

Findings from the Sub-Saharan Africa Urban Family Planning Study

OVERVIEW

of studies conducted in
Blantyre, Malawi
Bulawayo, Zimbabwe
Mombasa, Kenya

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John Snow, Inc., SEATS Project, Washington DC
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Blantyre Municipal Health Department
Southern Region Provincial Health Office (Malawi)
Bulawayo City Health
Zimbabwe National Family Planning Council
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Contents

List of abbreviations	i
Acknowledgments	ii
Introduction	1
Methods	1
Summary of findings	2
Background to the study	4
Urbanization in Sub-Saharan Africa	5
Urban contraceptive prevalence in Sub-Saharan Africa	10
Capacities of urban family planning systems	15
In Sub-Saharan Africa	15
In study cities	18
Service delivery by sector	23
Municipal services	24
The private sector	24
Pharmacies	25
Community-Based Distribution	26
Quality of services	27
Physical infrastructure	27
Method mix	27
Publicity and IEC	29
Recordkeeping and supervision	30
Commodities and logistics	31
Staff characteristics	32
Client/service provider interactions	32
Cost sharing	35
Integration of STD/HIV management with family planning services	36

Integration of other services with family planning	38
Implications: forging a new vision for urban family planning services	40
Bibliography	44

List of Abbreviations

AIDS	-	Acquired Immunodeficiency Syndrome
CAFS	-	Centre for African Family Studies
CBD	-	Community-based distribution
CPFH	-	Center for Population and Family Health
CPR	-	Contraceptive prevalence rate
DHS	-	Demographic and Health Surveys
FP	-	Family planning
FPPMES	-	Family Planning Program Monitoring and Evaluation System
HIV	-	Human immunodeficiency virus
IEC	-	Information, education, and communication
IUD	-	Intra-uterine device
JSI	-	John Snow International
LDC	-	Less developed country
LMP	-	Last menstrual period
MCH	-	Maternal and child health
MDC	-	More developed country
MOH	-	Ministry of Health
NGO	-	Non-governmental organization
ORT	-	Oral rehydration therapy
SDP	-	Service delivery point
STD	-	Sexually transmitted disease
TFR	-	Total fertility rate
USAID	-	United States Agency for International Development
WRA	-	Women of Reproductive Age

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Introduction

The SEATS Project of John Snow, Inc. in collaboration with the Centre for African Family Studies, The Population Council, and other population agencies, recently completed a major study to determine how family planning service delivery programs in Sub-Saharan African cities can be made more efficient and effective. In part, past decades of focussing development assistance on unserved and underserved rural areas has contributed to the inability of urban infrastructure to keep pace with rapid urbanization. The study, funded by the USAID Bureau for Africa, is based on the hypothesis that many/most urban family planning service delivery systems are overwhelmed by the recent rapid growth of urban populations and are not equipped to satisfy potential demand for contraceptive services. Three cities are included in the study: Mombasa, Kenya; Blantyre, Malawi; and Bulawayo, Zimbabwe.

Methods

The study methodology includes qualitative approaches using both existing data and data collected specifically for the study. Quantitative methods include: The Population Council's Situation Analysis methodology (Fisher et al., 1992), adapted to urban service delivery sub-systems; analysis of the urban sub-samples from existing Demographic and Health Surveys; mapping studies; the FPPMES (Family Planning Program Monitoring and Evaluation System) to generate estimates of contraceptive prevalence for "dispensed to user" data and to estimate the capacities of the urban programs under study (Gorosh, et al., 1994). Qualitative methods include: observations, group discussions, and focus group methods to complement the qualitative analysis. Dissemination workshops were held in each city to review preliminary findings with municipal and national officials. Finally, a regional workshop was conducted in Blantyre to review findings from all three cities and to create a new vision for urban family planning services in Sub-Saharan Africa.

Summary of Findings

Findings from the study provide information to policy makers, program managers, and donors on which to base a new vision for urban family planning services in Sub-Saharan Africa. This vision includes new directions and resource allocations for improving urban services. This report summarizes findings from Mombasa, Blantyre, and Bulawayo (detailed reports are available separately for each of these cities). Among the most important findings are the following:

- ! Cities' capacities to maintain current contraceptive prevalence levels will be severely strained as urban populations grow. Current capacities will have to be augmented if prevalence levels are to be maintained or increased.

- ! The most promising venues for increasing current capacity are through the large existing private sector (including pharmacies) and through community-based distribution which has not been fully developed in urban areas.

- ! Current urban method mixes are heavy in resupply methods, which will increase the future service delivery burden dramatically. New facilities and staff capabilities for providing long-term methods, including Norplant®, will have to be developed.

- ! The quality of urban family planning services is in some respects acceptable. Recommended improvements include: increased information given to FP clients, increased history-taking and examination of new clients, improved waste disposal facilities, access to laboratories, and increased production and use of IEC

materials.

- ! In addition, two areas particularly in need of improvement are provider training and SDP supervision.

- ! Many women are already paying for family planning services and many of those who are not currently paying for services report they would be willing to do so if required.

- ! Services other than family planning are available at many SDPs, but they are infrequently discussed with family planning clients. Staff knowledge of HIV/AIDS and other STD signs, symptoms, and modes of transmission are important constraints to integrated services.

- ! Municipal and national officials from Tanzania and Zambia joined their colleagues from the three cities in the study to call for the creation of an Urban Family Planning and Reproductive Health Network to promote collaboration, exchange, and technical assistance among cities.

Background to the study

Concern for urbanization and urban health issues in general in Sub-Saharan Africa is not new. Several conferences, workshops, and policy forums have addressed these issues intensively over the past few years (USAID 1991a, USAID 1991b, INMED 1994, United Nations, 1994). This attention has included a concern for urban population and family planning programs in particular (USAID 1992). Each of these meetings has concluded that relevant and useable data on urban health in Sub-Saharan Africa is in appallingly short supply. Few studies focus on urban systems alone, perhaps confirming the rural development focus of the past decades. While reports on individual cities do exist (Mensch, Miller, et. al, 1994; Jinadu, 1993; McGinn, 1990; Piotrow, 1990), urban data are most often presented as urban/rural comparisons within the context of national assessments and international comparisons.

In 1993, as part of its analysis agenda, USAID's Bureau for Africa approved an activity focused entirely on urban regions to "determine how family planning service delivery programs in major urban areas can be made more efficient and effective." In a communication to all Sub-Saharan African USAID Missions, the working hypothesis was put forth (USAID 1993): "many or most urban family planning service delivery systems are overwhelmed and not equipped by trained staff, facilities, or current technology to satisfy potential demand for contraceptive services."

The SEATS Project of John Snow, Inc. was named as the lead agency in carrying out this study, in collaboration with The Centre for African Family Studies in Nairobi, Columbia University's Center for Population and Family Health, and the Population Council.

Urbanization In Sub-Saharan Africa¹

This section presents a brief overview of the status and trends of urbanization in Sub-Saharan Africa, its regions, and the three countries included in this study (Kenya, Malawi, and Zimbabwe).

The United Nations estimates that the rapid urbanization now underway in less developed regions will continue for decades. By 2015, fully half of the populations of LDC nations will live in urban areas, and by 2025, the urban share will be 57%. This shift will also increase the proportion of the world's urban population in LDCs: in 1990, 61% of the world's urban population already lived in LDCs, and by 2025 the LDC urban population is projected to be four times the MDC urban population.

The urban population of Africa is growing faster than that of any other region of the world. The United Nations' assessment of urbanization in Africa clearly presents the dramatic growth that has taken place: "From a relatively modest 83 million urban residents in 1970, Africa increased to a substantial 206 million in 1990. Projections for 2005 put its urban population at 400 million and it will double again in the subsequent 20

¹ This section is based on National Research Council, 1993a, and United Nations Department for Economic and Social Information and Policy Analysis, 1993b. It is presented in full recognition of the limitations of models for projecting urban population growth, the varied experience in comparing past projections with actual growth, and the dangers of trying to make projections thirty years into the future (Findley, 1993; Hardoy and Satterthwaite, 1986; Cho and Bauer, 1987). Nevertheless, it is important to present a sense of the magnitude and urgency of urbanization in Sub-Saharan Africa.

years, to 857 million urban residents by 2025. As recently as 1950, Africa was home to only 32 million urbanites; six of every seven Africans lived in rural areas. Africa has been adding urban dwellers faster than any other region for some time, and it is expected to do so into the 21st century." (UN Department for Economic and Social Information and Policy Analysis, 1993b, p. 9)

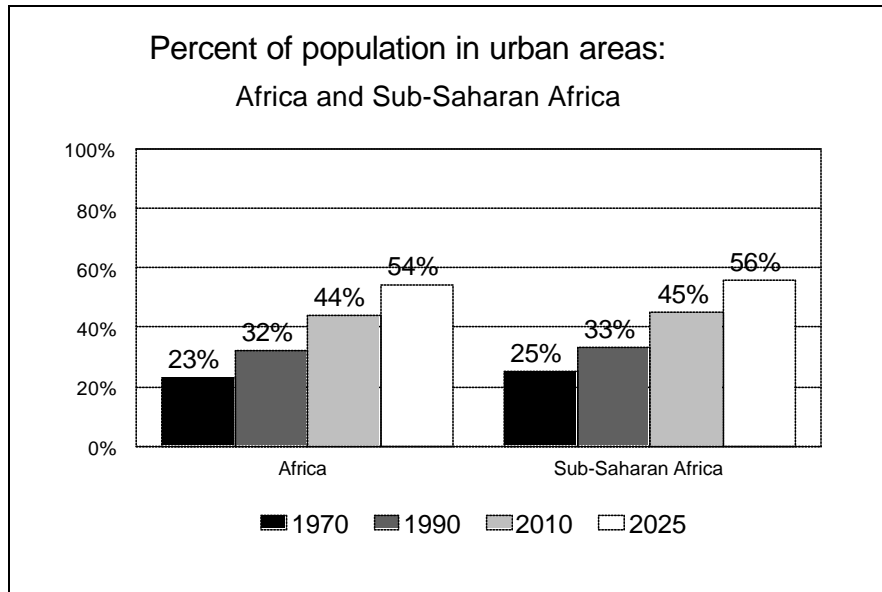


Figure 1

Although the urban populations of Africa are increasing, the overall *rate* of urban growth is declining. A National Research Council report notes that while the rate of urban growth is expected to decrease to a level of 3.45% per year by 2025, it is nevertheless a rate that implies a doubling every twenty years (National Research Council, 1993a, p. 279). Figure 1 presents the urban populations in Africa and Sub-Saharan Africa from 1970 through 2025.

The regions of Sub-Saharan Africa vary greatly in their projected urban populations. Figure 2 shows that southern Africa is the most urbanized region, with a projected 60% urban population by 2025. Western and middle Africa are about equally urban, and eastern Africa is the least urbanized region.

Projections for the individual countries of Sub-Saharan Africa show even greater diversity and at the same time an almost inexorable reach to hit the fifty percent urbanization mark

by 2025, when thirty-five of the forty-seven countries in Africa are expected to do so.
Figure 3 shows the projected urban populations for the study

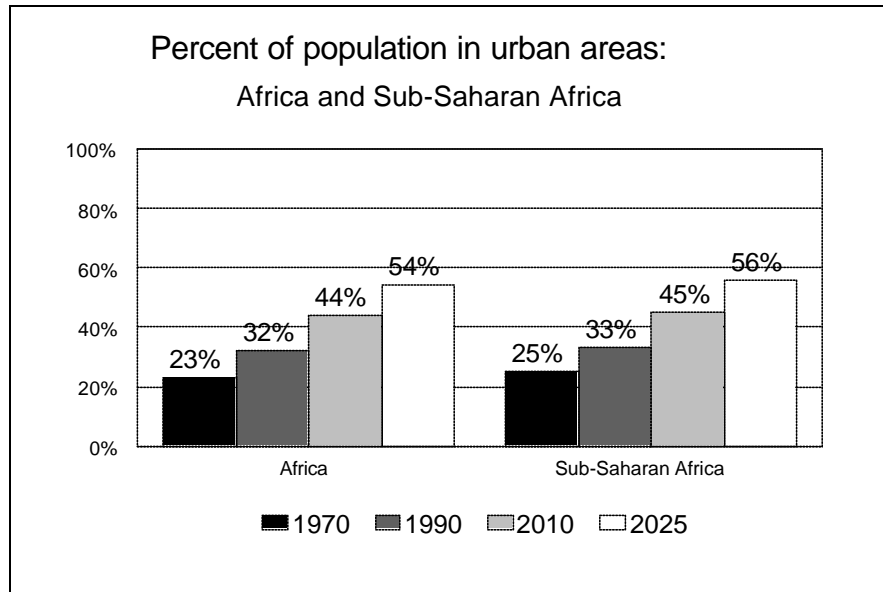


Figure 2

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Interestingly, the rural development focus of the last few decades, which was in part designed to stem rural-urban migration, may have actually accelerated urbanization:

"In fact, many countries found that rural development projects had a reverse impact, and actually contributed to accelerating rural to urban migration. Rural development policies, which leaned heavily on agricultural development, included road-building projects, agricultural extension training, agri-business development, and product commercialization, to name only some of the objectives. Unanticipated results of this policy have lead to dependencies upon the urban structure to provide necessary markets for goods, both sold and purchased, and supportive services. Newly constructed roads provided the conduit; not only for the flow of agricultural goods to city markets, but also people." (Olivola, 1991, p.2)

A USAID-sponsored workshop in 1991 forecast the consequences of rapid urban growth in Africa (see also O'Connor, 1986 and Teune, 1988):

"Cities... in Africa...were not planned to accommodate their present populations, much less those anticipated [by the turn of the century and beyond]. Consequently, preventive and curative health services, waste disposal, water supply, air quality, and other social services are declining and will continue to do so unless given serious attention. African urban centers will deteriorate, leaving millions to face political and economic chaos.

If the urban environment falters, so too will Africa's general economy. Urban areas in Africa account for greater economic output than rural areas. Their contribution has grown from 59 percent to 65 percent between the periods 1965-1980 and 1980-1989. Since the urban population was 28 percent of the population in 1989, it is clear that urban areas are responsible for a

disproportionate share of economic growth and production." (USAID 1992, p.v.)

The general deterioration of urban health services is exacerbated by the existing particular health conditions of urban residents:

"Contrary to common perceptions, urban dwellers may be as disadvantaged in terms of health care services, if not more so, than rural population. The most vulnerable are the poor, especially women and children. In addition to infectious diseases that one commonly associates with rural areas, the urban poor face health problems that tend to be more associated with developed countries: environmental pollutants, accidents, cancer, hypertension, substance abuse and violence. Compounding the problem, the urban poor often possess inadequate information about health services and access to such services, or too few resources to take advantage of them." (USAID 1991a, executive summary)

These observations foreshadowed Robert D. Kaplan's Atlantic Monthly article entitled "The Coming Anarchy," in which "scarcity, crime, overpopulation, tribalism, and disease" were seen as "rapidly destroying the social fabric of our planet." (Kaplan, 1994)

The Sub-Saharan Africa Urban Family Planning Study is a partial response to the monumental demographic shift taking place in Africa. The study considers only one aspect of urban services: family planning and related reproductive health services. It seeks to determine the extent to which these services, as they are presently constituted, have the capacity to meet the family planning needs of current and future urban dwellers. The study will also address how current capacities may be made more effective and efficient.

Urban contraceptive prevalence in Sub-Saharan Africa

As elsewhere in the world, urban CPR in Sub-Saharan Africa is generally higher than rural CPR. There are several reasons for this circumstance: "More [urban couples] are educated and have "modern" attitudes that include wanting smaller families; it is more expensive to raise children in the cities; conditions are more crowded; and urban couples have less need for children's labor than couples in agricultural areas. Also, family planning is often more available in cities and towns than in villages." (Robey, 1992, p. 12) This last point is the focus of the current study.

The difference between rural and urban CPRs varies greatly across the continent. In Mali, for example, the national CPR was recorded in 1987 as 5% (see Table 1)¹, but there was a large difference between urban and rural rates. The urban CPR was 11% and rural was 2%, giving a ratio of urban to rural CPR of 5.5. This ratio is high compared to a country like Togo, which in 1988 had an urban CPR of 23% and a rural CPR of 14%, for a ratio of 1.6.

Table 1 gives the total, urban, and rural CPRs for 22 Sub-Saharan African countries. In addition, the rightmost column shows the ratio of urban to rural CPR, and shows the wide variation in this ratio among countries. Where this ratio is high, contraceptive use is concentrated in cities, and where it is lower, contraceptive use is more evenly distributed throughout urban and rural areas. Notably, however, this ratio never falls below 1.0, since urban CPR is consistently higher than rural CPR.

Figure 4 plots these ratios of urban to rural CPR against the total CPR in each country. This graph shows that most of the variation in the urban:rural ratio occurs in countries with lower overall CPR. In countries with a total CPR below 20%, the urban:rural ratio

¹ The CPRs for all countries in Table 1 are for modern methods, among married women of reproductive age.

ranges from 1.1 (Mauritius) to 5.5 (Mali), but all the countries with a total CPR above 20% have urban:rural CPR ratios between 1 and 2. In other words, when the total CPR is high, contraceptive use in urban and rural areas tends to be more equal. When total CPR is low, contraceptive use in urban areas can range from far higher than rural areas to almost even with rural areas.

One conclusion that can be drawn from this relationship is that as a country's CPR increases, the largest gains are found in rural areas (as the rural CPR increases, the national CPR increases and the ratio of urban:rural CPR decreases). Indeed, rural services must be supported. However, the speed of urbanization in Sub-Saharan Africa, coupled with the difficulties currently facing urban programs, are threatening urban areas' ability to maintain the CPRs they have already achieved. If one reason for a stronger urban CPR is that FP services are more available, then the existing services must be expanded and improved in order to remain available.

National, rural, and urban contraceptive prevalence for twenty-two Sub Saharan African countries					
Country	Year	CPR	Rural CPR	Urban CPR	Urban:Rural Ratio
Benin	82	9	8	12	1.5
Botswana	88	33	26	38	1.5
Burundi	87	9	8	26	3.3
Cameroon	91-92	16	11	25	2.3
Cote D'Ivoire	80-81	3	2	5	2.5
Ghana	88	13	10	20	2.0
Kenya	88	26	26	31	1.2
	93	33	31	43	1.4
Lesotho	77	5	5	7	1.4
Liberia	86	6	3	12	4.0
Malawi	92	13	12	23	1.9
Mali	87	5	2	11	5.5
Mauritania	79	1	1	1	1.0
Mauritius	91	75	72	77	1.1
Niger	92	4	3	16	5.3
Nigeria	90	8	4	15	3.8
Senegal	86	12	10	15	1.5
Sudan (North)	78-79	5	4	17	4.3
Tanzania	91-92	10	8	18	2.3
Togo	88	12	14	23	1.6
Uganda	88-89	5	4	18	4.5
Zambia	92	15	10	21	2.1
Zimbabwe	88	43	40	52	1.3
	94	48	44	58	1.3

Table 1

National CPR and ratio of urban:rural CPR

22 Sub-Saharan African countries

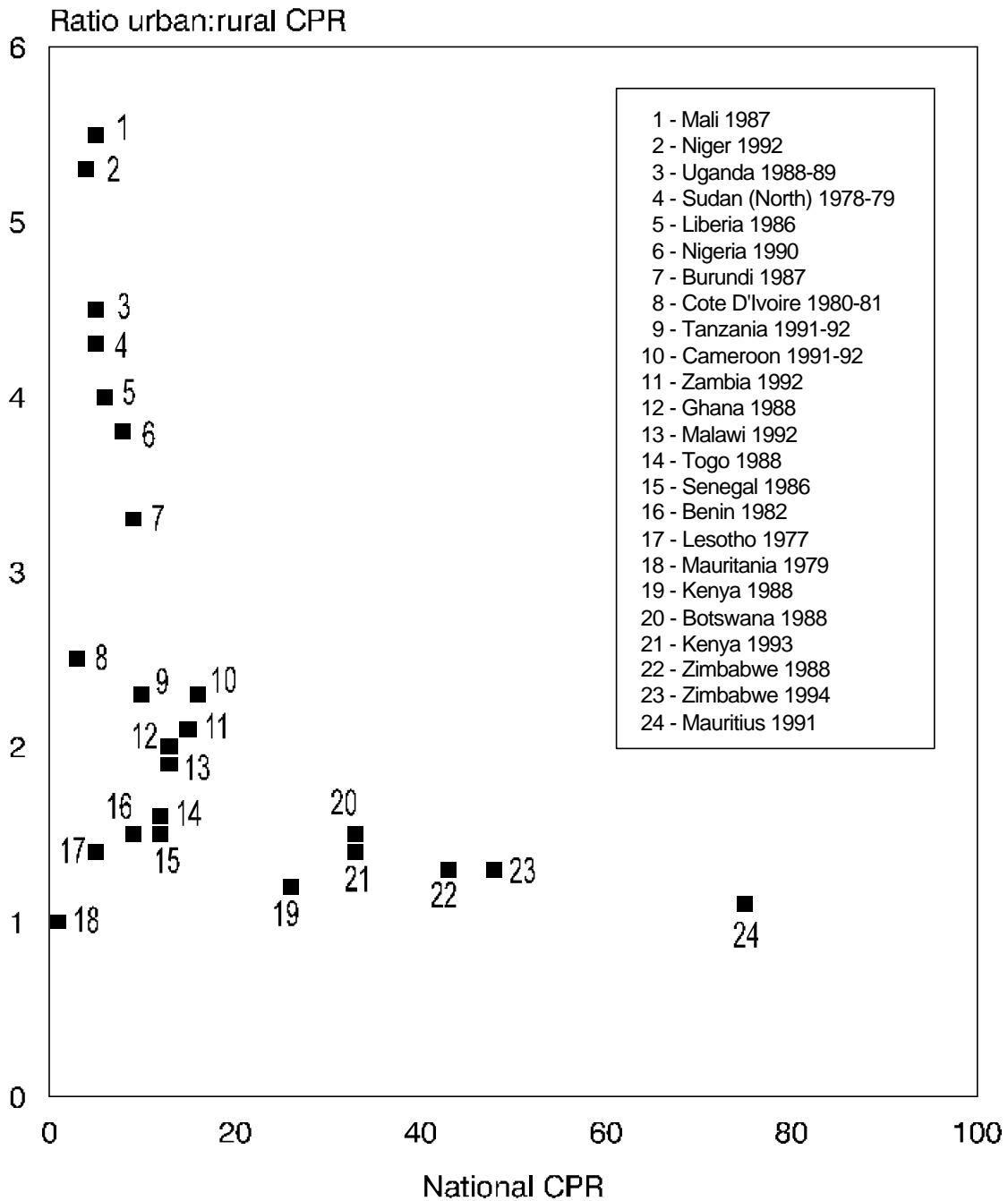


Figure 4

This discussion raises several points that might be useful in drafting a vision for urban FP systems in Sub-Saharan Africa:

- ! In low prevalence countries, is the large urban:rural gap explained simply by new programs starting in urban areas and being adopted by the "early innovators" who reside in the urban areas?
- ! Are prevalence increases in rural areas a result of the intensive efforts made to reach rural populations through PHC and CBD approaches?
- ! As overall prevalence increases as a result of the above mentioned efforts, are we really witnessing a lack of attention to increasing the capacity of urban services to serve a higher percentage of urban residents?
- ! Has there been an assumption that urban services are well-developed (relative to rural services) that led to neglect?
- ! Are urban services as "available" and "accessible" as they appear to be, i.e., are they functioning at or over their capacity and does capacity have to be increased in order to attain a higher rate of urban prevalence?
- ! Have urban services been neglected and are they among the many other urban sub-systems that are stretched and over-taxed?
- ! Is there a need to review the use of MWRA as the denominator for urban contraceptive prevalence? In Bulawayo, for example, nearly one-half of WRA are neither married nor in union.

Capacities of urban family planning systems

In Sub-Saharan Africa

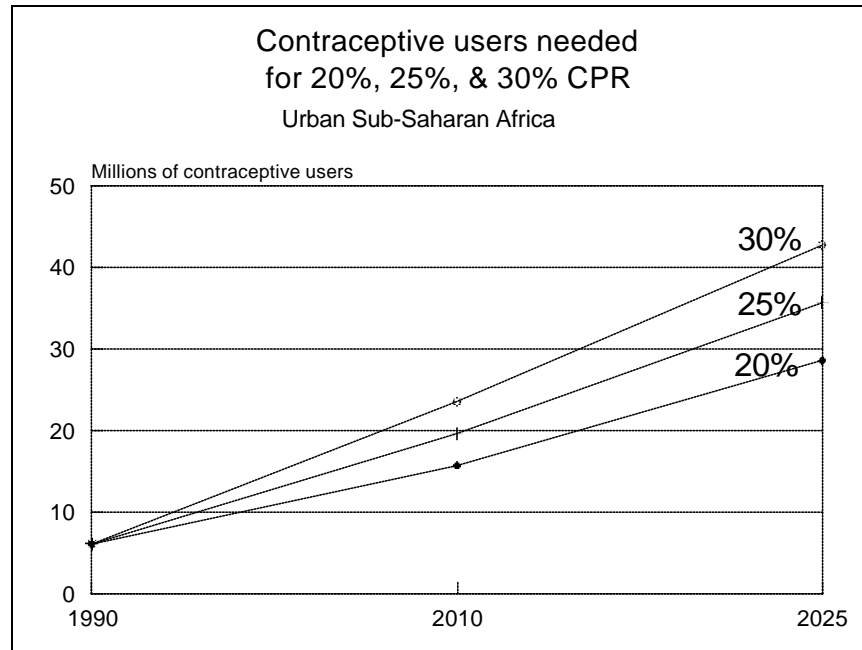


Figure 5

The high rates of urban growth in Sub-Saharan Africa will certainly strain the ability of urban programs to maintain or increase contraceptive prevalence. Figure 5 illustrates the magnitude of the task by estimating the number of contraceptive users required to achieve various urban CPRs through the first quarter of the next century⁴. (The current average urban CPR in Sub-Saharan Africa is 20%.)

⁴ Figure 5 was calculated as follows. Starting with a total urban population of 144 million in Sub-Saharan Africa in the early 1990's, and assuming that 21% are women of reproductive age, the WRA population is 30 million, and 20% of them (6 million women) are currently using modern contraception. At the projected population growth rates, this number would have to grow to 13 million users in 2010, and 28 million users in 2025 simply to maintain an urban CPR of 20%. These numbers increase if higher urban CPRs are targeted (to 42 million users in 2025 to achieve an urban CPR of 30%).

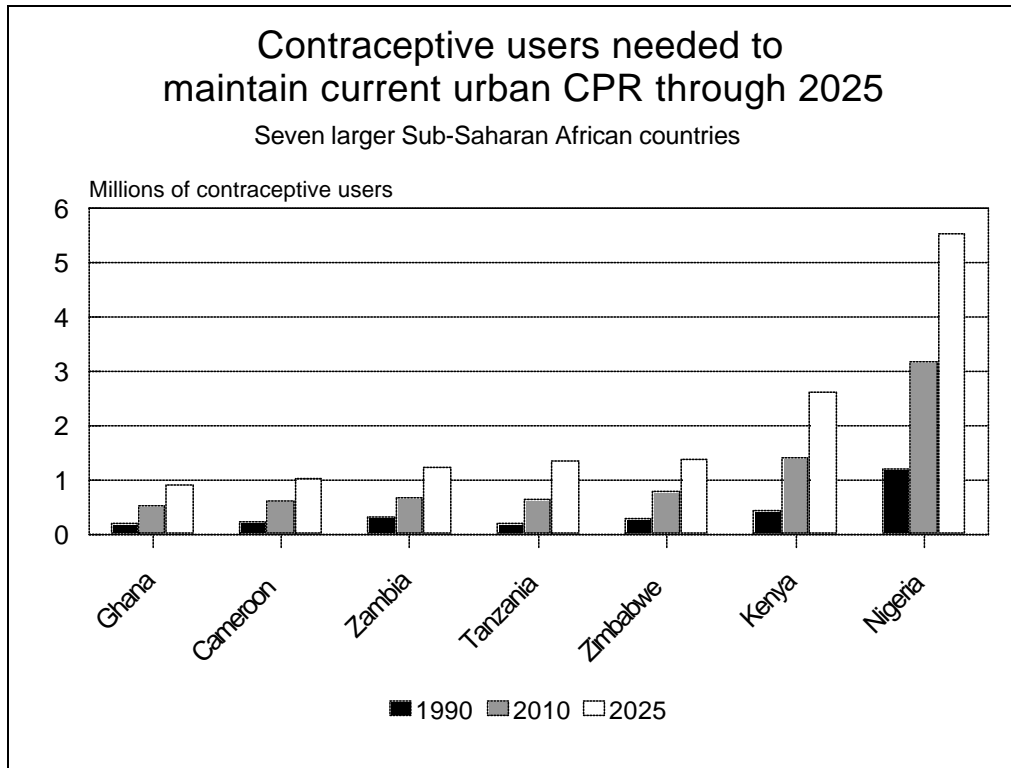


Figure 6

Figures 6 and 7 present the numbers of contraceptive users required to maintain current urban contraceptive prevalence rates for 16 Sub-Saharan African countries with prevalence surveys conducted since the late 1980's⁵. Figure 6 contains the 7 larger countries, and Figure 7 shows the 9 smaller countries. Again, both the absolute numbers and the relative increases in current contraceptive users are staggering.

⁵ The source for these current urban CPRs is Ross et. al., 1993 (Population Council).

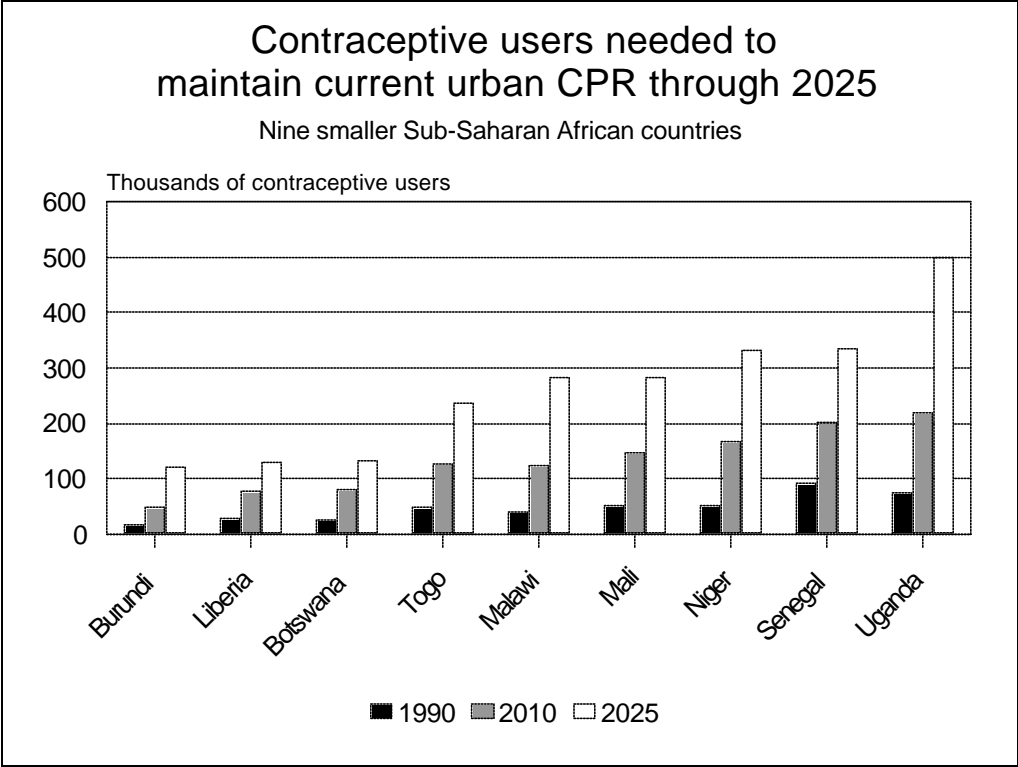


Figure 7

In study cities

For cities included in this study, a more refined estimate of future capacity requirements has been developed. This approach produces estimates of the number of client contacts needed to reach specified future CPRs.

For each city, the current CPR and method mix are used to construct a baseline of client contacts. The population of WRA is then projected through 2025 from current census data or population estimates, using United Nations urban growth rates. Two additional parameters are introduced at this point. The first considers maintaining or increasing the CPR⁶ and the second introduces various levels of use of longer-term methods of contraception.⁷ The results are then expressed as the number of client contacts⁸

⁶ For baseline estimation, the following current CPRs were used: Blantyre, 10%; Bulawayo, 30%; and Mombasa 25%. These CPRs are estimated with FPPMES, and are based on service statistics, not DHS figures (see the individual city reports for further discussion). By 2025, Bulawayo and Mombasa are assumed to double their CPRs. Two projections are made for Blantyre by 2025: the first assumes a 20% CPR and the second a 40% CPR.

⁷ These levels are set at 0%, 20%, 40%, and 60% users of IUD's, sterilizations, and Norplant®. Note that these figures do *not* refer to the percent of all women using long-term methods. Instead, they refer to the percentage of the overall CPR attributable to long-term methods. For example, if the CPR is 20%, and half of those users are practicing long-term methods, then for these purposes the "level of use of long-term methods" is 50%.

⁸ Standard numbers of client contacts are estimated as follows. These values may vary for individual programs, so the projections should be evaluated in light of these defaults.

oral contraceptives	4 visits per year
injectables	4 visits per year
sterilization	2 visits/current year acceptor (with 10% of total sterilization users assumed to have accepted in the current year)
IUD	2 visits/current year acceptor (with 33% of total IUD users assumed to have accepted in the current year)
Norplant®	2 visits/current year acceptor (with 33% of total Norplant® users assumed to have accepted in the current year)

Condoms are not included in this analysis. Assuming a condom user requires 12 contacts per year, including condoms in these projections resulted in astronomical figures. This was judged to be fairly misleading, since condom resupply visits normally take very little staff time as compared to other methods.

required in a future year under various combinations of these assumptions.

Admittedly, these estimates are long-term and essentially linear. They do not take into account social and economic change in the coming decades nor do they allow for changes in reproductive behavior or contraceptive technology. Nevertheless, they are presented here to raise questions about the capability of today's service delivery infrastructure to provide substantially increased services in the future.

The following three figures give the number of client contacts required by the year 2025 in each study city, assuming the current CPR doubles by then (see the individual city reports for further discussion of each one). These projections clearly illustrate two points: first, the current service delivery capacities in each city will have to be expanded, and second, the future service delivery "burden" can be eased by increasing the proportion of clients who choose longer-term methods.

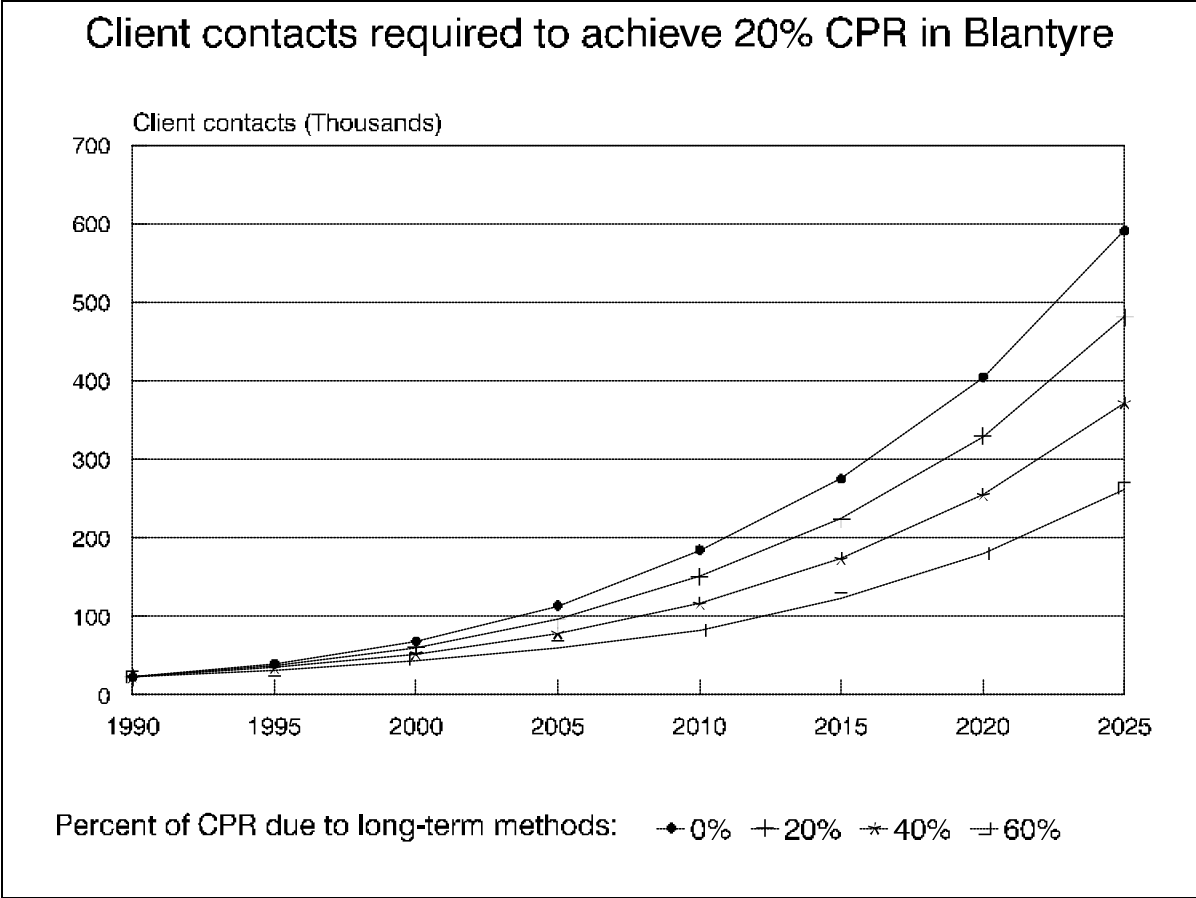


Figure 8

Figure 8 shows the estimated number of client contacts required to achieve a 20% CPR in Blantyre, assuming 0%, 20%, 40%, or 60% of that CPR is comprised of long term methods. The DHS shows that currently approximately 36% of all contraceptive users in Blantyre use long-term methods; continuing with this mix would result in roughly 400,000 client contacts by 2025.

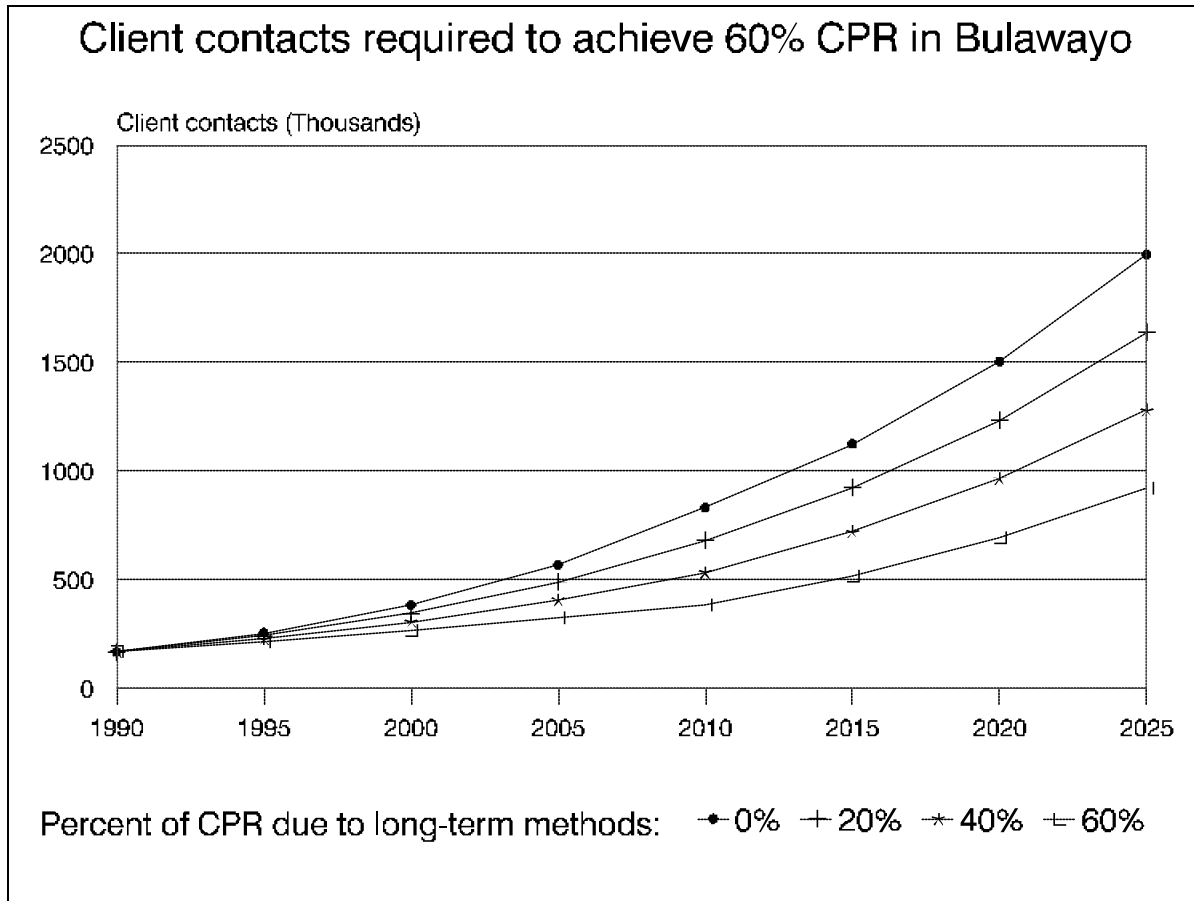


Figure 9

Bulawayo currently requires about 200,000 client contacts per year to maintain a CPR of 30%. If the CPR is doubled to 60% by 2025, then Bulawayo will need up to two million client contacts in some scenarios. Currently, approximately 20% of contraceptive users are on long-term methods; continuing with this mix would generate over 1.5 million client contacts by 2025.

Service delivery by sector

A large non-governmental sector exists in all three study cities. This sector includes private practitioners, NGOs, PVOs, and pharmacies. Several findings from the study reveal the role of these sectors in providing family planning services and point to the importance of strengthening them to help meet future service delivery requirements. To accomplish this several initiatives are required: increasing staff training, providing logistical support and IEC materials, and monitoring performance.

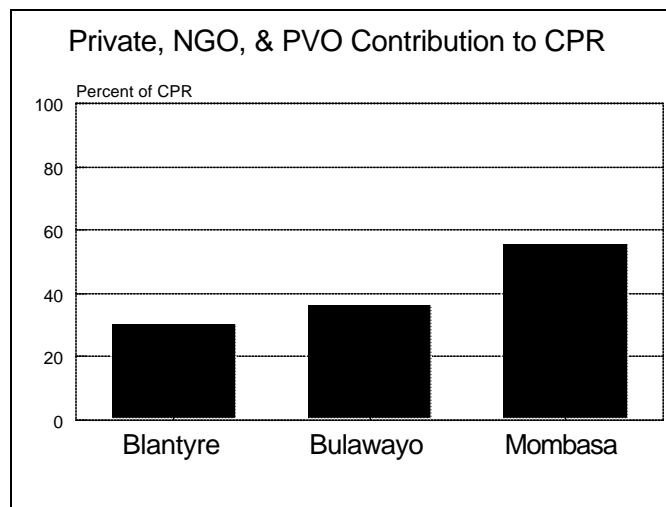


Figure 11

The FPPMES (Family Planning Monitoring and Evaluation System) was used to analyze the service statistics data collected during the study, and attribute the current CPR to the various sectors. The results of this analysis (Figure 11) illustrate the important contribution made by the private, NGO, and PVO sectors to the CPR in each city.⁹

⁹ In Bulawayo, the ZNFPC clinic and CBD contributions to the CPR were counted as being in the private-NGO-PVO sector. In addition, no data were available from the private sector in Bulawayo, so this figure is probably higher.

Municipal services

Within the public sector, services are generally divided between central government and municipal SDPs. The FPPMES analysis revealed that municipal services play widely varying roles in their contribution to the CPR in each city: 12% in Blantyre, 15% in Mombasa, and fully 58% in Bulawayo. Doubtless, this division of labor reflects a variety of circumstances, most notably the roles of the private sector and MOH facilities.

There is some debate as to the appropriate levels of central government vs. municipal effort in FP programmes. Municipal governments are generally recognized to be essential in the provision of services, but they often lack the resources of a central government - physical, managerial, and financial - to operate a program successfully (Olivola, 1991; Silimperi, 1991). A report on urban health from the 44th World Health Assembly puts the problem succinctly: "The task facing city governments is enormous, and there is no particular relationship between the scale of the situation and the capacity for tackling it." (World Health Organization, 1993, p. 57)

The private sector

In general, the private sector was the most difficult to study. In all three cities, record keeping and supervision among private providers is not as strong as in other sectors, so their quality or impact is not reliably measurable. However, the sheer number of private SDPs is impressive, and indicates a major possibility for expansion of family planning services. In both Blantyre and Mombasa, only 35% of private SDPs currently offer FP services. The first step towards involving the private sector in FP would be to institute standard reporting and supervision protocols, established and enforced by a recognized central body.

Pharmacies

Again, pharmacies represent a significant opportunity for expanding family planning services. In all three cities, pharmacies have reasonable infrastructures in place, and the pharmacists tend to rate sales of contraceptives as "important" or "very important" to their business (Figure 12). In Bulawayo and Mombasa, pharmacists also report that customers frequently consult them about contraception, mainly on use of the pill.

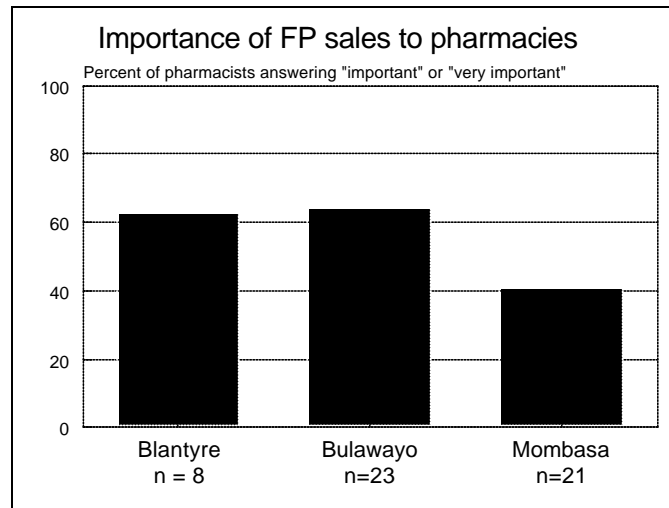


Figure 12

The primary barrier to increased FP in pharmacies is the training of the pharmacists themselves. Although in Bulawayo 91% of the pharmacists have received training in FP, their method-specific knowledge was not found to be as detailed as might be required by customers. In Blantyre, training of pharmacists in FP is rare, and in Mombasa, no pharmacists had received this training. However, the majority of pharmacists interviewed in all three cities expressed a desire to attend training sessions.

Further initiatives to increase pharmacy participation might include improved supply and storage of commodities and use of IEC materials.

Community-Based Distribution

Community-based distribution is an important source of family planning in only one of the three cities. Based on the analysis of service statistics collected in the field, CBD workers in Bulawayo are responsible for 13% of the contraceptive prevalence in that city. In Blantyre and Mombasa, each with four CBD workers¹⁰, the concept of CBD has yet to be fully developed. Areas for improvement include supervision, logistical and referral systems, training in FP methods and community participation.

CBD has proven to be an important component of family planning service delivery in Bulawayo and in other African cities. The lessons learned from successful urban CBD approaches should be applied and adapted in cities where CBD has not yet been developed.

¹⁰ Note that while the Mombasa inventory lists 56 CBD workers, all but four are either community social workers with a wide range of activities or condom depot holders who do not actively promote family planning.

Quality of services

Any detailed analysis of quality of services must be made on a city-specific basis (occasionally on an SDP-specific basis) to reflect the realities of service delivery and the differences between private and public sectors in each city. For example, provision of long-term methods is a problem in Blantyre; periodic power interruptions and water supply are seasonal problems in Mombasa; private sector availability of a full range of contraceptive methods is a problem in Bulawayo. The reader is encouraged to review the individual reports for the study cities for a detailed discussion of their quality of services. The following sections give a brief overview of the findings for each element studied.

Physical infrastructure

The basic physical infrastructure in all three cities is acceptable for providing basic FP services (including water, electricity, client waiting areas, working toilets, and private counseling and examination rooms). The infrastructure in Blantyre and Bulawayo is particularly strong. However, all three systems are severely lacking in sluice rooms (storage areas for soiled materials) and access to laboratories, both of which are necessary for providing long-term methods, assuring against cross-infection, and integrating STD services with FP.

Method mix

The modern contraceptive method mix varies in the three cities studied. Table 2 gives the method mix by city. These estimates are based on service statistics (calculated with the FPPMES), and therefore differ from the DHS estimates of method mix.

According to this data, Mombasa leads the way in use of long-term methods, with a combined 25% of users choosing sterilizations or IUDs. Interestingly and perhaps due to HIV/AIDS and STD prevention efforts, Mombasa has the greatest reliance on condoms, the least effective contraceptive method.

Percent distribution of modern contraceptive methods Estimated from service statistics using FPPMES			
METHOD	BLANTYRE	BULAWAYO	MOMBASA
STERILIZATION	7	4	10
IUD	5	4	15
INJECTION	36	8	18
PILL	48	71	34
CONDOM	4	13	23

Table 2

These data for Blantyre do not include previous long-term methods, but only those distributed in the past year, so the amount of long-term use is probably underestimated (this was corrected in the other two cities). The DHS can be used as an estimate for the true method mix in effect in Blantyre, and it shows a remarkably high 36% use of long-term methods. Since this figure is nationwide, however, it may not accurately reflect method use in Blantyre. The true figure is probably lower.

As for the methods offered by SDPs, all three cities display a heavy bias toward resupply methods. Most sites offer pills, condoms, and injectables, but provision of long-term methods is restricted to a small set of SDPs. Expanding the number of SDPs that

offer these methods is not a simple task, since IUDs and sterilizations require operating rooms, a range of sterile surgical equipment and supplies, well-trained staff, and infection prevention guarantees. (These capabilities are particularly important in areas of high STD prevalence.) Norplant® is another vastly underutilized method, which would require less technical expertise, but is enormously expensive and not readily available.

The importance of offering these long-term methods arises from their impact on the future service load, as discussed earlier. Although important improvements have been made, continued efforts are needed to promote the appropriate use of sterilization, IUDs, and eventually Norplant®. In conjunction with promotional and educational efforts, facilities need to be upgraded and staff need to be trained to provide these methods. Finally, while important for HIV/AIDS and STD prevention, high levels of condom use may not be consistent with effective family planning

Publicity and IEC

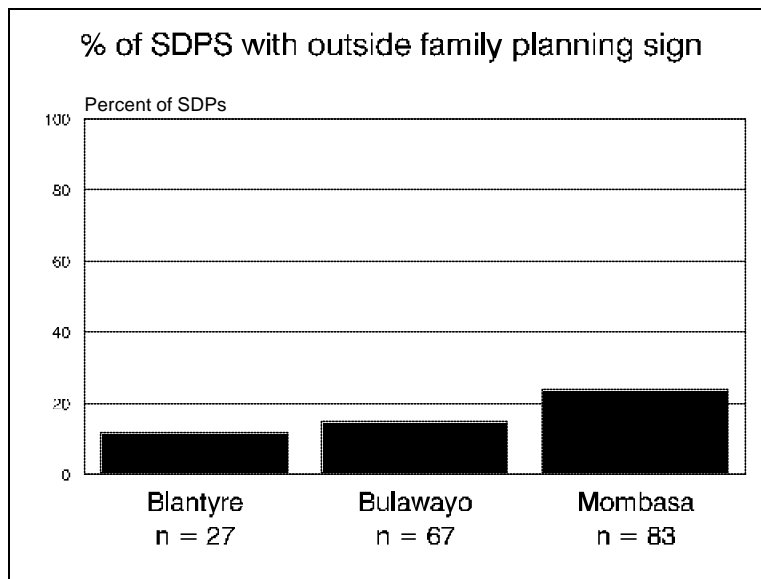


Figure 13

The availability of family planning services at SDPs in all three cities is not well advertised. In fact, very few of the SDPs have a sign outside announcing the availability of FP services (Figure 13), perhaps due to a reluctance to promote "vertical" services. Moreover, many of these signs are only in English, although many women cannot read or speak English easily.

In general, the study revealed an overall lack of IEC materials in all three cities. Other than the family planning posters found at SDPs in Bulawayo and Mombasa, the majority of SDPs in the three cities lack flip charts, family planning pamphlets, contraceptive samples, physical models, and audio-visual equipment.

Recordkeeping and supervision

In all three cities, the information in client records and daily record books was more accessible in the public sector than in the private sector. Monthly reporting is almost exclusively a public sector activity. In addition, Blantyre and Mombasa do not make efficient use of the reporting that is undertaken -- there are no centralized repositories for the records, and feedback to SDPs is extremely rare.

Supervision is also scanty, particularly in the private sector. In Blantyre, staff at 30% of SDPs had never had a supervisory visit or could not remember one. Similarly, staff at 41% of SDPs in Mombasa reported no supervisory visits, and in Bulawayo, staff at 49% of SDPs had never had a visit or could not remember one. Moreover, the supervisory visits that *are* made do not seem to follow standard protocols.

These findings clearly indicate that standardized recordkeeping and reporting as well as regular supervision would probably dramatically increase the quality of care in all three

cities.

Commodities and logistics

In all three cities, stockouts during the six month period prior to the study were experienced frequently. This problem is particularly significant in Blantyre and in the private sector in Bulawayo.

Blantyre and Bulawayo SDPs had little or no expired stock on hand at the time of the study. Mombasa SDPs, however, were found with substantial stores of expired stock.

Staff characteristics

Staff training is a paramount concern in all three cities. In general, staff are best trained in specific methods: course attendance in the theory and practice of providing pills and injectables is fairly high in all three cities. However, no more than 50% of the providers in all three cities have had broader training in FP, overall clinical services, IEC, MIS, or other issues. In Blantyre and Mombasa, nurse training in resupply methods is markedly higher than physician training. This may be appropriate, however, as nurses supply the majority of these forms of contraception. Physician training in long-term methods is also low: in the private sector in Bulawayo, only 20% of doctors are trained in vasectomy or mI/la.

In all three cities, staff displayed a distinct preference for pills, condoms, and injectables. This may simply have been a reflection of the methods available at the various SDPs, but may also have reflected an attitudinal bias.

Client/service provider interactions

The quality of these interactions varied from city to city. Overall, the interactions were adequate, but complete medical histories and exams were not always performed and information about all methods was not always provided. Nonetheless, client satisfaction was extremely high in all three cities -- upwards of 90% of clients felt they had received the information and services they desired.

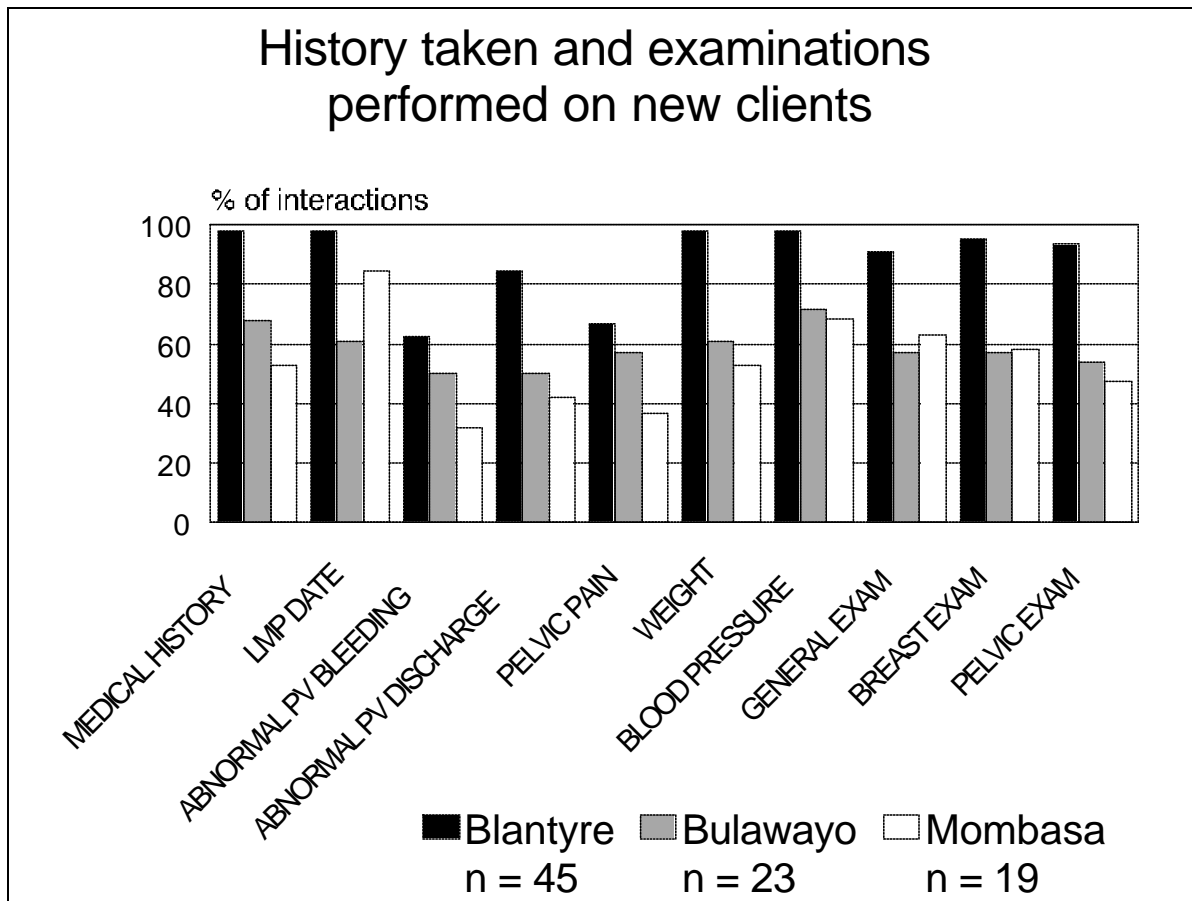


Figure 14

Figure 14 shows that the medical history taken and examinations performed on new clients in Mombasa and Bulawayo were not complete¹¹. In Mombasa, for example, only about half of new clients were asked about their medical history, and in Bulawayo, about a quarter of the patients did not have their blood pressure taken. The procedures in Blantyre seem to be more standardized.

¹¹ The type of medical history taken and examinations performed on clients should clearly differ depending on the client's medical status, reproductive intentions, and method of choice. For this reason, it is difficult to establish a standard set of procedures that should be followed in every case, particularly for revisit clients. A woman does not require a pelvic examination, for example, every time she refills her oral contraceptives prescription. However, for the purposes of this study, the procedures listed in Figure 14 constitute a basic standard for new acceptors.

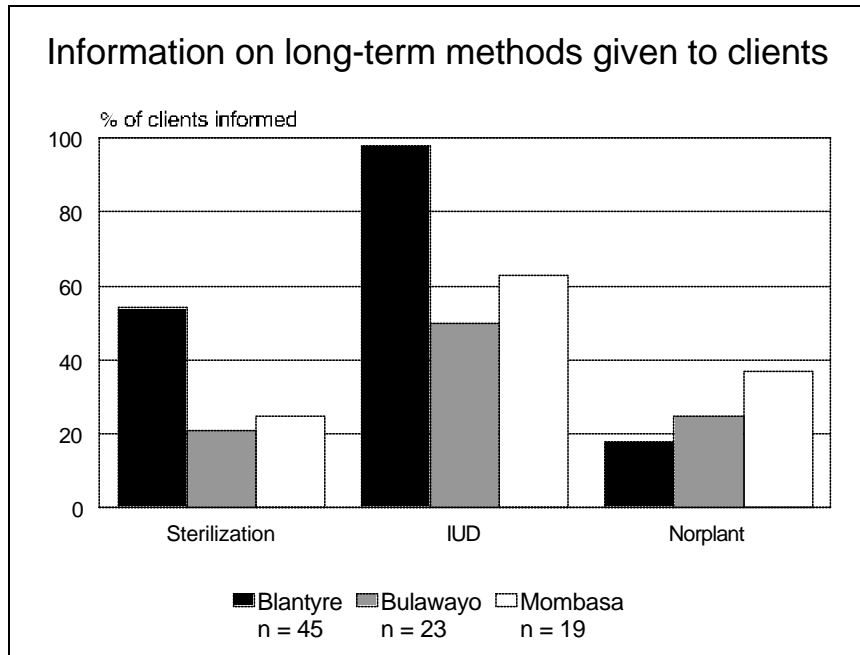


Figure 15

Information about the different contraceptive methods was given selectively in all three cities. Most clients were informed about resupply methods, but long-term methods were mentioned far less frequently. Figure 15 shows the percentage of clients exposed to information about long term methods. (Norplant® is not used to any appreciable degree in any of the three cities.) Clearly, not all clients are candidates for long-term methods, and therefore not all clients need this information. However, there is some evidence, particularly in Blantyre, that substantial unmet need for limiting exists. This need cannot be efficiently met unless more clients are told about long-term methods.

In Blantyre and Mombasa, most clients were given adequate information to facilitate follow up. About half of the clients were given such information in Bulawayo.

Cost sharing

Although the results differ across cities, there is some room in each city for cost sharing with clients. This finding supports the recommendations for stimulating private sector family planning in all three cities.

Although FP services are free in two of the three cities, many women are already paying for their family planning services (Figure 16), either through payments for supplies or by patronizing the private sector. Moreover, those women not already paying for FP services exhibit a significant willingness to pay, as shown in Figure 17.

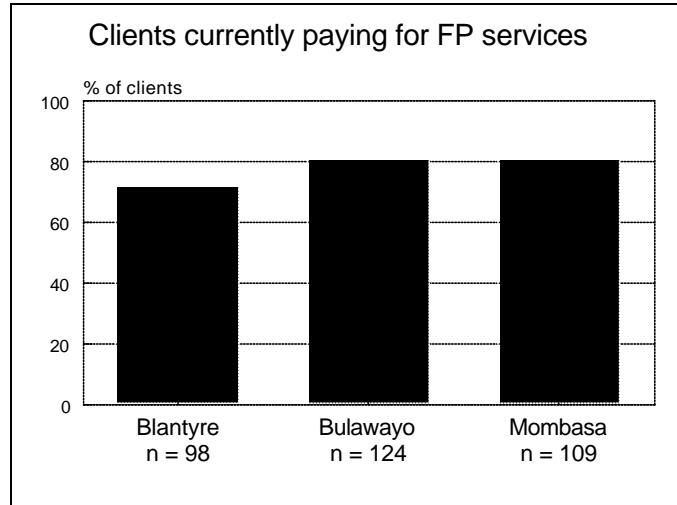


Figure 16

This willingness to pay is supported by a reasonably adequate ability to pay. About 40-50% of women in each city generate their own income, although control over this income often lies with the women's spouses. Nonetheless, a majority of women in all three cities report that if they were charged for FP services, their spouses would be willing to pay.

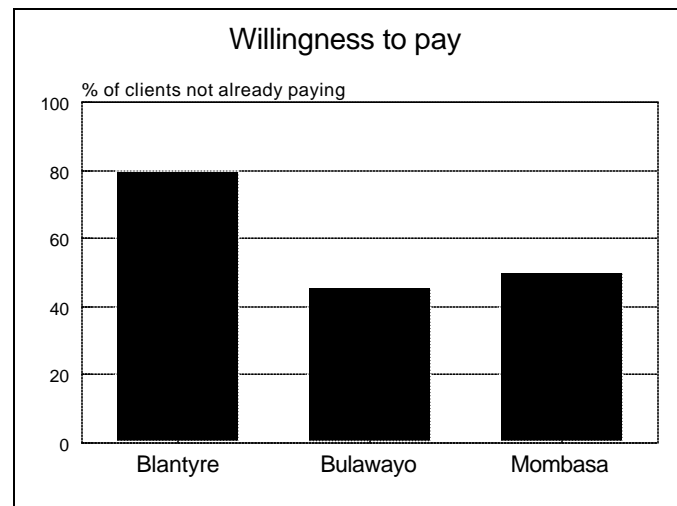


Figure 17

These findings suggest that modest charges would not decrease CPR significantly. Although the public sector might benefit most from instituting charges, this willingness and ability to pay can also assist the NGO, PVO, and private sectors, as well as pharmacies.

Integration of STD/HIV management with FP services

This study also examined attitudes and practices around integrating STD/HIV management with FP services. In all three cities, most SDPs already offer STD services, and most providers are in favor of integration. However, very little integration has actually taken place, and there are serious barriers against doing so, mainly a shortage of facilities and equipment, inadequate staff training, and a public stigma against integration.

The lack of sluice rooms (storage areas for soiled materials), sterilization equipment, microscopes, and access to laboratories seriously hinders many SDPs from providing STD/HIV services. Moreover, while the majority of service providers have received instruction in STD/AIDS concepts and management during their basic training, few have had any inservice training to upgrade their knowledge and skills (Figure 18). A series of questions about the management of various STDs revealed that provider knowledge in general is not adequate to deliver

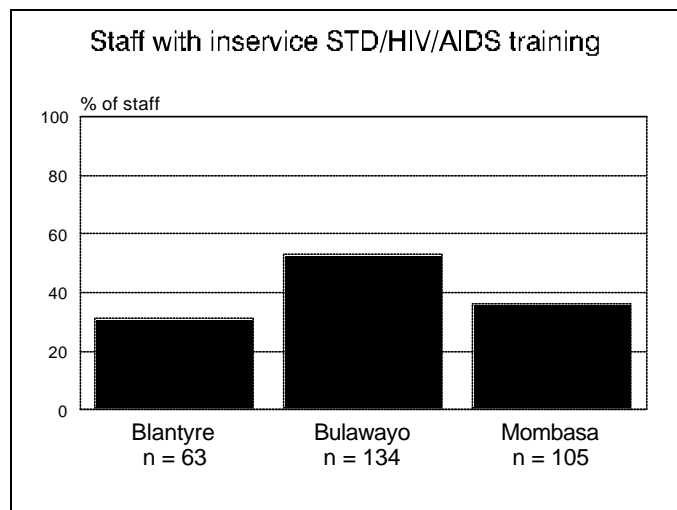


Figure 18

high quality of services. Staff are largely able to identify STDs, but are not well-informed on signs, symptoms, and modes of transmission.

Serious efforts to integrate STD with FP services will require upgrading of physical facilities and equipment, inservice training, and developing the logistics support required for diagnostic kits and pharmaceuticals for treatment. In addition, integration will also require the careful identification of services to be integrated, development of new service delivery protocols, and close supervision to assure that the new protocols are followed. Lastly, it will require public education to remove the stigma around STD services.

Integration of other services with FP ¹²

Services other than family planning are available at SDPs in all three cities. The pattern varies, but typically services such as immunization are more widely available in public sector facilities and infertility services are more available in the private sector in Blantyre and Mombasa. Table 3 summarizes the availability of services other than family planning by sector.

	% of SDPs					
	Blantyre		Bulawayo		Mombasa	
	PUB	PRI	PUB	PRI	PUB	PRI
Infertility	25	60	85	70	39	58
STD	60	80	89	85	65	78
Immunization	100	40	74	5	81	30
Antenatal	95	40	74	58	81	72
Postnatal	NA	NA	70	53	69	63
AIDS IEC	80	90	96	78	54	45
Complications of abortion	NA	NA	44	23	11	14

Table 3

¹² This topic is not addressed in the individual city reports.

Despite the wide availability of non-family planning services at both public sector and private sector SDPs, these services were infrequently discussed with family planning clients, as shown in Table 4. If integrated services are to become a reality, the availability of these services must be accompanied by a more aggressive effort to use family planning as an entry point.

Family planning clients with whom other services were discussed			
	% of clients		
	Blantyre	Bulawayo	Mombasa
AIDS/STD	29	14	6
ORT	0	0	0
Malaria	0	0	6
Immunization	2	18	6
Family health	4	18	11
Client topic	4	15	17

Table 4

Implications: forging a new vision for urban family planning services

The implications of this study are clear. A new vision is required for increased attention and resources for more effective urban services in Sub-Saharan Africa. New efforts are needed to segment the urban markets and to develop innovative service delivery strategies. Finally, new approaches have to be developed to work directly with municipal authorities to strengthen city capabilities in order to make the vision a reality.

The new vision requires policy reform, new program design initiatives, and strengthened management capabilities to provide high quality family planning and reproductive health services to all segments of urban populations in the future.

The key elements of the new vision are presented below. These elements were first presented and discussed at the Workshop on Family Planning and Reproductive Health in Sub-Saharan Africa, conducted in Blantyre, Malawi, 14-17 March 1995.

Policy Priorities of the New Vision

- New informational programs are needed for municipal and national officials and legislators, donors, and cooperating agencies to assure full consideration of city population dynamics, essential service delivery program components, and the magnitude of the task to be faced in the twenty-first century.
- Policies should be in place to promote the maximum participation of the private sector (NGOs, PVOs, industry, MDs, nurses, midwives, pharmacies).
- There should be greater development of CBD and alternative delivery systems.

- Donors and cooperating agencies need to work directly with municipal officials.
- Policies are needed to rationalize the tax base and resource flow to and from cities.
- Alternative payment and cost-recovery approaches (insurance, taxes, fees) should be stimulated.
- Policies are needed to promote future commodity sustainability.
- Urban health concentrations should be established in Schools of Public Health and Medical School Departments of Community Medicine.

Program Design Initiatives of the New Vision

- In each city, there should be at least one model comprehensive reproductive health service center for the general public, staffed with well-trained personnel and open for evening and weekend hours.
- In each city, there should be at least one model comprehensive reproductive health service center for young adults, staffed with well-trained personnel and open for evening and weekend hours.
- Programs should be designed to increase the capacity to provide long-term and permanent methods of contraception.
- Urban CBD and other alternative delivery systems can be effective approaches to improve access to and use of all contraceptive methods.

- New and clear linkages are needed within and among service delivery points for referral and backstopping between family planning and reproductive health services.
- Programs should maximize the participation of all segments of the private sector (NGOs, PVOs, Industry, MDs, Nurses, Midwives, Pharmacies).
- New advertizing and promotional campaigns are needed for family planning and reproductive health services.

Management Improvements of the New Vision

- Management Information Systems should be improved for monitoring progress and carrying out unmet need analysis.
- Improve quality of care in Family Planning and Reproductive Health Programs, especially the range of methods, the types of services, and the responsiveness of providers and provider organizations to the wants and needs of clients.
- Increase the number and types of workers allowed to provide clinical methods of contraception.
- Strengthen the target group focus of programs.
- Improve logistics management.
- Improve supervision.

- Train municipal officials in strategic planning, program design, and program development.

Urban Family Planning and Reproductive Health Network

- Create an Urban Family Planning and Reproductive Health Network to promote collaboration, exchange, and technical assistance among cities.

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