly from 14% to 19%.

In a clinic in Kinshasa, 43% of 101 MCH clients accepted a family planning method after services were integrated with an expanded program of immunization. In Mali, a rural-based CBD experiment increased prevalence from virtually zero to 11%.

In Madagascar, improving the skills of providers through training, increasing clinic education activities and assuring an adequate supply of contraceptive commodities resulted in a 45% increase in new acceptors during the quarter after the changes were introduced.

In our own Danfa Comprehensive Research Program area, in the 70's where we tested alternative approaches for delivering family planning services, we found that putting family planning educators, who were originally nutrition assistants, into the communities, helped to increase the uptake of contraception from virtually nothing to around 30% in a short period.

These and many other examples from operations research studies suggest that despite the numerous economic difficulties that Africa now faces, when accessible quality services are offered, Africans would be ready, like people everywhere, to use services and take charge of their reproductive health and manage their fertility.

In fact, I would like to share with you some of the findings from what the World Bank calls, "The Agenda" which is the shortened form for Agenda for Improving the Implementation of Population Programs in Africa. This is a research cum action program that seeks to find out from the people themselves what it is they think about population problems; how they see these as affecting their lives; what aspects they would like to see addressed and how they would like to see these addressed. These qualitative studies, based on in-depth interviews, participant observation and focus group interviews.

From studies in Kenya, Nigeria, and Ghana, we have come to some tentative conclusions which are important. One is that in practically every area, men are not as unconcerned about fertility management as the literature from Africa would lead us to believe. Men's concerns tend to be on the economic rather than the health. Men, in Kenya for example told the researchers that while they would be prepared to practice family planning, they were not prepared to go and stand in queues with pregnant women and children. So much for those who have been insisting that family planning can only be provided through integration with maternal and child health. There were instances where the providers' attitudes were the factor which turned people off most. We had instances where clinic hours or clinic markings were such that people even didn't know how to get to the clinic and when they got there, the timing did not suit them. Through investigations of this nature and efforts to get to understand and appreciate the people's concerns, we would be able to mount services that people would want and they would use.

## **Important Areas for Future Operations Research**

After so many years of implementing family planning programs, with ideas borrowed from existing programs in Europe, America or Asia, we have not had too much success in many instances in Africa. Since practically all African governments are now committed in one way or another, to provide family planning, both as a component of the primary health care system and also in some situations, to extend services in areas not covered by clinics, the issues for the rest of the 90's and early into the next century will be finding the means to develop and expand services and then sustain them. This is where operations research can help us most. We need to avoid costly mistakes while developing new programs; we have to try new approaches which are monitorable and which we can evaluate continuously and be able to make changes as and when indicated.

The practical problem focused approach that characterizes operations research is ideally suited to the African situation, where no single service delivery approach is ever likely to meet the needs of such a diversity of groups. OR will be particularly crucial in helping governments and service delivery agents, to come up with effective, culturally sensitive and economically viable approaches to a number of crucial issues, facing health and family planning programs. Of these issues, for our area, the following, in particular, may be identified.

### **Sustainability**

African governments alone cannot meet the growing financial burden of health and family planning programs. Nor can they depend on the whims of foreign donor countries for sustaining these programs. It is imperative, that other sources of support for health and family planning service delivery should be found locally, and these would include a more extensive use of private providers, some public insurance schemes, client fees, and fees from employers. It has been found that in many instances, people are prepared to pay fees for service, especially when they see these services as of good quality. It must be stressed that, for a very long time to come, sub-Saharan Africa, because of its economic difficulties, particularly in terms of its debt burden in relation to its foreign exchange earnings, cannot afford the foreign exchange component of most programs. It will therefore be expected that contraceptive supplies and family planning commodities would continue to be given, as a donation from the west or north.

### **Reaching Rural Areas**

Over 70% of Africans live and work in rural areas. And this is where most services must be delivered if our programs are to make an impact on national fertility issues. Effective ways must be designed, tested and implemented. Several countries such as Zimbabwe and Kenya have developed CBD programs which reach rural areas. In West Africa, several countries, including Ghana, are experimenting with CBD approaches. The experimentation needs to continue. There is no single CBD approach. In Kenya, for example, 23 different organizations implement 23 CBD programs, each with its own peculiarities. There are important questions that need to be addressed

relating to these programs. For example, what is the role of CBD in generating demand for services in a constrained environment? When and under what circumstances should CBD programs be phased out? Should service delivery organizations focus on upgrading and intensifying CBD activities in existing areas or should they focus on expanding to new areas? Should CBD activities be targeted for areas that are currently under served by clinic facilities or where a strong clinic network exists that can act as a referral and back-up for CBDs.

Would village level depot holders free CBDs to focus more on identifying new clients and referring continuing clients for clinical services rather than on merely re supplying existing clients? And if yes, how sustainable is the paid CBD program? The answers to these questions require research that can serve to guide the development of new programs.

In many of our towns and cities the potential exists for social marketing programs which are another type of CBD program in my view. Experiments going on in parts of Africa, one of which is going on in my own country, which is experimenting with establishing a social marketing foundation, need to be critically evaluated and if successful, their lessons disseminated widely.

### **Expanding The Method Choice Available in Programs**

In too many African countries, family planning has come to mean the distribution of one or two methods such as the pill, or condoms or foaming tablets. Such programs restrict the choices of couples and they severely limit the health and demographic impact of family planning. There seems to be a reluctance by policy makers and program managers to acknowledge that there are other methods besides some of the more established methods and there is a demand for these methods. Sterilization services are in high demand in Kenya and Tanzania and undoubtedly, would also be in high demand in other countries if made more readily available. I personally, had to identify that there was a waiting list of some 18 months for sterilization of women in Kenya before a lot more attention was paid to this. Methods such as NORPLANT®, injectables and IUDs would also be in high demand if they were made available in a user-friendly manner. The challenge is for programs to expand the method mix. In addition, we also want to experiment with supplier mixes, which are more in consonance with our manpower possibilities. What type of health worker should and can provide NORPLANT®, injectables and IUDs? What type of training should such providers get and what of their supervision? Is there a significant private sector market for these methods? What type of pricing structure should be used with these methods and what type of client follow-up systems should we require?

### **Family Planning and Sexually Transmitted Diseases**

Addressing questions related to STDs/AIDS and Family Planning should be very high priority for national programs. Over the coming years, we will have to address a lot of questions. The IPPF has taken the leadership in asking its family planning

associations all over the world, to combine STDs, counselling and referral with their normal work. How can a family planning organization implement such a mandate and address the needs of clients with STDs? What types of STD educational activities and prevention programs can be implemented through the programs?

What effect would these activities have on the acceptance of family planning? There have been instances where family planning associations have shied away from handling sexually transmitted diseases because they do not want to be "tainted" by public feelings and misgivings about STDs.

AIDS is a major case in point, where fear of the condition in many areas makes family planning workers anxious about their own safety and therefore tend not to want to be involved with AIDS education and counselling.

From the standpoint of cost and long-term sustainability, how much screening and testing for STDs is possible? Will integrating an STD program with an FP program overwhelm FP, discourage potential clients, or act as an attraction? Side by side with STD prevention and management should be addressed the question of infertility, prevention and management. There has been a lot of pressure by FPAs or on FPAs to undertake infertility management programs. The management and treatment of established infertility is a costly and rather unrewarding exercise. In many of the more advanced centers, the success rate so far is about 1 in 7. On the other hand, since we know that much of African infertility is due to post-infection blockage of either the tubes or the vas it should be mandatory on our programs to do their very best in education, counselling and all aspects of the prevention of sexually transmitted infections.

### **Reducing Septic Abortions Through Greater Access to Contraceptive Services**

Abortion complications are a major cause of morbidity and mortality among women. The issue of abortion cannot be ignored in Africa. One estimate suggests that there are 1.5 million abortions a year in Africa. Another study estimates that 50% of maternal deaths in Nigeria are due to criminal abortions; in a study in Addis Ababa, 54% of deaths related to pregnancy were abortion-related. The picture in other countries is similar or worse. In fact, workers on the safe motherhood program estimate that 20-50% of all maternal deaths in Africa are abortion-related. Many of these deaths are among young women, many of them school girls. Experimental research studies that seek to reduce the use of abortion through contraceptive education and service delivery interventions, are needed in all countries, as past studies have shown that effective family planning programs have a major impact on reducing maternal and infant deaths. Similar studies need to document the link between family planning education and service delivery programs and the reduction in abortion-related morbidity and mortality. Such studies have enormous potential to influence program directors and policy makers towards making contraceptive services, more available, acceptable and of higher quality.

Perhaps in relation to abortion and contraception, one has to pose the question, what happens to people who are failed by their contraceptives even though the evidence is clear that they have used contraceptives conscientiously. It is my personal opinion,

that abortion should be given to such people as a back-up option. It is necessary for our family planning programs to identify the importance of failed contraception and make policy makers relax the legal and policy requirements against abortion.

### **Reducing Medical Barriers**

There is an urgent need to document the medical barriers such as the need for prescriptions, the need for being in clinics and other health facilities at particular times, which make contraceptives less accessible to many of our people. Experimental field studies need to be implemented that measure what happens when such barriers are reduced. Does clinic utilization increase? Does contraceptive use and continuation increase? Are couples better able to meet their reproductive goals? What is the effect of such removal on restrictions in the quality of care?

### **Improving Adolescents Access to Family Planning**

Adolescents in Africa are resorting to abortion with considerable risks of experiencing complications, in some parts, because of medical barriers that restrict their access to safe and effective contraception. DHS studies mentioned earlier revealed that between 15 and 20% of all births occur to teenagers. These same studies also reveal that in 7 of the 11 countries, less than 10% of teenagers have correct knowledge of the fertile period and in 10 of the 11 countries ever use of contraception is below 12% among teenagers. Like abortion, the issue of improving adolescent access to family planning is sensitive; but just because it is sensitive does not mean it can be ignored.

### **Incorporating Gender Concerns in Family Planning Programs**

In the past, gender studies have not been central to the concerns of African family planning programs. This needs to change. All family planning activities need to be designed, reviewed and analyzed with gender issues in mind. This can be undertaken by involving both sexes as clients and partners in the design and implementation of programs. There are a number of important gender questions also for programs. What technologies or strategies can women use to protect themselves from STDs? What is the overall impact of family planning on women's lives? What is the role of male partners in determining women's method of contraception and in affecting continuation or discontinuation? What strategies can be designed to draw males into family planning counselling as support for women?

### **Testing Post Partum Family Planning Strategies**

These strategies which were developed very early in the 60's have largely been ignored by Africa. The time has come for Africa to learn from the experience of similar strategies that have been implemented elsewhere and we need to study them and publicize the finding. Post-partum approaches that provide all appropriate contraceptive

methods including pills, IUDs, PUBLICIZE and barrier methods need to be designed, implemented and evaluated. The cost effectiveness of this approach needs to be compared against interval approaches.

This is a very huge menu of research and action that is required if we are to make our programs meet the needs of our own people. The challenge is, do we have the will to mount these programs in ways that will meet the challenges? There is no doubt that if we do, success is assured. What is happening in family planning to date, in many parts of Africa, makes me feel very sure that the need is there. The people really do want to have quality family planning services. It is up to us program managers and planners, to identify, through operations research, through listening to the people more actively, how it is that the people would want their family planning services rendered and for us to join forces with them to render the services. I hope we are up to the challenge.

## **Family Planning in Africa: A Summary of Recent Results from Operations Research Studies**

**Andrew Fisher**

**Director, Africa OR/TA Project, The Population Council, Nairobi**

Critics have argued that regardless of how effective African family planning programs are in making services available and accessible, the use of family planning services in Africa will remain low because the demand for these services is very low. Until very recently, this "weak demand" hypothesis was the prevailing wisdom among many observers. Recently, however, this situation has changed. Three important sources of data have challenged the hypothesis of weak demand for contraceptive services:

- Demographic and Health Surveys (DHS) have provided information on fertility, mortality, knowledge about family planning methods, ever use, and current use and on the demand for family planning services.
- Situation Analysis studies initiated by the Africa OR/TA Project have focused on the supply side of family planning and have provided information on the availability, functioning, and quality of services offered at service delivery points (SDPs).
- Field based, operations research studies have set up experimental situations where new approaches to the delivery of services have made family planning more available, accessible, and acceptable.

Taken together, the data from these sources present three important messages:

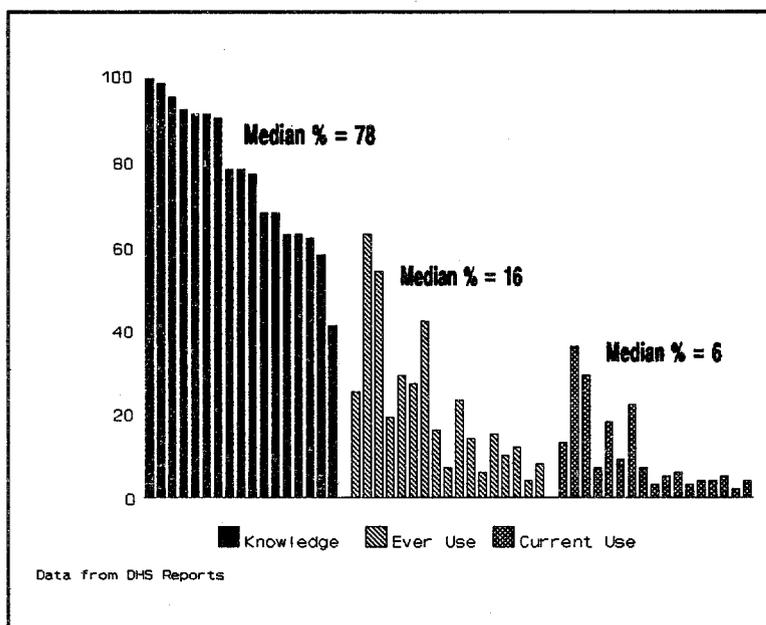
- The DHS reports indicate that throughout Africa, the demand for family planning services exists, often at very high levels.
- Situation Analysis studies reveal that in every country where these studies have been conducted, there are major weaknesses in the supply of services which affect the ability of programs to satisfy demand.
- Numerous operations research experimental studies demonstrate that when these supply side weaknesses are corrected, when services are made more available, easily accessible, and of higher quality, the use of family planning increases substantially and rapidly.

## The Demand for Family Planning Services

Data from 17 African countries - taken from DHS surveys (Figure 1), shows knowledge of modern methods is high. In only two of the 17 countries is it below 60 percent, and in 7 it is above 90 percent. The median for the 17 countries is 78 percent. In addition, ever use of a modern method in most countries is at moderate levels. In 3 countries it is above 40 percent of all currently married women, and in 7 countries it is above 20 percent. The median is 16 percent. However, in sharp contrast to knowledge levels and even to ever use levels,

with the exception of Zimbabwe, Kenya, Botswana, and Namibia, current use of a modern method is very low. The median for the 17 countries is only 6 percent.

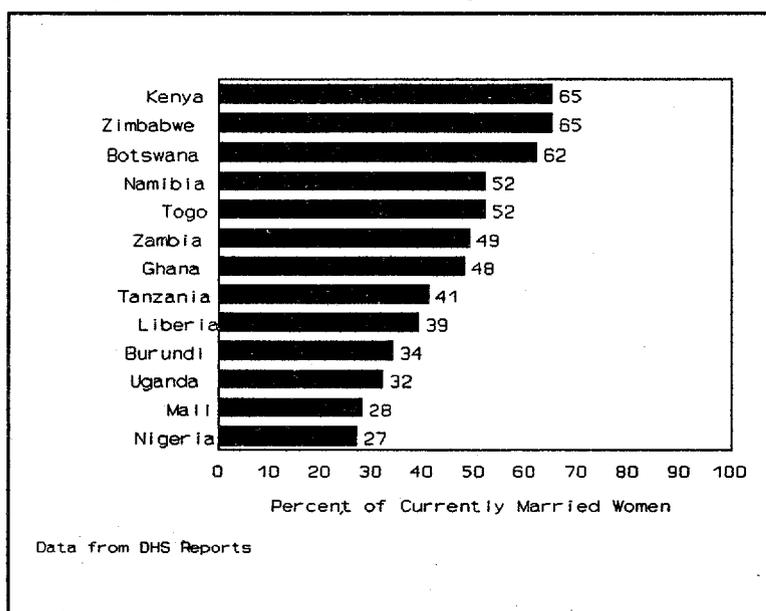
**Figure 1: Knowledge, Ever Use, Current Use of Modern Methods Among Currently Married Women 15-49 in 17 African Countries**



The DHS surveys ask women about their desire for more children and about their desire regarding the timing of future births. Women who say they would like to limit future births or delay the next birth for two or more years are considered to have a "demand" for family planning services. In 13 African countries the demand varies considerably (Figure 2) from 65 percent of currently married women in Zimbabwe and Kenya to a low of 28 percent in Mali and 27 percent in Nigeria. In all countries, total demand, according to this definition, is

far higher than current use. Clearly, in all countries, there is a considerable gap between demand and current use. The percent of total demand that has not been satisfied by

**Figure 2: Total Demand for Contraception Among Currently Married Women in 13 African Countries**



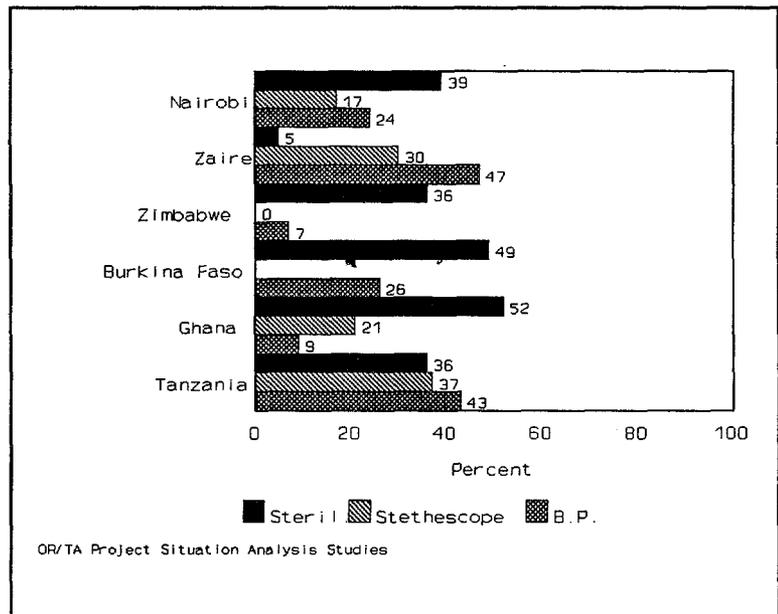
women using a contraceptive method is uniformly high -- in nine of the 13 countries, unsatisfied demand is above 60 percent of currently married women who want to delay or limit the next birth.

### The Supply of Family Planning Services

If demand appears to be less of a factor restricting family planning use than was thought to be the case just a few years ago, then it would seem likely that the supply of services is a barrier to use. Nine Situation Analysis Studies conducted in eight countries, with support from the Population Council's Africa OR/TA Project, provide evidence that this seems to be the case. In each country where a Situation Analysis has been conducted, there are major weaknesses in the availability, functioning, and quality of family planning services. These weaknesses are probably a major constraint on the ability of clients to satisfy whatever demand exists.

Before services can be made available, accessible, and acceptable to clients, an SDP may need to meet some minimum set of conditions with respect to available commodities, trained staff, and functioning equipment. Unfortunately, as the data from eight Situation Analysis studies illustrates, in many SDPs, minimum levels have probably not been met and consequently services can only be delivered sporadically or not at all. Equipment such as sterilizers and stethoscopes were found to be frequently broken or missing (Figure 3). Stock-outs of contraceptive commodities are also a problem. While most SDPs particularly in rural areas have pills and condoms, they are less likely to have IUDs or to provide sterilization services.

**Figure 3: Percent of SDPs with Missing or Broken Equipment**



The competence of staff, that is to say, their level of training in family planning is another problem area. Among providers who are currently providing family planning, in some countries, a substantial percent never received training in family planning during their basic training course and they have not received any subsequent refresher family planning training.

Without training, it is not surprising that family planning services tend to be limited to commodities that require less skill to provide such as foam tablets, condoms,

29

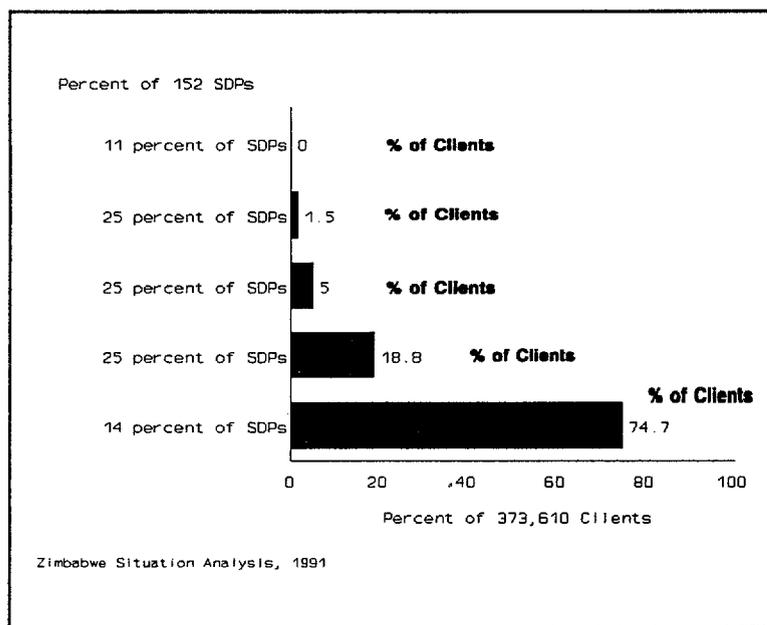
and pills but not to IUDs, injectables, and sterilization. Many Situation Analysis Studies show that, while almost all clients receive information on the pill, far fewer received information on IUDs, and hardly any received information on tubal ligation (17 percent of new clients in Kenya).

Other components of family planning programs also affect both the quantity and quality of services that can be offered to clients. Information and education materials are frequently absent in clinics. Only 16 percent of 99 rural SDPs in Kenya gave a health talk to clients that included information on family planning on the day the researchers visited. Supervisory visits to SDPs tend to be relatively infrequent in many family planning programs. For example, in Burkina Faso, 45 percent of the SDPs surveyed had not received a supervisory visit in the past six months. In Ghana 42 percent had not received a supervisory visit in this same period of time. With all these problems, it is not surprising that clients experience difficulty in obtaining family planning services.

### A Few Clinics Serve Most of the Clients

Taken together, the combination of deficiencies at family planning clinics means that there is a fairly high probability that services simply cannot be obtained by the many potential family planning clients that DHS studies have identified as having a demand for family planning. Not surprisingly, Situation Analysis studies show that a small proportion of SDPs serve a relatively large proportion of all clients (and that a large number of clinics serve few or no clients). For example, in 1990, 14 percent of the 152 SDPs surveyed by the Zimbabwe Situation Analysis Study provided services to 75 percent of all the clients who attended these SDPs (FIGURE 4). On the other hand, 36 percent of these same SDPs served only 1.5 percent of the clients. Nigeria presents a similar picture -- 19 percent of the SDPs in the Situation Analysis study sample served 75 percent of all new clients in 1991. In Ghana, 25 percent of 238 Government SDPs provided services to 71 percent of all new clients attending these SDPs in 1992. A similar phenomena can be seen among private maternities in Ghana, in health centers in Tanzania, and in hospitals in Tanzania.

**Figure 4: Zimbabwe: Percent of 152 SDPs Providing Services to 373,610 Clients in 1990**



These data indicate that even after controlling for type of SDP, whether rural health center or more urban hospital, Government SDP or NGO SDP, in general, between 20 to 30 percent of the SDPs provide services to about 70 to 80 percent of all clients. This suggests that in the remaining 70 to 80 percent of all SDPs, there is substantial underutilization. Some observers suggest that there is potential for meeting existing demand if services can be improved. However, to date researchers have not been able to clearly understand the differences between the more and less productive clinics based on sub-system indicators and existing measures of quality of care.

### **Operations Research Experimental Studies**

Despite some methodological difficulties in explaining the functioning of different SDPs, data from operations research experimental studies throughout Africa demonstrate that when family planning services are made available and accessible, and the quality of care is improved, use of family planning services increases. There is hardly a country in Africa that cannot point to at least one if not many longitudinal, field-based experiments that demonstrate rapid increases in contraceptive prevalence can be achieved. Some examples follow:

- At two factories in Dar es Salaam, Tanzania, offering family planning services (along with AIDS prevention) through a clinic based at the factory, use of contraceptives increased from 4 percent at the baseline to 44 percent after the program; in the other factory the increase was from 13 percent at the baseline to 52 percent after the program.
- Where male herbalists and female traditional birth attendants (TBAs) served as community based distributors of pills, condoms, and foaming tablets in two rural districts in Kenya, prevalence increased from about 7 percent to 15 percent. (In the control area prevalence remained at 6 percent during the two year intervention period.) In the second District, prevalence of modern methods went from 14 percent to almost 34 percent in the experimental area but only increased from 14 percent to 19 percent in the control area.
- In Kinshasa, Zaire, family planning services were fully integrated into a clinic providing immunizations and other maternal child health services. Contraceptive use increased from 3 percent in the first month of the program to a high of almost 43 percent in the fourth month (before civil disturbances in Kinshasa forced the project to close).
- In The Gambia, training on maternal health and family planning for Imams led to increases in current use of any method from 9 percent to 20 percent for males, and from 9 percent to 26 percent among females.
- In rural Madagascar, a change from a monthly mobile family planning service system to regularly available services in MCH clinics resulted in about a four-fold to five-fold increase in new acceptors at about one third

31

the cost per new acceptor (depending on the intensity of the program offered).

These five examples of successful service delivery demonstrated by operations research studies are not exceptions. Numerous other examples from Mali, Nigeria, Zaire, Burkina Faso, Ivory Coast, Cameroon, and other countries could also be cited. The body of OR research in Africa suggests that by increasing the availability and accessibility of reasonable quality family planning services frequently results in substantial contraceptive use.

## Conclusion

The DHS studies conducted in Africa show that the total demand for family planning services is large and that the proportion of this demand that has been met by family planning services is relatively low in most countries. Situation Analysis Studies reveal major, systemic weaknesses exist in the supply of services that restrict the ability of couples to satisfy their demand for services. In order for family planning programs to be able to satisfy demand, the major sub-systems of family planning -- training, supplies, logistics, IEC, and others -- may all need to be operating at some minimum level of efficiency. While the dynamics are not understood entirely, inefficiencies in any one sub-system may greatly inhibit the supply of services. But, as numerous operations research studies demonstrate, when family planning services are made available, when access to these services is increased, and when the quality of the service is perceived to be acceptable to the clients, rapid and substantial increases in prevalence occur.

Clearly OR has contributed to our knowledge of the African situation today by diagnosing the problems in existing family planning programs and demonstrating the impact of improved approaches to service delivery. However, much work remains. Operations research in the future must look to the next generation of questions, such as:

- How do we move from the diagnosis of systemic program problems, and small scale OR demonstration studies, to a better understanding and ability to improve large scale national programs?
- How do we deal with the new, cutting-edge issues -- integrating HIV and STDs and family planning, adolescents, and gender concerns, as well as reducing septic abortions and a variety of barriers to family planning services?
- How do we make programs more cost effective and sustainable and less dependent on donors?
- What is the best pattern of collaboration for institutionalizing the ability to conduct OR, strengthening human resources, and for increasing the utilization of program lessons?

## **2. Integrating and Expanding Family Planning With Other Service Delivery Programs**

### **A Puzzle of Will: Responding to Reproductive Tract Infections in The Context of Family Planning Programs**

**Christopher J. Elias, Ann Leonard and Jessica Thompson  
The Population Council, New York**

#### **Introduction**

For many years there has been considerable discussion of the prospects for integrating family planning efforts with other health programs -- including maternal-child health, primary health care, other categorical programs (such as the Expanded Program for Immunization), and, more recently, programs for the prevention and control of sexually transmitted disease, including AIDS. The rapid emergence of the global epidemic of HIV infection, with the associated morbidity, mortality, and economic devastation of AIDS, and an increasing awareness of the impact of this epidemic on women's health, has brought a renewed sense of urgency to this debate. Unfortunately, the debate has often proceeded primarily on ideological grounds and has been marked by a paucity of data reflecting the actual experiences of field-based programs. In this paper we would like to examine some of the pieces of this puzzle of will and suggest some steps for us to go forward in the name of action. We will draw, where possible, from the limited sources describing actual field-based programs.

We would like to explicitly avoid the usual discussion of how already existing vertical programs for family planning and STD control can be formally integrated. In political jargon, this issue is often a "non-starter" because of the extreme difficulty of combining the budgets and bureaucracies of existing programs under different lines of administrative authority. Family planning and STD control programs are often in different divisions of the Ministry and, in some countries, in completely separate Ministries. As a consequence, any discussion of formal program integration often quickly becomes a debate over administrative jurisdiction and budgetary control -- a debate that is totally disengaged from the reproductive health needs of the clients of either program.

Instead, we will make the argument that responding to the problem of reproductive tract infections is a worthwhile -- and long overdue -- challenge to be taken up within the context of existing family planning programs. Infections of the reproductive tract -- including the common STDs and HIV infection -- are of central concern to the providers of family planning services, as these infections influence the safety and quality of our service programs and impact on the demand for fertility regulation and the utilization of contraceptive methods. The puzzle to be solved, therefore, is not how to integrate two separate government departments, but rather how to expand existing family planning service to more adequately and comprehensively meet the reproductive health needs of clients. As we will discuss, there are very few examples of how this has been successfully done, especially in sub-Saharan Africa. We have much to learn about the

operational details of such programmatic expansion, therefore -- appropriate to the theme of this conference -- we will end with a detailed agenda for operations research. It is, however, very much a puzzle of will. We will not identify successful service models unless we make this topic one of our primary concerns and invest the requisite time and effort to answer the outstanding questions.

Let us first turn to the problem of reproductive tract infections, or RTIs. Through the advocacy of the International Women's Health Coalition and other concerned organizations, increased attention has been brought in the past several years to this largely neglected issue. Reproductive tract infections are of three general types: sexually transmitted diseases - including gonorrhea, chlamydia, and HIV infection; endogenous infections caused by overgrowth of organisms normally present in the vagina - such as yeast and bacterial vaginosis; and iatrogenic infections that are associated with medical procedures, such as abortion or IUD insertion.

A broader concern for RTIs, as opposed to a more narrow focus on STDs, is preferable because it more accurately reflects women's need for reproductive health service. When symptomatic, women present with specific syndromic complaints -- for example, vaginal discharge or lower abdominal pain -- that may or may not be sexually transmitted -- and may be the consequence of medical intervention, as well as sexual behavior. In any regard, all three types of RTIs are a significant source of morbidity and mortality for both the woman and her children.

RTIs are extremely common. In a recent exhaustive review of the available prevalence data for lower reproductive tract infections among non-prostitute populations -- mostly gathered from antenatal and family planning clinic samples -- Dr. Judith Wasserheit drew the following conclusions:

- First, RTIs are common in almost all of the developing countries in which they have been investigated, even among asymptomatic populations.
- Second, the prevalence of infection is greater in African populations than in Asian or Latin American populations.
- Finally, there are no consistent prevalence patterns across countries (even within the same continent) to indicate which groups of women are likely to be most in need of services.

Wasserheit summarizes the median prevalence of lower RTIs among non-prostitute, non-STD clinic populations of women by continent and by causative organism. Where data are available, the prevalence in Africa is generally higher and, in all areas, the range of prevalence is quite broad. Illustrative of the magnitude of these infections was Dr. Wasserheit's finding that "in 7 of the 8 asymptomatic, non-STD populations examined, at least 5% of women had gonorrhea, and in 4 of these studies, a prevalence of at least 10% was documented."

But, these are clinic-based data. What about the prevalence of RTIs in the community? In the Population Council's Cairo office, Dr. Huda Zurayk and colleagues

have conducted a community study of gynecological and related morbidities among women in two villages in rural Egypt. Table 1 summarizes their findings for the prevalence of lower reproductive tract infections. These investigators randomly sampled 509 women from households in two communities in rural Giza. Because of an uncommon investment of time in sensitive recruitment and counselling of women, only 8.6% of their sample refused participation in the study. Previous studies of this kind have been characterized by extremely high refusal rates that limit the generalizability of the study findings. As you can see, they found that a significant percentage of the women had either vaginitis, cervicitis, or both. Overall, 52% of the sample was found to have one or more reproductive tract infection.

**Table 1: Gynecological Morbidity in Rural Egypt**

LOWER REPRODUCTIVE TRACT INFECTIONS	Percentage
<b>VAGINITIS:</b>	
Laboratory Diagnosis	44.2
Bacterial Vaginosis	21.9
Trichomonas	18.3
Candida	11.0
<b>CERVICITIS:</b>	
Clinically Diagnosed	9.7
Chlamydia	8.6
Gonorrhoea	0
Nonspecific Mucopurulent Cervicitis	9.2

Source: Younis, N. et al., *Studies in Family Planning*, 1993; 24, 3: 175-186

In summary, data from both clinic and community studies indicate that a significant proportion of reproductive age women currently have RTIs. Studies also indicate that a large portion of these infections are totally asymptomatic.

### **Consequences of RTIs**

There are many consequences of RTIs, several of which are potentially fatal. There are significant associations between various reproductive tract infections and fetal wastage, low birth weight, and congenital infection. These outcomes contribute in turn to high neonatal and infant mortality rates and are also the cause of significant morbidity. Congenital gonococcal infection, for example, represents an important cause

of preventable blindness. Cervical cancer is another important consequence of lower RTI, having been epidemiologically associated with several strains of the Human Papilloma Virus. Recent evidence also suggests that the risk of HIV transmission is increased at least 3- to 5-fold in the presence of other RTIs, qualifying the acquisition of this fatal infection as a consequence of unrecognized and untreated RTI.

Another complication of lower RTI that leads to a range of complications is infection of the upper reproductive tract or pelvic inflammatory disease. Infertility, ectopic pregnancy, and chronic pelvic pain are common and serious results of such infection. Selecting just one of these outcomes for illustration, Table 2 indicates the estimated proportion of infertility attributable to RTIs by region. Note that, in keeping with the overall higher prevalence of RTIs observed in sub-Saharan Africa, the proportion of infertility attributable to these infections is higher and, indeed, represents the major cause of infertility in this region.

**Table 2: Proportion of Infertility Attributable to RTI**

Region	Percentage
Sub-Saharan Africa	50-80
Asia	15-40
Latin America	30
Industrialized Countries	10-35

Source: Wasserheit, JN. 1989, International Journal of Gynecology and Obstetrics

### **Impact on Family Planning Programs**

The role RTIs play in causing infertility is important to keep in mind when considering their impact on family planning programs. By compromising fertility, pregnancy outcome, and child survival RTIs may decrease the demand for contraception. In a more direct manner, when perceived as "side-effects" of contraceptive methods, RTIs may result in discontinuation of methods. Finally, real or perceived associations between RTIs and particular contraceptive methods may result in client or provider "bias" against these methods. "Bias", in fact, may be too strong a term in many settings where a reasonable suspicion of high RTI prevalence, combined with a lack of any facility for RTI screening, leads providers or appropriately counselled clients to use certain methods, such as the IUD, only with extreme caution.

So, what does all this mean for family planning providers and program managers? The prevalence and consequences of RTI form an important dimension in an expanded concept of unmet need. In a recent essay, Ruth Dixon-Mueller and Adrienne Germain define a broader scope of unmet need. Such an expanded concept of unmet need would

include recognizing the need among nonusers at risk of unwanted pregnancy for any method of contraception, as well as the need among some users for a more effective, satisfactory, or safer method; the need among both users and nonusers for treatment of contraceptive failure (or nonuse) through safe and accessible abortion services; and the need for related reproductive health services, such as the prevention and treatment of RTIs.

### **The Legacy of Categorical Programs**

Lack of sufficient recognition of the significance and scope of reproductive tract infection is not, however, the only ill we bear. We also bear the legacy of categorical programs which have historically been primarily, and sometimes too exclusively, focused on the control of fertility and population growth. An emphasis on "births averted" has led to both formal and informal program dynamics which discourage the embrace of a broader scope of unmet need.

One area where this dynamic is reflected is in the evaluation and reward of program effort. Consider, for example, the widespread use of CYP (couple years of protection) as the principle measure of family planning program success. As Jim Shelton discusses in his commentary entitled "What's wrong with CYP?", the secondary benefit of condoms and spermicides in preventing AIDS and other STDs is "difficult, if not impossible, . . . to be addressed by CYP per se." And yet, because other evaluation techniques are often not routinely used in family planning programs, CYP or other methods of program success exclusively focused on fertility reduction, remain the norm.

Such a dynamic in program evaluation and reward readily becomes reflected in provider attitudes which consider one method of contraception "better" than another solely because of it has a greater perceived contraceptive effectiveness. As discussed in the quality of care literature, a narrow focus on this single, albeit extremely important, dimension of contraceptive methods underplays other important dimensions, such as client satisfaction and the need for other reproductive health services, including RTI screening and treatment. Such attitudes obviously affect the content of information and counselling providers give to clients and, ultimately, client's choice of methods.

Similar concerns are also raised by the recent discourse on "medical barriers". While the removal of unnecessary obstacles to contraceptive accessibility is obviously a laudable goal, there is a danger that "STD screening" could become broadly conceived as a barrier to contraceptive access and, hence, reduce the interest of program managers in pursuing its appropriate application. Routine screening of potential IUD acceptors for RTIs prior to insertion is a reasonable goal and currently the standard of care in resource-rich environments. Its feasibility in resource-poor environments is currently limited by available diagnostic technologies, facility infrastructure, staff training, and financial resources. It would be inappropriate, however, to stop trying to overcome these difficulties because such screening became broadly signified by the somewhat pejorative term "barrier." We must remember that for many women throughout the world, MCH and family planning programs may represent their only contact with a health facility; and, hence, such encounters are an important opportunity to provide needed preventative and

curative service. The challenge -- and, as we see it, the responsibility -- of operations research is to determine how such opportunities can be realized without detriment to existing services.

Another aspect of the legacy of categorical programs relates to client perceptions and health seeking behavior. As discussed above, clients have a range of reproductive health needs. They are also keenly sensitive to the intent of programs and readily perceive when providers are only interested in or capable of addressing their need for fertility regulation. The available literature on client-provider interactions in family planning services suggests that women in developing countries often view such categorical programs with considerable suspicion. Services that met a broader range of women's needs could expect to be viewed more positively, provided that such services were of adequate quality.

A final issue relates to health seeking behavior and the "Culture of Silence" that surrounds women's reproductive tract infection and morbidity. While many RTIs are asymptomatic, most categorical programs have been poorly prepared to deal with those infections which are either symptomatic or detected during clinical examination. Several studies have shown that many women bear silently the symptoms and signs of RTI without seeking any health care. While some of this reflects lack of an awareness of reproductive physiology and expectations that this is a "woman's lot in life," it also surely reflects the reality that in many places there is simply no health care to seek, especially for symptoms that tempt the stigma of "venereal disease."

### **The Limitations of Current Technologies**

The final ill we bear is the limitation of our current technologies. We are in an unfortunate position where our most effective contraceptive technologies have either no protective effect on STD and AIDS transmission or potentially augment risk; and where the most effective means for avoiding STDs -- e.g. condoms and spermicides -- have a relatively poor track record regarding their use-effectiveness as contraceptives. Urgently needed are improved vaginal contraceptive methods that provide adequate protection against both unwanted pregnancy and sexually transmitted disease.

In the case of RTI screening, we face a further limitation in the available diagnostic technology for reliably identifying these infections. Urgently needed are simple, low-cost RTI diagnostics that would allow prompt identification of infections without requiring elaborate and difficult to sustain laboratory facilities. To this end, a consortium of donor organizations have recently created the STD Diagnostics Initiative to pursue the development of affordable diagnostic technologies for resource-poor environments. The Rockefeller Foundation has also recently announced its intention to offer a sizeable cash prize for the development of appropriate diagnostics for the developing world.

## **The Experience of Field-Based Programs**

Let us now turn to the experience of field-based programs. Unfortunately, there is an extremely scant literature regarding the incorporation of RTI, STD, or AIDS efforts within family planning programs. This reflects not so much a lack of experience, as a lack of well-designed, implemented, and evaluated program interventions that could be written up in either the published or the fugitive literature of population science. In other words, given that clients, providers, and managers of family planning programs struggle with the issues discussed in the first half of the paper every day, we believe that even though such program experience does not exist in Popline or Medline, it does exist in this audience; and we are hoping this review of the inadequate information on this subject will be a "call to arms".

Let us first consider some of the hesitations family planning program managers, policy makers, and donors have had regarding the incorporation of RTI, STD, or AIDS efforts into programs. Some of the more common concerns are that:

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

Some of the limited research to date has addressed these concerns. In Latin America, Population Council staff assisted in a number of operations research projects through INOPAL, the regional OR/TA project. For example, in Colombia two operations research projects demonstrated that AIDS prevention activities, including IE&C and condom distribution, could be successfully incorporated into the services offered by Profamilia, the country's FPA, without any harm and, indeed, considerable benefit to the program. These projects involved a controlled assessment of adding AIDS prevention responsibilities to the assignments of community marketing field workers and the assessment of an AIDS prevention radio campaign. In the experimental group, the field workers were instructed to dedicate 20% of their time to STD and AIDS prevention activities, while in the control group the workers simply responded to spontaneous demand for STD and AIDS information.

The principle findings of these studies were:

- There was a large demand for AIDS information among regular family planning audiences.

- Family planning field workers were able to reach target groups of high risk persons for AIDS information.
- Field workers who programmed a fixed proportion of their time to AIDS activities were more likely to give a larger number of talks to a larger variety of target groups than the field workers who mostly responded to requests for information.
- The field workers were able to establish condom distribution posts in meeting places of target groups and sell condoms through them.
- Workers who devoted 20% of their time to STD/AIDS-related activities established more condom distribution posts at a larger variety of places and sold more condoms through them than did control group workers.
- Carrying out AIDS-related activities did not cause the workers contraceptive sales to decline.
- Results of the radio campaign assessment revealed no negative effects on Profamilia's image.

In another Latin American OR study, researchers in Peru evaluated the feasibility of establishing comprehensive reproductive health services for a high risk group of commercial sex workers. This intervention was targeted to the over 600 commercial sex workers in Callao and involved the provision of STD and HIV education, HIV and STD testing, free condoms, and reproductive health services, including family planning.

Project evaluation focused on the utilization of services and changes over time among health center users regarding their frequency of condom use, HIV knowledge and attitudes, and the incidence of RTIs. Over 96% of the registered prostitutes attended at least one educational session. Over 1.1 million condoms were distributed over one year, and reported condom use increased greatly among the women. In addition, the annual incidence of gonorrhea decreased from 20% to 3%. A total of 69% of the women made use of the family planning services offered. This project demonstrated the feasibility, as well as the potential benefits of establishing an integrated service structure. Indeed, for this group of high risk women, the STD services may have been the primary attraction, providing an additional entry for contraceptive counselling.

The results of these and other OR studies from Latin America suggest that many of the initial hesitations about the potential harm of integrating STD and AIDS related activities into family planning programs were not warranted. They also suggest the potential for mutual benefits for the reduction of both unwanted pregnancy and RTIs through a more comprehensive approach.

But, what is the experience in Africa? There is very little documentation of efforts to address reproductive tract infections within family planning programs in sub-Saharan Africa. This is particularly unfortunate given the generally higher prevalence of both RTIs and infertility observed in this region. Within the scope of the Africa

OR/TA Project, a number of sub-projects dealt with diagnostic studies or technical assistance related to STDs or AIDS - notably in Zambia, Burkina Faso, Gambia, and Senegal, as well as Nigeria.

While there is little documented program experience, at the country level in Africa, program managers, providers, and, in some cases, governments have already begun to respond to pressure from their communities to take action. Awareness of AIDS throughout the region is high and people's concern is great. A recent study by Poptech of the potential for integrating AIDS prevention and family planning programs in sub-Saharan Africa found that a number of countries, notably Botswana and Zimbabwe, had begun to integrate STD and HIV into their family planning curricula. They noted that "the demand for this additional training comes mainly from the clients who want information about STDs and AIDS." With growing concern and little experience, we face a unique opportunity today, as we look forward to the next five years of operations research. The time has come to seize this opportunity and to design, evaluate, document, and disseminate the results of program interventions in this important area.

### **The Name of Action**

We would like to close this paper with a description of steps forward. As we see it, there are three types of steps to take: first, immediate opportunities -- these are things we can do today, based on the limited experience in other regions and the demand for information; secondly, operations research -- a series of specific OR questions that we believe are a priority for future work; and, finally, some discussion of opportunities to explore new service paradigms that might be of mutual benefit to family planning and RTI prevention programs.

Much can be done right now by family planning programs to respond to the concerns of their clients and staff about RTIs, STDs, and AIDS. For example:

- All clinic staff need to be well-informed about HIV/AIDS in order to be able to protect themselves and their clients from infection and to answer their clients' basic questions. In this respect, it is important that staff be helped to work through any fears they themselves may have about AIDS, or judgmental attitudes they may harbor toward people with STDs, so that they can respond accurately and with sensitivity to those who may be infected, or at risk of becoming infected.
- Clinic staff also should be aware of the basic symptoms of RTIs, so that even if diagnosis and treatment are not available on site, this knowledge can be taken into account when considering the method of family-planning most appropriate for each client.
- Family planning programs should also take into consideration the possibility that clients may have or be at significant risk of exposure to RTIs in determining protocols for providing various contraceptive methods. Barrier methods, particularly condoms, should become more prominent

options for some clients despite being considered "less effective" methods in terms of calculating CYP. In other words, for some clients the secondary benefits of RTI prevention may be as salient as the primary benefit of contraception.

- Programs should be sure to have on hand good quality IE&C materials dealing with RTIs, STDs, and AIDS for use by both staff and clients. Specifically, programs should have available simple, pictorial instructions on how to correctly use and dispose of condoms.
- Programs should also make the effort to find out what testing and treatment services for RTIs, STDs, and AIDS are available in their area and establish mechanisms to refer clients to these services as appropriate.
- Clinics should also make sure that they have ample supplies of condoms on hand at all times and that clients can be resupplied as quickly, efficiently, and unobtrusively as possible.

### **An Operations Research Agenda**

We will now turn to the question of operations research and outline a research agenda that begins to address the many unanswered questions concerned with responding to RTIs within the context of family planning programs.

#### **Choice of Methods:**

- Is it feasible for clients to adopt and use dual protection -- that is, condoms plus a "more effective" contraceptive method to achieve protection from infection, as well as unwanted pregnancy? If so, what are the implications of this strategy in terms of counseling, acceptability, compliance, and measurement of effectiveness?
- How can we use existing family planning services to more effectively promote condoms for the primary prevention of RTIs -- especially among men and youth?
- What are the associations between different contraceptive methods and the incidence and consequences of RTIs?
- What are the dimensions of acceptability of female-controlled methods such as the female condom and vaginal spermicides?

### **Counseling:**

- How do we best add RTI, STD and AIDS information to contraceptive counseling? How does this vary by setting? What are the training and supervisory requirements?
- What is the appropriate content of counseling for people who are at risk of RTIs within family planning programs? What is the role of risk assessment? And should such assessment be made primarily by providers?
- Recent work suggests that voluntary counselling and testing for HIV may be a useful strategy for behavior change. Are family planning clinics a feasible site to provide such services?
- How do we ensure the confidentiality of client information in the era of AIDS with its associated discrimination?

### **Service Delivery:**

- What are some of the obstacles to clients'--both male and female--use of family planning services for RTI information, counseling, or, where available, treatment?
- What is the relative cost effectiveness, acceptability, and quality of categorical vs. integrated approaches to providing service for RTIs and family planning?
- What would be the effect of comprehensive services on service dynamics: such as patient load, waiting times, provider-client ratios, and specific outcomes such as safer sex, RTI prevalence, unplanned pregnancy, and method continuation?
- What is the role of syndromic diagnosis (that is, the stratagem of diagnosis and treating clients on the basis of groups of symptoms rather than specific laboratory diagnoses) and the use of treatment algorithms for the management of RTIs and how are these best incorporated into existing services?

### **Information, Education and Communication:**

- What IE&C strategies are most effective in improving accurate knowledge regarding condom use and disposal?
- What are the pros and cons of combining messages for unwanted pregnancy and RTI prevention in IE&C programs? Is this a useful strategy for social marketing?

- What is the role of target audiences? Does such targeting lead to stigmatization?
- How can we elicit more client participation in the design of IE&C materials? Will this impact on the willingness to seek information and services?

**Cost Effectiveness and Referrals:**

- What would be the cost to family planning programs of providing condoms for the primary prevention of RTIs?
- How would inclusion of screening and referral for RTIs affect cost? What measure of effectiveness do we balance the increased cost against? A recent study in the United States documented that the cost of screening family planning clinic attenders on a per visit basis was significantly less than for patients who came with complaints or symptoms.
- What is the cost-effectiveness of syndromic management of RTIs?
- Once established, how effective are referral networks between family planning services and programs offering testing and treatment services for RTIs, including HIV? How can these be monitored and evaluated?

**Community Outreach:**

- Can traditional healers, TBAs, and other community practitioners be effectively used to disseminate AIDS information, distribute condoms, offer syndromic diagnosis and management of RTIs, or provide referrals for testing and treatment? For example, the Zimbabwe National Traditional Healers Association, known as ZINATHA, has worked successfully with the Zimbabwe National AIDS Control Program to increase collaboration among traditional healers in order to develop traditional methods for reducing HIV transmission and devise appropriate IE&C activities.
- Can dissemination of RTI/STD/AIDS information and condoms be effectively conducted by CBD or other family planning outreach workers?
- Male motivators be more effective in reaching men about both RTIs and family planning?
- How can peer counselors be most effectively used to reach young people with information about both RTIs and family planning?

### **Indicators/Evaluation:**

- What would constitute effective performance indicators for integrated programs?
- What are some practical methodological approaches to evaluation of integrated family planning and RTI activities?
- How can programs effectively assess the use of proper clinical procedures, the extent of provider knowledge, and the effect of provider bias towards specific contraceptive methods?
- What are cost effective quality assurance procedures for RTI diagnosis, including laboratory procedures?

### **Exploring New Service Paradigms**

In addition to operations research that begins with existing family planning programs and explores the expansion of activity, there are a number of areas where attention to RTIs, STDs, and AIDS may actually provide a catalyst for expanding the reach of family planning programs.

One area that family planning and AIDS control programs have both left inadequately explored to date is the challenge of involving men, whether it be in planning parenthood, assuming responsibility for support of children, or avoiding sexually transmitted infection. Developing models of reproductive health services that identify and address male involvement may present an important opportunity for improving the impact of both family planning and RTI control efforts.

A similar opportunity exists in meeting the reproductive health needs of youth -- a group at significant risk of sexually transmitted infection and often left out of traditional family planning services.

Finally, we must recognize the tremendous opportunity made available through cooperation with community-based organizations. As the devastation of the AIDS epidemic proceeds, one of the lessons we have learned concerns the relatively low cost and high effectiveness of community-based efforts in such areas as the provision of home care and support for orphans. These organizations are well placed to mobilize community resources, as well as articulate perceived needs. Communities rarely demand categorical service. Exploring the expansion of service through cooperation with community-based organizations will require a willingness to be flexible in program design and goals, but may provide an important avenue for reaching more people in need of family planning and RTI prevention information.

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# **Perceptions of Reproductive Morbidity Among Nigerian Women And Men And Their Implication For Family Planning Services**

**Dr. Adepeju Olukoya  
Lagos, Nigeria**

## **Introduction**

The burden of Reproductive Tract Infections (RTIs) on women in developing countries is great. Data available from Nigeria suggests that RTIs are likely to be of sufficient prevalence to cause concern. The information available, however, is minimal, especially when hospital based research constitutes the main source. This often ignores the vast majority of people, especially women who suffer in silence and whose perceptions do indeed affect their health and the success of family planning programs. Services for recognizing and treating RTIs are largely non-existent, family planning services perhaps being an important avenue to address these needs. Despite the lack of information, certain relevant information is known:

- There is a well documented threat to reproductive health resulting from common STDs, as well as the growing risk of infections with HIV.
- STDs other than HIV, both ulcerative and non-ulcerative, have been shown to significantly increase the risk of HIV transmission.
- The concern for Upper Reproductive Tract Infection in Nigeria is real. A survey from one community in a state in Nigeria showed the prevalence of infertility to be as high as thirty percent, over two thirds of which were considered to be secondary infertility.
- Despite many years of efforts at family planning provision, the prevalence of use of modern contraception continues to be relatively low. STDs may be a major reason for the failure to accept or continue contraceptive use.

Therefore, further investigation is important into the underlying factors related to reproductive morbidity, which can affect women and men's utilization of family planning services. The ongoing study under discussion has two phases:

- A qualitative phase to describe the perceptions of reproductive morbidity by men and women.
- A clinic phase, using information from phase 1 to develop and enrich a trial of integrating STD screening (using simple technology) in a busy family planning clinic, to be tested by Operations Research.

## **Methodology of Phase 1**

A wide range of societal groups were surveyed as to their perceptions on reproductive morbidity with the use of a discussion guide. The guide covered perceptions about reproductive morbidity in:

- Pre-menarche
- Sexual life
- Reproductive Life
- Pregnancy
- Post-partum
- Menopause
- Effects of FP on these perceptions, and vica versa
- Infertility
- Knowledge and perceptions about AIDS viz-a-viz reproductive morbidity

The groups studied were:

- Non-sexually active females (15-49)
- Single sexually active males
- Sexually active females (15-49)
- Married sexually active males
- Married females (20-45)
- Expectant mothers
- Nursing mothers
- Women FP users
- Menopausal women
- Traditional health worker
- Female herb sellers (in depth interview)

## **Findings From Phase 1**

Findings from the first phase of research showed:

- A lot of gaps exist in knowledge about reproductive morbidity related to the perceptions of what constitutes normal or abnormal symptoms and signs, from menarche, through the reproductive years, to menopause. For example, "normal occurrences" include blackish, smelly or yellowish vaginal discharge, while itchiness, hotness and burning in the vagina are often considered to be normal sensations. Another symptom considered normal is chronic lower abdominal pain, as this is considered to be part of being a "woman".
- Inappropriate help seeking behavior.

- Inappropriate blaming or ascribing some reproductive morbidity to the effects of, or results of, contraceptive technology.
- Other findings include the fact that menopause appears to be a vague concept. That is, for example, if a woman last menstruated two years ago, but again develops spotting, it could be regarded that "she has not yet finished going through menopause", when indeed, she could be having symptoms of reproductive tract neoplasm. This could be partly responsible for the fact that Nigerian women present late with symptoms of neoplasm of the genital tract. In fact many studies have confirmed the fact that most of the women present with Stage III and IV disease.
- Women and men are not sensitive to genital warts, rashes, ulcers, chancroid and so forth. These conditions lead to higher risk of HIV transmission.
- The results further indicate the vulnerability of women to infections especially during pregnancy and in the post partum period when they are expected to reduce the frequency of, or abstain from, sexual intercourse. During these periods their partners are socially sanctioned to "play the field". For example, men would refrain from sexual intercourse with their wives, but still maintain the right to come home to their wives for curious reasons. Intercourse during the second trimester is said to encourage the baby to kick better, and during the third trimester intercourse ensures that the baby will look like the father. During the post partum period IUD insertion, and incident STDs, may be occurring at the same time.
- Men and women are favorably disposed to FP and STD services integration. This they say is because confidentiality is likely to be guaranteed, and that they already discuss sensitive issues with the health workers.
- Perceptions regarding the effects of FP include:
  - FP removes sexual feelings and makes husbands sperm watery.
  - Foaming tablets remove sexual feelings in the vagina and make the penis numb.
  - Pills cause miscarriage and irregular menses.
  - Depo-provera causes itching in the vagina.
- The help seeking behavior is quite inappropriate from a medical point of view and can be positively dangerous. Traditional healers are often consulted, and these use methods ranging from herbal preparations taken orally to herbal pessaries.

- Home treatment of perceived morbidity includes, besides herbs, Ampicillin, yellow and red capsules (Tetracycline), blood tonic, alcohol ingestion, lime preparations to flush out the vagina, and the use of "kaun" preparations. "Kaun" is a potassium salt.
- The traditional healers (mostly men, as TBAs do not appear to get involved in the treatment of perceived reproductive morbidity) seem more knowledgeable about Physiology and what constitutes abnormality, when it is finally brought to them. They, however, could not always agree on the best treatment, but depend on herbal preparations and so forth.
- The women herb sellers in the markets will also prescribe, if consulted, and they also rely on herbs. They are not as knowledgeable as the traditional healers about the way the body works, or what constitutes abnormality.

## Discussion

- Women and men's perceptions about reproductive morbidity affect the success of FP programs. It is, therefore, imperative to understand the underlying factors that affect this utilization. The results of the first study phase have enabled the ethnovocabulary of reproductive morbidity to be defined, and a more qualitative phase in the clinic to be improved. For example, it helped the realization that there are various ways to enquire about vaginal discharge, as well as the various methods of handling menstrual flow.
- Integration of STD screening and FP programs is likely to be well accepted by the community. This is because they see the health workers involved as being able to discuss and manage the issues concerned.
- There is much need for information as to what is considered normal or abnormal, to help raise awareness concerning time perceived salience of signs and symptoms from the reproductive tract. This especially will enable women to better take control of their bodies, as well as adopt better help seeking behavior and also potentially improve adoption of FP.

Currently the clinic phase of the project is ongoing, with disruptions due to the political situation in Nigeria causing delays. It is intended to progress until ultimately interventions are developed that will be tested by Operations Research to make contraception safer for women in situations where there is high prevalence of RTIs.

## **Combinaison de la Planification Familiale au Program Elargi de Vaccination au Togo**

**Dr Aristide Aplogan  
Chercheur Associé ORSTOM**

### **Introduction**

L'étude que nous allons vous présenter cet après-midi est intitulée "Combinaison de la Planification Familiale au Program Elargi de Vaccination au Togo". Cette étude a été réalisée grâce au financement et à l'assistance technique de "Population Council", à la collaboration entre le Projet CCCD-Togo-USAID et la Division Santé Familiale du Ministère de la Santé et de la Population du Togo. Je profite de cette occasion pour remercier très sincèrement toutes ces institutions.

### **Le contexte socio-sanitaire de notre étude**

L'installation du program de Planification Familiale au Togo a reposé sur 3 points essentiels:

- le développement des compétences techniques
- la gestion des commodités et
- le développement des compétences en IEC

L'intégration des services de Planification Familiale aux autres activités de Santé Maternelle et Infantile n'est pas encore effective au Togo. Le Program Elargi de Vaccination quant à lui est bien implanté dans le pays; la couverture vaccinale en 1991 était de l'ordre de 64% chez les enfants de 12 à 23 mois. Par ailleurs, les clientes du PEV représentent un groupe cible important pour la Planification Familiale.

L'objectif général de notre étude est de développer et de tester un modèle durable d'intégration des services de PF au Program Elargi de Vaccination au Togo. Les objectifs spécifiques de l'étude sont les suivants:

- Mettre en exécution aussi systématiquement que possible la politique d'intégration du message de référence de Planification familiale lors des séances de vaccination
- Mesurer l'impact de la mise en exécution de cette politique
  - d'abord sur la connaissance et l'utilisation des services de Planification familiale par les clientes du Program Elargi de vaccination

- ensuite sur les activités du Program de Vaccination

Pour atteindre ces objectifs, nous avons réalisé une étude quasi expérimentale dans 16 centers de SMI/PF. Ces centers SMI/PF sont choisis selon un échantillonnage de type stratifié dans 2 régions du Pays. Les centers SMI/PF retenus sont répartis par tirage aléatoire simple en deux groupes: un groupe dit "d'INTERVENTION" et un groupe dit de "CONTROLE". Deux sources de données ont été utilisées:

- d'abord des interviews directes réalisées en Pré et Post Tests auprès de 1000 clientes PEV et des agents du PEV
- ensuite les statistiques des services notamment:
  - Les rapports mensuels de PF et du PEV des 9 mois précédant l'intervention et des 6 mois qu'a duré l'intervention;
  - la source de référence des nouvelles clientes PF qui indiquent si la nouvelle cliente PF a été référée grâce au message délivré lors d'une séance de vaccination.

L'intervention a consisté à fournir individuellement aux mères pendant la vaccination le message suivant:

- "Madame, vous avez la possibilité de tomber enceinte pendant que ce bébé est encore trop petit;
- Il existe dans notre centre des méthodes pour éviter la grossesse;
- Je vous conseille d'en discuter avec l'agent de santé de Planification Familiale qui se trouve à côté".

Dans les centers "CONTROLE" aucune intervention n'est faite. Les agents de santé ont continué à travailler comme par le passé. Afin d'assurer la qualité de l'intervention, un cours de recyclage de courte durée a été donné aux agents du PEV et à ceux du program de PF. Pour les agents du PEV, ce cours de recyclage a porté sur des notions d'Information, Education et Communication et le message de référence. Alors que pour les agents de PF le cours de recyclage n'a porté que sur l'utilisation des cachets de référence.

Aux nouvelles acceptrices on pose la question suivante:

- "Avez vous fait vacciner votre enfant dans ce centre depuis janvier 1992?"

Si elle répond "NON" elle est considérée comme "Pas concernée" car si pendant la période d'étude elle n'a pas fait vacciner son enfant dans le centre, elle ne peut pas recevoir le message de référence. Si elle répond "OUI", on lui pose la question suivante: Est ce à la vaccination qu'on vous a orienté vers la Planification Familiale? Si la

réponse à la deuxième question est "OUI", elle est considérée comme "REFEREE"; Mais si la réponse est "NON" elle est considérée comme "NON REFEREE".

Nous avons supervisé régulièrement les activités de l'étude en effectuant une visite mensuelle dans tous les centers SMI/PF retenus. Cette supervision avait pour buts de:

- vérifier la bonne exécution de la stratégie
- vérifier la bonne utilisation des cachets de référence
- corriger les erreurs "rattrapables"
- motiver les agents pour la continuation de la stratégie.

Les caractéristiques socio-démographiques des clientes PEV interviewées sont identiques entre le Pré et le Post Test. En effet, au Pré Test et au Post Test, l'âge moyen des clientes du PEV est de 25,6 ans et leur nombre moyen d'enfants de 2.5. La répartition des clientes du PEV selon la religion, le statut matrimonial et le niveau d'instruction est la même aux Pré et Post Tests. Les besoins en PF sont importants chez les clientes du PEV puisque 44% d'entre elles désirent attendre au moins 3 ans avant la prochaine grossesse et 14% ne veulent plus d'enfants.

L'intervention a eu un effet modeste sur les pratiques des agents de santé en matière d'IEC/PF. Ceci traduit leur réticence à changer leurs habitudes. Dans les centers d'Intervention, la proportion des clientes PEV à qui les agents de santé ont délivré le message de référence PF à la vaccination est passée de 9 à 21%. En revanche, dans les centers de Contrôle aucun changement n'est observé.

L'intervention a eu un effet positif sur la connaissance des clientes PEV de l'existence des méthodes PF dans le centre SMI. Dans les centers d'intervention, la proportion des clientes PEV connaissant l'existence des méthodes PF a augmenté de 40 à 58%. Cette augmentation est significative, alors que dans les centers de "Contrôle" cette proportion n'a pas varié significativement; elle est passée de 32% à 37%.

La présente courbe montre une augmentation régulière mensuelle du nombre des nouvelles acceptrices PF dans les centers d'intervention alors que dans les centers de "Contrôle" nous observons plutôt une stagnation de ce nombre. La connaissance de l'existence des méthodes PF dans les centers est donc accompagnée d'une augmentation du nombre des nouvelles acceptrices PF.

Par ailleurs, le nombre mensuel moyen de nouvelles acceptrices PF a augmenté significativement dans le groupe d'intervention entre le Pré et le Post Tests. Ce nombre mensuel moyen est passé de 200 à 307,  $p < 0,001$ . Dans le groupe Contrôle en revanche, aucune variation significative n'a été notée. Ce nombre n'est passé que de 144 à 167,  $p = 0,16$ .

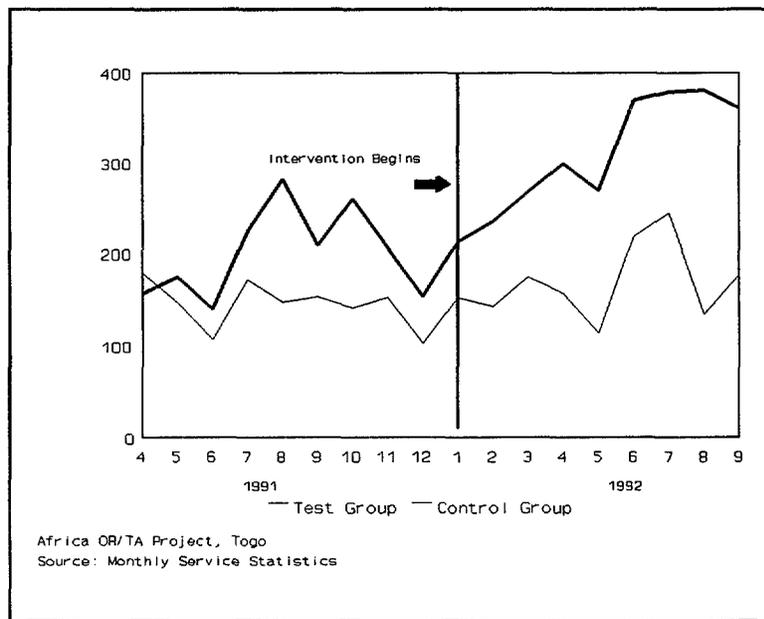
L'utilisation des cachets de référence a permis de déterminer la proportion de nouvelles acceptrices PF référées par les agents du PEV. Les résultats de ce graphique



**Figure 1: Le nombre d'acceptrices**

montre qu'au moins 50% des nouvelles acceptrices PF sont référées grâce au message-clé fourni par les agents PEV. Comme le montre cette courbe, aussi bien dans le groupe d'intervention que dans le groupe Contrôle, le nombre de doses de vaccin administrées chaque mois a significativement augmenté.

L'intervention n'a donc pas eu d'effet négatif sur les activités du PEV. Malgré la réticence des agents du PEV à changer leurs pratiques d'IEC, 90% d'entre eux ont reconnu à la fin de l'étude, que le message de référence individuel a eu un effet sur les activités PEV. 87% d'entre eux estiment que cet effet est positif contre 13% qui estiment l'effet négatif.



## Conclusions

Au terme de cette étude de Recherche opérationnelle nous pouvons tirer les conclusions suivantes :

- Le message de référence a eu un effet positif sur la connaissance et l'utilisation des services PF.
- Ce message de référence fourni individuellement n'a pas d'effet négatif sur les activités du PEV.
- Ces résultats montrent que le mécanisme d'intégration de la PF au PEV expérimenté dans notre étude est un mécanisme efficace, facile à réaliser et peu coûteux.

**3. Non-Clinical Delivery of Family Planning Services: The Role of Community based Distribution in Africa and The Field Research Agenda For The Future**

**Community-Based Distribution of Family Planning in Africa:  
Lessons From Operations Research**

**James F. Phillips and Wendy L. Greene  
The Population Council, New York**

**Introduction**

Efforts to improve family planning program performance often focus on developing strategies for community-based distribution (CBD) of contraceptives. Experience in a variety of settings has shown that non-clinical access to contraception can improve the quality, acceptability, and impact of family planning programs. This growing experience with successful programs has lead to a proliferation of CBD strategies in various cultural and institutional settings.

This paper reviews operations research and national-level CBD programs to extract themes from this experience and derive implications of findings for family planning organizations in Sub-Saharan Africa.

The terms "non-clinical approaches" or "CBD" are used to characterize a variety of family planning approaches:

- Village volunteers operate health posts in village locations.
- Trained paramedics operate "satellite clinics" by visiting village health posts,
- Traders sell condoms and oral contraceptives in traditional markets,
- Social marketing programs provide contraceptives at pharmacies, kiosks, and elsewhere at subsidized prices,
- Employers provide family planning services to employees at non-clinical work related locations,
- Village volunteers operate depots where family planning supplies and information are available,
- Salaried non-paramedical workers visit households and provide condom and pill services.

Although injectables, NORPLANT, and IUDs are provided in large-scale non-clinical pilots in some Asian countries, "non-clinical" family planning programs in Africa typically focus on the provision of oral contraceptives and condoms.

CBD is thus not one strategy, but several different approaches to non-clinical service delivery. Alternative structural designs, staffing patterns, compensation schemes, and outreach strategies have produced a greater degree of operational diversity in CBD design in Africa than has been characteristic of CBD efforts in other regions.

### **Evidence of CBD Impact**

"Success" in a project can be defined in one of several ways. CBD projects are typically labeled as being "successful" in that field efforts demonstrate the acceptability, feasibility, and quality of community-based family planning effort. By any of these criteria, however, "success" of a project is contingent upon use. It is therefore conventional to evaluate CBD projects according to the extent to which community distribution strategies increase contraceptive use, over and above levels that would be expected in the absence of CBD. Although several hundred papers have been written on CBD, and over a hundred separate projects have been launched around the world, few incorporate experimental designs that permit definitive conclusions about impact. There are nonetheless before-and-after comparisons from countries as diverse as Thailand, Mexico, Peru, Tunisia, Morocco, Egypt, Nigeria, Mali, Cameroon, The Gambia, Sudan, Tanzania, Kenya, and Zaire. In sub-Saharan Africa, only one controlled quasi-experimental study has been fielded-- a CBD experiment in Rwanda that produced equivocal results.

Results of these various projects suggest that CBD may have contributed to modest increases in contraceptive use. The fertility impact of CBD in Africa is unknown, however. Even less is known about the comparative advantages of alternative CBD approaches.

### **Perspectives on Why CBD Works**

If CBD represents a successful operational strategy, it is reasonable to question how such effects arise. Although CBD demonstrations typically show that convenient services satisfy "latent demand" for family planning, the possibility also exists that CBD services and information introduce new concepts and preferences that generate demand. CBD may thus influence reproductive behavior by:

1. ...altering the demand for children with economic and social policies, fostering new concepts of reproductive planning through the diffusion of reproductive innovation, and by altering reproductive aspirations through communication and persuasion efforts; and

2. ...mitigating the costs of fertility regulation, where costs are defined broadly to include social and psychological constraints to contraceptive behavior.

Research on the role of CBD in Asia has demonstrated that family planning services have effects that extend "beyond supply" -- that a well designed and culturally sensitive supply-side CBD program can generate credibility and demand for family planning that would not otherwise arise. "Beyond supply" effects are suggested by the observation that changing demand for children often follows, rather than precedes, the introduction of family planning programs. A well designed CBD program can legitimize family planning, introduce new reproductive planning concepts, and foster reproductive changes in ways that alter norms and behavior.

Deliberations on why CBD works and how services should be designed have focused rather narrowly on accessibility costs. OR should broaden consideration of how effective outreach can mitigate other constraints to contraceptive use.

### **Why CBD Sometimes Fails**

A CBD project can be considered "successful" if it introduces family planning in a population and results in higher levels of use than would be expected in the absence of CBD. By this criterion, many CBD demonstration projects in Africa have either failed, or have not provided convincing evidence of success. Reasons for failure are not typically discussed in reports, since projects are often addressed to the modest aim of demonstrating operational feasibility rather than establishing that the strategy has worked. Some general observations nonetheless emerge from this experience:

- **Dysfunctional responses to success.** So widespread is the idea that CBD works, that organizers sometimes forget that CBD can fail. The "success story" rationale for CBD can invite the impression that CBD is so simple that comprehensive planning, sound management, and service quality are somehow irrelevant to CBD development. Success story complacency may have contributed to the failure of CBD projects in Lesotho, Ghana, and Nigeria. **A key problem is the tendency to view CBD as a successful strategy that no longer requires OR.** While it is true that well designed and vigorously implemented CBD will probably work, most well designed CBD has grown out of experience provided by OR projects. Because CBD must be shaped by the social environment, recurring OR has renewed benefits in each site where CBD is tried.
- **Preoccupation with demonstrating discrete ideas.** OR on CBD has focused on demonstrating seemingly promising ideas. Given the comprehensive constraints to family planning in Africa, correspondingly comprehensive systems of family planning care are needed. When CBD fails, failure has less to do with what is tried than to the absence of other critical elements of comprehensive service systems.

- **Failure to adapt to the environment.** The main pitfall that can arise from premature CBD implementation is failing to use strategies that are guided by community opinion. The CBD record is marred by examples of large-scale projects that used the wrong type of distributor (TBAs in Ghana), the wrong type of support system (backup for market vendors in Nigeria) or the wrong type of training (Lesotho) because community opinion was not used to provide practical guidance on strategic plans. **Community participation may not be required for CBD management, but appears to be a crucial element of strategic planning.** The fragile climate of demand for family planning obligates CBD planners to adapt approaches to the social setting.
- **Failure to build commitment.** Most reviews of CBD failure allude to political resistance or local administrative objections. Strategies for building commitment should be an element of OR on CBD and possibly a theme of CBD research.

### The Role of Research

**What we know from research.** What we have learned from OR on CBD is that research is useful for testing the development of operations at manageable levels and demonstrating problems that must be solved when operations go to scale. Removing family planning from the controlled confines of clinics creates unpredictable management challenges that benefit from investigation, trial, and problem solving. OR has been crucial to the scaling-up process in Asian settings: i) Problems arising were solved in an objective fashion, and ii) administrators developed an adaptive style of "learning by doing" management. Research was crucial to developing programs that suited institutional capacities and public needs and preferences. OR freed programs from bureaucratic rigidity, fostered innovation, and moved programs forward, thereby adapting CBD strategies to the environment. These lessons from Asia are also relevant to Africa. While the operational details of programs may not be relevant to Africa, the step-by-step development of service systems may be useful for developing African models for CBD.

Five additional inter-regional lessons emerge from the research record:

- **Non-prescriptive sale of oral contraceptives is safe and effective.** Concerns about risks associated with oral contraceptive use led to a series of careful epidemiological studies on the relative risk of use and nonuse in various settings. Research has shown that benefits of contraceptive use far outweigh risks.
- **Non-clinical distribution of contraception is welcomed by the populations served.** Concerns about controversy are typically unfounded.
- **There is no single operational formula for a successful CBD program. In general, however, inputs produce outputs.** Where program effort is expended, results are achieved. Research has yet to provide a rationale for inaction. **Because there is no single formula, however, research is extremely important:** OR helps identify the appropriate formula for the setting.

- **Seemingly non-sustainable elements of programs often became the basis for sustained success.** Experience has shown that investments in intensive programs produced changes in reproductive behavior that have been sustained as donors disengaged.
- **Non-clinical distribution does not substitute for the need to focus on developing the quality and the availability of clinical services.** Adding service and method options, whether in clinical or non-clinical settings, improves the climate of care more generally. CBD should be viewed as a component of a service system, not a substitute for developing one.

**What we do not know.** The research record shows that CBD should aim to achieve comprehensive, culturally sensitive, intensive, quality-oriented services. Achieving this will require "open systems" OR. Open systems OR involves combining social and operations research with the aim of developing culturally appropriate service systems:

- **Diagnostic research is needed on the relationship of social structure to organizational structure.** Social scientists document ways in which African societies are highly organized and aspects in which demand for contraception are constrained. Operations research scientists need to take stock of what this tells us about the strategic design of CBD. Investigations of what communities recommend will lead to greater clarity about the elements and design of effective CBD systems.
- **Large-scale experiments are needed to examine the impact of alternative CBD designs in a variety of country settings.** Too much of the CBD literature is informal, anecdotal, and unguided by research designs. As a result, little can be confidently concluded about the nature of operational success or failure, apart from the rather unhelpful generalization that CBD strategies often work and sometimes fail. Experimental trials should assess the relative merits of alternative approaches to CBD. **More can be learned from natural operational variance.** Experiments are not always possible, but settings such as Kenya represent a resource for learning about what works in CBD design.
- **In addition to OR for evaluating the efficacy of CBD, more needs to be learned about the issue of sustainability.** Is sustainability a false issue? If funds are invested in CBD, is reproductive change self-sustained by the ideational changes that new fertility behavior represents? If so, CBD is appropriately organized as a short-term catalytic effort with major initial investments that can be scaled back to static services over time.

OR priorities should shift from CBD demonstrations to research that answers questions about why CBD works or fails and how operational systems could be improved.

59

## Conclusions

Non-clinical family planning strategies extend services from the controlled and artificial environment of clinics to the more familiar and convenient environments of the home, village, market, or workplace. Although non-clinical strategies have been critical to the success of many family planning programs, achieving optimum results involves adapting the approach to the social setting. For the foreseeable future, OR will represent an essential tool for determining what will work and what will not.

**Les programmes de distribution à base communautaire (DBC) comme mode de prestation de services de planning familial en milieu rural : expérience du Cameroun et du Mali.**

**Diouratie Sanogo  
The Population Council, Dakar**

**1. Introduction**

Les programmes nationaux de planning familial du Cameroun et du Mali ont en commun la particularité d'être des programmes très jeunes. Au Mali, la Division de la Santé Familiale (DSF) a été créée en 1980; tandis qu'au Cameroun, la Direction de la Santé Familiale et Mentale (DSFM) n'a vu le jour qu'en 1989. Parmi les mandats de ces deux structures nationales, figurent la promotion et la coordination de tous les services de PF sur l'ensemble du territoire.

L'idée de la stratégie de DBC dans ces deux pays émane de la volonté des responsables de ces programmes de PF d'essayer sous forme expérimentale de nouvelles stratégies d'intervention pour la promotion et l'expansion des services de PF en milieu rural.

Sur le plan programmatique, ces expériences DBC entrent dans le cadre de l'exécution des activités du projet de Recherches Opérationnelles et d'Assistance Technique mené par le Population Council en Afrique.

**Description rapide des projets DBC du Cameroun et du Mali**

La mise en oeuvre d'un programme de DBC nécessite l'utilisation d'un certain nombre de ressources humaines locales (communément appelées **agents DBC**) chargées de la distribution des méthodes contraceptives au niveau de la communauté. Le type de personnel ressource utilisé comme agents DBC est variable selon les cas de figures: Au Cameroun, les deux projets initiés ont utilisé des accoucheuses traditionnelles (AT) et des leaders d'opinion hommes. Au Mali par contre, ce sont des animateurs (homme et femme) choisis au niveau de chaque village du projet qui ont été expérimentés. Les études de cas du Cameroun et du Mali nous enseignent non seulement que le profil de l'agent DBC est très variable, mais également que l'exécution des activités d'un tel projet passe nécessairement par les mêmes étapes programmatiques dont les durées sont également variables. Les tableaux qui suivent présentent une description rapide des différentes expériences de projets de DBC au Cameroun et au Mali.

Cameroun	Mali
<p><b>DBC utilisant des leaders d'opinion (LO) comme agents de distribution</b></p> <ul style="list-style-type: none"> <li>■ Expérimenté dans 30 villages d'une région</li> <li>■ 2 à 3 agents DBC de sexe masculin dans chaque village</li> <li>■ Exécution en 3 phases : <ul style="list-style-type: none"> <li>■ Préparation : 9 mois</li> <li>■ Expérimentation : 12 mois</li> <li>■ Evaluation et dissémination : 6 mois</li> </ul> </li> </ul>	<p><b>DBC utilisant des animateurs comme agents de distribution</b></p> <ul style="list-style-type: none"> <li>■ Expérimenté dans 54 villages de 2 régions</li> <li>■ Deux agents DBC des deux sexes dans chaque village</li> <li>■ Exécution en 3 phases: <ul style="list-style-type: none"> <li>■ Préparation : 12 mois</li> <li>■ Expérimentation : 15 mois</li> <li>■ Expansion : 9 mois</li> </ul> </li> </ul>

Cameroun
<p><b>DBC utilisant des accoucheuses traditionnelles (AT) comme agents de distribution</b></p> <ul style="list-style-type: none"> <li>■ Expérimenté dans 48 villages de 2 régions</li> <li>■ 2 agents DBC de sexe féminin dans chaque village</li> <li>■ Exécution en 3 phases : <ul style="list-style-type: none"> <li>■ Préparation : 13 mois</li> <li>■ Expérimentation : 14 mois</li> <li>■ Evaluation et dissémination : 9 mois</li> </ul> </li> </ul>

## 2. Objectifs des programmes DBC du Cameroun et du Mali

Compte tenu de la jeunesse des programmes nationaux de PF dans les deux cas de figures, les objectifs spécifiques des projets a visé à :

- Tester un nouveau système de prestation des services de santé et de PF pour montrer la faisabilité et l'acceptabilité de l'approche DBC; et
- Evaluer l'effet des activités d'intervention sur les connaissances attitudes et pratiques de PF.

### 3. Activités

#### Activités de la phase préparatoire

Elles se résument d'une façon générale aux activités de sensibilisation et de préparation de la population à recevoir le projet.

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ Réunions d'information et de sensibilisation des autorités administratives, religieuses, chefs traditionnels, et des services techniques</li> <li>■ Identification du personnel clé de l'étude (sélection des agents DBC)</li> <li>■ Enquête CAP de base</li> </ul>	<ul style="list-style-type: none"> <li>■ Réunions d'information au niveau national, régional et local</li> <li>■ Identification du personnel clé de l'étude (sélection des agents DBC)</li> <li>■ Développement des études RO pour tester les composantes clés du système ( système de motivation, type d'IEC, et de supervision)</li> <li>■ Enquête CAP de base</li> </ul>

#### Activités de la phase d'intervention

Dans les deux cas de figures, elles portent exactement sur le même type d'activités suivantes:

- a. la **formation** des agents DBC;
- b. l'**information, éducation et communication (IEC)** sur les services de santé et de PF;
- c. la **distribution** (vente) de méthodes contraceptives modernes; et
- d. la **supervision** des agents DBC.

#### a. Formation des agents DBC

##### Processus de formation des agents DBC

Formation	Cameroun	Mali
Type	formation de base et cours de recyclage (projet LO)	formation de base seulement
Durée	respectivement 12 et 16 jours	une semaine

### Contenu de la formation

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ Espacement de naissances et méthodes de PF</li> <li>■ Maternité sans risques/ cas à hauts risques</li> <li>■ Allaitement au sein et nutrition de l'enfant</li> <li>■ Soins obstétricaux, pré-natals et post-natals (vaccination, TRO, PMI)</li> <li>■ MST et SIDA</li> <li>© Préparation et organisation de R.E. De village</li> <li>■ Distribution des contraceptifs non prescriptibles</li> <li>■ Utilisation de la fiche d'activité mensuelle du LO.</li> <li>■ Objectifs du program DBC et rôle de l'agent DBC</li> </ul>	<ul style="list-style-type: none"> <li>■ Objectifs du program DBC</li> <li>■ Espacement de naissances et méthodes de PF</li> <li>■ Techniques d'IEC:</li> <li>■ Distribution des contraceptifs non prescriptibles</li> <li>■ Soins obstétricaux, pré-natals et post-natals (vaccination, TRO, PMI, traitement et prévention du paludisme)</li> <li>■ Collecte de données</li> </ul>

#### b. Information, Education et Communication (IEC) sur les services de santé et PF

Les agents DBC ont eu la même description de tâches au Cameroun comme au Mali. Cette tâche consiste à:

- mener des activités d'IEC;
- assurer la vente de contraceptifs; et
- faire des références.

#### Forme des Activités d'IEC

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ Réunions éducatives de village</li> <li>■ visites à domicile</li> <li>■ références vers les centers de santé pour les autres services de santé et PF</li> </ul>	<p>( RO sur IEC coordonnée comparée à IEC non coordonnée)</p> <ul style="list-style-type: none"> <li>■ Réunions éducatives de village</li> <li>■ visites à domicile</li> <li>■ références vers les centers de santé pour les autres services de santé et PF</li> <li>■ pièce de théâtre</li> </ul>

### Contenu des Activités d'IEC

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ traitement et prévention du paludisme et de la diarrhée</li> <li>■ Maternité sans risques</li> <li>■ nutrition de l'enfant et allaitement au sein</li> <li>■ méthodes modernes de PF</li> <li>■ prévention des MST et du SIDA</li> <li>■ prévention des grossesses non désirées</li> </ul>	<ul style="list-style-type: none"> <li>■ les méthodes de PF :               <ul style="list-style-type: none"> <li>- avantages</li> <li>- disponibilité</li> <li>- utilisation</li> </ul> </li> <li>■ rôle des hommes face aux problèmes des femmes :               <ul style="list-style-type: none"> <li>- maladies</li> <li>- accouchement</li> <li>- entretien des enfants</li> </ul> </li> <li>■ rôle des femmes dans la communication avec le partenaire et les amies</li> <li>■ problèmes de PF pour et bien être familial</li> </ul>

### Contenu des références

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ vaccination des enfants de moins de 5 ans</li> <li>■ soins anténatal et postnatal</li> <li>■ cas de malnutrition</li> <li>■ femmes enceintes pour accouchement</li> <li>■ autres services de PF</li> </ul>	<ul style="list-style-type: none"> <li>■ autres services de PF</li> </ul>

### c. Distribution (vente) de contraceptifs par les agents DBC

#### Méthodes distribuées (vendues) par les agents DBC

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ condoms</li> <li>■ spermicides</li> <li>■ sachets de SRO</li> </ul>	<ul style="list-style-type: none"> <li>■ condoms</li> <li>■ spermicides</li> <li>■ pilules (dans la phase d'expansion)</li> </ul>

65

### Marges bénéficiaires pour les agents DBC

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ condoms (50 pour cent)</li> <li>■ spermicides (50 pour cent)</li> <li>■ SRO (40 pour cent)</li> </ul>	<ul style="list-style-type: none"> <li>■ 40 pour cent</li> </ul>

#### d. Supervision des agents DBC

##### Processus de supervision

Cameroun	Mali
<p>2 types de supervision complémentaires</p> <ul style="list-style-type: none"> <li>■ <b>supervision à partir du niveau provincial</b> <ul style="list-style-type: none"> <li>■ par le directeur provincial des services de PF</li> <li>■ durée: 2-3 jours par trimestre</li> </ul> </li> <li>■ <b>supervision à partir du niveau arrondissement</b> <ul style="list-style-type: none"> <li>■ par le coordinateur des soins de santé primaires</li> <li>■ durée: 1 jour par mois</li> </ul> </li> </ul>	<p>2 types de supervision comparés</p> <ul style="list-style-type: none"> <li>■ <b>supervision à partir du niveau cercle</b> <ul style="list-style-type: none"> <li>■ par les techniciens supérieurs des affaires sociales</li> <li>■ durée : 1 jour par mois</li> </ul> </li> <li>■ <b>supervision à partir du niveau arrondissement</b> <ul style="list-style-type: none"> <li>■ par les infirmiers chefs de santé</li> <li>■ durée : 1 jour par mois</li> </ul> </li> </ul>

##### Contenu de la supervision

Cameroun	Mali
<ul style="list-style-type: none"> <li>■ aider à planifier les Activités d'IEC (calendrier mensuel des R.E.)</li> <li>■ séances de recyclage</li> <li>■ assistance technique dans l'organisation de R.E.</li> <li>■ approvisionnement en contraceptifs</li> <li>■ collecte des ventes de contraceptifs</li> <li>■ distribution et collecte des fiches de rapports d'activités mensuelles.</li> </ul>	<ul style="list-style-type: none"> <li>■ suivre l'état d'exécution des Activités planifiées</li> <li>■ distribution de contraceptifs</li> <li>■ collecte des ventes de contraceptifs</li> <li>■ contrôle et exploitation du cahier de l'animateur</li> <li>■ recyclage et assistance en cas de besoin</li> </ul>

#### 4. Méthodologie: Procédé de recherches, évaluation, dissémination et utilisation des résultats

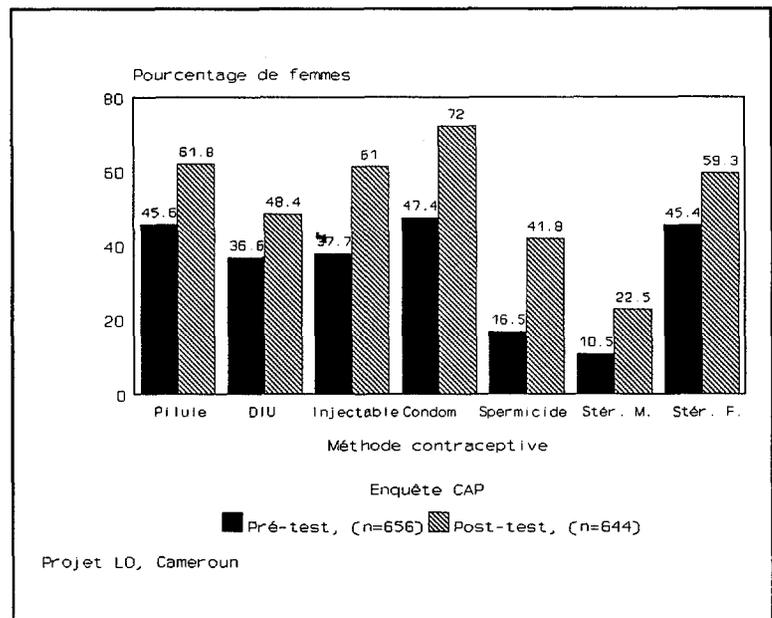
Compte tenu du caractère expérimental de l'approche DBC telle que définie dans les objectifs, le procédé de groupe expérimental sans groupe témoin basé sur une évaluation des indicateurs d'impact avant et après les activités d'intervention combinée au système de séries chronologiques mensuelles a été utilisé au cours de ces différentes interventions.

Dans tous les cas de figures, trois sources principales de données ont été utilisées pour l'évaluation de l'impact des activités d'intervention:

- les enquêtes CAP sur le planning familial;
- les séries chronologiques mensuelles sur les activités d'intervention (statistiques d'IEC, de ventes de contraceptifs, références); et
- les Interviews structurés avec le personnel clé de l'intervention (personnel de santé et agents DBC).

Chacun de ces projets DBC a fait l'objet d'un rapport final et les résultats de des études réalisées ont été présentés lors d'un séminaire national qui a duré une à deux journées suivant les cas. A l'issue de ces séminaires de dissémination, une expansion de la gamme de méthodes distribuées pour inclure de nouvelles méthodes contraceptives dans le système de distribution (pilule par exemple), aussi bien qu'une expansion géographique du système de distribution à d'autres régions du pays ont été envisagés (cas du Mali).

Figure 1: Connaissance des méthodes contraceptives modernes chez les femmes en milieu rural (assistée)



#### 5. Résultats

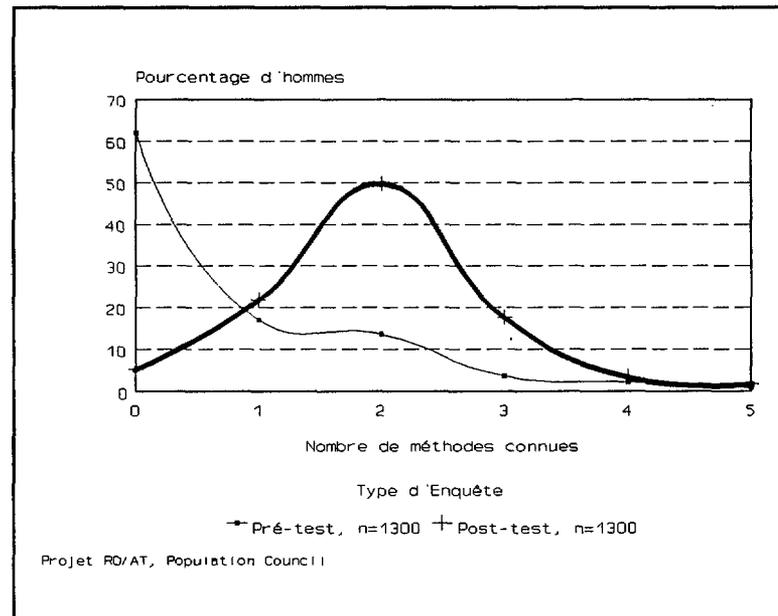
##### Faisabilité et acceptabilité de la DBC

Le déroulement des activités de la phase d'intervention a montré que la DBC était culturellement acceptable et techniquement faisable dans les deux cas de figures. Grâce aux nombreuses activités de sensibilisation menées pendant la phase préparatoire, l'on a pu obtenir le soutien et l'appui technique des populations villageoises dans la

réalisation d'un certain nombre d'activités du projet comme l'identification et la sélection des agents DBC, et l'organisation des réunions éducatives de village. Le taux élevé de participation des populations aux réunions éducatives de village, ainsi que le taux élevé de satisfaction avec les activités de l'intervention DBC (respectivement 80 et 90 pour cent des femmes et des hommes de la zone du projet au Cameroun ) témoignent également de l'acceptabilité de l'approche DBC.

En outre, l'évolution des séries chronologiques mensuelles des rapports d'activités a révélé la capacité des agents DBC à jouer leur rôle. D'une manière générale, la quasi-totalité des agents DBC formés sont restés actifs pendant la période d'intervention et ont prouvé qu'ils étaient habileté à fournir une information appropriée aux clients. Lors des interviews en profondeur en fin de la période d'intervention, l'on a observé un niveau assez élevé des connaissances des méthodes contraceptives modernes des agents DBC (cas des LO/Cameroun). L'évaluation a également révélé que la plus part des agents pouvaient fournir une information correcte sur le PF aux clients.

**Figure 2: Nombre de méthodes contraceptives modernes connues spontanément chez les hommes**



### Effet des activités d'intervention sur les CAP de la population cible

**Connaissances.** Les données issues des enquêtes CAP révèlent une augmentation statistiquement significative du niveau des connaissances de planning familial dans les cas du Cameroun comme du Mali. Cette tendance générale a été observée au niveau de tous les indicateurs de mesure utilisés:

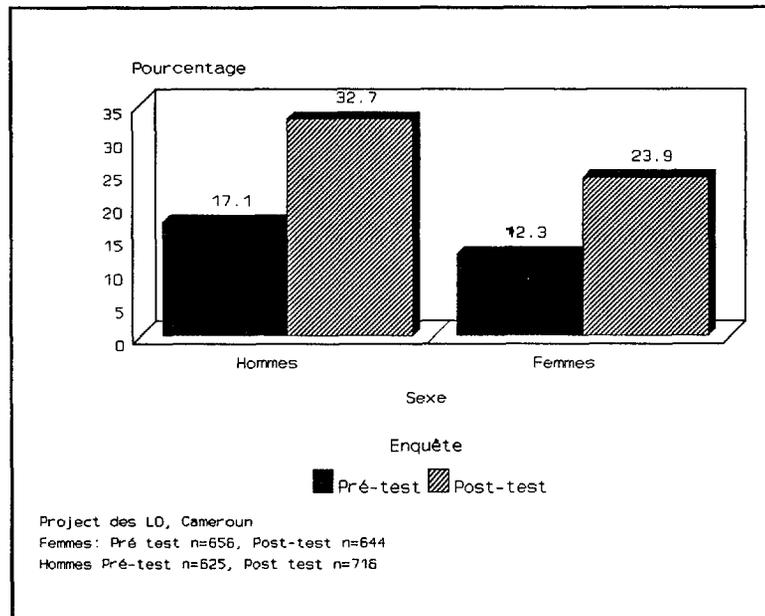
- la connaissance élémentaire de méthodes contraceptives modernes qu'elle soit spontanée ou assistée a subi des augmentations chez les femmes et les hommes;
- le nombre de méthodes contraceptives modernes connues; et
- le projet DBC est cité comme la principale sources d'information sur le PF dans environ 65 pour cent des cas au Mali.

**Attitudes.** Malgré que les périodes d'intervention soient courtes, quelques changements positifs d'attitude ont été observés. Selon les données des enquêtes CAP

menées avec la DBC du Mali, la proportion d'hommes qui étaient prêts à utiliser un préservatif si leur épouse ou partenaire le leur demandait est passée de 50 pour cent en début de projet à 84.8 pour cent à la fin des activités d'intervention après une période expérimentale de 12 mois.

L'exemple de la DBC avec les LO au Cameroun, montre comment la communication entre couples et/ou partenaires peut s'améliorer comme l'indiquent les données du tableau suivant:

**Figure 3: Communication entre couples ou partenaires selon les hommes et les femmes enquêtés en milieu rural**

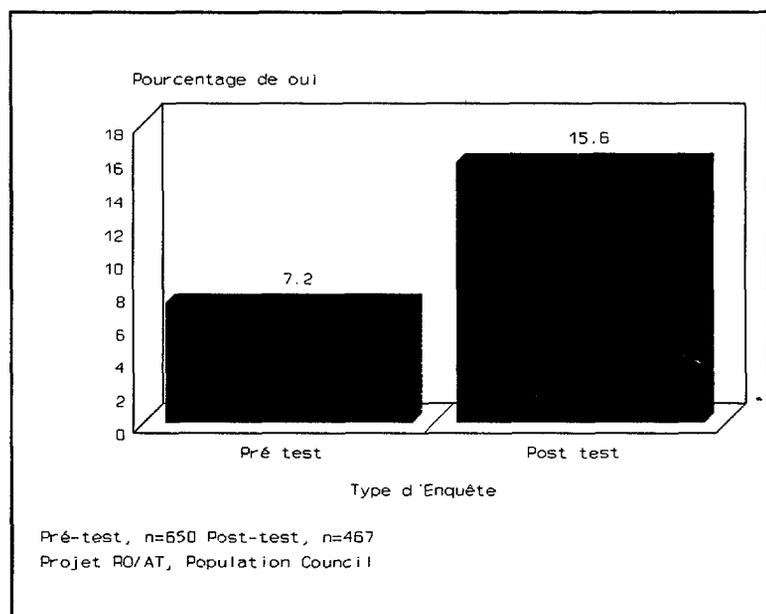


Pourcentage de couples et/ou partenaires qui affirment avoir discuté entre eux des problèmes de planning familial (Projet LO/Cameroun)

Sexe	Pré-test	Post-test
Femmes	12,3	23,9
Hommes	17,1	32,7

**Pratiques.** En règle générale, les interventions DBC ont eu un effet positif sur l'utilisation des méthodes modernes de PF. L'utilisation du condom set devenu plus courante comme l'indique le graphique 4; tandis que la prevalence contraceptive toutes méthodes confondues est passée de rien à environ 5 pour cent. Toutefois ce niveau de pratiques de la PF est assez faible et contraste avec les niveaux élevés de connaissances de PF observés après les activités d'intervention.

**Figure 4: Utilisation d'un préservatif par les hommes interrogés pendant la semaine de l'enquête en milieu rural au Mali**



69

Les changements d'attitude constatés plus haut, ne se sont pas encore traduits en changements de comportement de la population peut-être à cause de la durée très courte des périodes d'intervention.

Prévalence (proportion de femmes qui ont adopté une méthode d'espacement de naissances) chez les femmes.

Projet	Prévalence (pourcentage de femmes)	
	pré-test	post-test
Cameroun ■ LO ■ AT	0	5,3
	0	4,9
Mali ■ DB C	1	11,6

## 6. Conclusions

### Enseignements à tirer

- Les hommes ne constituent pas nécessairement un obstacle majeur de l'accès des femmes à la contraception. Ils ne sont pas toujours informés et ne sont pas souvent impliqués dans le processus de promotion des services de PF.
- Les hommes sont de bons créneaux de communication et de bons prestataires de services de planning familial.
- Ce type d'intervention contribue de façon significative à l'augmentation du niveau des connaissances des méthodes modernes de PF. Toutefois, son impact sur les pratiques reste faible dans le cours terme.

### Impact

- Le gouvernement du Cameroun et l'USAID sont en train d'étudier les voies et moyens pour étendre cette expérience des LO sur toute l'étendue du territoire.

#### **4. Situation Analysis Studies As a Means of Identifying and Solving Service Delivery Problems**

##### **The Development and Evolution of the Family Planning Situation Analysis Methodology**

**Robert Miller, Ian Askew and Andrew Fisher  
Africa OR/TA Project, The Population Council**

#### **Introduction**

Family planning programs have evolved over the last 30 years into complex organizational structures requiring detailed information on the program environment. This need for information appears to be particularly acute in sub-Saharan Africa where many family planning programs are relatively new. The programs, run most often by ministry of health (MOH) staff, are expected by national governments and donor agencies alike, to mature rapidly and become efficient. The need for rapid expansion and efficiency puts heavy demands on managers to know how their programs are functioning, and what should be done to improve program performance. Unfortunately, as has been well-documented by Keller (1991), most MCH/FP programs have extremely weak Management Information Systems (MIS) and in those programs that do have a functioning MIS "information is too infrequently brought to bear on management decision-making" (Keller, 1991:19).

The Situation Analysis approach originated in response to the need for program managers at the national level in Kenya to better understand how services were functioning at their service delivery points (SDPs) around the country. An important catalyst for focusing this overall need was an initial interest expressed by managers in Kenya in 1989 for information on equipment. A major donor agency had indicated a willingness to supply equipment to the Kenya program if the MOH could document its shortages. The Head of the Family Planning Program of Kenya, requested assistance from the Population Council's Africa Operations Research / Technical Assistance Project (Africa OR/TA Project) in determining the program's equipment needs.

The original intention was to undertake a survey of a representative sample of service delivery points from which the equipment needs of the entire program could be estimated. Earlier experience with the systems approach pioneered by PRICOR (Center for Human Services, 1988; Heiby, 1991) suggested that we collect basic information on the functioning of all family planning subsystems, rather than focus on equipment alone. Such an approach, it was argued, would yield the information on equipment, but also supply managers an overall picture of the functioning of the program from which other strengths and weaknesses could be ascertained. Managers were enthusiastic about this suggestion.

While the basic systems approach of PRICOR provided a foundation for the study, in deciding the number and type of variables and indicators that would be examined at the SDPs, we were influenced more by the concept of a "quick and clean"

survey approach, as developed, for example, by Frerichs' Rapid Survey Methodology (Frerichs, 1989; and Frerichs and Khin Tar Tar, 1989). While the complete PRICOR Thesaurus was available, we decided a simpler and quicker approach using fewer variables was more suited to a large sample study. An underlying assumption was "that the performance of various tasks and sub-tasks within a subsystem were probably highly correlated. Therefore, the task of assessing the subsystem could be simplified by identifying and measuring a few key indicators that could provide an overview of whether the subsystem was in place and functioning." (Miller et. al., 1992:90)

Again, based on previous experience in field research situations, the research team believed that data collected through observations was probably more valid than interview responses. Working in collaboration with MOH staff, we had completed the development of data collection forms which emphasized an observable inventory of SDP facilities and equipment, a summary of key service statistics available in the SDP records, along with an interview with the individual responsible for providing family planning services. The interview was necessary to obtain information on factors that were not observable at the time of the visit, e.g. whether supervisors visited the clinic or not and whether staff had received training.

At each SDP, we planned to collect information on a few key indicators of the following family planning subsystems:

- Logistics / contraceptive supplies
- Facilities / equipment
- Staffing / training
- Supervision / management
- Information, Education and Communication (IEC)
- Record Keeping and reporting.

Just prior to the initiation of the study, Council staff in Nairobi received a draft copy of Bruce's paper discussing the now famous Bruce and Jain Framework for Quality of Care (Bruce, 1990). This paper postulated six<sup>1</sup> dimensions of quality of care, namely:

- Provider - client relations
- Choice of FP methods offered
- Information provided to clients
- Technical competency of staff
- Type of services provided
- Mechanisms promoting continuity

Both the Council and MOH staff appreciated the importance of the quality of care issues and recognized that the study being planned in Kenya would provide an opportunity to operationalize and field-test the Bruce and Jain Framework. In so doing,

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<sup>1</sup> The dimensions have been subsequently revised to seven by the Quality Sub-Committee of the Service Delivery Working Group of The EVALUATION Project which added "outcomes."

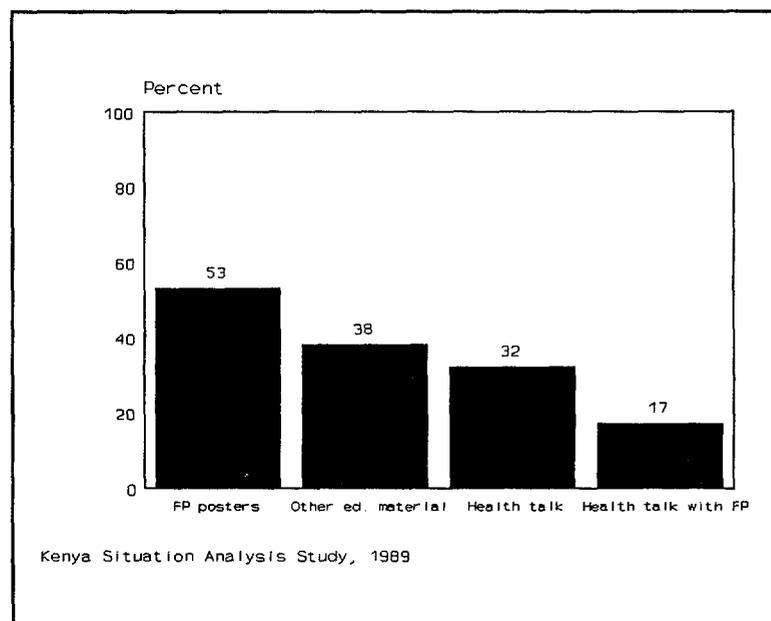
it was expected that the study would provide a more comprehensive picture of the functioning of the Kenya program. Thus, researchers quickly added data collection instruments for observing client-provider interactions and for interviewing family planning clients to those developed for measuring sub-system functioning.

This overall approach to describing what a family planning program looks like at the SDP level became known as Situation Analysis, defined as: **a diagnosis of the strengths and weaknesses of family planning subsystems and quality of care at a representative sample of SDPs using both interviews of staff and clients and observations of SDPs and service delivery, presenting easily understood results quickly for administrative action, and OR program design.**

### Diffusion of The Methodology

The results of this study were provided relatively quickly to program managers in graphic format (Miller *et al.*, 1989). The graphic format made the results easily understandable in both hard-copy and slide-based presentations, and greatly facilitated the dissemination of both the results and the methodology. Examples of just two of the graphs are given on Figures 1 and 2. The data proved useful to the managers of the Kenyan family planning program who felt they could better understand and manage their programs, as well as

**Figure 1: Percent of 99 SDPs with Educational Components**



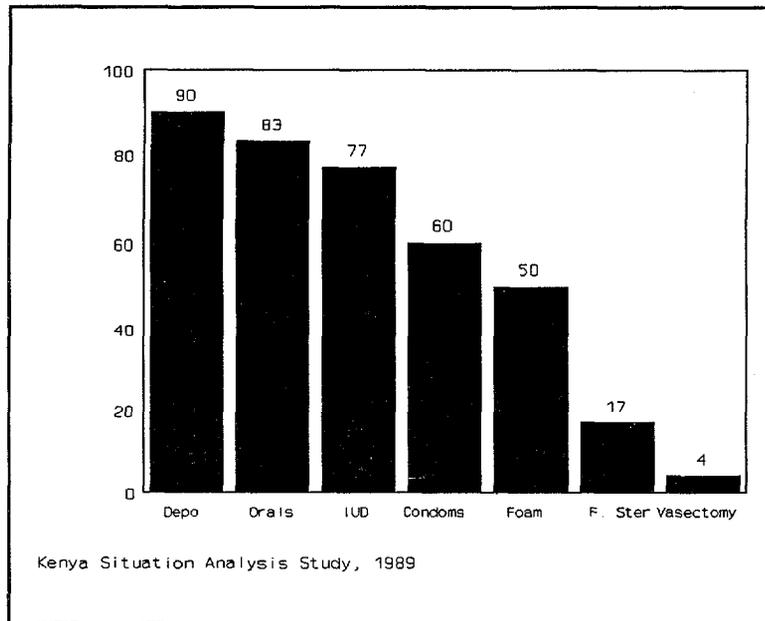
represent them to donor agencies. Some specific changes in curricula design and administration were taken to attempt to solve some problems quickly.

The study also served as a major component of an overall approach to the institutional development of operations research (OR) in Kenya--the integrated approach (Miller and Frerichs, 1992-93). The integrated approach consisted of the combined use of: (1) the Situation Analysis data for understanding program strengths and weaknesses; (2) the development of a computer spreadsheet model which utilized both DHS and Situation Analysis data for running "what if" experiments for estimating the possible impact of various family planning program change strategies on birth rates (Frerichs and Miller, 1992); (3) OR training for MOH and University staff; (4) OR quasi-experimental studies implemented in the field to solve three problems uncovered, and to serve as training in OR; (5) continued technical assistance to the OR studies; and (6) a

dissemination seminar to discuss jointly the findings and implications of all of the OR studies.

However practical the programmatic findings of the Kenya study were, Kenyan program managers also appreciated the results because they appeared to contribute to other important universal psychological needs, such as self esteem. Prior to this study, the international literature, relying on "expert opinion," rated the Kenyan program as "weak," "poor," and/or "a failure." (e.g. Lapham and Mauldin, 1984; Henin, 1986). Indeed, we recognized that we were acting contrary to accepted wisdom in concluding that the

**Figure 2: Percent of 48 New Clients Informed About Each Contraceptive Method**



Situation Analysis data indicated that the program could better be characterized overall as "moderate" than "poor." We were delighted when soon afterwards the DHS study showed a 50 percent increase in contraceptive prevalence over the previous five years and the first drop in total fertility rate (TFR) measured for the Kenyan population (National Council for Population Development, Ministry of Home Affairs and National Heritage, 1989). It appeared that the DHS data could be seen as validating the relative success of the MOH's family planning program which was the source of contraceptives for approximately 90 percent of family planning users in the country. Subsequently, the program effort rating score also placed the program in a moderate category (Mauldin & Ross, 1991).

Independent of the actual utilization of the Kenyan data, the potential applications of this type of easily understood field-based data was attractive to program managers, researchers and donors alike. Considerable effort with an active dissemination program reinforced the perceived value of the study. Africa OR/TA staff made presentations on the study to other national program managers, donor agencies, and researchers and program managers in several venues, including international meetings. Interest in the study was probably amplified by the rapid development of enthusiasm and acceptance of the Bruce-Jain Framework on Quality of Care, and the fact that the Kenyan data was the first attempt to use the framework in the field. Indeed, the Head of the Family Planning Program of Kenya was invited to present the findings to the leaders of family planning programs worldwide at the ICOMP meeting on "Managing Quality of Care in Population Programs" in Kuala Lumpur in November 1991 (Miller et. al. 1992).

The interest generated by this initial Situation Analysis study and its dissemination effort led to many requests for additional studies, initially in Africa, and later in all regions of the world. As Mensch et al. (Mensch et al., 1994a:6) have indicated:

"While borrowing from other methodologies, the situation analysis methodology is considered innovative because it integrates a number of approaches to family planning program evaluation. These include: (1) a systems perspective for identifying crucial sub-system components of program operation; (2) visits to a large sample of SDPs rather than visits to only a few SDPs or relying on expert opinion; (3) a client oriented focus on quality of care; (4) structured interviews with managers, providers and clients rather than with community informants as is the case with the DHS availability module; (5) recording of clinic facilities, equipment and commodities available on the day of the visit; and (6) non-participant direct observation of all family planning client-provider interactions on the day of the research team's visit."

A second study was undertaken in Kenya for all clinics managed by the Nairobi City Commission (Mensch *et al.*, 1994b). Also, studies were requested and undertaken under the auspices of the Africa OR/TA Project in Burkina Faso (Askew *et al.*, 1993), Zaire (PSND & The Population Council, 1991), Cote d'Ivoire (Kouakou *et al.*, 1992), Zimbabwe (Zimbabwe National Family Planning Council, 1992), Tanzania (Tanzania Ministry of Health, 1993), Nigeria (Federal Ministry of Health, 1993) and Ghana.

In Africa, national studies are currently underway in Benin and Senegal, and the USAID-funded HHRAA Project is planning to utilize the methodology for studying the family planning programs in six urban settings. The first Latin American Situation Analysis Study was conducted in Peru (del Valle *et al.*, 1993), and other studies are planned in Mexico, Guatemala, and Brazil. In Asia, the first study was carried out in Pakistan (Ministry of Population Welfare, 1993), and planning for other studies is underway in Indonesia, Nepal, Bangladesh, India, and Turkey.

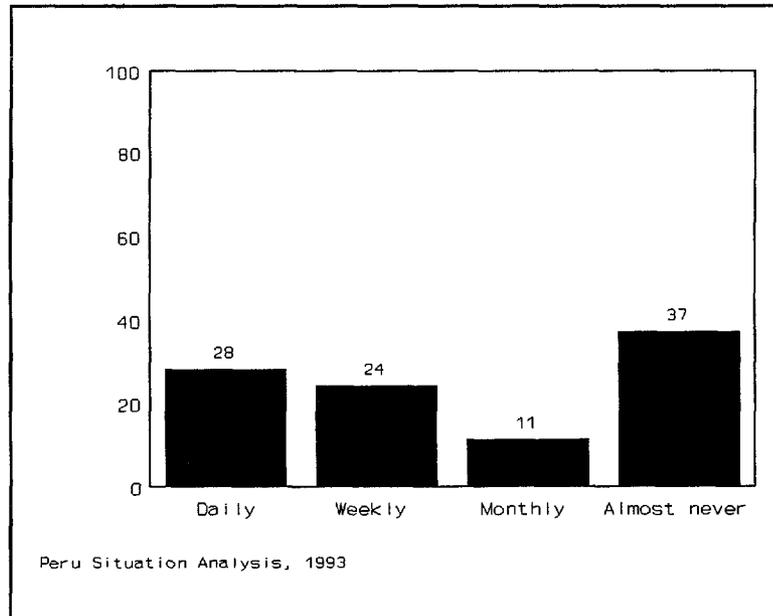
### **Evolution of The Methodology**

In the process of planning and conducting these Situation Analysis studies, numerous changes have taken place as a result of: (1) adaptation to local interests and program components; (2) critical analysis by a larger number of researchers involved in the studies; and (3) a desire to explore possible solutions to continuing methodological issues and problems. Some of the ways in which the methodology changed are discussed below.

- **Expanding the types of FP Delivery Systems Examined**

While the initial Kenyan study focused only on clinical SDPs operated by the MOH, subsequent studies have included other delivery systems. In Zimbabwe a module was developed for studying Community Based Distributors who were found on average to supply about 2.5 times the numbers of clients supplied by clinics. In Zaire, three systems were in operation including the MOH (PSND), an IPPF affiliate, and a Christian health organization. An interesting finding in this study was that while there was some

**Figure 3: Frequency of Customers Asking FP Questions in Peruvian Pharmacies**



prejudice against the Governmental system in the donor community, the government program was found to be substantially more active and successful in supplying clients than either of the other two groups. In Ghana, clinics from the IPPF-affiliate were included in the sample as were maternities operated by private midwives who are members of the non-governmental Ghana Registered Midwives Association. In Peru, the private sector was thought to be a major supplier of contraceptives and a module was developed to collect data in pharmacies. About half the pharmacists reported that clients ask questions about family planning either daily or weekly (see Figure 3). Parts of this pharmacy instrument developed in Peru is currently being used in Ghana by The Futures Group to evaluate the large-scale pharmacy-based social marketing program.

- **Expanding Sample Sizes**

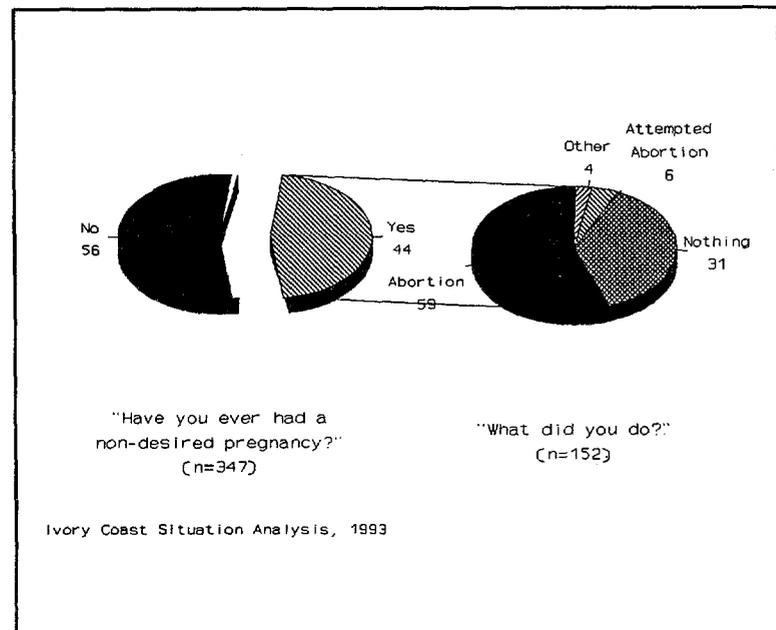
While the initial Kenyan study was based on 99 SDPs and observed 48 new clients, later studies have increased the number of SDPs visited, have observed and interviewed all new clients on the day of the visit and a substantial proportion of continuing clients, and interviewed all staff providing family planning services. Most studies now seek to visit a sample of at least 10% of the total number of SDPs, and consequently the number of SDPs studied is usually a minimum of 150 (e.g. Nigeria 181, Zimbabwe 152 plus CBDs), and usually more (e.g. Tanzania, 336 SDPs, Ghana 399 SDPs, and the Peruvian study included a total of more than 3000 sites, including clinics, hospitals, pharmacies, CBDs, and private practitioners). In some studies (e.g. Cote d'Ivoire and Nairobi City Commission, all SDPs were visited.

■ **Expanding the Issues Associated with the FP System**

A module was developed in the Burkina Faso study to interview MCH clients (not attending SDPs for family planning services) to ascertain their views of the SDP and of family planning; this module has now become part of the core data collection instruments. It was discovered that a substantial proportion of MCH clients who were themselves using family planning were not aware that contraceptive services were available in the facility they were attending.

**Figure 4: Percent of FP Clients Reporting Unwanted Pregnancy, and Steps Taken, Ivory Coast, 1993**

The Cote d'Ivoire study expanded the interview of family planning clients to include information on client experience with undesired pregnancies and induced abortion (Huntington et al, 1993). Researchers found the questions were well tolerated in the family planning service environment and responses were remarkably revealing. About half of the clients admitted an undesired pregnancy; two thirds of these women obtained or sought an abortion, often from MOH staff (see Figure 4). These questions are now routinely incorporated in all Situation Analysis studies.



In several studies (e.g. Nigeria, Ghana, and Tanzania) information was collected about barriers to providing various contraceptives. Numerous barriers were reported, including age, marital status, spousal consent, etc. for various methods. However, considerable caution was recommended in interpreting these findings (Mundy, 1993). It appeared that staff were responding to what they believed might be policy restrictions, rather than reporting their actual practices.

■ **Introducing Multiple Measures**

Since we interview providers and clients, and observe many program components, it was clear that there were opportunities for obtaining multiple perspectives on important subjects, such as whether family planning programs are truly integrated with overall MCH activities. In the Nairobi City Commission study, nurses reported that they usually discussed the family planning needs and interests with MCH clients. However, discussions with MCH clients led researchers to conclude that the subject of family planning was rarely raised with clients who attended the Nairobi City Commission clinics for MCH services (Mensch et al., 1994b).

11

Beginning with the Nigeria study, a self-administered questionnaire has been sent out to program managers at various levels in the family planning program. The purpose of this questionnaire is to ascertain their perceptions of the quality of service offered and their knowledge and perceptions of standard protocols and service delivery procedures and policies.

#### ■ **Increasing Refinements of Measurement**

The "information exchange," "choice", and "technical competence" dimensions of quality require the researchers to gather information on what clients are told, how many family planning methods are discussed, and whether the method chosen was appropriate to the client's situation. Initially we gathered this information in observations of the client-provider interaction with a focus on the provider. In Ghana, however, the data collection instruments and data processing were revised so that we could report whether relevant material was made available through either questions/comments by the provider or by the client. With this refinement, the client-provider interactions appeared to be somewhat more successful in making the appropriate information available for decision-making about family planning than they had appeared previously. For example, while only about 40 percent of the providers asked family planning clients about their reproductive goals, an additional 40 percent of clients volunteered this information to the provider. Similarly, though only about 25 percent of providers asked whether clients had a method preference, 25 percent of clients volunteered that information without being asked.

#### ■ **Standardization of General Guidelines and Instruments**

Initially there was little attention to the need to standardize guidelines, instruments and analysis procedures because we did not envisage that the methodology would become as popular as it did. However, the large number of requests soon made clear that standardization of the data collection approach and core instruments would be desirable both to guide the additional studies and to facilitate comparative studies. The resulting guidelines, developed through collaboration between Population Council staff in Nairobi and New York, were published in 1992 (Fisher *et al.*, 1992). However, as evolution has continued, a new set of guidelines and data collection instruments is needed again and will be produced in early 1994.

#### ■ **Increasing Analysis of National Data**

The initial studies focused on describing specific program elements and the quality of care observed; little relational or comparative analysis was included. Latter studies have included more analysis, both to test some of the underlying assumptions inherent in the Situation Analysis approach, and some major hypothesis in the field of family planning. For example an analysis of data from Ghana, Nigeria, and Tanzania investigated the assumptions regarding a relationship between subsystem functioning and SDP utilization (Mensch *et al.*, 1994a). The analysis suggested that the association was weaker than expected.

In Peru, Situation Analysis and DHS studies were carried out in the same geographic areas. With SDP and population based data, an attempt is being made to use both sets of data to test whether higher quality family planning services is associated with increased contraceptive prevalence rates in the surrounding geographic areas.

#### ■ **Increasing Cross-National Comparisons**

The availability of data from several countries has allowed for cross-national comparisons and brought to light, for example, a continent-wide pattern of service delivery. In all of the programs examined to date, 25 percent (the top quartile) of the SDPs provide services to about 80 percent of the clients (Fisher in these Proceedings). Specifically, for example, the top quartile of SDPs served 78.5 percent of new clients in Nigeria, 80.7 percent in Tanzania, and 83.1 percent in Zimbabwe. There has been considerable effort expended in trying to explain the differences between the top functioning SDPs and the others. Unfortunately, while there is some indication that the most productive SDPs have higher subsystem scores, and are better equipped, Mensch et. al. (1994a:24) concluded that "variation in the number of new acceptors is not adequately explained by subsystem functioning."

#### ■ **Quality of Care Indicators Developed**

Mensch (see paper in these Proceedings, and Askew et al., 1994) has been working on summarizing the large amount of data we have on quality of care into summary scores for each of the dimensions of quality in the Bruce-Jain Framework. The quality of care scores are derived to a large extent from the observations of interactions between provider and clients and are thus usually available for only about half the clinics where such interactions took place during the research visit. Utilized in Ghana, Tanzania, and Nigeria to date, the weakest scores were obtained for client/provider information exchange, i.e. asking about method preference; providing information on side-effects and the management of side-effects; asking about a desire to switch methods among women having problem with their methods. Higher scores are apparent for provider client relations. Mensch has argued that the simple index scores condense the information contained in the large number of graphs usually produced by the study methodology, allow for easier comparisons for such purposes as pre- and post-intervention measures, as well as allow for shared patterns to emerge between countries.

#### ■ **Adaptation and Use by Other Organizations**

The entire Situation Analysis methodology has been adopted and used by several organizations; others have adopted elements of the methodology. For example, the SEATS Project conducted national Situation Analysis studies in Morocco and, with Population Council staff involvement, in Madagascar. The Johns Hopkins University Population Communication Services (PCS) has incorporated the observation and client exit interviews into their methodology for assessing the counselling, information-giving skills and IEC material availability at SDPs in Kenya (Kim et al, 1992). Pathfinder International is carrying out a needs assessment of facilities and equipment in preparation for refurbishing the Planned Parenthood Federation of Nigeria (PPFN) clinics using a revised version of the Situation Analysis inventory. The Association for



Voluntary Surgical Contraception is collaborating with Population Council Staff in Asia for conducting Situation Analysis studies in countries where emphasis is placed on permanent and long term methods, such as Indonesia and Turkey. Management Sciences for Health staff had a keen interest in utilizing a Nepal Situation Analysis study as a baseline to evaluate the impact of their technical assistance to The Family Planning Association of Nepal. The term "Situation Analysis" now appears frequently in family planning literature instead of the older and more standard terms such as "needs assessment" or "diagnosis".

#### ■ **Model Developed for Maximizing Utilization of Data**

One of the strengths of the Situation Analysis methodology is the way in which the involvement of managers is required from the beginning and throughout its implementation. A model for implementing Situation Analysis studies is emerging which includes participation by managers in each of the key steps. First, a 2-3 day Planning Meeting is held, attended by the researchers and by the senior managers responsible for the SDPs to be visited. At this meeting, the sampling plan is developed to reflect the needs of all relevant family planning organizations in the country; the core data collection instruments are adapted to the specific service delivery system being analyzed, and the managers agree on responsibilities for ensuring the research teams' access to the SDPs. This meeting may need to be repeated at the regional / provincial levels if it is not possible to bring together all the managers at one meeting.

Once the data have been collected a 3-day Data Interpretation Workshop is held, at which the same group of managers and researchers reconvene to discuss the preliminary results produced. Rapid data entry and production of frequency tabulations of the variables, with some basic cross-tabulations where necessary, is essential for this and has been facilitated by the use of user-friendly computer programs such as Epi Info (Dean *et al*, 1990). The presentation of the results, normally through a series of bar charts of each indicator, appears to stimulate ready discussion and a search for solutions to the problems which emerge.

The purpose of the Data Interpretation Workshop is to allow managers to see the preliminary data before any meaning has been attached. In this way it is their responsibility (and not the researchers' as is the norm) to interpret the results and to agree on what the specific implications are for their program. This activity may include formulating some preliminary programmatic or policy recommendations; alternatively, the development of such recommendations may take place at the Dissemination Seminar(s) during which the final results and their programmatic implications are presented to a wider audience of managers, NGOs, donors, and technical assistance personnel. Again, this seminar may need to be repeated at the regional / provincial levels. At the dissemination seminar for the Nigeria study, for example, 19 recommendations for strengthening sub-systems, 13 for improving quality of care, 8 for policy development, and 21 for further operations research were identified in an afternoon session following presentation of the results (Federal Ministry Of Health *et al*, 1992).

## **Methodological Issues**

Despite the wide diffusion of the methodology, and the large number of studies undertaken, several issues, recognized as early as the first Kenya study, continue unresolved. The issues and problems relate to: (1) positive bias of observation and interviews; (2) the number and representativeness of observations; (3) program quality vs. individual SDP quality; (4) difficulty in summarizing the data; (5) linking subsystem functioning and quality to prevalence; (6) relationship to DHS service delivery module; (7) applied research needs versus theory testing; (8) a "top down" orientation.

### ■ **Positive Bias of Observation and Interview**

While the observations undertaken with the "SDP inventory" data collection instrument used to record items like equipment, posters, and the availability of contraceptives should be reasonably unbiased, the observations of the provider-client interaction by a third party are quite intrusive and most certainly bias the observations on quality of care in a positive direction. Responses from staff interviews are also probably biased in favor of representing the programs in a more favorable light. These problems have concerned the researchers from the first study and yet relatively little has been done to solve them or even to estimate the extent of the bias. One suggestion is to spend more than one day in each clinic, or at least in a subsample of clinics. This suggestion followed the general belief that the observed interactions would probably "retreat toward the mean" or become more usual as providers became more accustomed to the presence of the observers or developed rapport and familiarity with them (Simmons and Elias, 1993:30).

Unfortunately, most of the studies have been carried out under tight logistical limits, and many of the major clients requesting the studies have not been particularly concerned with this issue, perhaps because even the positively biased picture of each of the African programs have provided information on a plethora of problems deserving attention. One of the smaller studies (in Cote d'Ivoire) did include clinic visits of two days rather than the usual one day. However, analysis has not yet been carried out on whether there were differences between the observation experiences on the first and second day of the visits. There has been discussion of conducting "simulated client" visits (see Huntington & Schuler (1993) for a full discussion of simulated clients) as a component of a Situation Analysis study. This would allow a comparison of observations by an unannounced participant-observer as well as provide the less structured insights characteristic of this approach.

On a related point, Simmons and Elias (1993:18) have commented that, while appreciating many benefits of the Situation Analysis approach, "the rapidity of the assessment effectively excludes establishing the rapport needed to elicit the nuanced insights into program functioning that are obtainable through longer fieldwork." We would agree with this point and suggest that a better picture of the program as a whole comes from the utilization of a variety of research approaches supplementing each other.

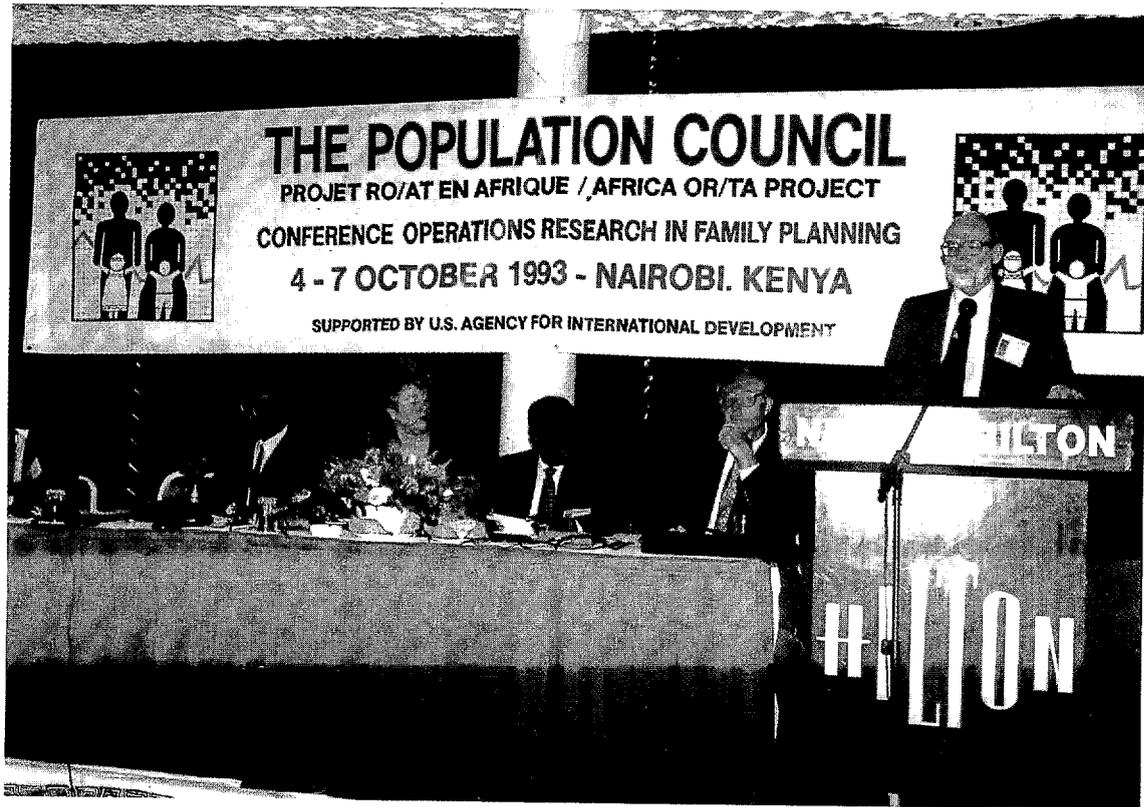
# THE POPULATION COUNCIL CONFERENCE PROCEEDINGS



Over 200 participants were registered.



Ms. Margaret Catley-Carlson, President, The Population Council, welcomes Dr. Onyonka, Minister for Research, Technical Training and Technology.

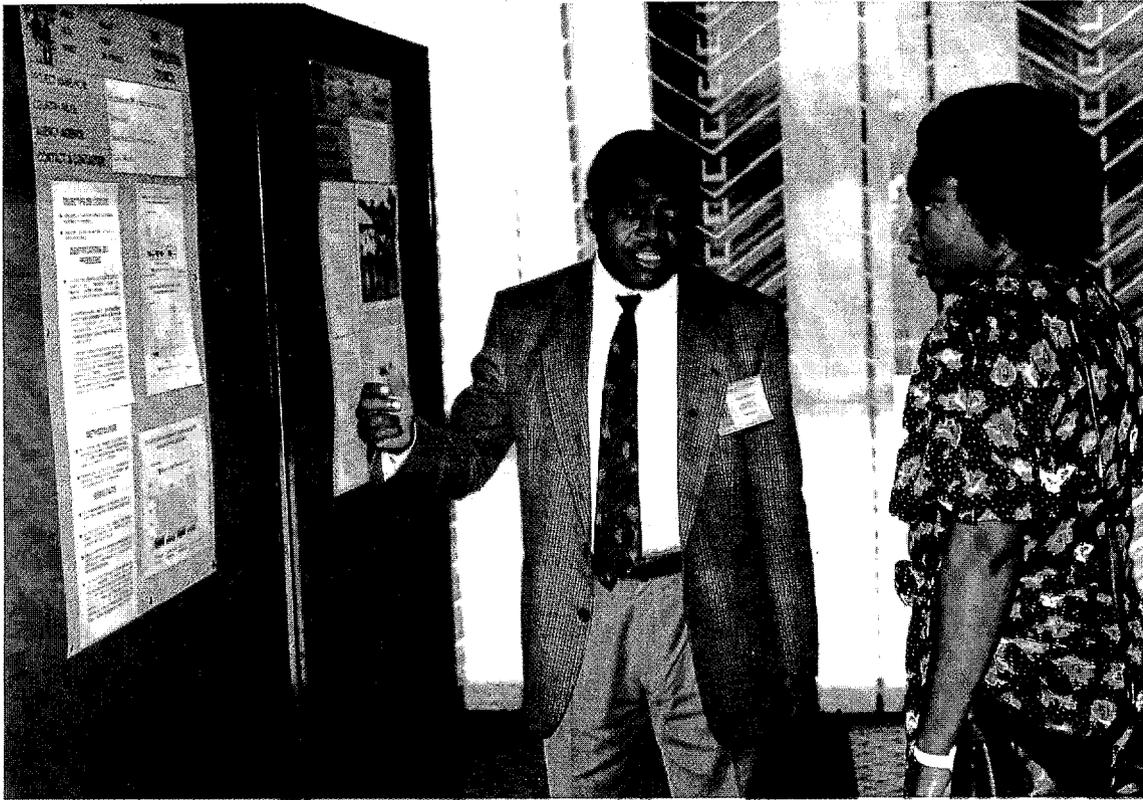


**Dr. George Brown, Vice President, The Population Council during the conference inauguration and opening session.**

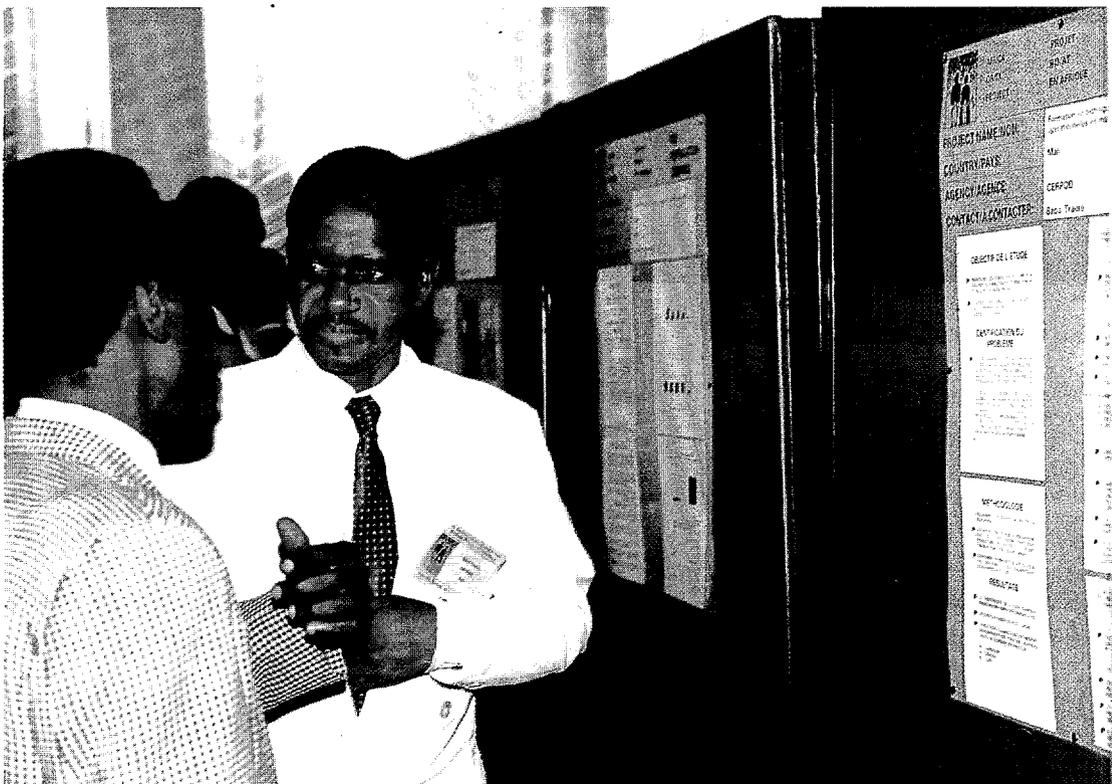


**Dr. Fred Sai, President, IPPF and inaugural guest speaker discusses a point with Dr. Mlingi and Dr. Kapiga from Tanzania.**





**Dr. David Awasum, Cameroon and Mrs. Dorsila Sundae, Kenya exchange experiences with or studies during the poster session.**



**Baba Troare of CERPOD, Mali discusses or activities in Mali.**



**Participants during conference sessions.**



**Participants during conference sessions.**

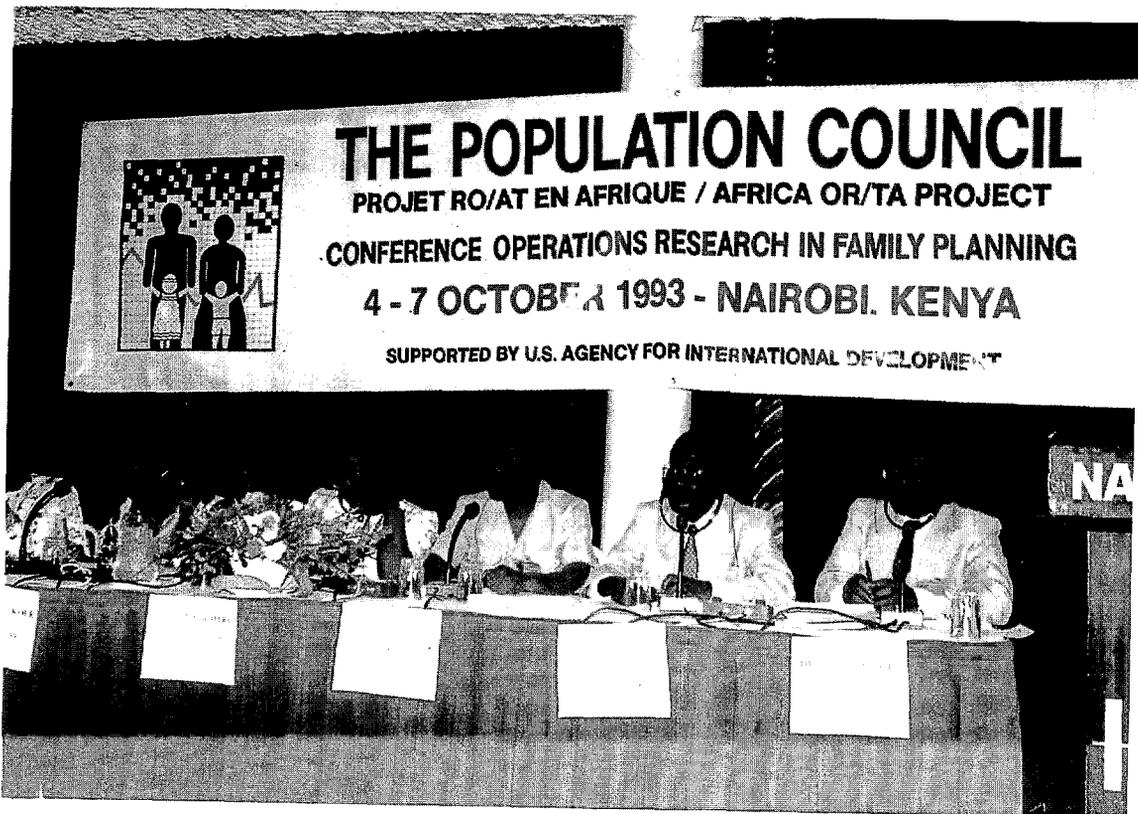
85



**Participants during conference sessions.**



**Participants during conference sessions.**



Panel discussion on the use of situation analysis findings to improve programs.



Working group session progress.

161



**Population council staff, Dr. Monica Kiorr, Dr. Nahid Toubia and Dr. Davy Chikamata.**



**Fran Farmer, Pathfinder networks with the Family Planning Association of Kenya.**



**Nancy Harris, SEATS networks with participants.**



**Dr. Brigitte Thiombiano from Burkina Faso networks with her francophone Colleagues.**

89

- **The Number and Representativeness of Observations**

The first Kenya study attempted to observe the client provider interactions for only one new client at each SDP. New clients, however, were available in only about half of the clinics on the day of the research visit. Subsequent studies expanded the observations to all new clients on the day of the research visit, and as many continuing clients as was feasible. However, in none of the studies do we have data on new client-provider observations from more than about half the SDPs. If we make the assumption that clients are less likely to be present at the worst quality SDPs, than the data collected from these observations further bias the resulting picture of the entire program in a positive direction.

- **Program Quality Can Be Better Measured Than SDP Quality**

To date, most studies have been used to gain a nationally representative "picture" of the overall program. An interesting methodological issue is arising in relation to ascertaining valid measures of service delivery quality for individual SDPs, namely the number of observations / interviews necessary to be able to draw valid conclusions. Given that a selection of SDPs are visited for one day, it is felt that the study gives "a day in the life" of the national family planning program and consequently it is not the objective, nor is it appropriate, to use the data to evaluate the quality of service provided at individual SDPs. The nature of the sampling for observing client-provider interactions and client exit interviews (all family planning clients on the day of the team's visit to the SDP) which provide the source of data for most of the "quality" indicators, means that only aggregate measures of quality across the sample, or a uniform sub-sample of SDPs, can be given. Frequently, particularly in Africa, there are very few or even no family planning clients on the day of the visit and so all SDPs are not equally represented in the sample of data on quality of service. This is, of course, not a problem when measuring sub-system functioning because data can normally be collected at all SDPs on the day of the visit. While there has been an expansion in the total number of observations in the latter studies, the number observed at each SDP (usually in the range of 0-5) is considered too small to represent quality at the individual SDP. Clearly, additional work is needed on this issue.

- **Difficulty in Summarizing the Data**

To date, beyond graphically presenting the findings from individual indicators, researchers have attempted various ways to make summary generalizations available. However, there have been difficulties in doing this. In part this is because of the multifarious nature of the concept of quality -- the fact that the most widely accepted conceptualization comprises a six-element framework, each element having several indicators. It is also due to the fact that the concepts of service quality currently being considered have not yet been tested empirically, and so the relative importance of each indicator and element are not known.

Three approaches have been tried. One approach to achieving a summary measure, used by Miller *et al* (1991) for the Kenya study, is simply to rate each of the elements subjectively and then to assign (again subjectively) an overall rating to the

program as a whole. A second approach used by Huntington *et al* (1992) for the Côte d'Ivoire study, is to identify a list of eleven elements drawn from the Bruce framework and subsequent modifications, and to summate standardized scores for a number of indicators that relate to each element, thereby creating a summative scale. Each summary scale can then be used to compare elements across SDPs, and the aggregate score for each SDP can be correlated with some outcome measure (in the Côte d'Ivoire study, continuity of use was the outcome measure).

A third approach, used by Mensch *et al* (1994a), uses regression analysis to identify those indicators drawn from both the sub-system functioning and quality of care components that are correlated significantly with an outcome measure (in this case, number of new acceptors). Additional work is needed to develop a recommended practice for summarizing data.

#### ■ **Linking Sub-System Functioning and Quality to Contraceptive Prevalence**

A major assumption inherent in the methodology is that quality of care matters, both for its own sake, and because higher quality services can be expected to recruit more clients and serve them for longer periods (Jain, forthcoming). Several researchers have been interested in testing this hypothesis, and indeed, the Peru study was set up to be coordinated with the DHS study which would produce prevalence rates for small geographic areas. However, this plan will require using the small number of observations as representative of SDP quality, and as discussed above there is some reluctance to do this.

For the immediate future, a number of countries (e.g. Kenya, Nigeria, Ghana) have indicated that they would like to carry out a second situation analysis in order to evaluate progress in developing their family planning program over time. Although such follow-up studies permit managers to evaluate progress in improving service quality over time, in themselves they do not permit the type of longitudinal study design necessary to analyze the relationship between continuity of use and quality of service delivery; to answer such questions will require a more elaborate research design than is currently used.

#### ■ **Relationship to DHS Service Delivery Module**

A further extension of this linkage between the two types of study is the potential for the Situation Analysis approach to fulfill the role currently played by the DHS Service Availability Module. The main purposes of this Module are to appraise the availability and accessibility of family planning services and to assess how effectively providers are delivering services. The study in Peru demonstrated that the direct substitution of a situation analysis study for the DHS Service Availability Module not only fulfilled these objectives but produced data that was felt to be more valid and that could be used to measure the quality of service delivery.

However, the applied nature of the situation analysis methodology has also led to certain constraints in exploiting the data more fully in the search for summary measures of quality of services. The approach was not developed originally as a research

91

tool to operationalize explicitly the concepts of quality of service; this aspect has evolved as the appropriateness of a rapid, representative survey of SDPs as a tool for measuring indicators of service quality became apparent from the early studies.

#### ■ **Applied Research Needs Versus Theory Testing**

As has been mentioned, the original purpose of the study was to describe the strengths and weakness of a family planning program. Where information was non-existent, this information was thought to be extremely valuable. The purposes of the study methodology have expanded, and in some cases perhaps become confused. Managers have in some countries hoped to be able to answer a number of questions from a Situation Analysis study for which it was not originally designed. For example, the sampling plan considered in one Asian country called for stratification of SDPs by community prevalence rates or by clinic productivity as measured by existing MIS data. The objective of this activity proposed but not finally decided was to test theories. In addition to broader questions of the appropriateness of the methodology to such purposes, issues such as weighting may need to be considered, if studies also wish to describe the national program with such samples. Weighting, while necessary under some circumstances, also seems to introduce some danger that the simplicity and usefulness of the earlier studies may be compromised by statistical complexities that reduce the usefulness of the findings to managers.

#### ■ **"Top Down" Aggregate Orientation**

Some researchers have objected to the centralized systems-wide orientation of the studies, suggesting that they do not provide sufficient help or motivation to individual SDPs to improve their own functioning. Quality assurance approaches (see Katz et al (1993)), such as the Client-Oriented-Provider-Efficient (COPE) methodology (Dwyer et al, 1991), are seen as more appropriate mechanisms for bringing change to individual SDPs. Twenty-five SDPs in nine African countries have so far been assessed (Lynam *et al*, 1992). While we agree that the COPE technique is a more effective way of ensuring direct utilization of self-assessment results, the technique so far is unable to provide aggregate measures for several SDPs and is thus only applicable for assessing individual SDPs rather than whole programs.

There is certainly room for both aggregate and individual approaches to assessing quality. We believe that family planning program improvement will probably be helped more by utilizing a diversity of approaches than any single approach. While appreciating the power for change inherent in the self-discovery process engaged in by clinic staff using quality assurance management techniques, it may also be true that the solution to problems facing the whole program may be better and more efficiently initiated at a centralized level. Revisions in centralized program functions such as training, supervisory practices, and policy guidelines are examples of the kinds of systems-wide issues that are appropriate for centralized change strategies.

## Conclusions

Situation analysis studies have the potential for being one of the key tools in assessing the impact of efforts to improve service quality. However, there are a number of issues and problems for which progress and solutions are required.

The Population Council is at present developing a proposal for a coordinated world-wide operations research effort to strengthen Situation Analysis studies. This initiative will include:

- revised guidelines, data collection instruments and procedures;
- development of data analysis and presentation plans;
- suggested solutions to outstanding methodological issues;
- empowerment of regional teams to conduct Situation Analysis studies with little or no Population Council staff input; and
- increased availability of Situation Analysis data in more comparable formats.

It is hoped that the strengthened methodology, based on both a theoretically sound framework and field-tested research methods, will provide a generally acceptable approach for assessing "supply-side" variables, in much the same way that the DHS is now the accepted methodology for assessing "demand-side" variables.

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## **Using Situation Analysis to Develop Quality of Care Indicators: Examples from Ghana, Nigeria and Tanzania**

**Barbara Mensch  
The Population Council, New York**

### **Introduction**

This paper is divided into two parts; the first provides some background on quality of care and the rationale for its quantification and the second is an application of quality of care indicators to Situation Analysis data from Ghana, Nigeria and Tanzania.

Until recently, the focus of research and program activity in family planning has been on increasing access and availability of contraceptives. Faced with a demographic mandate and perceiving quality to be a luxury in resource-poor settings such as Africa, international donors and national policymakers have directed their attention more to the expansion of services than to the nature of those services.

Reflecting this focus, family planning programs have been evaluated in terms of output, in particular the volume of contraceptives dispensed, through such measures as couple years of protection. In addition, as part of surveys or special data collection efforts, contraceptive prevalence rates and program effort scores are also calculated. Yet these measures of performance, while useful, do not reflect clients' experiences with the family planning program, experiences which are believed to have an impact on contraceptive use.

Why focus on quality? The standard evaluation measures do not deal with process either by definition (in the case of CYP and contraceptive prevalence) or by mode of data collection (in the case of program effort); they do not identify what aspects of service delivery and which facilities are most in need of improvement. Increasingly, there has been a realization that family planning programs exist to help couples in meeting their reproductive goals. In fact historically this was the avowed goal of family planning programs but it got lost in the concern with rampant population growth. If this is the purpose then it follows that programs should also be evaluated in terms of their ability to assist clients to achieve their reproductive goals, that is, in terms of the quality of services provided. In addition there has also been a recognition that neglect of quality may have consequences for the success of the program. That is, there is a belief, albeit based on limited empirical data, that the quality of services provided is an important determinant of contraceptive and fertility behavior.

What are the potential consequences of poor quality at the programmatic level? Inadequate attention to quality may lead to:

1. Underutilization of services - women don't come; word is passed around the community, rumors develop etc....

2. High dropout rates - even if women do come they dropout.
3. Contraceptive failure as a result of inadequate information provided to clients.
4. Increased risk of infection caused by septic services.

What exactly do we mean by quality of care? A working definition has been developed by Judith Bruce both to draw attention to quality and to establish a common analytic framework for practical application; this framework has been widely accepted by the family planning community. Five elements have been identified as being fundamental:

1. Choice of methods
2. Provider competence
3. Provider-client information exchange
4. Provider-client relations
5. Mechanisms to encourage continuity

Where does quality of care fit into the overall program assessment process? We distinguish between the structure or input, the process of caregiving itself and the outcomes. Structure is defined in terms of what those of us involved in Situation Analyses call sub-systems (see Miller *et al.* in these Proceedings). Examples are equipment, logistics system, supplies, facilities, training, record-keeping, etc. In some sense, structure is a partial determinant of quality. A functioning structure provides some necessary, although not sufficient, conditions, for adequate services. In other words, a family planning clinic might have a decent contraceptive logistics system with an adequate range of supplies, but not provide a woman with balanced information or a full range of methods.

Process is the actual assessment of the Bruce elements. Outcome measures are those factors for which quality is assumed to have an impact, most prominently, fertility through fulfillment of reproductive intentions (that is reduction of unwanted and unplanned pregnancies).

Turning now to indicators, the first question is why go to the effort of generating them? Situation Analyses collect a considerable amount of data on quality of care from clients, providers, and policymakers -- through both interviews and observations. Standardized indicators summarize these data. Thus they can help managers and policymakers more easily identify those elements most in need of improvement. And, they can also be used by researchers to investigate program impact, that is, the extent to which contraceptive behavior can be accounted for by variation in the quality of family planning services. In short, it can be argued that we need to develop a list of indicators to describe, monitor, and improve the quality of services provided, as well as to conduct research on the relationship of quality to contraceptive use and fertility.

How do we go about this process of measuring quality and creating indicators? The first step is to define the elements. That has already been done in the form of the

Bruce framework. Next we must list the indicators to measure each element. At the moment this process of identifying indicators is somewhat arbitrary and is dependent on the nature of our data collection instruments; however, as field testing of indicators proceeds a consensus will undoubtedly develop as to what constitutes a reasonable and useful set of indicators. Third, we must identify items in our data collection tools, here the Situation Analysis instruments, to measure the indicators. Fourth, we must develop scoring procedures. Some of this work is currently being undertaken by the Evaluation project Sub-committee.

To give a better sense of the process, the five indicators used here to describe the first element, choice of methods, are:

- Client told about at least one method in addition to the one accepted.
- No restrictions on non-permanent methods. Among the methods provided, what conditions have to be met before the method is offered? The data collection instrument lists four: age - you have to be within a particular age range; parity - you have to have had a specified number of children; marital status - you have to be married; spouse consent - you have to have the permission of your spouse or partner. The fewer the restrictions, the higher the score.
- The third indicator is no bias against methods. The more methods recommended and the fewer never recommended, the higher the score.
- Method preference asked. Does the provider ask a client whether she has a preference for a particular method?
- Method preference honored. Among clients indicating a preference, what percentage received the method they preferred?

To measure the first indicator of choice, namely "told about a method other than the one accepted", three items are needed from the Situation Analysis data:

- Did the client accept a method?
- If yes, what method was accepted?
- What methods were discussed with the client?

Here a decision was made quite consciously **not** to measure choice stringently. We sympathize with the sentiment that it is asking too much of providers to talk about all methods. But we think that at the very least two methods should be discussed. To measure this indicator we need information on whether a method was accepted, on which method was accepted and which methods were discussed. The score is the percentage of new acceptors who have been told about a method other than the method accepted.

This same process - of specifying indicators and the items to measure them - is followed for each of the elements of quality. The number of indicators per element ranges from 2 to 7 and the number of items needed per indicator ranges from 1 to over 30. The quality of care scores to be discussed in the remainder of the paper are derived from Situation Analysis studies from three countries - Ghana, Nigeria, and Tanzania. They are entirely clinic based.

It should be noted that reliance is placed most heavily on the observation instrument from the Situation Analysis approach, although where necessary the client exit interview, the staff interview, and the inventory are also used. It should also be noted that because the indicator scores are derived almost entirely from the observations of client-provider interactions, the data apply to only about one-half of the service points in the sample because these interactions were only observed in half the service points. In the other half of the service points no family planning clients came for services on the day of the field team visit. If we assume that the presence of clients on the day of the visit is indicative of higher quality services than indicators of quality will be upwardly biased because they are based on SDPs which are more likely to have clients. The number of service points and correspondingly, the number of client/provider observations and staff interviews, varies across the samples.

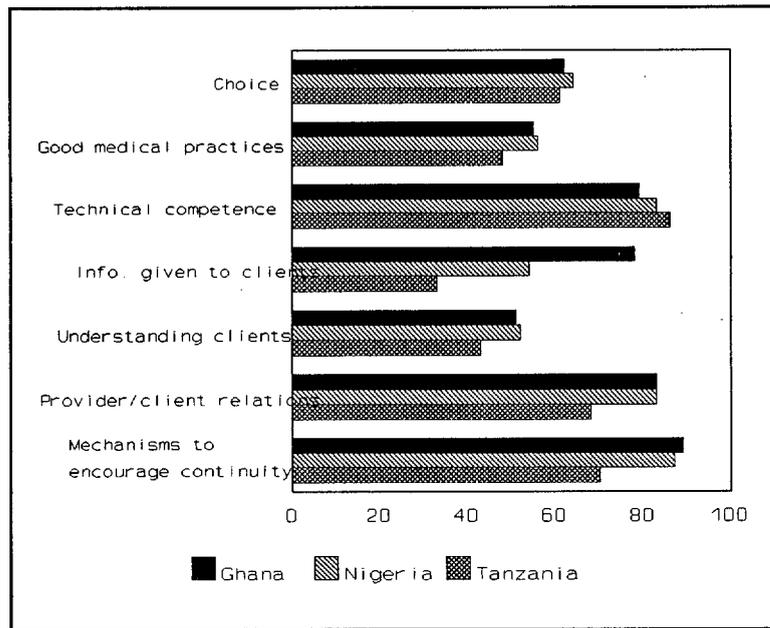
Before presenting the scores, I would like to make some comments about the process of improving quality. Those involved in the family planning programs in Ghana, Nigeria and Tanzania (and in all the other countries where Situation Analyses have been done) clearly recognize that in order to improve services they must know what level of quality is currently being provided. Thus their interest in Situation Analysis studies. These individuals and institutions should be congratulated for their willingness to go through this process and for allowing the results to be presented here. I would also like to note that although one country may score higher on a particular indicator, there is room for improvement in all programs. Decisions on which areas to focus attention and the level of resources needed for improvement should be made by managers and policymakers.

We do not wish to set absolute standards of care to which all countries should adhere. What is feasible managerially and financially in Ghana may not be feasible in Tanzania, and vice versa. Researchers can present indicators of quality of care offered to and received by clients. It is up to the policymakers and managers within each country to decide what quality of care their program intends to offer. That said, the following discussion will dwell on the negative rather than the positive. Given the constraints under which programs operate, we should applaud managers and providers for all the things they are doing well. But, because the purpose of this paper is to demonstrate the utility of quality of care indicators for problem identification, I am focusing on the things the programs do less well.

Turning to the scores it should be noted that each ranges from 0 to 100, with 0 the low and 100 the high. Each indicator contributes equally to the element score. The samples used to derive each score vary although for the most part are limited to new users or new acceptors of a method. This paper will not discuss the details of the scoring procedures used to go from the multitude of individual items to the 33 indicator scores. The set of 33 quality of care indicators shown here is not exhaustive. In particular, additional indicators have been developed for Ghana where we modified, and hopefully improved upon the Situation Analysis instruments used in Nigeria and Tanzania. The 33 indicators presented were selected because data were available on them for all 3 countries.

**Figure 1: Element Scores**

Figure 1 shows the element scores. Rather than calculating scores for the five Bruce elements, I disaggregated two: Provider competence, which I divided into good medical practice and technical competence in conducting a pelvic exam, and client/provider information exchange which I divided into information given to clients about the method accepted and attempts made by the provider to understand clients and their needs. Thus there are a total of 7 rather than 5 elements. This Figure



indicates that the best element scores are for competence in conducting a pelvic exam as well as provider client relations and mechanisms to encourage continuity of use. These scores are generally in the 70's and 80's. Note, however, that the percentage of women having a pelvic exam is not high, particularly in Tanzania. So this measurement is made on a very small sample. The worst element scores are for understanding clients. They range between 43 and 52 for the three countries.

This Figure is an aggregation of the 33 indicators and, in that sense is not very useful in pinpointing potential trouble spots. In addition, the element scores are entirely dependent on the weighting procedure used to combine indicators. Here, each indicator contributes equally to the element score. A case could be made however, for weighting some indicators more heavily than others. If, for example, for choice, more weight was given to method preference asked than to other indicators of choice, the element score would be lower than it currently is for all three countries because method preference is the lowest indicator score. So, both for methodological reasons and for programmatic utility, let's turn to the individual indicator scores.

**Choice of methods.** Figure 2 shows that the lowest score for all countries is "method preference asked". The scores range from 22 to 45. Apparently providers are not very likely to ask women what method they would like to use. The "preference honored" score, indicates among those who are asked or who indicate a preference, what percentage actually get the method of choice. The scores range from 67 to 77. These numbers are based on observation; we get virtually the same numbers when we ask women directly in an exit interview. That is, between one-quarter and one-third of women in these samples are not given the method they originally wanted. There is evidence from Asia to suggest that women who do not get the method they want, are less likely to continue using family planning.

**Provider competence.** Ideally, we would like to measure provider competence according to method accepted. Methods have different contraindications and therefore require different medical procedures and varying degrees of information to be obtained from clients. Because we had too few IUD acceptors in Tanzania we didn't compare countries here according to competence in providing particular methods.

**Figure 2: Indicator Scores: Choice of Methods**

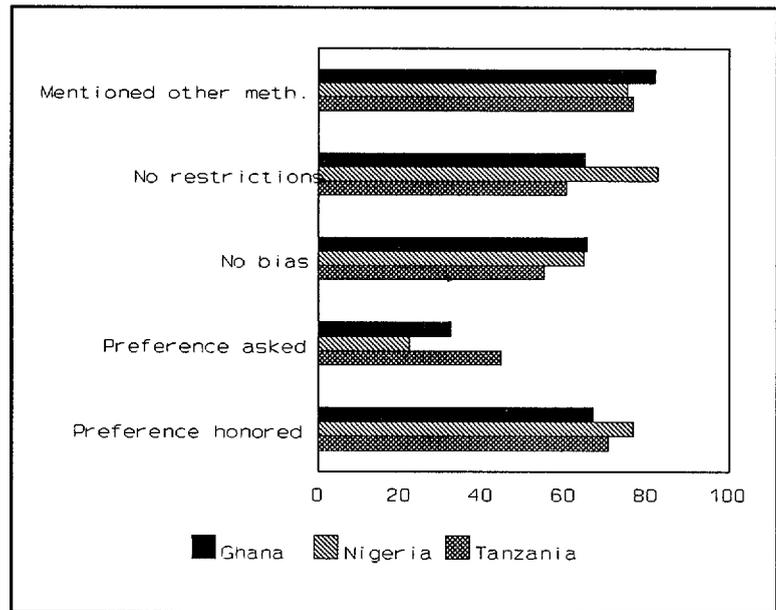
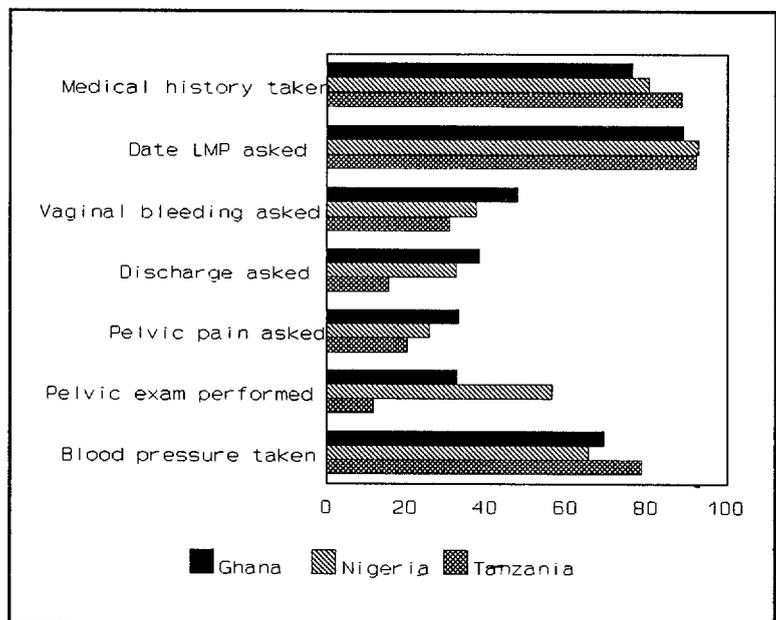


Figure 3 looks at what we have labelled, for lack of any other phrase, "good medical practice" for new users. Here we are measuring what questions providers ask new users and what procedures they perform. Recently there has been a lot of talk about medical barriers in the family planning community, that is procedural or policy obstacles to obtaining a particular method. We have to think carefully about this issue as the relationship between quality of care and medical barriers is not a simple one. We must determine which medical procedures, if removed, would actually improve quality of care, which would undermine quality, and which would have a neutral effect.

As can be seen, the lowest scores are for the questions on gynecological problems asked. These are the three middle items, vaginal bleeding asked, discharge asked, pelvic pain asked. The scores range from 15 to 47. Under one-third of clients are asked about whether they have pelvic pain. Under half are asked about unusual vaginal bleeding and unusual discharge. It would seem that in order for providers to ensure that the method given is appropriate, this information should be elicited from clients. Furthermore, the cost of obtaining this information is minimal and involves investments of time rather

**Figure 3: Indicator Scores: Provider Competence: Good Medical Practices for New Users**



103

than money. Moreover, the benefits of providing treatment if a diagnosis can be made based on symptoms are large both in terms of reproductive health and in terms of attitudes of users towards services.

The issue of performing a pelvic exam is more complicated. We don't want to hold women who want hormonal or barrier methods hostage to an exam. On the other hand, when women come to a service point they don't always know which method they want. And, for many women their only contact with a health provider may come when they visit a clinic. Given the high rate of RTIs within sub-Saharan Africa it may make good medical sense to perform an exam. The question is one of will, feasibility and cost. These issues need to be looked at more thoroughly within countries. At any rate, the scores for this indicator range from 12 in Tanzania to 56 in Nigeria. Although, not shown here, the scores for pelvic exam performed among IUD acceptors in Ghana and Nigeria are 57 and 83, respectively.

**Figure 4: Indicator Scores: Provider Competence: Technical Competence in Conducting Pelvic Examination**

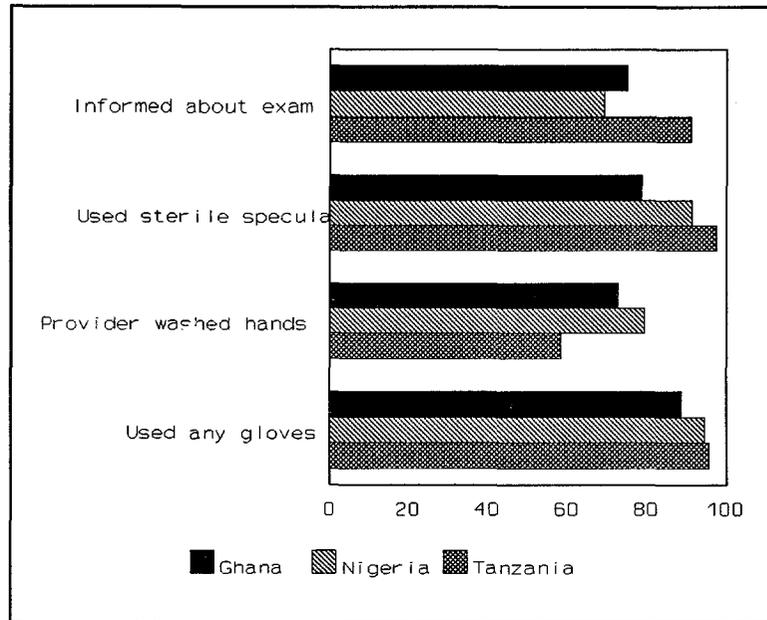


Figure 4 describes procedures followed when conducting a pelvic exam. The first indicator is whether the client is informed about what is going to happen during the pelvic exam. The lowest scores are for provider washed hands and they range from 58 to 79. The gloves score may be misleading. Except in the case of Ghana, we don't always know whether the gloves used are clean or not. However, based on debriefing of our observers in some countries, we believe that it is not uncommon for providers to use gloves to protect themselves rather than their clients.

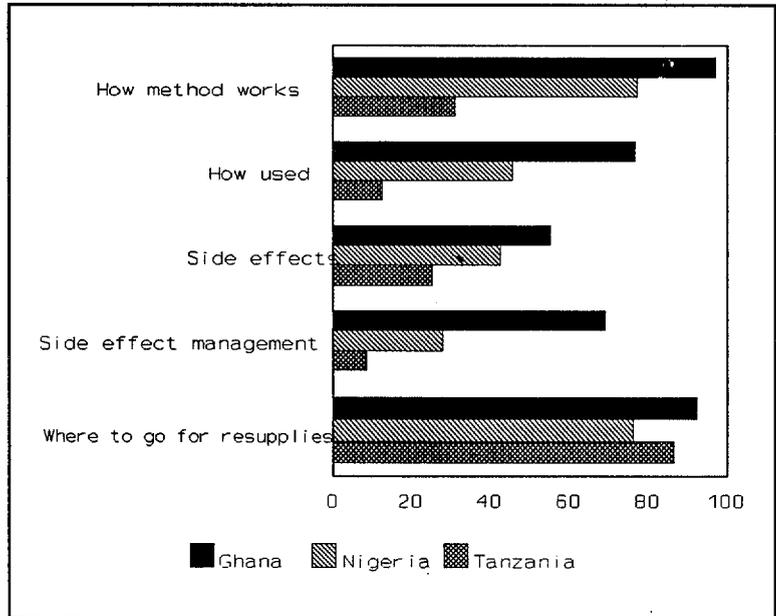
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**Information given to client.** Figure 5 describes the information given to the client about the method accepted. We don't think the provider needs to give women complete information about all methods. But at the very least, the provider should give information about the method accepted. There is more variation across countries for these indicators than for the others. Overall the worst scores are for information on side effects and management of side effects. In Nigeria and Tanzania fewer than one-third of clients are told how to deal with any problems that arise. It seems likely that women who are not given sufficient information would be less likely to continue using should a problem develop. What is also noteworthy is the extremely low score for Tanzania on the indicator measuring whether women are told how to use the method accepted.

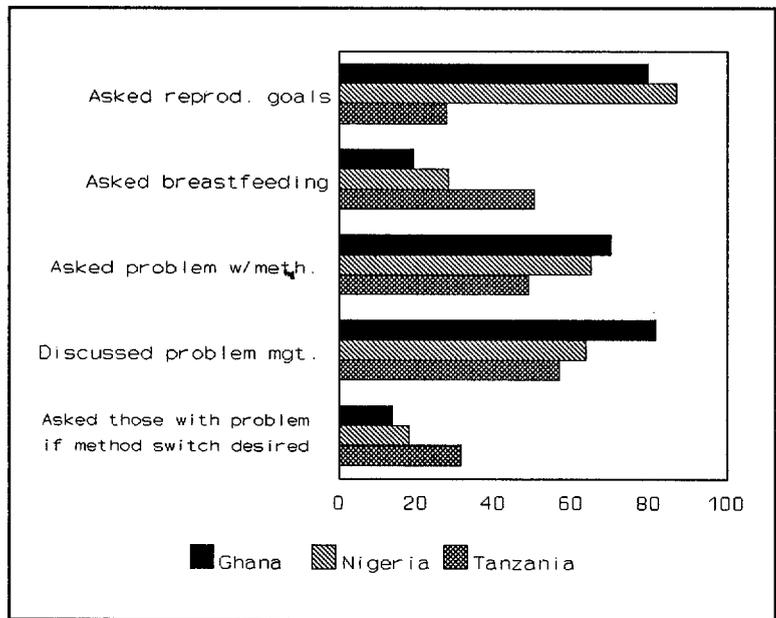
**Figure 5: Indicator Scores: Information Given To Client About Method Accepted**

**Provider understanding of client's needs.** Here the lowest score is the one relating to switching among returning clients (Figure 6). Few providers ask returning clients who have a problem with the method currently used if they wish to switch methods. Apparently, providers, perhaps because they are over-burdened or because the program tries to minimize switching, do not want to go to the effort of giving clients a different method. The consequences of that for continuation of family planning are unknown. But it stands to reason that dissatisfied clients will be more likely to become dropout statistics.

The other piece of information rarely elicited from clients relates to breastfeeding. Particularly in Ghana and Nigeria, clients are unlikely to be asked if they are breastfeeding. A potential consequence of this is that breastfeeding clients may be given combined pills which can undermine lactation.



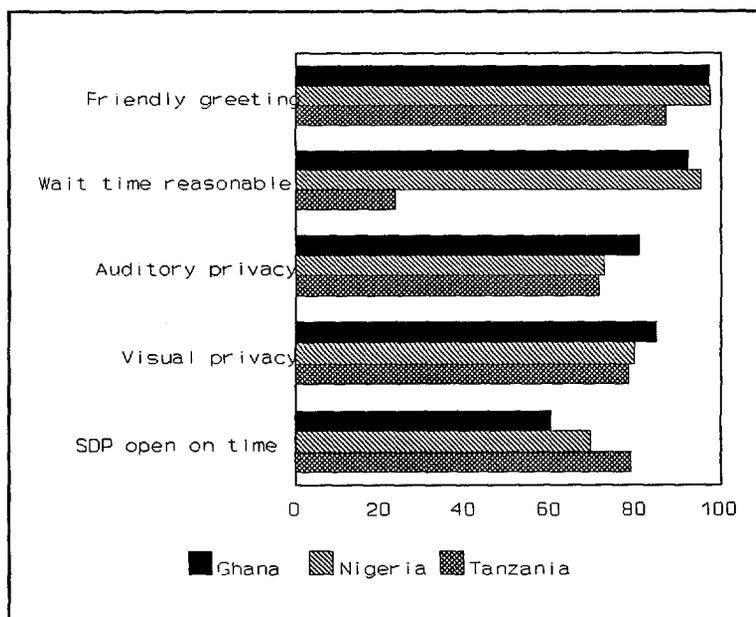
**Figure 6: Indicator Scores: Understanding Clients**



**Provider client relations.** The only really low score given on Figure-7 is for waiting time for Tanzania. This result is somewhat puzzling. Although waiting time is not longer there than the other two countries, clients are not happy about it. Interestingly, although many believe that privacy is a problem, these provider/client relation scores suggest the situation is not that bad. What is somewhat more problematic, particularly for Ghana and Nigeria is opening time. Between 30% and 40% of SDPs (for which this could be determined) did not open on time. Whether these service points lose potential clients is unknown, but it certainly is possible.

105

**Figure 7: Indicator Scores: Provider/Client Relations**



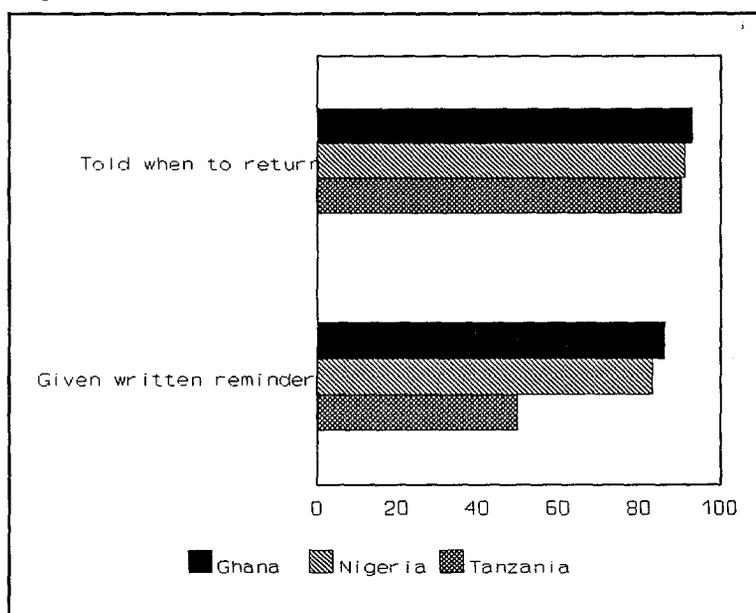
**Mechanisms to ensure follow-up.** As Figure 8 shows, most clients are told when to return although fewer are given a written reminder, particularly in Tanzania.

**Summary**

As mentioned earlier, this paper has deliberately focused on the problem areas rather than the areas of strength. The weakest areas relate to client/provider information exchange.

Limited information is obtained from and provided to clients. Clients typically are not asked about whether they have a method preference, about any gynecological problems and about whether they are breastfeeding. In addition providers often do not tell clients how to use the method accepted, about side effects, about management of side effects and about the possibility of switching methods if they have a problem.

**Figure 8: Indicator Scores: Follow-up**



It is my belief that these scores can be used to quickly identify deficiencies in the services provided. Instead of a multitude of graphs and tables - the standard output of a Situation Analysis - we have 33 numbers which fit on a page. In addition, if the countries are willing to undertake such assessments in the future, these scores could also be used as baseline data so that managers could easily assess whether the actions which were taken to improve quality had the desired effect. It

would be worthwhile to address the issue of utility. Are quality of care scores helpful in evaluating family planning programs and in diagnosing shortcomings in services? Do they serve the needs of managers, of those concerned with evaluating family planning programs and of researchers interested in demonstrating the impact of family planning programs on contraceptive use and fertility?

## **5. Barriers to Family Planning Services: Gender Issues, Medical Issues**

### **Gender Barriers to Family Planning**

**Dr. Nahid Toubia**  
**The Population Council, New York**

#### **What is Gender?**

It is simply the different roles ascribed to men and women in a particular culture and society. Gender is not the same as biological or sexual difference which is unchangeable, it is socially defined therefore it varies between societies at any given time and in the same society over time. Since gender roles are potentially changeable it seems reasonable to look at how the current interaction between men and women could be modified to benefit them as individuals as well as benefit their society.

But before going further to look into what are the gender barriers to family planning let me take a step backward and ask another question:

#### **Why Do We Promote Family Planning?**

There are two reasons why I, as an individual, and I believe the organization I work for, the Population Council, promote family planning:

- The belief that access to fertility regulation technology in this day and age is a human right of every individual man and woman. The ability to regulate the number and timing of children through modern methods has health, economic and social benefits that should be available to all people all over the world if they wish to use them.
- The concern over the rapid rise in population. In some countries, resources are overstretched and efforts towards economic and social development can be undermined by rapid population growth.

Whether the rationale for providing family planning is based on the right of the individual or concern for the whole population, it ultimately should stem from a larger commitment to better quality of life for all individuals women and men, young and old, regardless of whether they live in a rich or a poor country. To us as health providers, quality of life to all human beings means constant assessment of our services to see whether they are attending to the human rights values of justice, fairness, equity (and not equality) and freedom. It also means an obligation to redress possible imbalances of power between social groups.

Historically we have come to understand differential power relations along the lines of race, class, tribe and national boundaries. Gender is another component of

differential power distribution in society which is now being recognized. It is true that women were the ones to first realize and point out gender power relations since they are the ones who suffer most from it. Although the concern with gender started as a means to bring more justice to women, the more we study gender roles we have come to realize that the way society defines mens roles so narrowly is also not in mens best interest. Let us take a look at the specifics of our field of population policy, family planning and reproductive health and examine how gender issues affect their different components:

### **Population Policy**

To date population policies have not attended to the principle of equity. Equity means fair and just distribution of responsibilities and benefits. The reality is population programs have put the highest burden of responsibility for fertility reduction on women, whose bodies and time are already over burdened with childbearing, breast feeding and childrearing. Undoubtedly at the individual level women benefit from fertility reduction and less births. However, there is little evidence that the benefits of slower population growth to the community or nation is syphoned back to benefit women at a level proportionate to their contribution to fertility decline. The gender element in this policy choice is that women were (and still are) perceived as less powerful than men and will show less resistance to these new programs.

### **Contraceptive Development**

As a cause or an effect of population programs being directed primarily at women, contraceptive developers have been unfair to men. After forty years of modern contraceptive research we still have two methods only for men, condoms and sterilization. These two methods give men very little choice since they occupy the extreme ends of the contraceptive spectrum with nothing to fill the gap in between. Our friends working on expanding contraceptive choice will have to suggest new initiatives to expand men's choices. It is important that expanding men's choices means choices to use male contraceptives and not choice for men to have women use contraceptives. The deficiency in male contraceptives does not arise from lack of scientific ability to develop male contraceptives but from an assumption that men are not interested in, or do not need family planning. This is an example of cross-cultural gender bias. Developers of contraceptives are mostly men in Northern countries, who were unaware that in some cultures men traditionally carry the responsibility of contraception such as in Turkey and other Muslim cultures.

### **Family Planning Services**

One major gender issue in family planning services has been that the services are directed primarily to women, mostly poor women, while the providers are male physicians with much higher social status and power. With such a set up there is very little possibility that the relationship between the provider and the client will be one of fair exchange. Freedom of choice, adequate information, fair counselling as essential

elements of quality of care, which stresses the rights of the client, would be difficult to achieve. Fortunately many family planning programs have realized this gender and class barrier to their services and are changing their staffing configurations.

MCH/FP clinics in many countries are seen as a space for women and children which does not welcome men. Here again a cross cultural bias assumes that men are not concerned with fertility regulation decisions and not interested in the health and well-being of their children. Although most current contraceptives are used by women, men also need to know and understand how they work to improve effective use. In a study of women who have just received elective abortions in Turkey, when asked about the reasons for non-use of protection, women described their husbands fear of injury to their organ by the IUD which is the main method available in that country. Nobody ever talked to these men and addressed their fears. The gender power imbalance that allows the husband to order his wife to remove the IUD was not in the minds of the providers. As a result the women get pregnant and endure repeat abortions and the providers assume that they are stupid, lazy and irresponsible and that they prefer abortion to contraception.

On the other hand in Sierra Leone a clinic which provides high quality care, adopted a clear policy which welcomed men in the clinic right from its start in 1988. At the beginning men accompanied their wives, carried the children and asked questions. After a few years the men started to demand family planning for themselves which the services responded to by opening the first specialized male clinic this year.

Although encouraging men to take responsibility for their fertility and share the caring for children is desirable it is not always a straight forward issue for services. In Columbia an experiment to work with couples in the same session did not work very well. In assessing the experiment providers found that when the couple are counselled together for a female method, the male partner tends to dominate the session with more general intellectual questions like association between contraceptives and rare diseases like cancer, and the woman does not get a chance to ask questions that are more related to her immediate concerns like side effects of bleeding etc. Much more operational research needs to be done to verify the best way to include men without jeopardizing the rights of women in the services.

In my opinion the most important gender issue that family planning services have to address is their own inattention to their clients social reality. A woman who presents herself to the clinic is not just a physical body that has to be protected against physical side effects and complication. She is a social entity who will go home and live in a nuclear relationship or an extended family. She has a male sexual partner or partners with whom she has to negotiate. What are the services doing to protect the woman from the possible social side effects of using a specific contraceptive? Let us take an example which I am sure is not that uncommon in many societies.

The husband is unemployed, frustrated and drinks a lot. He tends to get violent when he gets angry and the wife is scared of his violence. They have 4 or 5 children and the burden is too much for her to handle. She goes to the family planning clinic and they fit her with an IUD. It causes irregular bleeding so she cannot be responsive to her

husbands sexual demands because it is a religious taboo to have sex while bleeding. As she says no he beats her up. She goes back and asks for the IUD to be removed. She is contra-indicated for the pills because of her age and slightly raised blood pressure. They give her some condoms. She has no idea how they are used but give them to her husband anyway. He thinks she is trying to harm his manhood so he beats her and the children some more. She gets pregnant and in desperation she attempts to abort herself. She dies in the attempt. Who is responsible for her death? Who is responsible for her orphaned children? Can the services claim that they have done their best to help her? I leave these questions for you to answer. If you analyze this case from a gender perspective a whole new set of questions and possible answers and solution will present themselves.

I would have failed to deliver my message if people leave with the impression that gender issues are about what men do to women. It is about what society dictates for both of them which makes them behave in certain ways. Let us take another example of how women internalize their own oppression even without anybody actually hurting them. A family planning client in her mid thirties keeps coming back to change contraceptives every few weeks. She is an educated primary school teacher with a husband, ten years her senior, who is becoming a successful businessman. They were known to be a close knit family with three wonderful children who are doing very well in school. What is her problem? Why is she behaving so strangely coming up with all these imaginary side effects as excuses to change contraceptives? The funny thing is she keeps coming back to the clinic. Why doesn't she just drop out if she does not rally want to use any method?

Let us have a look at her real story. As a successful businessman her husband now stays out all night at male only business parties where she heard they also have beautiful young women to entertain them. She is scared of loosing her husband if he chooses to divorce her or get a second wife. Although her husband does not come to her in bed very often now, she is scared that when he does he might carry disease that will affect her and she would never dare ask him to wear a condom. Besides she does not know for sure that he does sleep with other women but as a good wife and a respectable women, she cannot talk to him about her fears. Her mother always told her that the best way to keep a man is to keep giving him children. She does not want any more children but maybe her mother is right. She is in a total dilemma. At the FP clinic no body knows all these details because they never asked about her home situation or about her relationship with her husband. All they can see is a difficult client who is always complaining and some believe her to be a little stupid and psychotic despite her education. A gender sensitized provider can help this woman.

A recent study in Tanzania of women who came with abortion complication showed that the women under 20 years of age reported that their sexual partners were men who were 20 - 30 years their senior. Could we conclude that these women are just irresponsible loose girls who are having free sex then getting abortions? Most of these girls are still in school and struggling hard to secure an education. They cannot be that irresponsible. Although that particular study was not designed to ask further questions I wonder what we will find if we asked about their social and economic background, why they have relationship with these older men and most important what they will do after

they leave the hospital to protect themselves against another pregnancy or disease? Will they have the power in these clearly uneven relationship to protect themselves or are the too economically vulnerable to save themselves from the risk of dying with AIDS or a botched abortion?

Once we start asking these questions with a gender perspective in mind a whole new set of realities will come unfold to us. Some of these facts may be what society does not want to hear but as scientists can we afford to ignore the truth? Do we really want to know that a high proportion of teenage sexual activity below the age of 15 is due to incest? Are we ready to take the responsibility for socially created problems or are we happier hiding our heads in the sand and throwing the blame on the weakest elements of society?

I hope that I have demonstrated what gender issues are about. Gender issues are about justice, fairness, dignity, freedom and all the values we aspire for as human beings regardless of whether we are men or women. It is true that women have championed the cause for gender equity but men in their scores are joining in the call to address this form of social injustice. In fact it is the men who came up with the following slogan for their gender related activities:

"It takes a real man to support the rights of women"

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**B: CONFERENCE OUTCOMES AND RECOMMENDATIONS**

**1. Report From Working Groups on Using Operations Research to Improve Service Delivery**

With regard to agency utilization of OR studies, groups were divided and felt that the question could be answered "Yes" and "No". Programmatic OR has had substantial positive impacts in several countries (see chart below).

<b>COUNTRY</b>	<b>OR RESULTS USED</b>	<b>OR RESULTS NOT USED</b>
<b>NIGERIA</b>	<ul style="list-style-type: none"> <li>• Improved counselling</li> <li>• IEC Materials</li> <li>• NORPLANT</li> </ul>	
<b>KENYA</b>	<ul style="list-style-type: none"> <li>• NCC Situation Analysis/Project Redesign</li> <li>• DHS</li> </ul>	<ul style="list-style-type: none"> <li>• PUBLICIZE education study but no replication</li> <li>• Integration of FP /Diarrheal Control</li> </ul>
<b>TANZANIA</b>	<ul style="list-style-type: none"> <li>• Situation Analysis/national strategy</li> <li>• Curricula revisions</li> <li>• NORPLANT</li> </ul>	
<b>GAMBIA</b>	<ul style="list-style-type: none"> <li>• Use of Islamic motivators</li> </ul>	
<b>MALI</b>	<ul style="list-style-type: none"> <li>• CBD</li> </ul>	
<b>IVORY COAST</b>	<ul style="list-style-type: none"> <li>• MIS</li> </ul>	
<b>BURKINA FASO</b>	<ul style="list-style-type: none"> <li>• Situation Analysis</li> <li>• Efficacy of using volunteers</li> </ul>	
<b>RWANDA</b>	<ul style="list-style-type: none"> <li>• Integration of FP and EPI</li> </ul>	
<b>TOGO</b>	<ul style="list-style-type: none"> <li>• Integration of FP and EPI</li> </ul>	
<b>GHANA</b>	<ul style="list-style-type: none"> <li>• Situation Analysis/project redesign</li> </ul>	
<b>MADAGASCAR</b>	<ul style="list-style-type: none"> <li>• NORPLANT/IUD</li> </ul>	

113

Situation analyses may be different than OR studies in this context since situation analyses are broadly general, qualitative and descriptive. Therefore, their policy impact can reflect any objective sought by an organization. With OR studies that are more particularized or specific, whether implementation actually occurs may be more difficult to verify and generalizations are difficult to make. There are few if any research studies on the question of OR's broad-based impact.

## 1.1 Barriers

Barriers of OR study results included:

- Non-involvement of the community, Program Managers and services providers and policy-makers from the inception or design phases through dissemination, actual implementation and follow-up.
- Apprehension about the whole area of research and evaluation.
- Lack of institutional capacity, trained staff and resources.
- Lack of political will and support for both FP and OR.
- Poor dissemination and communication of OR results.
- Results that are inconsistent with national policies, goals and objectives.
- Donor policies, priorities, prerogatives and preferences.
- Overly-academic, pedantic, complex presentations that are not user-friendly.
- Time lags between framing of research questions and dissemination of results.
- Culturally inappropriate research designs and procedures.
- Failure to institutionalize research and OR as an integral component of program operations.
- Lack of linkages between research and "problem-solving" or "self-assessment techniques.
- OR results framed too generally without investigating or highlighting underlying causal factors.

## 1.2 Facilitating Factors

Facilitating factors for greater utilization of OR results included:

- Continuous re-analyses of data and monitoring of OR impact at national and sub-national levels.
- Creation and use of national networks to disseminate OR results more effectively.
- Implementation of training and other initiatives to strengthen institutional capacity to conduct self-assessments and other OR studies systematically.
- Making research inquiries more relevant, timely, pertinent and focused on practical programmatic needs.
- Investigating locally available resources (human and material) to support OR and guaranteeing use of results.
- Motivating users to pay attention to and implement OR research findings by involving them at all stages of OR project activities.
- Ensuring implementation by developing a specific action plan or action agenda that outlines detailed implementation tasks; identifies resources needed; persons responsible; and time frames based upon OR findings.

## 1.3 Recommendations

- Political, socio-economic, cultural and other contextual factors should be carefully considered in framing OR questions, designing projects and disseminating results.
- Careful consideration must be given to different structures (eg public, private, NGO) in tailoring OR projects and reports. Moreover, collaborative OR projects and exchanges of results, should be encouraged wherever possible.
- Reports should be written in non-academic and "user-friendly" style, with a clear section on how to use results for enhancing project or programmatic performance.
- OR projects should include clearly delineated follow-up plans of action; programs for monitoring; evaluation protocols; and means of institutionalizing both OR findings and capability to conduct on-going OR.

- Donors should provide adequate funding not only for the OR but also for sustainable implementation and utilization of results and findings. Creation of implementation plans and steps should be an integral part of all OR projects.
- Community residents, program managers and policy-makers should be integral partners with researchers in all phases of OR, implementation of results, study follow-up, dissemination and evaluation. OR studies should be practical--not just donor-driven--and relate closely to perceived problems or service delivery objectives of communities, Program Managers and service providers. The emphasis should be on *operations* versus *research*.
- There should be fewer OR studies but those that are conducted should have broader applicability or relevance to African family planning service providers. These studies can serve as the basis for replicable models of more effective service delivery and practical, culturally and technologically appropriate solutions to service delivery problems.
- OR researchers should incorporate cost-effectiveness and -efficiency assessments and feasibility analyses as part of OR project designs as an important basis for cost-effective implementation strategies.
- The recommended future research agenda included:
  - Impact of socio-political changes on family planning program implementation;
  - Consequences of service provider attitudes or biases on acceptance of family planning services;
  - Impact, and most effective or appropriate methods, of training, and role of various cadres (including medically-trained personnel), in providing more effective family planning service delivery;
  - Male attitudes toward family planning;
  - Appropriate models for, or limitations of, integrating family planning service delivery with other health or development interventions;
  - Roles of private sector networks and institutions in commodity distribution and IEC;
  - Modes of service delivery, motivation and counselling for adolescent populations;

- Appropriate and sustainable incentive and motivational strategies for volunteer and paid family planning project staff;
- Benefits of utilizing private sector organizations (e.g. industrial or commercial employers, associations, community groups, institutions of higher education, etc.) to extend the reach and accessibility of family planning services or to provide models of more "competent" or effective service delivery;
- Method mix and strategies for expanding utilization of all methods, including longer-lasting or permanent methods.
- Family planning projects should be designed in phases that make OR an integral part of the project design and that make project implementation strategies contingent upon OR findings.
- Situation Analyses should be followed by diagnostic OR studies that reveal causal factors and suggest comprehensive plans for addressing them.

## **2. Report from Panel Discussion on: The Use of Situation Analysis Findings to Improve Programs**

A panel discussion was held to review how the findings of Situation Analysis have been utilized to improve service delivery programs. Representatives from Zimbabwe, Kenya, Tanzania, Nigeria and Cote d'Ivoire were invited to address these issues. The discussion was structured around certain questions:

- What were the major reasons for conducting a SA?
- Were there any surprises in the findings?
- What did you do to bring the information for the SA study to family planning managers and service delivery providers?
- How did family planning staff at various levels react to the information?

The case of Zimbabwe has been used here as an illustrative example of the outcome of the conference session.

### **How The Findings of The Situation Analysis of The Family Planning Program in Zimbabwe Have Been Utilized**

#### **2.1 Background to Family Planning Program of Zimbabwe**

Limited family planning services have been available to a few couples in urban areas since 1953. The early 1980s saw an expansion in family planning (FP) service delivery through:

- the provision of FP services from all Ministry of Health (MOH), Mission and Municipal facilities as part of MCH services;
- the number of the Zimbabwe National Family Planning Council (ZNFPC) clinics increasing to 34;
- the integration of an family planning module into all health training curricula;
- conducting family planning courses for service providers;
- strengthening the CBD program and increasing the number of CBDs.

The ZNFPC, a parastatal under the MOH, is mandated to oversee FP service delivery in Zimbabwe. The Zimbabwe Situation Analysis Survey (ZIMSA) of the Family

Planning Program highlighted the strengths and weakness in service delivery, most of the identified weaknesses being amenable to correction. The ZIMSA was executed at a time when the ZNFPC was formulating its Five Year Strategy (1991-96) aimed at increasing the Contraceptive Prevalence Rate, promoting the use of long term and permanent methods and improving the quality of care. ZIMSA findings, therefore, allowed ZNFPC to "fine tune" the activities aimed at improving service delivery in Zimbabwe. The inclusion of most of the suggested interventions into the ZNFPC's Five Year Strategy has contributed to the rapidity of its current implementation.

## **2.2 Equipment Available for FP Service Delivery at the Service Delivery Points Visited**

The ZIMSA showed that:

- 78 percent of the clinics had a specula while 72 percent had an examination couch, both of which are essential for pelvic examinations;
- a working sterilizer was found in only 64 percent of the clinics;
- very few SDPs had IUDs and the necessary equipment for IUD insertions, such as a uterine sound and tenacula;
- only one percent of the SDPs had minilap kits for PUBLICIZE procedures.

The inventory of equipment at the health facilities visited, therefore, showed that most rural health centers were well equipped for screening clients for oral contraceptives. Most ZNFPC, District and Provincial Hospitals were well equipped for IUD insertions. Furthermore, those District and Provincial Hospitals visited had the basic equipment for minilaps. ZNFPC, in collaboration with MOH and City Health Departments, and with funding and technical assistance from SEATS, has since, in March 1992, compiled the Zimbabwe Family Planning Service Delivery Policies and Protocols/Standards. The document stipulates the minimum/basic equipment and the type of provider training required for family planning service delivery at the various levels of the health care system, as a strategy to ensure high quality care, uniformity and safety. The phase two of the Family Health Project will fund the purchase of equipment, based on the FP Service Delivery Policies and Standards, thus enabling facilities to expand the method mix and so improve the quality of care.

## **2.3 Issues Pertaining to Provider Client Interaction**

The ZIMSA revealed that the family planning service providers, both the clinic personnel and CBDs, in general, were observed to be taking appropriate actions to screen clients and check for possible medical contraindications. Furthermore, exit interviews of clinic clients revealed that ninety-one percent were told or shown how the supplied method was used and seventy-two percent discussed the side effects and their

119

management. However, observations of the interaction between service providers and new or restart clients revealed issues highlighted below which required to be addressed.

- Thirty-six percent of clinic new and restart clients and 42 percent of similar CBD clients were not asked what their reproductive goals were before they were supplied with oral contraceptives.
- Seventeen percent of the clinic based service providers and 24 percent of the CBDs did not ask the breast feeding status of new, restart or method switching clients before starting them on a method.
- Twenty-nine percent of clinic based service providers did not take the medical history of new, restarting or switching clients.
- Seventy-four percent of the observed CBDs mentioned the POP while 69 percent mentioned the condom to new or re-start clients. Slightly more than a quarter of CBDs mentioned the COC and the IUD.
- Although condoms should be given as a back-up method to all new or restarting clients, 61 percent of clinic clients were not told about the condom.
- Other methods were discussed less frequently with new and restarting clients. Fourteen percent of the clinic staff discussed the IUD and six percent discussed tubal ligation. Only two percent discussed injectables, although this could have been due to the restricted use of injectables at the time of the survey. Seven percent of CBDs talked about tubal ligation to their new and re-start clients.
- Before being resupplied, 41 percent of clinic and 19 percent of CBD continuing clients were not asked if they had any FP method-related problems since the last visit.
- Sixty-one percent of CBDs had the family planning method sample-kit, a tool which the CBD use for motivational talks and also for showing potential clients the range of family planning methods available in Zimbabwe. However, the ZIMSA also revealed that only thirty-five percent used the kit during their interaction with new or restart clients.
- The training manuals for the clinical and CBD courses had not been revised since they were initially written in 1985 -- ZIMSA findings, therefore, highlighted areas which needed to be reviewed in the procedure manual.

These issues have been addressed in various ways outlined below.

- The ZNFPC Training Unit, with the participation of the Medical/Clinical and CBD Units and the IEC Unit, has since revised the Basic FP Curriculum to include all the methods available in Zimbabwe.
- The revised procedure manuals encourage service providers (both clinical and medical) to inform all clients about:
  - . Available FP methods
  - . How they work
  - . The method effectiveness
  - . Advantages and disadvantages of particular methods
  - . Side effects and
  - . Sources of the methods.
- ZIMSA findings also highlighted the weaknesses in the counselling skills of service providers especially those pertaining to long term and permanent methods. In order to improve the service providers' knowledge, attitudes and counselling skills to ensure high quality of FP services with special emphasis on long term and permanent methods of family planning, a counselling skills module was developed (April 1992) for both the clinic-based service providers and the CBDs. The module can be used either as a "stand alone" course or integrated into the basic FP training for nurses and CBDs.
- In order to strengthen the communication skills of service providers, an Interpersonal Communication Module was developed, taking the ZIMSA findings into consideration.
- The IEC Unit with the participation of the Training/Clinical and CBD Units, and funding and technical assistance from JHU/PCS, has produced the "GATHER" video to strengthen the counselling skills for service providers. GATHER means: **G**reet the client; **A**sk the client about self and reproductive goals; **T**ell the client about all the FP methods and side effects; **H**elp clients to decide the FP method to use; **E**xplain how to use the chosen method; and record the **R**eturn visit date. The high demand for the locally made "GATHER" video during the training of service providers is an indication of its usefulness.
- The ZNFPC Training Unit has also designed a follow-up check list for use by service providers during their interaction with revisit cases. The check list, therefore, ensures that service providers do not over-look important aspects of FP service delivery and thus improve the quality of care.

121

## **2.4 Service Provider Basic Family Planning Training**

Thirty-nine percent of clinic service providers and 29 percent of CBDs felt that they were not adequately trained to deliver family planning services available to rural clients. This and other findings from the ZIMSA have led to a number of interventions:

- ZIMSA highlighted the need to have at least one FP trained service provider at every health facility to ensure that clients referred by the CBDs receive the appropriate attention, and also to broaden the range of FP methods and services. ZNFPC, with the participation of MOH, has since revised the selection criteria for FP training to ensure that all clinics have at least one service provider trained in FP.
- In order to increase the number of service providers trained in basic FP, the ZNFPC Training Unit has equipped the MOH trainers in the Family Health Project II (FHP II) Districts with FP training skills as a strategy to decentralize training to the 16 FHP II Districts.
- Training materials for the FP Provincial Trainers have been developed to facilitate the decentralized training.
- In order to increase the number of service providers trained in the provision of long term and permanent methods of contraception, ZNFPC has since stepped up its training of doctor-nurse teams for VCS services and the IUD.
- The revision of the selection criteria for injectables has increased the type of methods available for clients. The ZNFPC has since conducted re-orientation workshops for service providers to facilitate the provision of injectables.
- The Population Council has also increased the number of facilities offering implants, thus increasing the choice of FP methods.

## **2.5 Refresher Family Planning Training Received by Service Providers.**

- Only six percent of clinic-based service providers had undergone FP refresher courses. Forty percent of CBDs had attended refresher courses within one year of their graduation, forty-five percent after two to three years and fourteen percent after four or more years.
- Provincial staff (both MOH and ZNFPC) have been trained in basic Adult Training Methodology so that they can organize and refresh Provincial and District level nurses and CBDs every two years. Training materials for use by Provincial Training Teams for such courses have been developed by the ZNFPC Training Unit.

## **2.6 Availability of IEC Materials**

The use of supportive IEC materials during provider-client interaction was also observed. However, about three quarters of the facilities visited did not have any copies of IEC materials available for distribution to clients. Twenty-eight percent of CBDs used the PO booklet during their discussions with clients. The IEC Unit has since improved the distribution system of IEC materials to the provinces.

## **2.7 Record Keeping**

Sixteen percent of the Health facilities visited during the study did not have complete FP service statistics records for 1990. The MOH has since revised the Health Information Forms, and incorporated the teaching of the correct completion of the FP component of the "T" forms into the basic FP training curriculum as a strategy to improve the quality of service statistics.

## **2.8 IUD/GTI Project**

- The clinic service providers were observed to discuss the IUD in only fourteen percent of cases while six percent were observed to discuss RTI/STDs/AIDS. ZNFPC used the ZIMSA findings to formulate a proposal for integrating the GTI module into the IUD curriculum. An IUD/GTI curriculum was subsequently designed and will be pre-tested. The selection criteria for IUD training now includes the need for the trainee to have undergone the GTI training.
- Under the JHPIEGO IUD/GTI Program, the ZNFPC Training Unit will train core trainers at Central, Provincial and district levels and thus increase the number of service providers trained in IUD.
- The same findings have also been used to develop a project proposal to integrate STD/HIV/AIDS into FP service delivery. The recently produced male motivation posters incorporated this aspect. A curriculum funded by DANIDA (FHP II) has been drafted and workshops, co-funded by the MOH's National AIDS Council (NACP) and DANIDA, have been held.

## **2.9 The Depot Holder Project**

ZIMSA also highlighted that CBDs spend five of their eight hour working day re-supplying oral contraceptives to rural clients. The study also indicated the willingness of the clients to be re-supplied by a non-CBD trained in the re-supply of pills and condoms. Furthermore, the clients reported that they would be willing to collect their supplies from a trained non-CBD in the village. These two findings strengthened ZNFPCs intention to pilot an alternative community-based FP service delivery system

for the rural areas. (The project is now under way and the training of the Depot Holders took place in November 1993).

## **2.10 Conclusion**

The ZIMSA findings would not have been used to such an extent had the ERU not meaningfully participated in all the research activities. The involvement of senior MOH and ZNFPC provincial staff in the data collection process allowed them to learn of the situation on the ground and facilitated the acceptability of the findings. Furthermore, the recommendations were formulated with the participation of policy makers (ZNFPC and MOH), ZNFPC Unit heads and FP service providers from the various sectors. This enabled the formulation of feasible recommendations which were relatively easy to implement given the available resources.

Finally, the ZIMSA was a success due to technical assistance provided by The Population Council and the meaningful involvement of the ZNFPC's ERU in the study. This enabled the unit to take over the dissemination of the findings. Early participation in activities, such as the revision of the curricula and the designing of training modules, allowed the ERU to highlight relevant aspects of the Zimbabwe Situation Analysis Survey findings.

### **3. Report from Working Groups on Gender Issues in Family Planning**

Three broad priority research issues emerged from the discussions within the groups:

#### **3.1 Adolescent Sexuality:**

- How best to communicate appropriate and gender-specific messages so that they encourage responsibilities and safer sex, particularly amongst younger adolescents?
- Which service delivery models are most appropriate for reaching the various groups of adolescents, i.e. younger/older, married/single, in-school, out-of-school? Again, the importance of testing gender-specific approaches was emphasized.

#### **3.2 Gender Issues During Service Delivery:**

- FP should be available as a basic human right without restrictions which are gender-related (i.e. marital status, spousal consent). Provider attitudes plus statutory regulations may contribute to such restrictions. Strategies for eliminating these need to be tested/studied.
- Exclusion of males from service delivery - how best to involve males more fully in service delivery? Some attempts have been made through CBD but others need to be explored, e.g. male-specific centers, demedicalized SDPs.
- How best to raise service providers and program managers awareness of gender issues in service delivery? Perhaps during training.
- Does the gender of the senior management in a family planning program affect its implementation?
- Does the gender of the provider affect the quality of service provided or is quality more dependent on other variables?
- Testing strategies for integrating sexuality education into FP IEC and counselling activities.
- Testing strategies for empowering women to recognize and exercise their reproductive rights.

## 2.3 Gender issues and women's status

- Test approaches to integrating FP with non-health activities e.g. adult education with the aim of enhancing the status of women.
- Studies to identify religious barriers to women's improved status and how these can be eliminated.

Participants' examples of gender insensitivity at Family Planning service delivery:

- FP policy makers are mostly men
- FP service providers are mostly women hence limiting men's access to services
- Female CBD agents discriminate youths and unmarried women from services
- Need for husbands' consent for a woman to receive certain methods

#### 4. Report from Panel Discussion on:

##### **The Process of Institutionalizing Operations Research: Examples from Mali, Burkina Faso, Ghana, Nigeria and Kenya**

- 4.1 The main objective for establishing institutional OR capacity within a country should be the development of a critical mass of OR specialists who can address key program and policy questions regarding the improvement of family planning services. Achieving the institutionalization of OR will require formal links between researchers and service delivery managers. The research agenda for OR should be based upon a service delivery agenda identified by programs managers. This will give a practical focus to the OR agenda and facilitate the end-use of research findings by service delivery agencies.
- 4.2 With regard to defining clearly responsibilities for coordination, training and implementation, and the impact on dissemination and end-use of OR results, the panelists agreed that:
- Training responsibilities should lay within universities and medical schools and other special institutions that focus on research.
  - Coordination should be separated from implementation and, the coordinating institutions should be the ones having to deal with broader population issues. In addition, coordinating agencies should be responsible for providing a policy and regulatory environment that is conducive to the development of OR; for facilitating the links between various research institutions; and for mobilizing resources needed to conduct extensive and comprehensive OR programs.
  - Implementation should be the responsibility of the actual end-users of the findings with a close monitoring of researchers to ensure quality work. This strategy entails that technical capacity to implement OR should be developed within service delivery agencies.

The panelist noted that the weak interaction between OR units, governmental programs, and university departments is probably one of the major factors explaining why OR findings are underutilized. One possible approach to address this issue is to: a) have coordination agencies guide the process of defining a global OR agenda based upon identified population policy issues; b) to assist universities in developing OR training programs; c) to develop OR capacity within service delivery agencies; and d) to build formal consultative and feedback mechanisms among all partners involved in Operations Research.

**4.3** With regard to the issue of sustainability of research in general and OR in particular, the panelists agreed that two major areas need to be further investigated:

- From a technical standpoint, integrating OR methodologies into university programs is essential to the long term sustainability of OR within a country.
- From a resource mobilization point of view, it is critical that the skills of university scholars and public health staff in mobilizing public resources for operations research programs be strengthened. This suggestion entails that substantial attention is placed in the future on making OR more attractive to government decision-makers by emphasizing OR as a practical, problem solving tool for managers.

APPENDIX A

**SCHEDULE FOR**  
**FAMILY PLANNING OPERATIONS RESEARCH CONFERENCE**  
4 - 7 October 1993, Hilton Hotel, Nairobi, Kenya

**OCTOBER 4**

**8:00 - 9:00**                      **Registration of Participants, Hilton Hotel, 1st Floor**

**TOPIC:**                              ***INAUGURATION AND OPENING OF CONFERENCE***

Moderator: Dr. George Brown, Vice President,  
The Population Council, New York, U.S.A.

**9:00 - 9:15**                      Conference Opening by the Hon. Minister for Research, Science  
and Technology, Dr. Z.T. Onyonka

**9:15 - 9:30**                      Welcome Address by Mr Fred Fischer, Director of the U.S.A.I.D.  
Regional Economic Development Services Office (REDSO) for  
East and Southern Africa

**9:30 - 9:45**                      Overview of Population Council world wide activities and focus on  
21st century, Ms. Margaret Catley-Carlson, President, Population  
council, New York, U.S.A.

**9:45 - 10:15**                      Inaugural Guest Speaker, Dr. Fred Sai, President, International  
Planned Parenthood Federation, Accra, Ghana. Family Planning in  
Africa and the role of Operations Research/Technical Assistance.

**10:15 - 10:30**                      Organization of the conference, review of objectives and schedule

**TOPIC:**                              ***POSTER SESSION AND PARTICIPANT NETWORKING***

**10:30 - 12:30**                      Major findings from completed Africa OR studies will be displayed  
on posters in the first floor lobby and in smaller rooms. The  
principal investigator(s) for each study will be available to explain  
the major findings from the study and to answer questions. Final  
reports and other publications from each study will also be  
available for distribution.

129

12:30 - 2:30

**LUNCH**

**TOPIC:**

***OPERATIONS RESEARCH IN AFRICA***

2:30 - 3:00

Family Planning in Africa: A Summary of Recent Results from Operations Research Studies. Dr. Andy Fisher, Senior Associate and Director, Africa OR/TA Project, Population Council, Nairobi, Kenya.

**TOPIC:**

***INTEGRATING AND EXPANDING FAMILY PLANNING WITH OTHER SERVICE DELIVERY PROGRAMS***

Moderator: Dr. Placide Tapsoba, Associate, Population Council, Dakar, Senegal.

3:00 - 4:30

Presentations and discussion

- A Puzzle of Will: Responding to Reproductive Tract Infections in the Context of Family Planning Programs. Dr. Chris Elias, Associate, Population Council, New York, U.S.A.
- Perceptions of Reproductive Morbidity Among Women and Men in Lagos, Dr. Adepeju Olukoya, Nigeria
- Integrating family planning with the expanded program of immunization (EPI), Dr. Aristide Aplogan, Lome, Togo

**TOPIC:**

***POPULATION, FAMILY PLANNING AND HEALTH EDUCATION MATERIALS EXCHANGE***

4:30 - 6:00

Family planning, population, and health materials and publications room open to participants. Organizations active in family planning and population in Africa will display materials and publications. Operations research posters will also continue to be on display.

6:30 - 8:30

**RECEPTION FOR CONFERENCE PARTICIPANTS AND INVITED GUESTS**

**TOPIC:                    *USING OPERATIONS RESEARCH FINDINGS TO IMPROVE SERVICE DELIVERY***

Moderator: Ms. Elizabeth Lule, Vice President Africa Region, Pathfinder, Nairobi, Kenya

- 8:30 - 8:45                    Introduction to morning session
- 8:45- 10:45                    Working group discussions on using operations research to improve service delivery. Participants will work in four groups. Drawing on their own experience with operations research studies, participants will discuss specific ways in which OR can improve service delivery programs and suggest recommendations for service delivery agencies to make greater use of OR study findings.
- 10:45 - 11:15                    **COFFEE AND TEA BREAK**
- 11:15 - 12:15                    Plenary session with reports from working groups
- 12:15 - 2:00                    **LUNCH**

**TOPIC:                    *NON-CLINICAL DELIVERY OF FAMILY PLANNING SERVICES: THE ROLE OF COMMUNITY BASED DISTRIBUTION IN AFRICA AND THE FIELD RESEARCH AGENDA FOR THE FUTURE***

Moderator, Dr. David Neba Awasum, Director, Division of Family and Mental Health, Ministry of Health, Yaounde, Cameroon

- 1:30 - 2:00                    Community Based Distribution of Family Planning in Africa: Lessons from Operations Research, Dr. Jim Phillips, Senior Associate Population Council, New York, U.S.A.
- 2:00 - 2:15                    Community based distribution programs as a means of delivering family planning services in rural areas: The experience in Cameroon and Mali, Dr. Diouratie Sanogo, Associate, Dakar, Senegal
- 2:15 - 2:30                    Questions and Discussion

131

- 2:30 - 2:35 Introduction to working group discussion: procedures, room assignments, facilitators, key questions to address, outcomes desired.
- 2:35 - 4:15 Working group discussion on non-clinical based distribution programs and the field research agenda for the future. Four small groups.
- 4:15 - 5:00 Plenary session: Reports by working groups with recommendations for future field research.
- 5:30 - 7:00 Special meeting with OR Principal Investigators on subcontract administrative and financial procedures, audits, disposal of equipment, closing the books. Ms. Carol Hendricks, Awards Coordinator, Population Council, New York, U.S.A.

**TOPIC: SITUATION ANALYSIS STUDIES AS A MEANS OF IDENTIFYING AND SOLVING SERVICE DELIVERY PROBLEMS**

Moderator: Dr. Twum-Baah, Director,  
Ghana Statistical Service, Accra, Ghana.

9:00 - 9:30 Development and Evolution of the Family Planning Situation Analysis Methodology, Dr. Bob Miller, Associate, Population Council, New York, U.S.A.

9:30 - 10:00 Using Situation Analysis Studies to Develop Quality of Care Indicators: Examples from Nigeria, Ghana, and Tanzania. Dr. Barbara Mensch, Associate, Population Council, New York, U.S.A.

10:00 - 10:30 Discussion and questions from the floor

10:30 - 11:00 **COFFEE/TEA BREAK**

11:00 - 12:00 Panel Discussion on: The use of situation analysis findings to improve programs

**Panel Members:**

- Dr. A. Zinanga, Director, Zimbabwe National Family Planning Council, Harare, Zimbabwe
- Dr. F. Mrisho, Deputy Director, Preventive Health Services, Ministry of Health, Dar es Salam, Tanzania
- Dr. M. Gachara. Deputy Director, Division of Family Health, Ministry of Health, Nairobi, Kenya
- Mme. Yvette Lou Koue, Director, AIBEF, Abidjan, Ivory Coast
- Dr. A. Sorungbe, director, Primary Health Care, Federal Ministry of Health, Lagos, Nigeria

12:00 - 12:30 Questions and Discussion from the floor

12:30 - 2:00

**LUNCH**

**TOPIC:**

***GENDER ISSUES IN FAMILY PLANNING PROGRAMS***

Moderator, Mrs. Cecilia Ndeti, Associate, The Population Council, Nairobi, Kenya

2:00 - 2:15

Introduction to the session

2:15 - 2:30

Overview: Gender Barriers to Family Planning, Dr. Nahid Toubia, Associate, The Population Council, New York, USA

2:30 - 2:45

Medical and Gender Barriers to Family Planning Services in Africa, Dr. Khama Rogo, Senior Lecturer, Department of OB/GYN, Kenyatta National Hospital, Nairobi, Kenya

2:45 - 3:00

Findings on Barriers from Operations Research Studies, Mrs. Cecilia Ndeti, Associate, The Population Council, Nairobi, Kenya

3:00 - 4:15

Working Groups meet on Gender Issues in Family Planning

4:15 - 5:00

Plenary session. Reports by working groups.

**TOPIC:                    *INSTITUTIONALIZING OPERATIONS RESEARCH***

Moderator: Mr. Herve de Lys, Management Technical Advisor,  
The Population Council, Dakar, Senegal

8:30 - 9:30                Panel discussion on the process of institutionalizing operations  
research: Examples from Mali, Burkina Faso, Nigeria, Kenya and  
Ghana

**Panel Members**

- Dr. Ouaidou Nassour, Director, CERPOD, Bamako, Mali
- Dr. Didier Bakouan, Director, Direction de la Sant de la  
Famille et de l'Action Sociale, Ouagadougou, Burkina Faso
- Dr. Sam Adjei, Director, Health Operations Research Unit,  
Ministry of Health, Accra, Ghana
- Prof. Alfred Adewuyi, Director, Operations Research Unit,  
Obafemi Awolowo University, Ife Ife, Nigeria
- Dr. Okoth Ogendo, Chairman, National Council for  
Population and Development, Nairobi, Kenya

9:30 - 9:45                Discussion and questions from the floor

**TOPIC:                    *SUMMING UP: FAMILY PLANNING ISSUES FACING AFRICA  
IN THE 1990s***

Moderator: Dr. Ian Askew, Associate, The Population Council,  
Nairobi, Kenya

9:45 - 10:00              Introduction to working group sessions on Family Planning issues  
facing Africa in the 1990s

10:00 - 11:30             Working groups on Family Planning issues facing Africa in the  
1990s

11:30 - 12:15             Reports by working groups

12:15 - 12:30             Summary and Future Directions of Operations Research in Africa,  
Dr. Andy Fisher

12:30 - 12:45             Closing remarks, Dr. Ayo Ajayi, Senior Representative, Population  
Council, Nairobi, Kenya

135

## APPENDIX B

### THE POSTER SESSION

Major findings from completed Africa OR studies were displayed on posters during the conference. Major projects from 14 African countries were disseminated in this way. The table below summarizes the session.

POSTER/PROJECT		IMPLEMENTING AGENCY	CONTACT PERSON	PUBLICA-TIONS
COUNTRY	NAME			
Burkina Faso	FP Motivation & Referral Program Using Satisfied Acceptors & Midwives	ABSF	Brigitte Thiombiano	Final report
Burkina Faso	Situation Analysis	DSF	Didier Bakouan	Condensed report
Burkina Faso	A MIS Needs Assessment of the Management Information System	Population Council	Youssef Ouedraogo	Final report
Burkina Faso	An Evaluation of a TBA Training Program	DSF	Youssef Ouedraogo	Final report
Cameroon	Integrating Community Based FP Education	Save the Children Federation	Luke Nkinsi	Final report
Cameroon	Promotion & Delivery of FP Services in Donga -Mantung - The Role of Male Opinion Leaders	MOH/DSFM	David Awasum	Final report
Gambia	The Influence of Village Level Health & Birth Spacing Meetings Conducted by Religious Leaders	Save the Children Federation	Alhaji Bah	Condensed report
Gambia	Strengthening PHC & FP Services Through TBA Training	Save the Children Federation	Alhaji Bah	Final report
Gambia	Employment Based FP Services	Gambia FP Association	Tunde Taylor-Thomas	Final report
Ghana	Situation Analysis	Ghana Statistical Services	K. Twum-Baah	Final report

POSTER/PROJECT		IMPLEMENTING AGENCY	CONTACT PERSON	PUBLICATIONS
COUNTRY	NAME			
Ivory Coast	Diagnosing the Quality of Care Through an Improved MIS	AIBEF	Yvette Lou Koue	Condensed report
Ivory Coast	Situation Analysis	AIBEF	Yvette Lou Koue	Final report & Condensed report
Kenya	An Integrated Approach to the Development & Implementation of OR Studies	NCPD/ MOH	Dr. Mulinge	
Kenya	Expanding Health & FP Delivery Systems Using Traditional Practitioners	African Medical & Research Foundation	David Nyamwaya	Final report
Kenya	Situation Analysis	MOH	Dr. Mulinge	Condensed report
Kenya	Increasing Male Involvement in the FPAK FP Program	Family Planning Association of Kenya	Dr. Isaac Achwal	Final report
Kenya	A Situation Analysis of Nairobi Clinics	Nairobi City Council	Dr. Mohamedalli	Final report
Madagascar	Impact of Strengthening Clinic Services & Community Education Programs on FP Acceptance	JIRAMA	Solofo Rajaonera	Final report
Madagascar	Experimental Program to Increase IUD Acceptance	FISA	Edwige Ravaomanana	Final report
Madagascar	Effect of Husbands' Involvement in the Pre-Intro. Trial of NORPLANT®	FISA/HJRA	Lilia Rajoelison	Final report
Mali	Training in OR & TA in Diagnostic Studies	CERPOD	Baba Troare	French Training Manual

137

POSTER/PROJECT		IMPLEMENTING AGENCY	CONTACT PERSON	PUBLICATIONS
COUNTRY	NAME			
Mali	CBD	DSF	Seydou Doumbia	Final report
Nigeria	Development of a University Based OR Unit & Network	OR Unit, Ile Ife Univ.	Alfred Adewuyi	Annual report
Nigeria	Situation Analysis	OR Unit, Ile Ife Univ	Alfred Adewuyi	Condensed report
Nigeria	Assessment of Six Rural CBD/FP Projects in Five States	Association for Reproductive & Family Health	Grace Delano	Final report
Nigeria	Review of Market Based Approach	OR Unit, Ile Ife Univ.	Musa Jinadu	Final report
Senegal	User's Perspective on the Delivery of FP Services	ASBEF	ASBEF	Condensed report
Tanzania	Situation Analysis	MOH	Peter Riwa	Final report
Tanzania	Workbased FP/AIDS Services: A Field Test of 2 Strategies	Tanzania Occupational Health Services	Mrs. E. Delem	Final report
Tanzania	An Evaluation of the Use of FP Services at the BIT Clinic	Board of Internal Trade Clinic	Dr. K.P. Reddy	Final report
Togo	EPI & FP Integration	CCCD/MOH	Aristide Aplogan	Condensed report
Zaire	Situation Analysis	Population Council	Herve Ludovic de Lys	Condensed & Final report
Zimbabwe	Situation Analysis	Zimbabwe National FP Council	Dr. Zinanga	Condensed report
Regional	Barriers to FP: - Medical - Gender	Population Council	Cecilia Ndeti	
Regional	Situation Analysis Methodology	Population Council	Bob Miller	

## APPENDIX C

### PARTICIPANTS LIST

Dr Benedicta Ababio  
Deputy Chief Health Population &  
Nutrition Officer  
USAID  
P O Box 1630  
Accra  
GHANA

Dr Ayorinde Ajayi  
Senior Representative  
Africa Region  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Mrs Lucy Abubaker  
Program Administrator,  
Expanding Contraceptive Choice Program  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Dr Akinwunmi Akinyemi  
Deputy Project Administrator  
USAID  
1601 Adeola Hopewell St  
Victoria Island  
Lagos  
NIGERIA

Dr Ominde Achola  
Acting Program Manager  
Division of Family Health  
Ministry of Health  
P O Box 43319  
Nairobi  
KENYA

Dr Benjamin Andriamintantsoa  
Evaluation Officer  
FISA  
BP 703  
Tananarive  
MADAGASCAR

Dr Isaac Achwal  
Senior Program Officer  
Family Planning Association of Kenya  
P O Box 30581  
Nairobi  
KENYA

Dr Aristide Aplogan  
Coordinator Operations Research  
CCCD-Togo-USAID  
03 BP 2309  
Cotonou  
BENIN

Prof Alfred Adewuyi  
Director  
OR Unit  
Obafemi Awolowo University  
Ile-Ife  
NIGERIA

Dr Ian Askew  
Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Dr Sam Adjei  
Head  
Ministry of Health Research Unit  
P O Box 184  
Accra  
GHANA

Dr David Neba Awasum  
Ministry of Health  
Yaounde  
CAMEROON

Mrs Sophie Azorbo  
Head Information/Documentation Unit  
Center for African Family Studies  
P O Box 60054  
Nairobi  
KENYA

Mr Alhaji Bah  
Monitoring & Evaluation Officer  
Save the Children USA  
P O Box 828  
Banjul  
THE GAMBIA

Dr Didier Bakouan  
Directeur  
Ministère de la Santé de  
l'Action Sociale et de la Famille  
03 BP 7247  
Ouagadougou 03  
BURKINA FASO

Ms Julia Beamish  
Training Officer  
Family Health International  
P O Box 13950  
Research Triangle Park  
N C 27709  
U S A

Dr Rosa Befidi  
Executive Secretary  
National Epidemiology Board  
BP 12304  
Yaounde  
CAMEROON

Mr Hammouda Bellamine  
Regional Associate  
IEC/Training  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Ms Beverly BenSalem  
Assistant Regional Director  
AVSC  
79 Madison Avenue  
New York NY 10016  
U S A

Dr Bill Bertrand  
JHPIEGO  
570 Walnut  
New Orleans La  
U S A 70118

Mr Benjamin Bilbao  
The Population Council  
One Dag Hammarskjld Plaza  
New York NY 10017  
U S A

Dr Fred Binka  
Director  
Ministry of Health  
P O Box 114  
Navrongo  
GHANA

Dr George Brown  
Vice President Programs Division  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mrs Maggie Catley-Carlson  
President  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Dr Davy Chikamata  
Medical Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Ms Patricia Coffey  
CTO  
RO/POP/R  
USAID  
Washington D C 20523  
U S A

Ms Perle Combarry  
Project Manager  
USAID  
01 BP 35  
Ouagadougou 01  
BURKINA FASO

Mrs Romana Cooke  
Population Fellow  
Family Planning Private Sector  
P O Box 46042  
Nairobi  
KENYA

Dr Mountaga Coulibaly  
Directeur National de la Santé  
Publique  
Direction Nationale de la Santé Publique  
Bamako  
MALI

Dr Carlos J Cuellar  
Executive Director  
PROSALUD  
P O Box 1231  
Santa Cruz  
BOLIVIA

Dr Colette Dehlot  
Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Mrs Eliseba Delem  
Project Coordinator  
Tanzania Occupational Health Services  
P O Box 3520  
Dar es Salaam  
TANZANIA

Mr Gemechu Demissie  
Project Manager  
SCF/USA  
P O Box 387  
Addis Ababa  
ETHIOPIA

Ms Harriett Destler  
Regional Coordinator  
POL/CDIE/F  
AID  
Washington D C 20523  
U S A

Mr Alpha Dieng  
Director  
SANFAM  
BP 1343  
12, Av. Nelson Mandela  
Dakar  
SENEGAL

Mrs Marieme Diop  
Directrice  
Programme National PF  
BP 49 - USAID  
PSE/PF  
Dakar  
SENEGAL

Dr Seydou Doumbia  
Resident Advisor  
The Population Council  
BP 1803  
Bamako  
MALI

Mr Joseph Dwyer  
Director  
Africa Region  
AVSC  
P O Box 57964  
Nairobi  
KENYA

141

Mr Keith A Edwards  
Project Coordinator  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Dr Chris Elias  
Associate  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr Thomas Fenn  
Regional Director  
Technical Services  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Ms Suzanne Fenn  
Resident Advisor/Kenya  
MSH/FPMD  
P O Box 14996  
Nairobi  
KENYA

Dr Alan Ferguson  
Team Leader  
GTZ  
P O Box 41607  
Nairobi  
KENYA

Dr Andrew Fisher  
Senior Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Ms Farmer Francesta  
Associate for Institutional Development  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Dr Margaret Gachara  
Deputy Director  
Division of Family Health  
Ministry of Health  
P O Box 46566  
Nairobi  
KENYA

Dr Laura Gibney  
Fellow  
The Rockefeller Foundation  
17S E 96th St #6L  
New York NY  
U S A 10128

Ms Joanne Gleason  
Administrator Africa OR/TA Project  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr Sahlu Haile  
Regional Director  
SEATS  
BP 3068  
Lome  
TOGO

Mr Robert Haladay  
Population Advisor  
Africa Bureau  
USAID  
State Dept NS 2847  
21st Virginia Avenue  
Washington D C 20523  
U S A

Ms Nancy Harris  
Vice President  
John Snow  
1616 N Fort Meyer Drive  
Arlington VA 22209  
U S A

Ms Carol Hendrick  
Awards Coordinator  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Dr Marjorie Horn  
Regional Coordinator  
R & d/Pop/RCD  
USAID  
Washington D C  
U S A

Ms Mildred Howard  
Program Manager  
USAID  
P O Box 30261  
Nairobi  
KENYA

Ms Jane Hughes  
Associate Director Population Services  
The Rockefeller Foundation  
1133 Avenue Americas  
New York, NY 10036  
U S A

Mr Aloys Ilinigumugabo  
Head Research Unit  
Center of Africa Family Studies  
P O Box 60054  
Nairobi  
KENYA

Dr Musa Inambao  
Director  
Health & Population  
Regional Management Development  
Assistance  
P O Box 56628  
Nairobi  
KENYA

Arch Rafael Indaburu  
Project Manager  
USAID  
Casilla 2577  
La Paz  
BOLIVIA

Mr Momodou Jasseh  
Program Officer  
GFPA  
P O Box 325  
Banjul  
THE GAMBIA

Ms Kathy Jesencky  
Senior Representative for Population  
Activities  
P O Box 38835  
Nairobi  
KENYA

Ms Wanjiku Kabira  
Gender Coordinator  
FEMNET  
P O Box 54562  
Nairobi  
KENYA

Mrs Mary Kairu  
Regional Program Coordinator  
CEDPA  
P O Box 14996  
Nairobi  
KENYA

43

Dr Nagbandja Kambatibe  
Chief MCH  
Ministry of Health  
BP 306  
Lome  
TOGO

Mr Musa Jinadu  
Reader  
College of Health Sciences  
Obafemi Awolowo University  
Ile-Ife  
NIGERIA

Mr Lenni Kangas  
Technical Advisor  
A I D  
Bureau for Africa, Room 2744  
320 21st Street N W  
Washington D C 20523  
U S A

Dr Saidi Kapiga  
Lecturer  
Muhimbili Medical Center  
P O Box 65015  
Dar es Salaam  
TANZANIA

Dr Lazare Kaptue  
Professor  
University of Yaounde  
P O Box 1937  
Yaounde  
CAMEROON

Mr Jean Karambizi  
Regional Representative  
Pathfinder International  
16G Blvd du 13 Janvier  
BP 12774  
Lome  
TOGO

Ms Jayne Kariuki  
Project Officer  
Innovative Communication Systems  
P O Box 59328  
Nairobi  
KENYA

Mrs Kathy Keel  
Evaluation Specialist  
USAID  
Africa Bureau/DP/PSE  
Washington D C 20523  
U S A

Dr Patrick Kelly  
JSI  
1616 N Fort Myer Drive  
11th Floor  
Arlington VA 22209  
U S A

Mrs Monica Kerrigan  
Associate Director  
JHPIEGO  
1615 Thomas St  
Baltimore MD 21212  
U S A

Mr Nelson Keyonzo  
Associate Regional Representative  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Ms Arjmandbanu Khan  
Program Administrator  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Dr Shanyisa Khasiani  
Senior Lecturer  
University of Nairobi  
P O Box 30197  
Nairobi  
KENYA

Mr Peter Kibunga  
MIS Specialist  
FPMD  
P O Box 14996  
Nairobi  
KENYA

Dr Christine Kigundu  
Senior Researcher  
Department of Ob/Gyn  
University of Nairobi  
P O Box 19676  
Nairobi  
KENYA

Dr Stephen Kinoti  
Coordinator Health Research  
CRHCS  
P O Box 1009  
Arusha  
TANZANIA

Ms Margaret Kirimi  
Lecturer  
Geography Department  
University of Nairobi  
P O Box 30197  
Nairobi  
KENYA

Dr Wilson Kisubi  
Senior Medical Officer  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Mr Paul Kizito  
Senior Demographer  
National Council for Population  
and Development  
P O Box 30478  
Nairobi  
KENYA

Dr Anthony Klouda  
Coordinator  
AIDS Prevention Unit  
IPPF  
Regent's College  
Regent's Park  
London  
NW1 4NS  
UNITED KINGDOM

Ms Monica Knorr  
Senior Advisor to President  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr Koffi Kouame  
Chef Division Recherche et Evaluation  
AIBEF  
01 BP 5315  
Abidjan 01  
COTE D'IVOIRE

Mrs Yvette Koue-Lou  
Executive Director  
AIBEF  
01 BP 5315  
Abidjan 01  
COTE D'IVOIRE

Mrs Lalit Kraushaar  
Regional Advisor  
CEDPA  
P O Box 14996  
Nairobi  
KENYA

Mrs Jane Kwawu  
Senior Program Officer  
Center for African Family Studies  
P O Box 60054  
Nairobi  
KENYA

Ms Joellen Lambiotte  
Regional Director  
Family Planning International  
Assistance  
P O Box 53538  
Nairobi  
KENYA

Ms Evelyn Landry  
Director  
Evaluation & Research  
AVSC  
79 Madison Avenue  
New York NY 10016  
U S A

Mr Gary Leinen  
O/PH  
USAID  
P O Box 30621  
Nairobi  
KENYA

Ms Angela Lord  
Population Advisor  
USAID/REDSO  
P O Box 30261  
Nairobi  
KENYA

Mrs Elizabeth Lule  
Regional Director  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Mr Seth Luvutse  
Deputy Manager  
Maendeleo Ya Wanawake  
P O Box 44412  
Nairobi  
KENYA

Mr Amadou Ly  
Project Manager/HPNO  
USAID  
BP 49  
Dakar  
SENEGAL

Dr Pamela Lynam  
Senior Medical Program Officer  
For Quality  
AVSC  
P O Box 57964  
Nairobi  
KENYA

Mr David Ludovic de Lys  
Management Associate  
The Population Council  
BP 21027  
Dakar  
SENEGAL

Dr Baker Maggwa  
Program Officer (Research)  
Center for Africa Family Studies  
P O Box 60054  
Nairobi  
KENYA

Mr Gilbert Magiri  
Program Officer  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Mr Timothy G Manchester  
Country Director  
PSI  
1120 19th St NW  
Washington D C 20036  
P O Box 33500 DS7 TN2  
U S A

Dr Pasiens S Mapunda  
MCH/FP Program Director  
Ministry of Health  
P O Box 2179  
Zanzibar  
TANZANIA

Dr Charles Maringo  
Country Representative  
JHPIEGO  
P O Box 47243  
Nairobi  
KENYA

Dr Cheikh Mbacke  
Senior Scientist  
The Rockefeller Foundation  
P O Box 47543  
Nairobi  
KENYA

Ms Beth Mbaka  
Program Officer  
Pathfinder International  
BP 12774  
Lome  
TOGO

Mr Michael Mbaya  
Senior Population Officer  
National Council for Population  
and Development  
P O Box 30478  
Nairobi  
KENYA

Mr Salim Swaleh Mbete  
Area Manager  
Family Planning Association of Kenya  
P O Box 98223  
Mombasa  
KENYA

Mr Fara Guedel Mbodji  
Chef etudes et Evaluation  
Division Planification Familiale  
CERPOD  
BP 1530  
Bamako  
MALI

Mr Walter Mbunda  
Research & Evaluation Officer  
UMATI  
P O Box 1372  
Dar es Salaam  
TANZANIA

Dr F M Mburu  
Senior Population Program Specialist  
USAID  
P O Box 9130  
Dar es Salaam  
TANZANIA

Dr Peggy McEvoy  
Senior Associate  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr Tewodross Melesse  
Associate Regional Representative  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Dr Barbara Mensch  
Associate  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Ms Elba Mercado  
Project Coordinator  
USAID  
Casilla 13419  
La Paz-Bolivia  
SOUTH AMERICA

Dr Robert Miller  
Associate  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr Marc Mitchell  
FPMD/MSH  
400 Center Street  
Newtown MA 02158  
U S A

Dr Louis Mlingi  
Director General  
Tanzania Occupational Health Services  
P O Box 3520  
Dar es Salaam  
TANZANIA

Ms Polly Mott  
Program Manager - CBD  
USAID  
P O Box 30261  
Nairobi  
KENYA

Mr Traore Mamadou Moussa  
Manager  
PPM/SOMARC  
BP 277  
Bamako  
MALI

Mrs Grace Mtawali  
Regional Clinical Program Officer  
INTRAH  
P O Box 55699  
Nairobi  
KENYA

Ms Pauline Muhuhu  
Regional Director Anglophone Africa  
INTRAH  
P O Box 55699  
Nairobi  
KENYA

Ms Mary Mujomba  
Program Administrator  
Center for African Family Studies  
P O Box 60054  
Nairobi  
KENYA

Ms Altrena Mukuria  
Director  
Services for Health Care Development  
P O Box 59424  
Nairobi  
KENYA

Miss Jacqueline Mundy  
Research Fellow  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Mrs Jane Muturi  
Program Officer  
Family Planning Private Sector  
P O Box 46042  
Nairobi  
KENYA

Mr Ityai Muvandi  
Program Officer  
Center for Africa Family Studies  
P O Box 60054  
Nairobi  
KENYA

Ms Nellie Mwanzia  
Program Management Specialist  
USAID  
P O Box 30261  
Nairobi  
KENYA

Mr Godwin Z Mzenge  
Executive Director  
Family Planning Association of Kenya  
P O Box 30581  
Nairobi  
KENYA

Dr Penda N'Diaye  
Medical Associate  
The Population Council  
BP 21027  
Dakar  
SENEGAL

Ms Donna Nager  
Aneorda Progam Administrator  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Mr G Ouaidou Nassour  
Director  
CERPOD/INSAH  
BP 1530  
Bamako  
MALI

Dr Muia Ndavi  
Lecturer  
University of Nairobi  
P O Box 20944  
Nairobi  
KENYA

Mrs Cecilia Ndeti  
Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Mr Lewis Ndhlovu  
Associate  
The Population Council  
P O Box 17643  
Nairobi  
KENYA

Gary Newton  
Chief  
O/PH  
USAID  
P O Box 30621  
Nairobi  
KENYA

Mr Jean Jeannot Ngoma  
Senior Interpreter  
Shelter Afrique  
P O Box 41479  
Nairobi  
KENYA

Mrs Mueni Ngumbi  
Nurse Manager  
Egerton University  
P O Box 536  
Njoro  
KENYA

Mrs Christine M K Nsekela  
Consultant  
UMATI  
P O Box 1372  
Dar es Salaam  
TANZANIA

Mr Josephat Machuki Nyagero  
Demographer  
Health Behaviour & Education  
Department  
AMREF  
P O Box 30125  
Nairobi  
KENYA

Dr David Nyamwaya  
Director  
Health Behaviour  
AMREF  
P O Box 30125  
Nairobi  
KENYA

Mrs Dorothy Nyong'o  
Program Officer  
IPPF  
P O Box 30234  
Nairobi  
KENYA

Prof A B C Ocholla-Ayayo  
Researcher  
University of Nairobi  
P O Box 30197  
Nairobi  
KENYA

Mr Dan O Odallo  
Resident Advisor  
JHU/PCS  
P O Box 53727  
Nairobi  
KENYA

Dr Omondi Odhiambo  
Research Associate  
Family Health International  
P O Box 38835  
Nairobi  
KENYA

Mr David Ojaka  
Program Officer  
Research & Evaluation  
P O Box 30234  
Nairobi  
KENYA

Ms Melinda Ojermark  
MIS/Evaluation Specialist  
JSI/SEATS  
P O BOX 308B  
Harare  
ZIMBABWE

Prof H W O Okoth-Ogendo  
Chairman  
National Council for Population &  
Development  
P O Box 30197  
Nairobi  
KENYA

Mr Charles Olenja  
Program Officer  
United Nations Population Fund  
P O Box 30218  
Nairobi  
KENYA

Dr Adepeju Olukoya  
Acting Director  
Institute of Child Health  
& Primary Care  
P M B 21178  
Ikeja  
NIGERIA

Dr Adekunbi Kehinde Omideyi  
Deputy Director  
Operations Research Unit  
Obafemi Awolowo University  
Ile-Ife  
NIGERIA

Mrs Pamela Onduso  
Program Officer  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Prof John Oucho  
Director  
PSRI  
University of Nairobi  
P O Box 30197  
Nairobi  
KENYA

Dr Marie-Michelle Ouedraogo  
Director  
UERD  
BP 7118  
Ouagadougou  
BURKINA FASO

Dr Yousouf Ouedraogo  
Resident Adviser  
The Population Council  
01 BP 3331  
Ouagadougou  
BURKINA FASO

Ms Susan Palmore  
Director  
Family Health International  
P O Box 13950  
Research Triangle Park  
N C 27709  
U S A

Mrs Helena Perry  
Health & Population Support Officer  
ODA  
P O Box 30465  
Nairobi  
KENYA

Mr Godwin Peter  
Population Advisor  
World Bank  
P O Box 30577  
Nairobi  
KENYA

Dr Lilia Rajoelison  
National Project Director Norplant project  
Service Gynécologie Obstetrique  
HJRA BP 4150  
Antananarivo  
MADAGASCAR

Dr Gerard Rakotondrainibe  
HPN Specialist  
USAID  
BP 5253  
Antananarivo  
MADAGASCAR

Dr Justin Ranjalahy  
Director  
Ministry of Health  
BP 88  
Antananarivo  
MADAGASCAR

Dr Edwige Ravaomanana  
Chargé de Prestation de Services  
FISA  
P O Box 703  
Antananarivo  
MADAGASCAR

Mrs Joyce Riungu  
Director CHD  
PCEA Chogoria  
P O Box 35  
Chogoria  
KENYA

Mr Peter Riwa  
Research Officer  
Ministry of Health  
National FP Program  
P O Box 9083  
Dar es Salaam  
TANZANIA

Dr Khama Rogo  
Senior Lecturer  
University of Nairobi  
P O Box 44399  
Nairobi  
KENYA

Ms Deborah S Ruhe  
Senior Family Planning Advisor  
FPMD/MSH  
400 Center Street  
Newtown MA 02158  
U S A

Dr Naomi Rutenberg  
Senior Research Scientist  
The Futures Group  
1050 17th St NW #1000  
Washington DC 20902  
U S A

Dr Eugene Rwamucyo  
UNR/ONAPO  
BP 68  
Butare  
RWANDA

Prof Fred Sai  
President  
IPPF  
P O Box 9983 KIA  
Accra  
GHANA

Mrs Dorsila Sande  
IEC Acting Head  
Ministry of Health  
P O Box 43319  
Nairobi  
KENYA

Dr Catherine Sanga  
Deputy Program Manager  
Ministry of Health  
Family Planning Unit  
P O Box 9083  
Dar es Salaam  
TANZANIA

Dr H C G Sanghvi  
Chairman  
Department of Ob/Gyn  
University of Nairobi  
P O Box 20857  
Nairobi  
KENYA

Dr Diouratie Sanogo  
Associate  
The Population Council  
BP 21027  
Dakar  
SENEGAL

Mr Peter Savosnick  
MIS Advisor Kenya  
FPMD-MSH  
P O Box 14996  
Nairobi  
KENYA

Ms Esther Sempabwa  
Program Officer  
Center for African Family Studies  
P O Box 60054  
Nairobi  
KENYA

Mr Paul S Shumba  
Regional Director  
of Evaluation  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Dr Vincent Simiyu  
Interpreter  
P O Box 30197  
Nairobi  
KENYA

Mr Jason Smith  
Senior Research Associate  
Family Health International  
P O Box 13950  
Research Triangle Park  
North Carolina 27709  
U S A

Ms Rhonda Smith  
Policy Analyst  
Population Reference Bureau  
1875 Connecticut Avenue #520  
Washington D C 20009  
U S A

Dr Akanni O O Sorungbe  
Executive Director  
National Primary Health Development  
Agency  
Federal Ministry of Health  
P M B 1009  
Yaba  
Lagos  
NIGERIA

Ms Enid Spielman  
ESARO Regional Program Director  
SEATS  
Private Bag 308B  
Harare  
ZIMBABWE

Dr Placide Tapsoba  
Medical Associate  
The Population Council  
BD De l'Est  
Rue 2 Bis Point E  
Dakar  
SENEGAL

Mr Tunde Taylor-Thomas  
Executive Director  
Family Planning Association of Gambia  
P O Box 325  
Banjul  
THE GAMBIA

Dr Ezra Teri  
Regional Associate  
Medical Services  
Pathfinder International  
P O Box 48147  
Nairobi  
KENYA

Mrs Brigitte Thiombiano  
Presidente Coordinatrice  
Association Des Sages-Femmes  
Projet BF01/CPSF  
01 BP 4686  
Ouagadougou  
BURKINA FASO

Mr Marcio Thome  
Associate  
The Population Council  
CERPOD  
BP 1530  
Bamako  
MALI

Mr Peter W Thumbi  
Assistant Director  
National Council for Population  
and Development  
P O Box 34888  
Nairobi  
KENYA

Mrs Margaret Thuo  
Program Manager  
Family Planning Association of Kenya  
P O Box 30581  
Nairobi  
KENYA

Ms Barbara Tobin  
Administrative Officer  
MSH/FPMD  
P O Box 14996  
Nairobi  
KENYA

Dr Nahid Toubia  
Associate  
The Population Council  
One Dag Hammarskjold Plaza  
New York NY 10017  
U S A

Dr Fatoumata Toure  
DSFC Mali  
BP 1149  
Bamako  
MALI

Ms Rikka Trangsrud  
Program Officer  
Family Planning Association of Kenya  
P O Box 30581  
Nairobi  
KENYA

Mr Baba Traore  
Chef DPF  
CERPOD  
BP 1530  
Bamako  
MALI

Dr Richard B Turkson  
Africa Regional Director  
IPPF  
P O Box 30234  
Nairobi  
KENYA

Dr Kwaku A Twum-Baah  
Deputy Govt Statistician  
Ghana Statistical Service  
P O Box 1098  
Accra  
GHANA

Mrs Amelda Urasa  
Nursing Officer/PH  
BIT Clinic Ltd  
P O Box 1682  
Dar es Salaam  
TANZANIA

Dr Gilberte Vanseintean  
Medical Technology Advisor  
AVSC/USAID  
BP 5253  
Antananarivo  
MADAGASCAR

Mrs Elina Visuri  
Counsellor  
FINNIDA  
P O Box 30379  
Nairobi  
KENYA

Mrs Jedida Wachira  
Regional Deputy Director  
INTRAH  
P O Box 55699  
Nairobi  
KENYA

Mr Kenneth Waithiru  
Planning Officer  
National Council for Population  
and Development  
P O Box 30478  
Nairobi  
KENYA

Dr Munyua Waiyaki  
Secretary General  
NACCO  
P O Box 44502  
Nairobi  
KENYA

Dr Samson Wanjala  
Senior Lecturer  
University of Nairobi  
P O Box 20807  
Nairobi  
KENYA

Dr Stephen Wanyee  
Medical Coordinator  
Family Planning Private Sector  
P O Box 46042  
Nairobi  
KENYA

Mrs Martha Warratho  
Training and Quality Supervisor  
Population Health Services  
P O Box 59328  
Nairobi  
KENYA

Mrs Esther Njeri Waruhiu  
Supervisor Clinical Services  
Population Health Services  
P O Box 59328  
Nairobi  
KENYA

Mrs Margaret Watani  
Research Officer  
Maendeleo Ya Wanawake  
P O Box 44412  
Nairobi  
KENYA

Dr Susan Watkins  
Professor  
3718 Locust Walk  
Population Studies  
University of Pennsylvania  
Philadelphia PA 19104

U S A

Mr David Wilkinson  
Program Director  
Innovative Communication Systems  
P O Box 59328  
Nairobi  
KENYA

Dr Melinda Wilson  
Advisor  
Family Planning Private Sector  
P O Box 46042  
Nairobi  
KENYA

Dr Pam Wolf  
Technical Advisor  
USAID  
American Embassy Accra (2020)  
Washington D C 20521-2020  
U S A

Dr Alex Zinanga  
Executive Director  
Zimbabwe National Family Planning  
Council  
P O Box ST 220  
Sotherton  
Harare  
ZIMBABWE

## APPENDIX D

### AFRICA OR/TA PROJECT CONFERENCE

#### EVALUATION

1. Please check the boxes that best represent your rating

	EXCELLENT	GOOD	FAIR	P O OR
Overall quality of conference	47	49	4	0
Conference format	40	58	2	0
Preconference information	31	57	10	2
Conference Location	45	45	8	2
Hotel Accommodation	49	44	5	2
Conference Food	38	55	7	0
Overall Administration	55	39	6	0

2. What did you expect from the conference?

- "Being the first one of its kind [that] I have attended, I did not know what to expect."
- "Country experience; new ideas on FP innovations and OR"
- "A review of lessons learned; discussion of OR in Africa; strategies for the future."
- "Lessons from OR which were delivered on Quality of Care, CBD and others."
- "To learn."
- "Results of OR studies that could be replicated/applied elsewhere. I was disappointed in the poster session during which results and final reports were available, should have been incorporated into the main meeting."

- "Learn and share experiences with other colleagues."
- "Needed to bring out the difficulties encountered during the research projects."
- "To network with other researchers, get a broad overview of project activities, focus towards future uses of OR in SSA."
- "To learn what Operations Research Projects are about in Africa."
- "Introduction to OR methods, findings, applicability of service delivery."
- "More lectures in conducting and integrating OR in the programs. Experiences from other countries."
- "To learn of study results, findings, and practical ways of utilizing such research results. To find out about research topics/methodologies that would be useful in my own work"
- "Stimulate new ideas. Reflect on past activities."
- "Learn from the experience of other countries."
- "To see how OR, through Situation Analysis can be used to improve Health Delivery in other countries."
- "To learn about OR/TA and the activities in Africa."
- "Learn more about OR studies, the role of africans in research, and the applicability of the research to service delivery."
- "A review of OR findings and important research issues."
- "What's happening in African FP. What's new - where are lessons learned."
- "More presentations of results."
- "Summary of main lessons learnt from past 5 years that would be useful in improving service delivery."
- "To learn from the OR experiences of other African countries and level of implementation of the OR results."
- "Ideas on how to organize OR back home."
- "Review of OR programs; networking"

- "Sharing of research findings of OR studies conducted throughout Africa in a technical way. Expected the audience to be more academic."
- "A review of current OR methodologies and results."
- "Nothing but the best."
- "Share ideas; learn from others experiences."
- "An overall view of OR performance in Sub-Saharan Africa during the past five years. Approaches of meeting future OR needs at place of work and country in general."
- "Opportunity to discuss and exchange experiences with other colleagues from other institutions dealing in OR and FP."
- "Experience sharing; identifying weakness & strengths"
- "Key results of OR in FP and a discussion of new directions for OR."
- "Acquire more information on evaluation on OR and share experience with population colleagues."
- "To know the advantages of different research undertaken in Africa and their impact on the improvement of FP services in general."
- "More light of OR; OR orientation and coordination; exchange of experiences."
- "Precise information to better develop OR in my country."
- "Exchange of experiences in OR."
- "To obtain a better understanding of what has been done in OR in Africa, and what are OR perspectives for the future."
- "Fruitful exchange of information on FP programs in Africa."
- "To know results of OR projects done in Africa; exchange of information; and documentation."
- "Exchange of experience; to discover FP problems and figure out where to find the solutions."
- "Solutions to problems that have occurred during recent years in order to improve services for the future."

- "Communications that will assure a continuation of the application of OR results."
- "Exchange of information with other countries."
- "To know OR experiences in other countries and how problems were resolved; exchange of perspectives in FP and research in Africa; other possible subjects in research."

**3. How well did the conference meet your expectations?**

31	Very Well
52	Well
11	Adequately
6	Poorly
0	Not at all

**4. How appropriate was the subject matter to your interests?**

61	Very appropriate
39	Appropriate
0	Inappropriate

157

**5. Please check the boxes that best represent your rating for the usefulness to you of the sessions.**

	VERY USEFUL	USEFUL	NOT USEFUL
Poster session	46	52	2
OR Activities in Africa	61	39	0
Using OR Findings to Improve Service Delivery	52	40	8
Integrating & Expanding FP With Other Service Delivery Programs	61	37	2
Non-Clinical Delivery of FP Services	42	50	8
Situation Analysis Studies	55	41	4
Barriers to FP Services	67	29	4
FP Issues Facing Africa in 1990s	50	50	0
Institutionalizing OR	35	57	8
Future Directions of OR in 1990s	42	58	0

**6. What did you find most valuable?**

- "Barriers to Family Planning Services, using OR findings to improve Service Delivery."
- "Concerns from so many individuals about their FP programs."
- "Opportunity to discuss ideas and meet my colleagues; session on Situation Analysis."
- "Opportunity to meet so many colleagues. Excellent presentations by many. Gender [Session] greatly expanded thinking."
- "Experiences of other countries in OR and in FP."
- "Poster Session; integrating & expanding FP with other service delivery programs."

- "Situation Analysis studies."
- "Situation Analysis presentations; CBD presentation."
- "The over conference format that allowed participants to assess the different aspects related to OR."
- "Quality of Care discussion."
- "Small Group discussions; panel discussions."
- "Discussion of Situation Analysis, quality indicators and cross country comparisons; gender presentations."
- "Development of quantitative indicators for Quality of Care."
- "Focus on the IEC and integration and expansion of FP with other service delivery programs."
- "Operational Research methodology, especially Situation Analysis methods)."
- "Conducting OR to get baseline information at the beginning of projects."
- "Presentations on gender barriers to FP and the overview of Situation Analysis methodology."
- "Poster Session, Situation Analysis, Gender Session."
- "Hearing broad view of perspectives from Africans from many countries; meeting senior African FP managers"
- "Situation Analysis presentations; some suggestions and plans for OR in the next 5 years."
- "Group discussions."
- "The working group sessions. Most field experiences were shared at these groups."
- "Discussions on topics for new research agenda and how to organize/institutionalize research."
- "Exchanging ideas."
- "Quality of Care presentation and Situation Analysis. Discussion groups were very, very useful to give participants a chance to share their burning comments, ideas and experiences."

- "The mix of presentations and networking opportunities."
- "The sincerity, concern, professionalism, and good humor of those involved."
- "Gender issues."
- "Different areas of OR can assist in solving managerial and operational problems."
- "Dr. Fred Sai's introduction was the most informative and stimulating presentation during the seminar."
- "Future directions of OR; future analysis of OR data."
- "Situation Analysis presentation; non-clinical delivery discussion; informational exchange with participants - very useful."
- "Situation analysis studies."
- "Better comprehension of the role of OR to improve FP programs in Africa."
- "Exchange of experiences and making contacts."
- "Exchange of experiences with different researchers and directors of programs."
- "Contacts made during the conference for future reference."
- "The organization was without flaw."
- "Exchange of experiences." (2)
- "The exposition of posters; sharing of experiences in OR; contact with funders and the different members of The Population Council."
- "Contacts and management of the debates."
- "All themes in FP were touched upon."
- "Future directions of OR in the 1990s."
- "A reminder to be aware of the socio-economic problems and the political situations in the countries."
- "Issues treated."

- "The choice of issues treated and the kind of work was very positive by the group; the collaboration between the numbers of international agencies during the conference."

**7. What was missing from the conference?**

- "More participation from non-Council [staff] would enrich the conference."
- "Educative entertainment."
- "Enough time for question and small group discussion."
- "Lessons learned and findings across countries. What did five years of OR add up to. Also, little attention to import of TA component."
- "Closer attention to scheduling to allow more Q & A. (However, I recognize the difficulty in achieving this.)"
- "Not enough results and applications. This was an end-of-project conference - what did the project accomplish? What's up for the next five years?"
- "Nothing."
- "CBDs who could give their personal experiences and other service providers who could give their field experience."
- "More time for discussion, particularly for the issues of integration, and at least one other organized social event."
- "A little time off in the afternoon in the middle of the conference to recover from so many sessions, although the format had a good mix of presentations and participatory sessions."
- "A system whereby members/participants sign for attendance to give a more strict approach. At one time our group had only seven participants."
- "Nothing, extremely well organized and conducted."
- "Groups too large. Would have been more useful to group reps from countries facing similar problems: (i.e. put all Kenyans & Zimbabwe participants together.)"
- "Nothing."
- "I found it very disappointing that there were hardly any USAID representatives, not even from the Kenya mission across the street."

163

- "Not enough consolidation of lessons learned. Would be interesting to compare African experience with other regions. More time to look at posters and speak with investigators."
- "Very little impact from specific lessons learned in last five years that could help improve service delivery on a National scale."
- "Papers should have been presented earlier."
- "More information on OR results implementation, what has worked and what has not worked and the occurrences in each case."
- "Adequate discussion of objectives and boundaries of family planning."
- "Medical barriers got drowned in gender bias. A balance of the two issues was needed."
- "More USAID/Washington attenders and other donor representatives who need to hear more from this project, especially the African investigators."
- "A.I.D Representatives."
- "Some topics could have done with more time."
- "Nil"
- "The groups being too large, very few occasions to stimulate exchanges between people's experiences in implementation of OR in FP activities. The leaders in FP and OR success stories did not have the chance to expose, in detail, their activities."
- "More specific program designs by country."
- "Controversy, no heated debates or arguments."
- "Not enough time for question/answer."
- "Groups anglophone, francophone isolated; lack of meetings outside the conference; lack of social activities (excursions, etc.)."
- "The translation and time management were weak."
- "The lack of distribution of documents before the sessions. The plenary room should have been set up like those of the working groups."
- "Not enough time for discussion during plenary; bad translation."
- "Documentation and organization."

- "The availability of certain documents in French; the amount of documents available (not enough); absence of an affordable excursion for the participants."
- "There were none."
- "Organization and issues."
- "Concrete recommendations were lacking."
- "Organization of sessions."
- "Lack of scientific communication."
- "The translation English to French was not good enough for the francophone."

**8. Are the Population Council publications that have been made available during the conference of use to you?**

- "Yes" (36)
- "Very useful" (6)
- "No" (2)
- "Absolutely"
- "Yes - I appreciate the opportunity to get materials from many organizations."
- "Yes. I plan to share these with my colleagues."
- "Yes indeed, I made sure I got a copy of each."
- "Some of them were very useful while others could be considered as only advertising materials."
- "Very useful because they provided a way to better present the issues treated by the conference."
- "Not sufficient conference papers"

165