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**HIV/AIDS PREVENTION AND CONTROL
AND POPULATION/FAMILY PLANNING:
THE POTENTIAL FOR INTEGRATION
OF PROGRAMS AND ACTIVITIES IN
SUB-SAHARAN AFRICA**

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Glossary

ACP	AIDS Co-ordination Programme (Zimbabwe)
A.I.D.	Agency for International Development
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention (project)
AIDSCOM	AIDS Communication Component of AIDS Technical Support Project
AIDSTECH	AIDS Technical Component of AIDS Technical Support Project
ARC	AIDS-related complex
ATSP	AIDS Technical Support Project
AZT	zidovudine, an antiretroviral drug
BDF	Botswana Defence Force
BOFWA	Botswana Family Welfare Association
BOTSPA	Botswana Population Sector Assistance Program (project)
CBD	community-based distribution
CDC	Centers for Disease Control
CIDA	Canadian International Development Agency
CSM	contraceptive social marketing
CYP	couple year of protection
DAMP	District AIDS Mobilization Project (Uganda)
DANIDA	Danish International Development Agency
DFA	Development Fund for Africa
DHS	Demographic and Health Survey
EIL	Experiment in International Living
ESAP	Economic Structural Adjustment Programme
FHI	Family Health International
FP	family planning
FPAU	Family Planning Association of Uganda
GPA	Global Programme on AIDS
GTZ	German Technical Cooperation
HAPA	HIV/AIDS Prevention for Africa (project)
HIV	human immunodeficiency virus
HPN	health, population, and nutrition
IEC	information, education, and communication
INOPAL	Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean (project)
INTRAH	International Programme for Training and Health
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	<u>Johns Hopkins Program for International Education in Reproductive Health (project)</u>
JHU/PCS	Population Communication Services (project)
KAP	knowledge, attitudes, and practice
MOH	Ministry of Health
MCH	maternal and child health
NACP	National AIDS Control Program
NGO	non-governmental organization

NORAD	Norwegian Agency for Development Cooperation
ODA	Overseas Development Administration (United Kingdom)
P/FP	population/family planning
PIO/T	project implementation order/technical
POPTECH	Population Technical Assistance Project
PPI	program performance indicators
PSI	Population Services, International
PVO	private voluntary organization
R&D	Bureau for Research and Development
REDSO/WCA	Regional Economic Development Support Office/West Central Africa
SADCC	Southern African Development Coordination Congress
SEATS	Family Planning Service Expansion and Technical Support (project)
SIDA	Swedish International Development Authority
SOMARC	Social Marketing for Change (project)
STD	sexually transmitted disease
TASO	The AIDS Support Organization
TFR	total fertility rate
TOT	training of trainers
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development (mission)
WHO	World Health Organization
YWCA	Young Women's Christian Association
ZNFPC	Zimbabwe National Family Planning Council

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The U.S. Mission in Geneva arranged interviews with appropriate personnel in the World Health Organization who provided valuable insights into the policies and activities of the Global Programme on AIDS.

The assistance of health, population, and nutrition officers and secretaries in the USAID missions in Zimbabwe, Botswana, and Uganda was much appreciated as they identified persons to interview and project activities to visit and made the necessary arrangements. Their insight into these programs was a valuable adjunct to the team's observations.

Above all, the team appreciates the cordial welcome from the staff of the organizations visited and the personnel with whom discussions were held. From the minister of health in Zimbabwe to the counselor in a family planning clinic in Fort Portal, two hundred miles from the capital of Uganda, the team found frank and helpful responses from persons greatly concerned about family planning and HIV/AIDS and the welfare of their country. The team was moved by the stark reality of the AIDS epidemic in Africa and the problems faced by families in feeding and educating their children in present economic conditions. The task is indeed formidable. Yet, hope can be taken from the commitment and compassion with which the persons contacted are addressing these problems.

Executive Summary

Introduction

AIDS has grown to epidemic proportions in much of sub-Saharan Africa in a few years; urban and peri-urban antenatal HIV infection rates have reached 25-40 percent in countries such as Zambia and Rwanda. Rapid population growth, averaging about 3 percent in sub-Saharan African countries continues to outpace the capacity of these societies to feed, keep healthy, and educate their children and provide jobs for them when they mature. The consensus among most demographers is that although the impact of AIDS on future population growth will be significant — approximately one percentage point — the rate of growth will continue at a high level. At the same time, it is important to note that the impact of AIDS will be more substantial than the general population numbers would suggest because of its disproportionate impact on the economically productive segments of the society (i.e., the 20-35 age group).

Although the rate of demographic growth is a key element in economic development, the concern for the health and welfare of individual mothers, children, and families continues to be a dominant rationale for family planning in sub-Saharan Africa. In many cases, this concern is accentuated by the AIDS epidemic as increasing numbers of orphans are seen and as substantial additional care and support burdens are placed on families afflicted with AIDS.

There are definite points of contact between the programs that deal with the threat of AIDS and those that deal with reproductive patterns threatening the lives of mothers and children and the economic well-being of families. The public health community sees a potential for more effectively addressing these two critical concerns through some degree of integration of population/family planning and HIV/AIDS programs and activities through increased coordination of efforts.

Scope of Study

Through A.I.D.'s HIV/AIDS Prevention in Africa (HAPA) project, a team of five family planning and HIV/AIDS experts, supplemented by A.I.D. personnel, was commissioned by REDSO/WCA to undertake this study of the potential for integration of HIV/AIDS prevention and control and population/family planning programs and activities in sub-Saharan Africa. The scope of work for the study requested that the team

- assess the technical and administrative feasibility and program implications for integrating HIV/AIDS activities into established population/family planning programs, and
- provide strategic guidance and practical, appropriate advice to USAID missions with regard to ways in which population/family planning programs can contribute effectively to deterring the spread of the AIDS epidemic.

Interviews with program leaders in Washington, D.C., Geneva, and several countries of sub-Saharan Africa, review of pertinent documents, and site visits to various family planning and HIV/AIDS

activities in Zimbabwe, Botswana, and Uganda, enabled the team to review the potential for and implications of integration of family planning and HIV/AIDS activities.

Study Findings and Conclusions

Advantages and Disadvantages of Integration

Although the study cautions against wholesale integration of activities, it sees many potential advantages to integration under certain circumstances. The possible advantages include such things as exploiting the experience of non-governmental organizations (NGO) which have been working in the family planning field; moving both family planning and HIV/AIDS programs into a more non-fixed facility, community-based mode; addressing target audiences of men and youth more effectively (including more open and frank discussion of human sexuality and contraceptives); and carrying out research or developing policy thrusts common to both interests more efficiently. Some disadvantages include previous disappointing experience with integration of family planning with maternal and child health (MCH); the potential for overloading presently weak systems; and the difference in the opinions of HIV/AIDS and family planning programmers as to which are the more appropriate contraceptives.

Lessons Learned from Family Planning Programs

Some of the lessons learned from family planning programs are applicable to HIV/AIDS programs. These lessons range from the need to develop strong policy support to the programmatic imperative of getting outside the clinic, perhaps outside the health system itself, to take programs closer to the community and address the audiences that to date have been ill served by family planning, especially men and youth. Family planning programs have also demonstrated the need for strong training and information, education, and communication (IEC) programs and the paramount importance of the consistent availability of appropriate services and a full supply of commodities.

Country Experience with Family Planning and HIV/AIDS Programs

In visits to Botswana and Zimbabwe, two of the best family planning programs in Africa were observed. The family planning program in Uganda, however, is more like that of many others in sub-Saharan Africa which have not developed the infrastructure, the trained personnel, the systems of supervision and logistics, and the strong IEC program necessary for effectively serving more than a small portion of the population. Botswana and Zimbabwe have vertical and integrated approaches to family planning, with MCH and family planning both operating in a strong policy climate that suggests that further integration with HIV/AIDS could be productive. Efforts by NGOs in Uganda to integrate family planning with MCH and HIV/AIDS, on the other hand, demonstrate that considerable effort will be required to make integration successful.

In each country visited, the perception of local government and health care leadership was that some kind of integration between family planning and HIV/AIDS is inevitable. The understanding of integration and the steps suggested to be taken were country specific and varied with the policy climate, the relative strength of the family planning program, and the previous experience with integration of other activities. A common theme was that regardless of the degree of integration planned at top program levels, there was bound to be some kind of integration at the client level. Clients come to family planning and HIV/AIDS service providers with concerns that cut across both

programs. This means that service providers must be better equipped to deal with these concerns. As HIV/AIDS is recognized as affecting the total population in sub-Saharan Africa more than being confined to specific target groups, HIV/AIDS and family planning programs were seen to have much the same population to be served. A concern for orphans, burdens on extended families, and the health of mothers exposed both to HIV/AIDS and pregnancy were the basis for most service providers seeing a close relationship between the two programs.

Suggested Areas for Integration of Activities

Although the report emphasizes that any attempt at integration must be selective, country and program specific, and must emphasize coordination of efforts rather than a complete merging of program operations, suggestions are made for the kinds of integrated activities that might be undertaken. For example, policy dialogue could be combined to increase national support of both family planning and HIV/AIDS programs, reduce constraints on open discussion of human sexuality (especially with youth), and remove barriers to the importation or advertising of condoms. Cross training or joint training of HIV/AIDS and family planning service providers could be developed to assure minimum competence of the two groups in each of the disciplines, to improve counseling skills, to involve additional service providers, and to improve program management. Consideration could be given to the opportunities for joint planning, if not joint programming, of IEC activities, not only for the general public but also for special targeted programs for youth and men. These will be especially effective if mass media and interpersonal communication are complementary, if IEC programs are accompanied by strong service delivery, if the popular media of song and drama are utilized, and if the community is involved in the production and testing of the messages.

The greatest potential for integrated actions in service delivery lies in expanding non-clinical, community-based approaches that may be made more acceptable to health planners as HIV/AIDS concerns are combined with those of family planning. These could be especially productive if organized to reach men and youth who have to date been poorly served by family planning programs. Social marketing of contraceptives, especially condoms, would be a logical way to join the objectives of both HIV/AIDS and family planning programs in a cost-effective way that catalyzes the participation of the private sector, improves the overall policy climate for both family planning and HIV/AIDS prevention, and meets the needs of a substantial number of the population. Concerns are expressed, however, that non-targeted free distribution of condoms may impede development of effective social marketing and that an excessive emphasis on self-sufficiency may inhibit reaching the lower-income groups.

Many areas of social and biomedical research lend themselves to an integration of the concerns of family planning and HIV/AIDS. This is especially so of those areas that provide more knowledge of human sexuality, decision making, power relationships between men and women, the impact of AIDS on family formation, how contraception or pregnancy affects the progression of HIV/AIDS, improved contraceptive technology in the midst of the HIV/AIDS epidemic, and improved methodologies for assessing the cost-effectiveness of integrated programs or measuring their impact.

Greater integration of the commodities/logistics systems of family planning and HIV/AIDS programs could provide a joint opportunity for improved forecasting of condom needs. At present, a serious problem is seen in the projection of needs, purchase, and distribution of condoms. Improved modeling for projections will be required as well as better means to measure actual use. Decisions

are essential regarding the most appropriate sources of supply and funding. Training and support for improved warehousing and distribution will be required to meet the growing demand for condoms.

Although substantial problems are recognized in developing cost-effective approaches to the prevention of sexually transmitted diseases (STD) and in meeting logistics requirements, a potential is seen for including more attention to this area both as a way to enhance family planning programs and to combat the HIV/AIDS epidemic.

Program Management Concerns

Program management concerns are identified such as the high number of donor-driven programs which necessitates substantial efforts at coordination of donor agencies if integration is to be successful; the weakness of most local organizations which calls into question their capacity to carry out effective integrated programs; and the problems of reorganization which may be exacerbated by economic structural readjustment programs. A.I.D.'s management concerns include an overall shortage of qualified personnel assigned to positions essential for planning and implementing integrated programs and bureaucratic procedures in A.I.D. which are more likely to foster separate rather than integrated programming. USAID missions need more flexibility to be able to combine family planning and HIV/AIDS activities within one strategic objective and thus be able to support local initiatives towards integration. Suggestions are given for dealing with these concerns both in the management section of the study and in an appendix which provides a checklist for assessing the potential for integrating HIV/AIDS and family planning programs.

Constraints to Integration

Constraints to integration are seen both at the policy and programmatic levels with inadequate national support, inflexible bureaucratic procedures, lack of coordination, lack of enthusiasm on the part of entrenched interests in bureaucracies, and shortages of resources impeding progress. Insufficient supplies of commodities and inadequate distribution systems further constrain programs that also suffer from excessive medical orientation, weak approaches to youth and men, contraceptive technologies for HIV/AIDS and family planning which are not fully compatible, and the concentration of technical and financial resources in the urban areas.

A further, important constraint to successful integration of activities is the dichotomy between the apparent policy on HIV/AIDS prevention and control in A.I.D./Washington and that expressed in sub-Saharan Africa by host country personnel and staff at USAID missions. The perceived A.I.D./Washington position focusing more on specific core group, high-risk target populations inhibits integration with family planning programs which target couples of reproductive age. The opinion in sub-Saharan Africa is that HIV/AIDS is much more affecting the general population, making integration with family planning more rational.

(Subsequent to field visits, A.I.D. Office of Health staff reported to the study team that the A.I.D./Washington approach to HIV/AIDS control and prevention is both more flexible than that which had been stated by A.I.D./Washington staff and staff of the centrally funded AIDS Control and Prevention (AIDSCAP) project and broader than the perception of the Washington position which predominated in discussions with field personnel. This clarification of policy needs to be articulated by the Office of Health to all concerned.)

Recommendations

Policy

1. A.I.D.'s Offices of Population and Health and Bureau for Africa should prepare joint guidance for USAID missions in sub-Saharan Africa which will

- clarify the present and potential demographic impact of the AIDS epidemic and emphasize continuing a strong population and family planning program, both for family health and welfare and demographic/macroeconomic development reasons;
- indicate the potential for integration of HIV/AIDS and family planning activities that should be examined on a country-specific basis;
- demonstrate how centrally funded projects can be used to implement integrated activities, as appropriate;
- clarify the way in which the Bureau for Africa will review project implementation documents to allow for flexibility for integration of HIV/AIDS and family planning activities within the context of funding, strategic prioritization, management considerations, and the limitations of present methods of cost-effectiveness analysis;
- resolve issues relating to the dichotomy drawn between target populations in HIV/AIDS and family planning programming; and
- elevate the priority to be given by USAID missions working with other donors in policy dialogue with host countries to efforts to secure greater national financial commitment and leadership for both family planning and HIV/AIDS programs.

2. Those designing projects either for HIV/AIDS prevention or family planning programs should carefully assess the potential for integration within these projects, articulating mutually supportive objectives. Only in exceptional cases should these designs attempt full integration of the two programs. They should initially focus on selective integration or coordination of specific activities in which joint action is clearly advantageous and in which mass movement of human or financial resources is not required.

3. In policy dialogue and project development, program leaders should look beyond the health rationale for support of family planning or HIV/AIDS programs and the health system for solutions.

Programmatic

4. Program designers seeking to maximize the potential benefits of integration should give first priority to those joint activities that lead programs outside of fixed facilities, involve the community, and make services readily available and culturally sensitive through community-based activities (e.g., community-based distribution, workplace programs, social marketing, utilization of traditional healers, and programs with youth organizations). African leadership must be fully involved in the design and implementation of the program to assure its sensitivity to local customs and responsiveness to local needs.

5. While not ignoring the particular needs of men and of women of reproductive age, highest priority in integrated programming must be given to developing more effective programs to deal with the needs of youth.

6. Program designers should also give attention to the potential for integration of family planning and HIV/AIDS activities both within clinics in the family planning program and within the fixed facilities of the HIV/AIDS program (e.g., counseling centers).

7. Collaborative efforts should be taken by family planning and HIV/AIDS program managers to include family planning information/counseling in the services offered to the increasing numbers of couples who are making use of the HIV/AIDS anonymous testing centers.

8. Regardless of the degree and complexity of integration planned, project designers must give attention to securing adequate numbers of and providing training for program managers and service delivery personnel.

9. Those engaged in family planning and HIV/AIDS programming should initiate a dialogue to identify the points at which IEC campaigns could be mutually supportive.

10. Whether integrated or not, IEC campaigns should utilize both mass media and interpersonal communication in mutually supportive ways.

11. In light of the serious nature of the population/family planning and HIV/AIDS issues, programs must take every reasonable action to assure frank and open discussion of human sexuality and the dangers posed for adolescents by pregnancy and HIV/AIDS.

12. Program managers must assure that the development of adequate services accompanies the IEC programs that are promoting them.

13. A strong program of research should be developed, especially as the potential for integration gives more impetus to reviewing certain issues important to both family planning and HIV/AIDS.

14. The donor community, together with host countries, must give highest priority to finishing the work begun on rationalizing the projection of condom needs, purchasing the highest quality condoms at the cheapest price, delivering commodities, and developing adequate procedures for internal logistics and quality control.

15. More emphasis should be placed on social marketing. Programs should be viewed as having important benefits for both family planning and HIV/AIDS prevention. The creation and development of HIV/AIDS prevention condom social marketing programs should be encouraged and assisted by family planning organizations.

16. Social marketing should be viewed as a cost-effective service delivery mechanism. In developing these programs, however, such emphasis should not be placed on financial self-sufficiency that it leads to low sales and restricts the ability to reach low-income populations.

17. Family planning programs should include the STD and HIV/AIDS components in their curricula, service delivery guidelines, and training programs for service providers.

Management

18. If increased programming for HIV/AIDS and family planning is contemplated and especially if the programs are to effectively explore opportunities for integration in bilateral programs, A.L.D. must strengthen its staff, especially at the USAID mission level.

19. A.L.D. should continue to be supportive of the many private and international organizations that are in the family planning and/or HIV/AIDS programming arena.

20. The donor community, together with host countries, should increase attention to coordination and information sharing, especially if there are to be attempts to bring two programmatic elements together that are often supported by different donors. Care should be taken, however, to ensure that coordination is facilitative and does not inhibit initiative.

1. Introduction

1.1 The Status of the HIV/AIDS Epidemic in Sub-Saharan Africa

Acquired immune deficiency syndrome (AIDS) was first recognized in Africa in 1985. Since that time, the disease has spread rapidly throughout all parts of sub-Saharan Africa. Of the 263,051 AIDS cases worldwide reported to the World Health Organization (WHO) through June 1990, 25 percent (or 64,404) were from sub-Saharan countries. This was up from the June 1989 statistics which showed that only 16 percent of the cases reported to WHO were from sub-Saharan Africa.¹

WHO has estimated that as of the end of 1991, there have been more than 400,000 cases of AIDS in sub-Saharan Africa and that 6.5 million sub-Saharan African adults are infected with the human immunodeficiency virus (HIV) which causes AIDS.² WHO estimates are generally considered to be significantly lower than reality. Although these figures are alarming in themselves, it must be noted that AIDS cases are greatly under-reported throughout Africa (probably more so than in the rest of the developing world) and that the percentage of the world's AIDS cases attributable to Africa is therefore even higher.

The countries hardest hit by the epidemic were originally in East and Central Africa (Uganda, Rwanda, northwest Tanzania, Congo, Zaire, Zambia, and Zimbabwe). However, the epidemic has spread throughout the rest of Eastern Africa, Southern Africa (especially Botswana), and parts of Western Africa.

Although seroprevalence (i.e., rate of HIV infection) in high-risk behavior populations (commercial sex workers, truck drivers) is often used to describe the epidemic, seroprevalence levels obtained from antenatal clinics give a better picture of the infection rate among the general sexually active population. Urban and peri-urban antenatal seroprevalence rates in many countries have increased to 25-40 percent (e.g., Zambia, Zimbabwe, and Rwanda).

It has frequently been hypothesized that seroprevalence rates will level off (i.e., the number of new infections will equal the number of deaths) in a given population. Although this is a phenomenon typical of communicable disease epidemics, the level of seroprevalence at which the AIDS epidemic will stabilize is still unknown.

Throughout Africa, it has generally been found that the better educated, wealthier individuals have tended to have higher infection rates. This was certainly true in the earlier stages of the epidemic. When antenatal seroprevalence rates reach 30-40 percent, however, differences in infection rates become insignificant. This initial socioeconomic impact, combined with the disproportionate impact AIDS has on the young adult population, has grave consequences for economic development. Given trained personnel shortages in all skilled fields, a country's ability to develop at previously planned rates is questionable.

¹Statistics from WHO 1990. AIDS 4:703-7.

²WHO: *Current and Future Dimensions of the HIV/AIDS Pandemic: A Capsule Summary*. January 1992, WHO/GPA RES/SFI/92.1.

Infection rates are now growing rapidly among youth (e.g., Zambia and Uganda) and rural populations (e.g., Uganda, Zambia, Zimbabwe, and Botswana). In most sub-Saharan countries, the age group with the highest number of AIDS deaths as well as the highest seroprevalence levels is women aged 20-25. This means that most of these individuals were infected during their teenage years.

Rural infection rates have generally been significantly lower than urban rates, but rates in many rural areas are beginning to increase following the pattern observed in urban areas. Therefore, it can be expected that rates in many rural areas will approach those of urban areas over the next three to six years. Furthermore, the absolute number of infected persons may be greater in rural areas even if the rates are lower; the majority of people live in rural areas in sub-Saharan Africa.

Although these numbers are themselves significant, numbers alone do not adequately reflect the situation. Consider, for example, that many employers are now finding it increasingly difficult to maintain a daily work force due to the increased number of deaths and funerals; that mortuaries and cemeteries are now being overloaded so that there is an additional 2-3 day wait for funerals; that the number of orphans has begun to overwhelm traditional coping mechanisms (e.g., Zambia and Uganda); and that a key custom of African societies — attending the funerals of family friends — is eroding due to the overwhelming number of funerals (e.g., Uganda and Kenya).

1.2 HIV/AIDS Programmatic Trends in Sub-Saharan Africa

All countries in sub-Saharan Africa have National AIDS Control Programs (NACP) based in the Ministry of Health (MOH). The NACPs have developed, in conjunction with WHO's Global Programme on AIDS (GPA), medium term plans which have been operationalized into practical intervention projects. Most countries have been operating under these plans for three to five years.

The NACPs were established as vertical programs within the MOH, but act as independent organizations. Frequently, NACPs are housed in buildings separate from the MOH and their budgets are totally donor supported. With a few exceptions (e.g., Ethiopia), the costs for HIV/AIDS-related activities have been borne almost totally by the donor community. On an Africa-wide basis, the largest donors have been the United States, the Scandinavian countries, France, and Germany.

In general, the country donors have continued to pledge increasing amounts of resources each year to international donor agencies for HIV/AIDS activities. There has, however, been a growing trend among donors to fund bilateral activities within the context of countries' medium term plans but outside the control of the WHO/GPA-MOH structure. This shift has resulted from an increasing frustration on the part of the donor community with the perceived lack of WHO/GPA effectiveness at the country level (as indicated by a WHO/GPA self-evaluation).

The above-described system has functioned largely within the context of a formal, "Westernized" health system. However, given the general weak infrastructure and resource limitations of many health delivery systems in sub-Saharan Africa, there is a growing trend to establish HIV/AIDS-related activities through other sectors such as the business community and traditional healers. Although the MOHs and WHO/GPA have accepted this trend, it is being driven by those outside the system, namely those being affected by the epidemic — the community.

The Agency for International Development's (A.I.D.) programs in this area have been dominated, to date, by the centrally funded AIDS Technical Support Project (ATSP) — specifically by

AIDSTECH, the technical component and AIDSCOM, the communication component. These projects have been completed and replaced by the AIDS Control and Prevention Project (AIDSCAP) which is to provide assistance to 10-15 "priority countries" worldwide (5-6 in Africa). The remainder of A.I.D.'s centrally funded HIV/AIDS prevention portfolio is divided between a direct grant in support of the WHO/GPA and funding for behavioral research, support to the Centers for Disease Control for activities in developing countries, non-governmental organization (NGO) networking support, and biomedical research in STDs and microbicides.

A.I.D. also supports bilateral mission-designed HIV/AIDS prevention projects which are being designed and implemented at the country level with significant local input. In general, these locally designed projects are targeting the general population through community-based activities, youth, involving traditional healers, and establishing anonymous testing and counseling centers (e.g., Ghana, Côte d'Ivoire, Uganda, Zambia, and Zimbabwe). This differs from the centrally funded A.I.D. activities which have focused more on specific core group, high-risk target populations.

Another major programmatic trend is the increasing use of professionals living in Africa and African community leaders to implement and direct HIV-related activities rather than relying almost exclusively on technical assistance provided by non-Africa-based consultants.

The impact of HIV-related activities in reducing the transmission of HIV is not well known. Although there have been some attempts at impact evaluation, there is no consensus among researchers on a set of consistent outcome and impact indicators.

1.3 Population and Family Planning

In sub-Saharan Africa, the rationale for family planning is frequently expressed in terms of family welfare and the high levels of infant and maternal mortality associated with present reproductive patterns. A situation in which children are born too early or too late in a woman's lifetime, or are too closely spaced or in large numbers contributes to premature births, poor nutrition, and a host of family economic problems.

Additionally, the rate at which society's responsibilities increase with rapidly growing total numbers is staggering. At the current growth rate of about 3 per cent per annum, the population size of sub-Saharan Africa will reach one billion people during the second decade of the next century, only 23 years from now. Some of the countries in the region have more than half their populations below age 15; the average size of this age group in the region is 45 percent of the population. This high proportion of young people means there is a growing number of females in the reproductive age group, which in turn means future high population growth. It is expected that the group of women between ages 20 to 24 on the African continent will reach 38 million by the year 2000 and 79 million by the year 2025. More than one-quarter of the world population by the year 2050 will live in Africa, according to the United Nations population projection, a tremendous increase in its share from the current 12 percent. This situation may not change much despite the HIV/AIDS epidemic. Some epidemiological studies have concluded that although the impact of AIDS on future population growth will be significant (approximately one percentage point), the rate of growth will continue at a high level. For this reason, as well as for reasons of family health and welfare, serious interventions for fertility reduction as well as HIV/AIDS prevention will need to continue. (Appendix F provides a fuller discussion of the demographic impact of the AIDS epidemic on sub-Saharan Africa. The most significant conclusion of the discussion is that the only circumstances that would lead to negative

population growth would be replacement level fertility combined with national adult HIV prevalence levels of 15 percent or more, and that the largest contribution to reduced population growth rates in such situations would be reduced fertility, not increased mortality due to AIDS.)

Rapid population growth is aggravating the already precarious economic situation in the region, particularly in countries with little arable land such as Burundi, Ethiopia, Ghana, Kenya, Nigeria, Rwanda, and Togo. High infant and child mortality rates are, in part, caused by malnutrition and food shortage due to agricultural stagnation in the region. A reduction in fertility, therefore, still stands to encourage faster economic growth.

The demographics for the region are presented in Table 1 below, which includes the size of certain target groups for both family planning programs and HIV/AIDS programs. The countries of the region have been grouped into five categories according to their urban populations. The number of males above age 15 is 123 million and 102 million women are in the childbearing ages, 15 to 49 years. Some 86 million are youths between ages 15-24 years.

The concentration of population in several countries has some implications from the strategic point of view in establishing development projects. Six countries have fewer than 1 million people. Twelve countries having 10 million people or more constitute 72 percent of the total population in the region; 31 countries have the remaining 28 percent. The same 12 largest countries have similar shares for males above 15 years (70 percent), women 15-49 (71 percent), and youths 15-24 (72 percent). Family planning and HIV/AIDS projects could have a major impact in terms of population served if developed properly in these larger countries.

Table 1
Population in Sub-Saharan Africa
(1992)

Population Urban	No. of Countries	Total Population	Males Age 15 +	Females 15-49	Youth 15-24	Urban Pop. %	Growth Rate	FP Donor Orgs.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
less than 1 million	6	2.6	0.7	0.6	0.6	38.9	3.6	4
1-4 million	12	26.4	7.9	6.0	4.7	32.5	2.7	6
5-9 million	13	100.8	28.3	23.1	19.4	23.6	3.1	9
10-19 million	7	98.0	26.5	21.8	18.4	27.6	3.3	10
20 and more	5	235.9	59.9	50.9	43.6	20.2	3.1	18
TOTAL	43	463.7	123.3	102.4	86.7	28.5	3.1	9.4

Source: Population Reference Bureau Population Data Sheet 1992; United Nations Inventory of Population Projects in Developing Countries 1992

(2) (3) (4) (5) in millions of people

(6) percentage of total population

(7) annual rate of natural increase

(8) average number of donors per country providing external assistance to the family planning programs

Family planning programs in sub-Saharan Africa are at different stages of development. Most are integrated with the maternal and child health (MCH) services provided by the government. Some countries (e.g., Côte d'Ivoire, Ghana, and Kenya) have established private sector programs which are in the preliminary stages of implementation. Community-based distribution (CBD) programs have not spread substantially; Zimbabwe's is the only example of a program with significant CBD activity. Social marketing is beginning to play a significant role in the region. About 15 social marketing programs have recently been established, largely in response to the AIDS epidemic. These programs are expected to provide a substantial share of condoms. Among the most effective methods, oral contraceptives are the most popular, but some countries have a good participation of more permanent and semi-permanent methods. In Kenya, for example, sterilization and the IUD combined are the most used methods. The use of the condom is still low, and it is used more for sexually transmitted disease (STD) prevention than contraception.

Implementation of family planning programs has been possible because of donor support (see the last column of Table 1 for the amount of institutional support from multinational and bilateral donor organizations). Approximately 18 donors and A.I.D. Cooperating Agencies are currently helping family planning programs in sub-Saharan Africa.

With a few exceptions, modern method contraceptive prevalence rates are low (see Table 2 on next page). Only two countries, Botswana and Zimbabwe, have passed the 20 percent level of modern method contraceptive prevalence considered necessary to initiate fertility reduction. Kenya and Swaziland are approaching the 20 percent prevalence level; the other countries are still at a very low level — 6 percent or less. Condom-specific prevalence rates are insignificant: 1.2 percent in Botswana and Zimbabwe, 0.5 percent in Kenya, and below that level in the rest of the countries. This has been despite the campaigns of some countries in the region to promote the condom as a contraceptive method during the past few years.

Family planning programs have developed contraceptive logistics and management information systems which have been implemented or are in the process of being implemented in a few countries. The development of standard indicators and definition of terms have been important tools for managing the programs. The amount of contraceptives distributed and couple years of protection (CYP) are some simple measures used to monitor program performance. Records on new acceptors and visits and continuation rates have also contributed to program monitoring, although to a lesser extent. Impact indicators such as contraceptive prevalence rate and fertility rates estimated from Demographic and Health Surveys (DHS) are becoming widely used by government programs and donors. The extensive use of some methods for testing acceptance of family planning messages, such as small group discussions, has also been important in the implementation of information, education, and communication (IEC) activities.

1.4 Purpose of Study, Scope of Work, Team Composition, and Methodology

A.I.D.'s Regional Economic Development Support Office/West Central Africa (REDSO/WCA) has recognized the importance of addressing both the problem of HIV/AIDS and the need for family planning to sustain and/or improve the quality of life in sub-Saharan Africa. REDSO has also noted that gains have already been made in more closely associating these issues in program development and implementation. Moreover, African leaders and HIV/AIDS and family planning service providers

Table 2
Contraceptive Prevalence and Birth Rates
in Selected African Countries

Population	Countries	Contraceptive Prevalence Rate*	Birth Rate (per 1,000 population)
Less than 1 million	Swaziland	17	44
1-4 million	Lesotho	2	41
	Togo	3	50
	Liberia	6	47
	Botswana	32	40
5-9 million	Benin	1	49
	Burundi	1	47
	Rwanda	1	51
	Mali	1	52
	Malawi	1	53
	Senegal	2	45
10-19 million	Côte d'Ivoire	1	50
	Uganda	3	52
	Cameroon	4	44
	Ghana	5	44
	Zimbabwe	36	41
20 and more.	Ethiopia	3	47
	Nigeria	4	46
	Kenya	18	45

* Percentage of married women in the reproductive ages using modern contraceptive methods.

Source: Population Reference Bureau Population Data Sheet 1992; United Nations Inventory of Population Projects in Developing Countries 1992

Note: Prevalence rates are taken from Demographic and Health Surveys conducted at different times, some of them as long ago as 1985. The situation described by this indicator may have changed during the past few years.

stated that with the AIDS epidemic there is even more reason to have family planning programs. This is based on their recognition of the health and economic burden of excessive childbearing on families as they deal with the consequences of the AIDS epidemic. In the words of the minister of health of Zimbabwe, "... these issues [family planning and HIV/AIDS] are inextricably intertwined."

Through A.I.D.'s HIV/AIDS Prevention in Africa project, REDSO/WCA commissioned this study to review more closely the potential for increased collaboration/integration in these two program areas. According to the scope of work (see Appendix A), the study's objectives were to

- assess the technical and administrative feasibility and program implications for integrating HIV/AIDS activities into established population/family planning programs, and
- provide strategic guidance and practical, appropriate advice to USAID missions with regard to ways in which population/family planning programs can contribute effectively to deterring the spread of the AIDS epidemic.

In reviewing these issues and in discussions with the Bureau for Africa, it became clear that the potential for including family planning activities in HIV/AIDS prevention programs was equally relevant. Although a review of the relation to STDs was not required in the scope of work, the Bureau for Africa representative requested this be addressed to the degree time and team expertise permitted. He also requested that the recommendations be addressed to a broader audience than the USAID missions. The scope of work was also modified to include review of programs in only three countries.

The Population Technical Assistance Project (POPTECH) fielded a team of five family planning and HIV/AIDS professionals which was to be supplemented by REDSO/WCA staff. William Bair and Juan Londono were selected to provide expertise in the field of population and family planning; Joseph Wiseman in the area of HIV/AIDS prevention and control; Ann Leonard in IEC and training; and Peter Clancy in the private sector and social marketing. As REDSO/WCA was unable to participate in the field review, William Lyerly of A.I.D.'s Bureau for Africa Office of Analysis, Research, and Technical Support (ARTS) assisted the team in the field. John Paul Clark of that same office joined the team as Lyerly returned to Washington following fieldwork in Uganda. Celia Woodfill of the Office of Population of A.I.D.'s Bureau for Research and Development joined the team for the fieldwork and analysis. Souleymane Barry of REDSO/WCA was able to assist the team throughout the analysis and report writing stage in Côte d' Ivoire.

The team conducted a literature review (see Appendix B for a bibliography) and interviewed key persons in Washington, D.C. and at WHO in Geneva. The team undertook field visits to Zimbabwe, Uganda, and Botswana to interview African leaders and USAID personnel as well as to review programs in operation. (Appendix C provides a list of contacts.) The framework for reviewing the country situations included the standard components of population/family planning programs — policy, training, IEC, research, evaluation, and service delivery — with a few additions to meet the needs of this particular review. The framework also drew on material prepared by Mario Jaramillo for assessing family planning and HIV/AIDS programs.

2. Advantages and Disadvantages of Integrating HIV/AIDS and Population/Family Planning Programs

2.1 Definition of and Rationale for Integration

In discussing the integration of family planning, HIV/AIDS, and STD activities, the concept of "integration" needs to be understood in terms of a spectrum of activities. That is, integration could range from a coordination of selected activities to a full integration of programs. The exact point on this spectrum would be country specific. It would also vary depending upon the area of the country (urban, peri-urban, or rural) and upon the administrative level (national, regional, district, or village). For example, in some areas, integration may take the form of family planning and HIV/AIDS professionals establishing regular meetings to inform each other of activities and to exchange useful strategies. In other areas, integration may coordinate certain activities so that family planning and HIV/AIDS educators are better informed about the other discipline and will know where to refer clients when questions are raised. In still other areas, specific activities (e.g., targeting youth, condom supply and distribution) may be fully combined so that both disciplines develop one joint program to achieve mutual goals.

Integration is also a process which involves the identification of opportunities to consolidate or combine family planning and HIV/AIDS activities/resources in a manner which would enhance the ability of each to meet its objectives. This process needs to identify the relative strengths of each discipline that can be used to help each succeed.

At whatever level family planning and HIV/AIDS activities are integrated, there must also be a mutual advantage to both parties as a result of the integration. Mutual advantage may mean that the programs can more effectively meet the established needs of their client populations, or that programs are better able to identify and meet the unmet needs of new target populations. Mutual advantage may also be characterized by improvements in the quality or appropriateness of program initiatives.

The case for integration of family planning and HIV/AIDS activities can be made on several fronts. Primary among these are that limited resources means effective use of those resources is essential and that integration would facilitate more effective outreach to key target groups especially youth and men. Other reasons for integration are particular to the AIDS epidemic — factors which intensify the need for expanded, effective family planning programs. These include the increasing number of deaths of parents which is causing the number of orphans to rise rapidly and the increasing number of deaths among the economically productive population which is greatly increasing the dependency ratio.

Yet another reason for pursuing integration lies in the profound impact the AIDS epidemic is having on relations between men and women. The epidemic is requiring new levels of communication between men and women. With the AIDS epidemic adding a life-and-death overtone to sexual activity, women must more than ever be able to exercise more authority over the conditions under which they are willing to participate in such activity. Although economic and cultural conditions often exert a strong bias in favor of male sexual dominance and present disease prevention technology (use of the condom) is more in the control of the man than the woman, programs need to work toward increasing the sense of responsibility on the part of the two partners as well as giving the woman confidence and communication skills to enhance her protection. Through this increased

communication, women would also be enabled to take a more active and effective role in decisions related to the number and timing of their offspring, an obvious concern for family planning programs.

2.2 Advantages of Integration of Activities

Operationally, integration will mean different things in different countries depending on the relative strengths of the programs, the degree to which either AIDS or population growth is or is not perceived to be critical, and the leadership styles and aspirations of the several parties involved. As stated above, it will take various forms ranging from simple exchange of information among organizations, formal coordinating commissions and meetings, sharing of certain facilities, transportation or commodities, joint planning and implementation of discrete activities to union of program direction and implementation. It will mean something different at the headquarters level from what goes on at the service delivery point or in the community.

Experience suggests that integration will be most effective when not forced but arrived at by voluntary decisions of the various groups, each of which has something to contribute to the overall goal and each of which will recognize a benefit. The following are suggested ways in which potential advantages could accrue to both family planning and HIV/AIDS programming.

- With a more integrated approach, it may be easier for NGOs to develop experience and expertise in HIV/AIDS. Over the years many NGOs, universities, and national and international public agencies have developed interests and strengths in population/family planning, but this does not necessarily mean they are qualified for work in HIV/AIDS activities. Through integrated efforts, their private sector, organizational development, training, or research capabilities could be tapped more effectively for HIV/AIDS programming. Other donors who have become interested in HIV/AIDS might initiate or increase their support for family planning as well. The key institutions, those at the national level, may find it more attractive, if not more efficient, to work on these two critical development issues in a more comprehensive and coordinated fashion.

- Integration may strengthen the rationale of policy makers at USAID or in host countries for resource allocation (personnel and financial) to population and HIV/AIDS activities since a "critical mass" of program activities is more easily managed if the activities are closely coordinated. This recognizes that, with the additional economic burden imposed upon countries and families by the AIDS epidemic, there is even more reason to strengthen family planning's contribution to slowing population growth and ameliorating the family welfare problems caused by large numbers of closely spaced children. The possibility must also be considered, however, that joining the two might lose the constituency for one or the other resulting in a net loss instead of gain.

- Ongoing family planning programs are largely clinical in much of sub-Saharan Africa with a weak infrastructure and a coverage network that can only deal with a limited percentage of the population. The AIDS epidemic adds a new dimension that could elicit the approval and support from medical, religious, community or political leaders necessary to make non-clinical, private sector, and commercial approaches possible. The same is true for mass media advertising, promotion, and IEC for both family planning and HIV/AIDS activities. There is a great potential for wider coverage of the population (with both HIV/AIDS and family planning activities) by jointly developing non-clinical approaches to adolescents, men, and women through expanded CBD programs, factory or workplace services, work with traditional healers, and social marketing.

- Although not all target audiences are the same, there is a considerable overlap between those for family planning and those for HIV/AIDS prevention activities, particularly as HIV in Africa is being transmitted widely in the general population. If program priorities are carefully maintained, an integrated approach has the potential for providing more efficient service delivery to this similar target population.

- HIV/AIDS program objectives provide more potential for contacts with men and youth — areas which are weak in present family planning programs.

- Integrated efforts could be more effective in achieving improved status for women, which is important to developing the changed behavioral patterns necessary for both effective HIV/AIDS and family planning programs.

- Non-clinical HIV/AIDS and family planning programs have more potential to reach the adolescent population in those places (such as Kenya, Sierra Leone, and Tanzania) where this kind of information and services may presently be denied them. Integration could produce a more effective vehicle to combine the messages of avoiding an undesired early pregnancy and avoiding HIV/AIDS with much the same prevention mechanisms.

- Direct and explicit language about contraceptives (condoms) which may not have been possible for family planning may now be acceptable in the light of the AIDS epidemic. Concern about HIV/AIDS may open the door for more direct and frank discussion of sex and contraceptives in the media, in schools, or even in religious settings.

- Integration would provide the opportunity for family planning and HIV/AIDS workers to learn together about improved techniques in individual and group counseling for imparting information on contraceptive use, reproductive health, and risk avoidance.

- Concern about HIV/AIDS transmission to clinic clients or care providers may be useful in enhancing quality of care in family planning clinics.

- Integration of family planning and HIV/AIDS IEC activities and counseling in the appropriate environment could increase the options available to clientele of either service.

- Integrated counseling could provide the motivation to use effective family planning as HIV-positive women may not want to have another child when counseled about the 25-40 percent chance they have of transmitting AIDS to the child or the possibility of the mother, father, or both dying and not being able to care for a child. The desire to have a child may still outweigh these concerns; some behavioral research that is of interest to both family planning and HIV/AIDS programs could be undertaken jointly to measure the validity and strength of this supposition.

- Integration could provide a joint opportunity for strengthening the system for projecting needs, procuring, storing, and distributing family planning contraceptives and condoms for HIV/AIDS and for family planning. On the other hand, unless additional resources are added to strengthen the present weak logistics system, large additional supplies of condoms could create substantial problems.

- Many behavioral research questions are common to both family planning and HIV/AIDS programs — e.g., what is required to change sexual behavior, age of initiation and

frequency of sexual activity, taboos or special cultural patterns surrounding sex, number and frequency of change of partners, power dynamics and issues of economic dependency between men and women, decision making/communication on sex between partners, fears and rumors about sexually transmitted disease or about side effects of contraceptives.

- Concern about AIDS could increase attention to prevention and treatment of STDs and could stimulate development of less expensive and easier-to-use detection and treatment technologies which could generally enhance the quality of family planning programs. Additionally, this could reduce the number of female disorders presently attributed to side effects of contraceptives.

2.3 Disadvantages of Integration of Activities

- The integration of activities may offer the opportunity for expanding and strengthening current institutional capabilities. If additional resources are not made available, however, integration could overload weak structures to the detriment of achieving either family planning or HIV/AIDS program targets. With rare exceptions, neither public nor private sector family planning organizations in sub-Saharan Africa have thus far demonstrated the institutional capacity to reach more than a small percentage of the population required to effect fertility reduction or to have an impact on the rate of HIV infection.

- A major reason for the weakness of family planning delivery systems in sub-Saharan Africa has been the decision in most countries to integrate family planning into programs of one of the least powerful ministries, the MOH. Even within the lower-level MCH department in which it is usually placed, a family planning program receives low priority. In many instances, the presumed advantages of integration (similar to those suggested in Section 2.2) have not been obtained. Attention to family planning has been diluted and health workers overloaded with an additional responsibility which they did not see as contributing to their other objectives. This is not to say that integration cannot work, but that in most cases it has not been carried out in a way to secure its positive benefits.

- Association with HIV/AIDS activities may be perceived by leaders and clients in such a way as to tarnish the "image" of family planning. HIV/AIDS activities could be perceived as dealing with sick people (who could pass on the disease to family planning clients), dealing with prostitutes or with men who engage in extra-marital sexual activity, or as stimulating adolescent promiscuity. This concern could be mitigated by emphasizing the preventive aspects of both HIV/AIDS and family planning activities and their support for and protection of healthy family life.

- Although both HIV/AIDS and family planning activities target the sexually active population, the motivational messages to be communicated are sufficiently different that IEC activities must use careful research and a variety of approaches. Exceptions to this would include activities targeting youth or social marketing which in some instances have found ways to combine themes appealing to several target audiences as, for example, in Zaire.

- As family planning clinics may be urged to get more involved in STD and HIV/AIDS prevention and control, there could be a temptation to move toward a more comprehensive reproductive health program with tests, diagnoses, and treatments that may not be cost-effective public health interventions. This must be balanced against the value of a "client needs" orientation to service delivery which places greater emphasis on more comprehensive services in response to

individual client requirements rather than emphasizing the greater coverage/cost-effectiveness concerns of public health programs. Operations research and further analysis would help to determine the degree to which family planning or HIV/AIDS objectives would be furthered or hindered by a more comprehensive approach.

- The concern for protecting family planning service providers and clients against HIV/AIDS infection could have a backlash effect if excessive emphasis creates fear of procedures which have not been proven to be substantially "dangerous" in this regard.

- There is some dichotomy between the emphasis in clinical family planning programs on utilization of the more effective longer-acting contraceptives and the HIV/AIDS program emphasis on condoms as the only effective method of disease prevention. This need not be a critical issue in the development of joint HIV/AIDS-family planning non-clinical community-based distribution, social marketing, or programs for youth, however. These would be new activities in much of sub-Saharan Africa and would represent gains in fertility control even though using less-effective methods.

- If coordination or integration is developed with such rigidity and control over finances or policy that it stifles initiative or limits the involvement of the private sector, it could constrain project growth.

- Bureaucratic problems which delay or adversely affect the implementation of either the family planning or HIV/AIDS program in a given country may consequently undermine the effectiveness of the "partner" program if the two programs are linked in that country. This situation could be ameliorated by more flexible regional or central funding mechanisms and/or integrated bilateral projects. At present, choosing locations for joint family planning-HIV/AIDS activities is hampered by the differences in criteria used by donors for determining emphasis countries for population/family planning and HIV/AIDS prevention and control activities.

- Until more clear-cut decisions and better forecasting are made by donors and local governments on condom supply to meet the requirements of HIV/AIDS programs, there will be some disadvantage to the population/family planning program. A.I.D.'s Office of Population questions spending disproportionately more for condoms in the future than it normally would for their perceived value for fertility control.

3. Lessons Learned from Family Planning Activities with Relevance for Programming HIV/AIDS Activities

This section discusses those lessons learned from family planning activities³ that are relevant to HIV/AIDS activities, in general, and not specifically to issues concerning the integration of family planning and HIV/AIDS activities. While recognizing that the specific lesson identified is important, it must be emphasized that the lesson still needs to be interpreted in an HIV/AIDS-specific context before implementation.

3.1 Policy

- Population and family planning programs are solidly justified on economic, environmental, and health grounds. Nevertheless, there are strong political and religious considerations that must be addressed to secure the permission and active support of key individuals at both the national and community levels in order to implement effective programs. To this end, family planning programs have developed good analytic tools for presentation in policy dialogue. Equally important for success has been the strength of a committed group of leaders on the national scene to bring both the political and technical dimension to the forefront and to drive the program in the face of opposition.

Policy dialogue is key to implementing effective HIV/AIDS prevention programs. Experience has shown that without the active support of key individuals, HIV/AIDS prevention activities cannot be initiated or are initiated in such a manner that they are doomed to failure. Although the need for this support is true for all aspects of HIV/AIDS-related programs, the support of key individuals is especially needed for activities targeting youth.

- Family planning programs have stressed the concept of voluntary choice in reproductive decisions. In some instances, in which countries have delayed making family planning information as well as services available until population growth became a crisis, program managers, with the support of national leaders, have moved toward more drastic approaches. In China, these approaches effected reductions in the birthrate. Coercive approaches to sterilization in India, however, have produced negative results.

Throughout most of sub-Saharan Africa, the AIDS epidemic has already reached crisis proportions. As the situation worsens over the short- and medium-term,⁴ substantial dialogue with national and community leaders will be needed so that coercive measures are not implemented and so that effective behavior modification programs can be allowed to effect change. However, a discussion of the more coercive family planning methods that have been implemented elsewhere may be important in inducing national and community leaders to act before such methods become essential.

³Many parallels are found in Zabin, Laurie et al. *Lessons Learned from Family Planning and Their Application to AIDS Prevention*, WHO/GPA. Draft 1992.

⁴The number of AIDS cases will continue to increase as those individuals already infected with HIV become ill with the disease.

- Complete integration of programs (e.g., family planning with MCH) may be necessary for political reasons and/or because of limited resources. For integration to be effective, the limitations of integration must be recognized and mechanisms and checkpoints introduced to ensure attention to priority concerns. These include personnel in place with sole responsibility for the program and with sufficient organizational status to have control over resources, strong interdisciplinary training programs, and clearly stated targets which are consistently monitored. Integration is not a panacea; it has as much potential for damaging programs as it has for improving them. Care must be taken to ensure that the right conditions exist to use this approach if the optimum benefit is to be gained.

- A great number of local and international NGOs and agencies have played a key role in the development and implementation of population/family planning programs. They have provided a constituency for family planning which has survived the ebb and flow of interest by political and development leaders. They have produced a cadre of experienced and dedicated personnel who provide much of the innovative thinking, technical expertise, international contacts, and day-to-day management of programs that have contributed greatly to the expansion of the program. They have also provided a buffer for political leadership which may not have wanted direct involvement.

This same type of constituency is developing around HIV/AIDS at the local level. As national governments have been slow to react to the AIDS epidemic, local and international NGOs and agencies have led, and continue to lead, the fight against the epidemic.

- A strong involvement of the private sector has been key to success in many family planning programs. The private sector often brings more entrepreneurial experience, flexibility, initiative, and willingness to experiment with new approaches than governments can or will provide and is often the key to gaining popular support for or involvement in programs.

HIV/AIDS programs are already demonstrating the value of private sector participation especially in countries where national governments have been slow to respond. There is still much more that can be done, however, to fully engage the business community, factories, and commercial farms in HIV/AIDS-related activities.

3.2 Training

- Successful family planning programs have developed a strong training component to develop the management and administrative skills of program directors, as well as the technical and communication skills of service providers (clinical and non-clinical, public and private).

This emphasis on training is valid for HIV/AIDS-related programs especially given the high rates of turnover of well-trained individuals. As reducing this turnover is a priority, training must also be accompanied by the development of career tracks.

- One of the failures in family planning has occurred when training provided to local organizations and individuals has been grounded in principles that are of little use to the local community, for example, when medical policies are based on risk assessment and care-giving potential appropriate to Western conditions when, in fact, local conditions are quite different.

HIV/AIDS programs have suffered the same problem as prevention and control approaches have often been based on a more Western world epidemiologic model.

3.3 IEC and Motivation Campaigns

• **Mass media campaigns can be used successfully to inform people about issues and the availability of services and can also be helpful in beginning to change attitudes.** Carefully designed and tested messages carried by mass media are an efficient way to reach a broad audience with a consistent message. They have proved most effective when they provide specific information, such as where to go for services. They have generally been less effective, however, in modifying behavior which requires a coordinated effort in the areas of education, training, interpersonal communication, and community outreach. Interpersonal communication is generally more effective when coordinated with and supported by mass media campaigns.

The crisis nature of the AIDS epidemic has opened the way in a few circumstances for a more frank and direct communication campaign. In general, however, the impact of mass media in modifying behavior has been limited. This has been due, in part, to the political and religious restrictions placed upon the format of media campaigns as well as the specific information to be presented through the media.

• **In order to develop effective IEC and motivation campaigns, it is necessary to involve the intended audience in the design and dissemination of materials and programs.** Expatriate advisors and project staff have perceptions and biases that often result in production of materials and design of programs that have little or no meaning for the intended users. Rather, IEC and motivation activities must effectively deal with the individual and social pressures that determine an individual's sexual behavior.

To date, the IEC/motivation component of HIV/AIDS prevention programs has not adequately dealt with the underlying individual and social pressures determining an individual's sexual behavior. Newer research, however, such as that conducted in the Copper Belt of Zambia with traveling fish sellers is leading in this new direction. There also appears to be an increasing use of local individuals in the design and implementation of IEC/motivation campaigns which will help to improve the quality and impact of the activities.

• **Effective counseling that provides clients with information needed to make choices and that addresses fears and misconceptions can result in more successful and long-term use of family planning methods.**

Given the nature of AIDS, HIV/AIDS-related programs are developing counseling skills beyond those required for many forms of contraceptive choices. It will, therefore, be easier to add family planning to these skills than for family planning communicators to develop a full range of counseling skills related to HIV/AIDS and to have the time to apply them.

• **The general population is often less sensitive than its leadership as to what is acceptable to talk about or do in family planning.** Sensitivities held by leadership and/or the incorrect perceptions of sensitivities by the donor community have often resulted in less than effective programs and inadequate information being communicated.

HIV/AIDS programs are also demonstrating this phenomenon, especially as they expand efforts to deal with youth and to introduce humor and frank language into discussions of human sexuality, including condom use. Although leadership perceptions must be dealt with, communities are finding ways (e.g., through local drama groups) to openly discuss the issues and to provide a variety of behavior modification techniques.

- **The involvement of community personnel in the delivery (if not the development) of services and information is one of best ways to ensure that a program is more "needs oriented" and being delivered in a culturally acceptable and understandable way. Although communicators must talk of sexual practices in dealing with family planning matters, they can speak in euphemistic or culturally safe terms without doing damage to the informational requirements of explaining contraceptive use.**

HIV/AIDS counselors must be more direct in discussing the sexual practices that should be changed. They must be comfortable with the technical language and yet must understand the cultural language as only a person from the community can.

3.4 Service Delivery

- **An emphasis on physician involvement, especially at supervisory levels, in program design or implementation can be a serious constraint to program impact. This is not to denigrate the outstanding contribution of the medical profession to family planning programs, especially in performing specialized medical functions. Rather, it is to emphasize the importance of non-physicians who can design and implement programs with a greater understanding of the intended beneficiaries, and who can maintain community-based programs more consistent with resource availability. It is also to emphasize the need to break out of a health-oriented and clinic-based approach to family planning and to explore other ways of delivering contraceptive services to the community.**

HIV/AIDS programs also acknowledge the contribution of the medical profession which has made a tremendous contribution in identifying the virus and its routes of transmission and in efforts to discover a biomedical approach to its control. Until a medical solution (e.g., vaccine, drugs) to the epidemic is found, however, effective interventions remain based in behavioral science, community mobilization, and preventive health approaches, which tend to be the area of social scientists rather than physicians.

- **A public health orientation to goal setting is essential, although care needs to be taken to not lose sight of the needs of individual clients and families. Family planning programs must reach coverage levels consistent with fertility reduction objectives (i.e., exceeding 20 percent contraceptive prevalence) or levels likely to have an impact on infant or maternal mortality or nutritional status. On the other hand, quality care must be provided to individual clients and their needs and concerns must be recognized.**

In facing an epidemic which is demonstrating such a rapid doubling time as AIDS, it is even more important to reach coverage levels that are significant in containing the spread of the virus. At the same time, any program that depends on behavior change must be particularly cognizant of the human element in its programming.

- **Programs cannot afford to miss opportunities to work with important target groups, as has generally been the case with family planning programs vis-a-vis adolescents and often men. Many, if not most, of the family planning programs in sub-Saharan Africa have addressed primarily the women of reproductive age, usually those who already have children and come to an MCH clinic. Generally, programs have not done well in dealing with men despite their key role in reproductive decisions. Additionally, limited organizational capacity and/or policy decisions have precluded effective work with adolescents among whom the rate of pregnancy is rapidly increasing, presenting both health and social problems.**

The urgency of responding to the AIDS epidemic is opening avenues to these groups which both family planning and HIV/AIDS activities can utilize. HIV/AIDS prevention activities have demonstrated the key role of focusing on these groups, especially youth and men.

- **Family planning programs have tended to be implemented among urban populations which are easier and cheaper to reach and communicate with and where program management as well as supply and supervision is easier to maintain. Program expansion to other areas has then been planned with interventions based on initial success. There has also been a transfer of knowledge and an attitude change from the urban to the rural population due to normal patterns of internal migration.**

To date, a similar urban-oriented approach to HIV/AIDS prevention has occurred. This is because the epidemic has been significantly greater in the urban population. As the epidemic rapidly increases throughout a larger section of the peri-urban and rural communities, however, HIV/AIDS programs will be forced to actively target rural populations. In addition, as a major target group for HIV/AIDS-related programs is migrant labor, it is increasingly important to educate the laborers before they migrate to the urban area.

- **In general, family planning service providers, communicators, and community personnel are already overburdened and becoming more so. Prioritization of family planning activities is required to ease the burdens on providers as is the provision of additional resources to support additional responsibilities.**

There is a great scarcity of personnel able to develop and implement effective HIV/AIDS prevention activities. As the epidemic grows and new areas of service delivery (treatment, home-based care) are given greater emphasis, the need for additional service providers will become even more critical.

- **Successful family planning programs have been more client oriented than provider oriented in their approaches. For example, when programs have changed the hours of clinic operation or the availability of service providers to be more responsive to clients' work or transportation constraints rather than the providers' schedules, attendance has increased. When clients have been given more choice of contraceptive methods rather than having to respond to a provider bias with regard to choice of methods, client satisfaction has increased. Additionally, services available in the community rather than at fixed facilities more convenient to services providers have served more clients.**

This is an important lesson for HIV/AIDS-related programs. Too often, HIV/AIDS activities have been designed by and for people outside (whether expatriate or MOH) the community. These activities reflect the attitudes of the "outsiders" designing the program rather than helping the

community to cope with, and adapt to, the impact of the epidemic as well as develop local methods to reduce HIV transmission.

- **Development of effective contraceptive technology offering several choices for users and experimentation with new service delivery modalities have been key to successful programming.**

Similarly, IEC/motivation components of HIV/AIDS programs are realizing that presenting a spectrum of risk-reduction behaviors to an audience is more effective in modifying behavior than presenting only one or two alternative behaviors.

- **The concept of relative risk assessment (as it applies, for example, to the distribution of oral contraceptives) has been effective in designing programs and in securing the support of political, professional, and community leaders.**

This concept can be applied in HIV/AIDS programs; for example, as high-risk HIV clients are counseled in choosing the most effective contraceptives to avoid the risk of pregnancy or as seropositive women are counseled in terms of breastfeeding their infants.

- **Clinical services are essential for some technologies. However, programs that are largely clinic based without additional outreach activities tend to serve a limited population in a manner not sufficient for accomplishing stated public health objectives.**

As there exists no HIV/AIDS prevention technology deliverable through a clinical setting, HIV/AIDS programs are already experimenting with outreach approaches to youth, men, and the rural population that could benefit family planning in an integrated effort.

3.5 Social Marketing

- **Social marketing is one part of an effective distribution program. Although there are limits to the percentage of the population social marketing can serve, it has great potential in its cost-efficient use of private sector resources. In sub-Saharan Africa, however, an over-emphasis on financial self-sufficiency would limit access to key target groups, especially the very poor.**

The AIDS epidemic has given new impetus to the social marketing of condoms in Africa and is demonstrating its value for HIV/AIDS prevention and control.

3.6 Commodities

- **A key to success for family planning programs has been the constant and adequate supply of contraceptives, supported by an effective system of procurement and distribution.**

This principle cannot be overstated in HIV/AIDS programming as a rapidly expanding demand for condoms is already presenting procurement and distribution problems. In the HIV/AIDS context, commodities also include HIV testing kits, STD medications, gloves, and needles.

3.7 Research and Evaluation

- In addition to emphasizing action-oriented programs to extend contraceptive services to the general population, family planning programs have realized the need for a strong program of biomedical, behavioral, and operations research. This research was required to improve contraceptive technology; increase knowledge of sexual, reproductive, and contraceptive-use behavior; improve IEC programs; develop more efficient service delivery; and measure impact.

For nearly identical reasons this same emphasis on research (and some of the same research) is required for HIV/AIDS programming.

- Programs need to develop both process and impact measurements for monitoring progress. Targets must be established within the perspective of achieving overall goals, yet they must be realistic in the light of what is practically achievable. In general, family planning programs have adopted the use of contraceptive prevalence and total fertility rates as measures of success.

Due to the perceived sensitivities surrounding the AIDS epidemic, impact evaluations of HIV/AIDS prevention programs have not been carried out. Rather, most evaluations to date have been limited to some kind of management review. Some qualitative and process evaluations carried out to date have been useful. The present absence, however, of impact evaluations of ongoing and proposed HIV/AIDS-related activities is severely hindering the ability of professionals in the field to reduce the transmission of HIV. At the same time, it should be noted that it is more difficult to document increases and decreases in HIV infection rates than it is to document increases in contraceptive use.

3.8 Management Considerations

- Family planning programs are much more labor intensive than capital intensive as they involve both technical and political considerations, require substantial changes in human behavior, and have considerable technical assistance as well as procurement requirements.

This concept is just as valid for HIV/AIDS programs and the requirements for adequate personnel at the management and service delivery level are just as great and often in just as short supply.

- Appropriate utilization of A.I.D. resources requires adequate technical and management support at the USAID mission level to plan, coordinate, monitor, and facilitate the implementation of A.I.D.-supported activities. The quality and quantity of technical and administrative backstopping from A.I.D./Washington and the REDSOs has also had much to do with the success or failure of these efforts.

Similarly, the quality of A.I.D.-funded HIV/AIDS-related activities will be related to the quality and quantity of the assistance provided by A.I.D. field and Washington personnel.

- Although the role of A.I.D. technical and management personnel and those of international NGOs and agencies must be recognized, host country institutions and leadership are key to successful program implementation. Program design must be responsive to their needs and interests and must have their involvement. Solutions to problems of implementation frequently lie within the indigenous institution.

As the HIV/AIDS prevention program is too often donor driven in Africa, this lesson has not been applied. IEC messages have often not been responsive to local needs; research has been designed to answer questions more of interest to Western researchers than to the local communities; and targeting strategies have not been consistent with the realities of the spread of the epidemic. Significantly more national and local leadership and involvement in the design and implementation of activities is needed.

4. Ways in Which Family Planning and HIV/AIDS Activities Can Be Integrated

4.1 Policy Development

Policy development efforts have been carried out independently by those concerned with either HIV/AIDS or population/family planning. The potential exists for dealing with both these issues in a more integrated way, not only to capture the attention of policy makers but also to clarify the inter-relationships between the two programs and to gain recognition of the crisis nature of both issues. The integrated approach to policy making would be especially important to unify action and maintain priorities if a decision has been made to pursue further integration at the programmatic level.

Before integration or coordination of activities can take place, groundwork needs to be laid in three areas in which policy development can occur: the policy environment, the day-to-day implementation of activities, and the donor community.

Policy Environment

The first level of policy development involves providing an enabling environment in which technical issues can be solved. This requires the active support of senior-level persons in order to implement effective family planning and HIV/AIDS programs. These individuals include political and religious leadership and key members of the business and local communities. This support cannot be limited to a few speeches made primarily for the donor community's benefit, but must be continuous, despite other demands, and must point toward implementation-related issues. It is important that this support be manifested in key areas:

- The amount of host country resources budgeted and provided for family planning and HIV/AIDS-related activities (Zimbabwe provides significant resources for its family planning program but few for its HIV/AIDS prevention program);
- The removal of governmental and church restrictions on effectively targeting youth to prevent HIV infection and teenage pregnancy (as is needed, for example, in Uganda and Zimbabwe);
- Mobilization of the trained and educated elite; and
- The elimination of governmental policies that prohibit the use of mass media for condom and contraceptive promotion (as is needed, for example, in Uganda).

Additionally, if there is interest in developing more integration between HIV/AIDS and family planning efforts, policy discussions must review the benefits that will accrue to each program through integration and must clearly determine what contribution each of the program elements is expected to make.

Overall, with regard to both family planning and HIV/AIDS, the national policy environment has not responded to the crisis nature of these two issues. Host countries have been slow in recognizing the existence of AIDS (not recognized in Zimbabwe until June 1990) or in devoting significant resources to combat the problem (Botswana still does not have a full-time head of its HIV/AIDS program).

Day-to-Day Implementation Issues

At this level, policy development is more straightforward, but its success depends upon work done at the first level discussed above. Activities required at this level include

- Removing tariffs, duties, and other restrictions on importing condoms and contraceptives as has been done in Côte d'Ivoire (and as is needed in countries such as Zimbabwe, Uganda, and Tanzania); and
- Decreasing the cost of advertising time for family planning and HIV/AIDS messages on state-controlled television and radio as has also been done in Côte d'Ivoire (and which needs to be done in countries such as Zimbabwe and Zambia).

The Donor Community

The donor community has an important role to play in both family planning and HIV/AIDS policy development. This role extends beyond the limited emphasis placed by donors on the formal health sector and includes their wider influence in the general economic development of the host country. Although family planning and HIV/AIDS prevention are health issues, they are also based in broader socioeconomic and development contexts. Donors could exert their influence outside the health sector to help develop a real commitment to family planning and HIV/AIDS-related issues. The power of donors to influence commitment from multiple sectors is not without precedent. For example, donors have exerted their influence to establish economic structural adjustment programs despite host government reluctance (e.g., in Zimbabwe, Zambia, and Tanzania). Similar influence could be exerted to establish effective HIV/AIDS prevention and family planning programs, perhaps more effectively if the two areas were dealt with in an integrated fashion.

The donor community has, however, been unwilling to establish policy dialogue with host governments, especially in the Office of the President; as a result, programs have been implemented that were doomed to fail. With few exceptions, USAID missions and U.S. embassies have been reluctant to enter into policy dialogue with presidents, cabinet members, and other influential persons to help establish effective programs. One of the exceptions is Uganda, where discussions with the government resulted in the establishment of AZT (an antiretroviral drug) trials (they did not, however, succeed in changing government policy on key issues such as the effective promotion and distribution of condoms).

Certain of the policies of donors and their contractors have also proved to be problematic. Many of these policies are based on U.S. or European concepts which are insufficiently sensitive to the unique issues related to implementing effective family planning and HIV/AIDS prevention programs in sub-Saharan Africa. These policies include

- WHO/GPA and A.I.D./Washington's insufficient response to host country requests for support to establish anonymous testing centers

(which are attracting couples in situations in which integrated HIV/AIDS and family planning counseling would be possible);

- The continued emphasis on the part of the donor community to fund short-term consultants (who often have a more narrow focus on either family planning or HIV/AIDS) rather than developing expertise in host countries;
- An unrealistic emphasis on sustainability in a declining economic situation (which affects both HIV/AIDS and family planning programs); and
- A.I.D./Washington's apparent policy on HIV/AIDS prevention which focuses more attention on core, high-risk groups (different from those targeted for family planning) unlike African leaders who see HIV/AIDS affecting a much broader group and requiring more preventive work among the general population. The African leaders' approach is more compatible with integration of HIV/AIDS and family planning activities.

(Subsequent to field visits, A.I.D. Office of Health staff reported to the study team that the A.I.D./Washington approach to HIV/AIDS control and prevention is both more flexible than that which had been stated by A.I.D./Washington staff and staff of the centrally funded AIDS Control and Prevention (AIDSCAP) project and broader than the perception of the Washington position which predominated in discussions with field personnel. This clarification of policy needs to be articulated by the Office of Health to all concerned.)

4.2 Training

Training activities in support of both family planning and HIV/AIDS activities in sub-Saharan Africa remain weak. Short-term, didactic, lecture-style courses are still the norm, and participants are sent to the field with little or nothing in the way of follow-up and support. Because the cadre of professional trainers is small, much use has been made of the training of trainers (TOT) approach. Botswana, for example, has relied heavily on this approach. Training and performance assessments, however, have revealed that few of those attending TOT workshops actually impart to their fellow workers any of the knowledge or skills gained because frequently they have no time to do so, they lack the skills needed to train others, and because there is a lack of incentives.

One-time, centralized training programs are not likely to have much impact on increasing people's skills and improving their performance as service providers. There is a need to develop medium- and long-term planning of training activities that includes provision for refresher courses, adequate supervision, support from program administration, and career tracks for skilled personnel. Such planning should be in response to the long-term needs of the institution rather than being driven solely by the availability of donor funding for specific training initiatives.

Most training activities (except for more complicated clinical procedures) would probably be more meaningful to participants if they were held locally and if they offered a chance for on-the-job

experience and supervision within the place of work. Likewise, the need to monitor the continuing performance of staff periodically and provide reinforcement are critical to bringing about an overall improvement of services. Such an approach is central to the training support to be provided through the new USAID population project in Botswana. The MOH in Uganda also has realized the importance of situating the locus of expertise for training and supervision at the district level. A more comprehensive approach to providing training to health care workers can also be a means of improving morale of health workers and reducing job turnover.

Given the weakness of the training system within both the public and private sectors, the integration of HIV/AIDS into family planning training or vice versa must be approached carefully. Likely areas would appear to be the following:

- **Family planning workers could be trained to provide basic information about HIV/AIDS to answer family planning clients' questions and to protect themselves and their clients from infection.** Unless staff are already doing fairly comprehensive counseling (which is seldom), it is doubtful they will be able to deal with the added requirement of providing counseling for HIV/AIDS. Introducing comprehensive HIV/AIDS counseling requires particular skills on the part of trainers as well as trainees because both will have anxieties about HIV/AIDS. An integral part of such a process is coming to terms with one's own anxieties and attitudes regarding sexuality and HIV/AIDS. Therefore, for the short term, the sensible approach would be to provide family planning workers with basic information to enable them to help clients understand the implications of HIV/AIDS in making a choice of contraceptives and to make referrals for further counseling, HIV testing, or HIV/AIDS support services. In cases in which good counseling is already a part of a family planning program, consideration could be given to doing more in-depth counseling of clients about prevention, testing, and notification of partners.

In addition, the Western, one-on-one model of counseling may not be appropriate in the African context. For example, counselors at the STD Clinic in Mulago Hospital in Kampala were discouraged that despite extensive counseling, clients frequently returned to them within a matter of months reinfected with an STD. Further investigation led them to an understanding that, in Africa, an individual does not necessarily take action on her or his own. Rather, the individual's behavior is a product of a broader familial and societal context. Therefore, modification of behavior to adopt safer sexual practices or to adopt family planning must be considered in this broader context. Group counseling, training of peer counselors, and broader community education programs are examples of ways to approach this concern.

Family planning service providers would require additional training (similar to that being provided in Uganda) both to allay their own fears about AIDS and to provide protection for themselves and their clients against infection. This is particularly important for those engaged in surgical procedures but should be part of other service delivery training as well. This training would need to be carefully designed to provide appropriate protection, but would also need to be a practical approach designed to recognize local capabilities to provide equipment and supplies.

- **HIV/AIDS workers could also be trained to provide basic information to clients to help them make choices about their reproductive life style, sexual activity, and contraceptive options in the light of their HIV status.** Training would need to be updated as further knowledge is gained through biomedical and social science research on the interaction of these factors and on the availability of newer contraceptive technology associated with AIDS concerns. HIV/AIDS workers would also need to know where to refer clients for additional family planning services. In some

instances, training could also prepare HIV/AIDS workers to deliver other contraceptives in addition to the present distribution of condoms.

- In some instances, joint training could be provided for program managers of both family planning and HIV/AIDS programs. There are areas of general program management that are common to both programs such as policy development, fund raising, program planning and budgeting, delegation of responsibility, supervision, development of training programs, organization of IEC programs, focus on outreach and community involvement, emphasis on youth, common understanding and approaches to contraceptive issues, personnel management, coordination and information sharing, procurement of goods and services, optimum use of technical assistance, monitoring and evaluation, and development/contracting and dissemination/utilization of appropriate research. One area of particular importance to both programs is in the projection of condom needs, proper warehousing, and distribution.

- Training for certain specialized skills could be coordinated for HIV/AIDS and family planning workers. Some laboratory skills are common to both programs as are those of the development of IEC materials, elements of research design and implementation, computer technology, advertising, and marketing. In some cases these skills could be taught in joint training programs; in others it may be more appropriate merely for one program to include trainees of the other program in its specialized course.

- As highly respected and influential members of the community, traditional healers are a potential resource for providing information and counseling for both family planning and HIV/AIDS and also for the diagnosis and treatment of STDs, if they are better trained for these roles. Traditional healers continue to play an important role in the delivery of health care in Africa. In many areas, more than 75 percent of people will consult with a traditional healer, sometimes in concert with seeking medical attention. Although family planning programs have been generally ineffective in involving traditional healers or traditional birth attendants in providing contraceptive services, further experimentation in this area is justified in light of the significant role they play in health care.

4.3 IEC Activities

Integration of family planning and HIV/AIDS IEC activities could take place at several levels: in general and targeted mass media campaigns; in targeting specific audiences such as people in the workplace (including management), the trained and educated elite, men, and youth; and in interpersonal communication at the motivation/service delivery level such as in clinics, CBD programs, and other outreach activities.

Throughout the process of planning integrated activities in these various areas, it will be important to keep in mind some of the lessons learned over the years in the implementation of IEC activities. For example, underlying the design and implementation of effective IEC activities is the requirement that the messages/information take into consideration the individual and social pressures which determine sexual behavior, whether in terms of family planning or HIV/AIDS-related issues. Most early IEC campaigns for both family planning and HIV/AIDS were done without addressing these considerations. IEC for HIV/AIDS prevention campaigns in all three of the countries visited, for example, have promoted the adoption of behavior that generally does not make sense within the cultural context and offers no assistance to individuals seeking to successfully integrate safer sexual

behavior into their lifestyles. Although these campaigns have been able to raise awareness of HIV/AIDS, they have done little to influence positive behavior modification.

To successfully address issues of behavior modification, IEC activities must be carefully planned and tested to be sure that they are relevant to the target community. Where the population is fairly homogeneous, media channels are adequate, and literacy is relatively high, design and production of some materials and messages at the national level may be appropriate (such as for most of Botswana). In a country like Uganda, however, with a predominantly rural population, low literacy, and poor coverage by mass media, programs will have to be developed and/or modified at the local level if they are to be effective.

A little, but increasing amount of research is being done (particularly in Uganda) on perceptions of sexuality among different segments of the society. It will be important for the results of this type of research to be incorporated into IEC programs. In addition, the need to be subtle, to use humor and not be boring is of increasing importance in affecting behavior modification, whether for family planning or HIV/AIDS. In both Botswana and Uganda, the most popular print materials developed by HIV/AIDS prevention programs have been comic books. In other countries, comic strips running in newspapers have shown popular appeal.

Another important communication channel is community drama and music. Both traditional and modern (e.g., "rock") music have proved to be effective ways to convey information and create awareness of both family planning and HIV/AIDS in a variety of settings around the world. The "AIDS Song" recorded by one of Zaire's most popular singers is reported to have had a significant impact on increased sales on condoms in that country. Likewise, in Uganda, singer Philly Lutaaya's public disclosure of his HIV-positive status and documentation of his fight against AIDS on film have played an important role in bringing discussion of HIV/AIDS prevention out into the open.

Underlying many aspects of IEC is a series of policy-related questions which must be dealt with before effective IEC can be implemented. For example, IEC issues relating to the prevention of pregnancy for HIV-positive women is first a policy question, i.e., have policy makers decided that HIV-positive women should be advised not to become pregnant? Similarly, should women be taught about and provided with effective methods to protect themselves from both HIV infection and pregnancy? Is reliance on condoms as a family planning method going to put more women at risk of an unwanted pregnancy? Are school girls going to be taught techniques with regard to safe sex with older men who support them financially in return for sexual favors? Dialogue, debate, and study of these questions will be necessary to establish national and institutional policies. Both family planning and HIV/AIDS programs will then be able to incorporate these policies into the design of their IEC and counseling activities.

Finally, an important consideration in the development of any IEC strategy is that people need to be provided with a variety of alternative behaviors from which they can select rather than simply being told what they should do. The element of choice empowers people to take action in support of their own health needs and objectives. Integration of family planning and HIV/AIDS IEC activities and counseling in the appropriate environment could increase the options available to clientele of either service.

The following are suggested ways in which integration of HIV/AIDS and family planning IEC activities could be implemented:

- **An initial step toward integration would be for staff working on HIV/AIDS and family planning IEC to initiate a dialogue in terms of where their needs overlap and where they differ, what works and what does not work, and where they might be able to share or jointly develop resources.**

As part of this process, it would be helpful to examine the ways in which many family planning and social marketing programs have made use of research and marketing techniques originally developed in the private sector. These techniques could be useful to family planning and HIV/AIDS programs in determining where, when, and how integration of family planning and HIV/AIDS messages would be appropriate and when they would not. Although integration of family planning and HIV/AIDS-related IEC may seem natural since both deal with sexual issues, there are differences between the two sexual relationships. For example, the audience for family planning information is more often couples in some type of longer-term relationship while for HIV/AIDS prevention, the two individuals are often involved in a short-term relationship. The motivations to practice safe sex in these circumstances are very different. Mass media could be used to deliver messages for both family planning and HIV/AIDS prevention, but it is not necessary, and perhaps not possible, that information relating to both issues be effectively communicated in every message.

One rationale often given for the integration of family planning and HIV/AIDS-related IEC is that the family planning message will help to cover any stigma attached to HIV/AIDS. Such an approach may be true in some cases but should be used only after an in-depth analysis of the local situation. Basically, IEC should be used to get rid of any "stigma," not to cover it up. In Uganda, where there is a very conservative and powerful religious influence, the Islamic Medical Association has gained support from its religious leaders to discuss use of the condom for prevention of HIV/AIDS because condom use is already acceptable as a method of family planning. On the other hand, a Catholic missionary hospital is now promoting use of condoms solely because they are the only effective way to prevent the spread of HIV even though the hospital cannot promote condom use as a method of family planning.

- **A simple step that would benefit both family planning and HIV/AIDS activities would be the development of simple, easy-to-understand, pictorial instructions on how to correctly use and dispose of condoms. These instructions could be made available wherever condoms are being distributed.**

- **The increasingly large number of HIV-testing centers provides an especially good opportunity for providing family planning counseling. These centers are frequently utilized by couples; in some, couples make up more than 50 percent of the clientele. Originally developed in Rwanda and Uganda, these centers have now been established in many countries and are proving to be an important element in a comprehensive behavior modification program.**

- **The importance of targeting youth and men for HIV-prevention activities offers an opportunity for family planning programs to reach these audiences with family planning information. In the past, family planning programs have generally neglected these groups.**

As observed in all the countries visited, the urgency of addressing the AIDS epidemic has often been instrumental in creating a more open climate for discussion of issues that have been ignored or kept vague within the family planning context. In trying to change behavior to prevent the spread of HIV/AIDS, it is necessary to deal with issues such as sexuality, gender, and the economic dependence of women on men. This will mean addressing real issues such as sex as recreation, motivation of men

to modify behavior, need for dialogue between men and women, protection of teenage girls, etc. The lessons learned will also be useful in designing more effective IEC for family planning.

- **Establishing mechanisms for distribution and utilization of relevant IEC materials by both family planning and HIV/AIDS components with multi-sector institutions (such as the Ministry of Health) and between institutions (e.g., Ministry of Health and Ministry of Education) could be a relatively simple and cost-effective step toward integration.**

No matter how good IEC materials may be, they will be of little use if they do not get into the hands of clients. In two of the three countries visited, clinics and health posts in outlying areas were frequently devoid of any information materials about either family planning or AIDS. Botswana, for example, has skilled staff and good production facilities within the MOH and has produced a great deal of material on both family planning and HIV/AIDS. However, recent evaluations of both programs stress the fact that few if any of these materials can be found outside of Gaborone and that no mechanism has been established either to routinely supply all health facilities or for staff of those facilities to order materials. In Uganda, the AIDS Control Programme (located within the MOH) produces IEC materials on AIDS but these are not distributed through the MOH system. Rather they are made available to NGOs who make the effort to travel to Entebbe to pick them up. Effective and timely distribution of materials should be an important consideration of any IEC campaign.

See Appendix J for a brief review of experience with family planning and HIV/AIDS IEC activities in Africa and other locations.

4.4 Service Delivery

Non-Clinical Activities

- **Given the limitations of clinical services in dealing with a substantial portion of the population, it is imperative to develop community- or workplace-based outreach activities beyond fixed facilities.** Both family planning and HIV/AIDS programs now tend to take a health-based approach when a broader community development orientation is required. The programs are typically headed by physicians and the health system is the priority for service delivery. Innovative service delivery modalities are inhibited by health policy, the resources of the private sector are not appropriately involved, and coverage of the population is limited. In Uganda, for example, family planning programs have been successful in reaching only a small proportion of the population (less than five percent of the women of reproductive age). Though dealing with an important target population for HIV/AIDS (women of reproductive age) they have made little effort in reaching men and youth. They are underfunded and do not have a widespread infrastructure or adequate support systems of logistics, supervision, monitoring, or evaluation. While more vigorous and well supported than the family planning activities, the HIV/AIDS prevention services are also only dealing with a small proportion of the population, often through fixed facilities which are limited in number and coverage of program. The integration of family planning and HIV/AIDS service delivery could contribute to changing this approach if both concerns are brought together on community- or workplace-based outreach beyond the fixed facilities.

NGOs may be more susceptible to change and improvement than cumbersome public sector institutions. These groups have more flexibility and often more willingness to experiment with new

approaches than public sector agencies. At the same time, they are generally not adequately funded and their ability to develop widespread coverage to the rural population is limited. If resources are made available, however, family planning NGOs could make an important contribution (along with public sector activities) to the development of integrated HIV/AIDS-family planning activities. Generally, family planning programs in the private sector and in Zimbabwe through the parastatal Zimbabwe National Family Planning Council are more vertical in approach, focusing more specifically on family planning methods and information. They have often emphasized clinical services, but increasingly they are developing outreach CBD activities.

Community- or workplace-based programs can be directed to business or factory employees or agricultural workers on large tea estates or sugar plantations as is being done with varying degrees of success through the Commercial Farmers Union in Zimbabwe or the Federation of Ugandan Employers. Programs can be directed toward youth as envisaged by the recently instituted private family planning association in Botswana. They can extend services to families beyond the reach of present fixed facilities through CBD programs and could include the rapidly growing community-based HIV/AIDS support groups such as The AIDS Support Organization (TASO) in Uganda or the home-based care program reported to be successfully reaching out to the community surrounding the Chinkankata Hospital in Zambia.

This non-clinical effort would be largely new territory for both HIV/AIDS and family planning programming. Mutually supportive objectives could be identified in initial planning and benchmark progress measures could include indicators common to both. Efforts could be funded to achieve both purposes. Emphasis on the use of the condom for these "new" target populations regardless of whether for family planning or HIV/AIDS prevention and control purposes would obviate much of the concern over the appropriateness of hormonal contraceptives in the presence of HIV/AIDS. It would also mitigate the concerns of family planning leaders who may continue to emphasize the longer-acting, more effective contraceptives in clinic programs but who would appreciate the contribution this new outreach emphasis on condoms can make to attaining family planning objectives.

MOH MCH/FP Programs

- Efforts could be made to integrate HIV/AIDS activities in those family planning programs that have been accorded high priority within an MCH program. In this situation, the policy climate is such that the introduction of HIV/AIDS activities should not divert attention from other important MCH/FP priorities. Public sector family planning programs have usually been developed within the MCH program of the MOH. In the best of circumstances, family planning is given appropriate priority in the organizational structure of the ministry and high-quality personnel are assigned responsibility within the structure to plan, supervise, and monitor the family planning activities. Some personnel are trained with specialized family planning skills, and personnel at all levels have adequate training to understand family planning as an essential health intervention and to be supportive of the family planning services at the service delivery level (as in the integrated MCH/FP program in Botswana and in the Municipal Health programs in Zimbabwe). New responsibilities cannot be added without appropriate training, however. Additional financial, material, and personnel resources are required to add HIV/AIDS activities if the system is already operating at full capacity.

In other circumstances, family planning appears in name only in the MCH/FP organizational chart of the MOH. There is no one with authority responsible for the family planning program. The

program may be further diluted through decentralization to weak regional or district levels which are even less well equipped to provide appropriate attention to family planning management requirements. A few persons may be identified to provide family planning services in poorly equipped facilities at specified times during the week. There is little support from other clinic workers who see family planning as taking time away from rather than contributing to their particular objective. The programs are poorly funded, administrative and logistics systems are inadequate, and there is little management information available or analysis being made of it. These conditions are often exacerbated by medical policies that either do not provide for adequate delegation of responsibility to lower level professionals or which require clinical procedures that impede rather than facilitate access to family planning services. Although this describes the extreme, family planning programs have many of these characteristics in countries such as Uganda, Mali, Senegal, Ghana, and Zaire. The degree to which these conditions are impeding performance in integrated MCH/FP or the extent to which they can realistically be changed will determine whether much can be gained in either improved family planning performance or effective support of HIV/AIDS activities as a result of integration.

The family planning program with both vertical and integrated components in Zimbabwe is already significantly addressing HIV/AIDS prevention concerns through the distribution of condoms in the urban and rural areas. Similarly, a strong MCH/FP program is poised in Botswana to be a significant channel for HIV/AIDS information and condom supply. In Uganda, however, the Basic Health Services Project (funded by the German Technical Cooperation [GTZ]) demonstrates that the road to more unified programming is not easy. Despite having both AIDS and family planning emphases in the program for more than two years, only in the last six months has the program been able to bring the two components together in practical planning exercises. The family planners must continue to be a "squeaky wheel" to gain adequate attention in the vigorous efforts at HIV/AIDS prevention. This appears to be due to several factors, among them leadership's perception of the relative importance of the two facets of the program and an ambivalence over the role of hormonal contraceptives — the emphasis in family planning activities on hormonal contraceptives and (to a lesser degree) the IUD is somewhat in conflict with the emphasis on the condom in the HIV/AIDS prevention program. (See Appendix E for a fuller discussion of service delivery in these three countries.)

- **Clinic services which are not a large supplier of condoms at this time could do more in this regard.** For example, family planning clinics in Zimbabwe have reduced client registration requirements to a minimum and increased supplies of condoms to clients to a maximum, thereby greatly expanding distribution. Evaluators may be concerned whether these condoms are distributed for family planning or HIV/AIDS. This distinction, however, does not seem as important as that of addressing both fertility and disease prevention concerns in the most practical way possible.

HIV/AIDS Programs

- **The opportunity exists for offering at least a minimum level of family planning information and commodities along with HIV/AIDS activities.** HIV/AIDS counselors recognize that for those at high risk for HIV infection, pregnancy represents a considerable risk for the AIDS client, the outcome of the pregnancy, the future of a potentially orphaned or HIV-positive child, and the health and economic welfare of the extended family. There is genuine interest on the part of service providers to make the connection between family planning and HIV/AIDS. Counselors and their supervisors, however, express the need for more training in family planning before they can effectively add this component in their work with HIV/AIDS clients.

In Botswana, much of the HIV/AIDS prevention activities are expected to be integrated into the MOH and local government service delivery system; in Zimbabwe, they are already to some degree within the MOH system and the parastatal family planning council. Other avenues of service are aimed toward target groups at high risk such as commercial sex workers. Men and their families are targeted on large commercial farms. An even more diverse approach is taken in Uganda. There, the HIV/AIDS program is finding ways to work through a broad variety of outlets with many public and private sector institutions delivering both HIV/AIDS information and counseling and condoms.

It will likely require more policy development efforts as well as training to help all service providers to see the inter-relationship of these activities. It will also require continued monitoring to assure the integrated delivery of these services.

Cross-Infection Control

- A specific area in which family planning providers must be aware of HIV/AIDS concerns is in assuring sterile clinical procedures to protect themselves or their clients from the spread of the HIV virus. This has been recognized, for example, in Uganda in those clinics in the program of the Family Planning Association of Uganda that emphasize the IUD. Disposable gloves have been made available in some locations as well as inexpensive bleach solution for decontamination, disinfectant for cold sterilization, or autoclaving equipment for sterilizing instruments through boiling. The requirements for sterile procedures, the cost and logistics implications, and the potential for undue apprehension on the part of the client calls into question the requirement both in Uganda and Zimbabwe for a pelvic examination before initiating hormonal contraceptives. The need for strict attention to aseptic procedures is particularly important in the voluntary surgical contraception programs which are beginning to take on importance in such countries as Kenya and Ghana and are being encouraged in others such as Zimbabwe and Uganda. Only a small amount of HIV is spread from clinic procedures. It is essential, however, that family planning programs not contribute to the problem. The clinical protocols of the International Planned Parenthood Federation (IPPF) and the Association for Voluntary Surgical Contraception (AVSC) as well as the training programs of the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) on controlling infection are assisting in this area.

Referral Mechanisms

- Establishment of effective referral mechanisms will be a critical element of any integration strategy. Since it is unlikely that many of the family planning or HIV/AIDS centers or services will have or want to develop full capability in the other discipline, the development of referral systems will need to be undertaken. It should be recognized from the outset, however, that because little of this nature has been functional in Africa to date, it will be important for providers to keep the process simple and the expectations modest. At a minimum, service providers will need to know where other services are available. Operations research could help to determine whether additional mechanisms such as referral slips or means of verification of outcome are feasible.

4.5 Social Marketing

- The potential for social marketing to link family planning with HIV/AIDS prevention in a mutually reinforcing manner is considerable. The growth of social marketing programs in Africa should be viewed as an important opportunity for integration. Social marketing programs serve the

interests of both family planning and HIV/AIDS prevention activities. The advantages of using social marketing as a bridge between the two go beyond a shared interest in the condom; important advantages also accrue in the overall policy environment and through improved outreach strategies, strengthened institutional capabilities, and increased cost-effectiveness.

Both family planning and HIV/AIDS programs benefit from changes in the policy environment which social marketing can effect. In Côte d'Ivoire, for example, an HIV/AIDS prevention social marketing effort was the catalyst for reforming several condom distribution and promotion issues. Changes which occurred include the removal of the pharmaceutical monopoly on retail sales, removal of import duties and sales taxes, allowing brand name mass media advertising, and granting reduced advertising rates. Family planning benefits from all changes in the policy environment which make contraceptives more affordable and available. Family planning will also benefit as the social marketing program develops and markets other contraceptives.

All interests are served by social marketing programs because they increase condom use. Possible family planning concerns about the need to emphasize longer-term methods are tempered by the number of new users that condom social marketing can attract. In Côte d'Ivoire, a recent consumer intercept survey showed that about 30 percent of all purchasers had never used a condom prior to the introduction of condoms through social marketing.

Both family planning and HIV/AIDS efforts are served because condoms appeal to consumers for multiple reasons. In Zaire, Cameroon, and Côte d'Ivoire, where brands are positioned primarily for HIV/AIDS prevention, consumer intercept studies indicate that up to 40 percent of consumers use the condoms for contraception as well as HIV/AIDS prevention. Alternatively, research shows that brands positioned for family planning purposes can be reinforced by HIV/AIDS information campaigns; many consumers perceive the condom's role in STD prevention as an important additional benefit. In Zimbabwe, where contraceptive social marketing began as a family planning initiative, condom sales are driven largely by consumers seeking protection from STDs.

Experience shows that different marketing approaches are effective. In some countries, a positive "lifestyle" approach to condom promotion has succeeded in generating demand among consumers seeking to use the condom for multiple reasons. Other countries, such as Cameroon and the Philippines, have used different brands to segment the market.

Both family planning and HIV/AIDS programs benefit from communication strategies and programs which advertise condoms and educate the public on the benefits of condom use. In some cases, brand-specific condom advertising for family planning has facilitated the eventual acceptance of HIV/AIDS prevention communication activities. In Côte d'Ivoire and Burkina Faso, condoms are brand advertised in the mass media for HIV/AIDS prevention whereas the same campaigns for family planning purposes would be unthinkable. In Uganda, where brand advertising of condoms met resistance from religious and government sources and had to be withdrawn, the controversy created by the debate intensified discussion about the HIV/AIDS epidemic and the effectiveness of various prevention strategies. In most cases, mass media condom advertising has the long-term benefit of desensitizing the public promotion and discussion of contraceptives.

Both family planning and HIV/AIDS programs seek expanded contraceptive distribution. *Family planning could benefit by adopting more creative distribution strategies which target youth and men and extend service delivery outside of the clinic.* Examples of these strategies are found in many HIV/AIDS prevention social marketing campaigns which use a variety of non-traditional commercial outlets,

including bars, hotels, restaurants, night clubs, and roadside stands. In a few cases, HIV/AIDS prevention programs can be assisted by better use of existing family planning distribution networks. This was the case in Uganda and Zimbabwe, where family planning programs possess important clinic and CBD networks, yet socially marketed condoms sold in the commercial sector were not available in these networks.

Social marketing's use of private sector resources could help bring new skills and technical support to family planning programs. For example, commercial advertising and public relations organizations could help family planning programs develop more effective communication strategies and programs. In Zimbabwe, for example, the family planning organization has an impressive video and recording studio which is underutilized. An example of more effective cooperation with the private sector would be the loan of the facilities to local advertising firms in exchange for creative assistance in the preparation of family planning IEC materials. Finally, promoter/salesmen who are employed by many social marketing programs to train retailers in order to improve knowledge of contraceptive methods can also train retailers about the use of the condom and in HIV/AIDS prevention strategies. This approach is being used in Uganda.

See Appendix I for a brief review of experience with family planning and HIV/AIDS social marketing in Africa and other relevant locations.

4.6 Condom Supply and Logistics System

- Both HIV/AIDS prevention and family planning programs need a sure supply of product and a place to store it. **Greater integration of the commodities/logistics systems of family planning and HIV/AIDS programs could provide a joint opportunity for improved forecasting of condom needs.** Family planning could also benefit from the experience gained by many HIV/AIDS prevention social marketing programs in the importation of low-cost, high-quality Asian brands. Finally, some economies of scale might be gained through combining storage facilities.

Although greater integration with regard to coordination of condom commodity needs, warehousing, quality control, and distribution makes sense, two realities may preclude immediate realization of this goal: difficulties in estimating the condom needs of HIV/AIDS and family planning programs and the inadequacy of most government logistics systems in sub-Saharan Africa.

Estimation of Condom Needs

The donor community has shown some concern about the growing demand for condoms to prevent HIV/AIDS. WHO has sponsored several meetings of an interagency group to grapple with this issue, but as yet there is no clear understanding of who will be responsible for providing condoms in the future. WHO estimates that, to satisfy the growing demand for condoms, an additional billion units will be needed annually worldwide by the year 2000 at a cost exceeding \$23 million per year. Shipments of condoms to the developing world, and in particular to sub-Saharan Africa, have been increasing tremendously during the past few years. USAID, the principal donor of this product, provided about 30 million condoms to African programs in 1985, and for the year 1991 the shipments to the area increased to more than 150 million.

Several models have been developed to estimate the amount of condoms needed for HIV/AIDS prevention programs. Estimations based on two of these models for 14 sub-Saharan countries show

that the differences between the amount supplied and the estimated figure are quite large (see Appendix H). Further, there is little knowledge of how well the condoms in those countries have been used; on the contrary, there is some indication that they may not have been used. The case of Zimbabwe is a good example: the specific prevalence rate from the 1988 DHS for condoms was 1.2 percent; the prevalence rate obtained from CYPs generated by the condoms supplied in that year was 9.6 percent. Although it is difficult for a DHS to verify actual condom use, this degree of difference must raise some concern.

In addition, the number of family planning and HIV/AIDS programs in sub-Saharan Africa is expanding rapidly, creating an illusion of demand. For example, among the 33 institutions working in family planning and HIV/AIDS prevention programs in Uganda, 18 were either created or started their involvement during 1992. The new outlets and regional warehouses have to acquire stock for the first time to feed the pipeline; this does not reflect actual use. Distribution may reflect use once the program becomes fully operational and clients are demanding the condoms on a regular basis.

Logistics Systems

In family planning programs, contraceptives are made available through government logistics systems. HIV/AIDS projects usually have a parallel distribution system or are integrated within the existing government logistics system for all contraceptive methods. Social marketing programs have their own logistics systems.

Most government logistics systems are experiencing several problems: 1) Because of delays resulting from clearing contraceptives through customs, it can take from 3-24 months for consignments to be available at the central warehouse (considerably reducing the shelf-life of the contraceptives). 2) With few exceptions, facilities, particularly in the public sector, are inadequate. The central medical stores where contraceptives are usually stored are often inadequate to guarantee product quality. Staff fail to maintain good records and to follow a first-in, first-out supply system, and insufficient transportation is common. 3) Personnel at almost all levels are not well trained to provide good supervision and sound management of contraceptives. All of these problems yield frequent stock-outs and expired contraceptives including condoms at almost all levels of the distribution system.

The establishment of social marketing programs may increase the capacity of countries in sub-Saharan Africa to distribute condoms. Some countries (e.g., Zaire, Cameroon, Côte d'Ivoire) claim success for their social marketing programs; these programs in other countries (e.g., Zimbabwe, Uganda, Ghana) are experiencing difficulties.

4.7 Research and Analysis

Research Topics

- **Some particularly important research topics are of interest to both HIV/AIDS prevention and family planning programmers and have a direct bearing on integration of activities. Topics include, among others, research on adolescent sexuality and sexual behavior; referral systems and the effective implementation of infection control procedures; and different methods of disease and pregnancy prevention, including female barrier methods (see Appendix K for a more comprehensive list of research topics.)**

Adolescent Sexuality and Sexual Behavior

There is an urgent need for practical, focused behavioral research on both HIV/AIDS prevention and family planning, in general, and especially with regards to youth. This includes research on adolescent sexuality and sexual behavior and condom use. More needs to be learned about the individual and social pressures influencing the sexual behavior of adolescents in different settings and the economic pressures influencing the issue of girls and boys providing sexual favors to older men and women in return for financial support.

Referral Systems

Effective referral systems (for counseling, HIV testing, STD diagnosis and treatment, and family planning services) is important in countries such as Uganda, where it may not be feasible or desirable to fully integrate family planning, STD, and HIV/AIDS activities. Operations research on ways to design and optimize the functioning of referral systems should be a top priority in such settings. Methods for monitoring these systems and for assessing their effectiveness need to be fine-tuned and/or developed.

Infection Control

Infection control is an important issue for family planning, STD, and HIV/AIDS prevention programs. Clients and providers must be protected from the potential risk of HIV and STD infection. Operations research is needed to develop methods for ensuring that procedures for infection control are consistently implemented.

Disease and Pregnancy Prevention

Additional research concerning different methods of protection is needed. For example, the relative risks of methods which are more or less effective at pregnancy prevention and disease prevention should be analyzed per community. With regard to barrier methods, there appears to be a large demand in Uganda and in other countries for female-controlled methods that will provide protection against HIV/AIDS. Acceptability and efficacy trials with the female condom and other female-controlled methods should be considered by interested communities, especially if costs can be reduced. Ongoing local research concerning knowledge, attitudes, and practices about male condoms (such as that being conducted in Uganda) is extremely important and should continue. More research on local conditions and condom quality is also urgently needed.

Another issue is that concerning the use-effectiveness (for disease prevention and contraception), the cost-effectiveness, and the acceptability of the simultaneous use of two contraceptive methods in contrast to the use of only one mechanical or chemical barrier method. This issue will be different per setting and should be considered locally by those implementing the family planning program.

HIV Status and Attitude toward Family Planning

A topic of interest to both HIV/AIDS and family planning programs is the relationship between an individual's HIV status and his or her attitudes concerning family planning.

Involvement of Traditional Healers

More studies are needed on ways to involve traditional healers in both family planning and HIV/AIDS activities, such as those being conducted in Zimbabwe and Uganda. Those programs testing the feasibility of using traditional birth attendants and traditional healers to educate their communities about HIV/AIDS prevention and family planning and/or to distribute condoms should be continued and expanded upon. Operations research on utilizing family planning CBD workers as HIV/AIDS educators should also be considered. In Zimbabwe, voluntary HIV/AIDS educators in the workplace appear to have been quite successful at educating their peers. The potential for utilizing these educators as family planning motivators in the workplace could be explored further in operations research studies.

Surveillance and Health Information Systems

More information is needed about the incidence of STDs and HIV/AIDS in the population. Surveillance and health information systems need to be expanded or developed to provide information to managers and policy makers responsible for designing, monitoring, and evaluating effectiveness of health services. Information about the incidence of reproductive tract infections and HIV/AIDS among women attending ante-natal and family planning clinics and on relevant sexual behavior could be collected by adding a reproductive tract infection-HIV/AIDS component to existing data collection instruments, such as the demographic and health surveys. The module would contain questions about recurring and new infections, use of condoms for disease prevention, and number of sexual partners and would need to be complemented by physical exams and laboratory tests. One limitation of the DHS is that in its present form, it is primarily designed to analyze information about married women of reproductive age and information is needed about the rest of the population, especially adolescents.

Evaluation Methodologies

Although there are common methods for evaluating family planning, STD, and HIV/AIDS prevention programs such as knowledge, attitudes, and practice (KAP) surveys, condom sales, STD reinfection rates, and teenage pregnancy rates, more appropriate ones need to be developed.

Economic Analyses

• Another area of interest to both HIV/AIDS and family planning programs is the use of economic analyses in both resource allocation and program evaluation. Population and health initiatives, new or established, compete for limited resources. This competition has required decision makers to seek tools to aid them in allocating resources and choosing among competing program alternatives. Economic tools, such as *cost-benefit and cost-effectiveness analyses*, have been developed to aid in this process. These two approaches relate program costs to program outputs or benefits. Although there are debates about methodological issues such as valuation, discounting, and differential weighting for time, age, and social preference, these assessments are becoming increasingly influential criteria for both resource allocation and program evaluation.

Cost-effectiveness methodologies have been used to evaluate both family planning and HIV/AIDS prevention programs. One of the advantages of cost-effectiveness analysis for the evaluation of health and population programs is that the benefits or "effects" of a program can be described in non-monetary terms. Cost-benefit analysis, by contrast, requires that all benefits be expressed in monetary

terms, meaning that a monetary value must be assigned to benefits such as averted death, illness, or pain. Cost-effectiveness analysis circumvents the value judgements imposed by cost-benefit analysis and allows programs with similar objectives to be compared on the basis of a single, appropriate cost-effectiveness ratio. This methodology requires that the various benefits of a program be combined into a single measure of effectiveness linked to program impact or outcome objectives. For example, if a disease prevention or treatment program seeks to reduce mortality and morbidity in the target population, the observed effects may be combined into a single measure such as healthy years of productive life gained. The cost-effectiveness ratio would be expressed as programmatic cost (in monetary terms) per healthy year of productive life gained. Family planning programs may use a different measure of impact, such as percentage increase in contraceptive prevalence, and calculate accordingly the cost-effectiveness ratio as programmatic costs (in monetary terms) per couple contracepting.

Integrated programs will face the challenge of dealing with multiple and possibly non-commensurable outcome objectives. A single measure of program impact is unlikely to be adequate for program evaluation and alternative strategies will need to be identified. Simple solutions to the problem of evaluating integrated programs in economic terms may not be adequate. An apparently simple approach could be the measurement of traditional family planning and HIV/AIDS prevention outcomes separately with separate attributions of cost. This "dis-integration" of combined programs at the time of evaluation could significantly obscure the unique benefits to be derived from program integration. If integrated initiatives are to be successful in establishing their efficiency and competing with alternative formulations for health promotion, considerable attention will need to be focussed on this issue.

5. Integration of STD Control with Family Planning and HIV/AIDS Prevention Programs

5.1 Integration with Family Planning Programs

STDs can lead to such reproductive health problems as pelvic inflammatory disease, cervical cancer, infertility in women, and blindness in children born to infected women. In many developing countries, STDs rank among the top five diseases for which health care services are sought.

The incidence of STDs may have a negative impact on family planning programs at the community level because, in addition to their impact on women's reproductive health, STDs may create the perception of a contraceptive side effect. STDs also may act to diminish willingness to delay initial childbearing or to space births in a community because of the fear of STD-associated sterility.

Currently feasible areas of integration into family planning programs include symptom-based diagnosis; simple, low-cost tests for identifying STDs; education about STDs and HIV/AIDS and counseling about condoms; partner notification; training family planning workers about STDs and HIV/AIDS; referral systems; and development of tailored STD management guidelines. STD prevention includes curative treatment because treating an infected person means that future transmission of STDs to other individuals is also prevented. An international STD Diagnostic Network of leading experts in the field of STD research and control was formed in 1990 to facilitate the development of inexpensive, simple, and rapid diagnostic tests that can be performed easily and quickly by health care workers in a village setting.

The potential benefits of incorporating STD control activities into family planning programs include improved quality of family planning services, increased accessibility of services for youth and men, and decreases in unwanted pregnancies and disease with the more effective use of condoms. Improved referral and treatment services can result in the improved functioning and credibility of all services involved.

Many family planning programs already include some components of STD control in their curricula, service delivery guidelines, and training programs. For a number of reasons, however, the impact of these integrated activities has not been determined.

Some family planning program managers assert that they provide "integrated" STD-family planning services which include STD prevention, screening and/or diagnosis and treatment. In some cases, integration means referral to STD clinics and other treatment facilities. In a very few cases, family planning programs are attempting to provide diagnosis and treatment on site. In other cases, integration has taken place in name only.

5.2 Integration with HIV/AIDS Programs

The presence of STDs, particularly genital ulcers, may enhance the transmission of HIV by as much as fifty-fold in a single act of intercourse. At the same time, HIV infection can prolong the course and increase the severity of many STDs. Bacterial STDs, which include chancroid and syphilis (the

primary bacterial STDs causing genital ulcers), gonorrhea, and chlamydial infection, can be cured. Diagnosis and treatment, as well as prevention of bacterial STDs, are important both as an HIV/AIDS prevention strategy and as a reproductive health strategy. No cure is available for HIV/AIDS or for other viral STDs; prevention, therefore, is essential to their management.

Efforts to prevent and control STDs have the potential to reduce the transmission of HIV as well as the after-effects and secondary results (such as pelvic inflammatory disease and infertility) of STD infection. Recent analyses have shown the relative low cost of many interventions to prevent STDs and their after-effects or secondary results in comparison to other widely accepted health interventions such as childhood immunization (*Global Access to STD Diagnosis*, 1992; Germain et al., 1992; and Over, 1990).

A.I.D.'s HIV/AIDS prevention strategy includes STD diagnosis and treatment as one of its primary components. STD diagnosis and treatment have been added to HIV/AIDS prevention programs in Burkina Faso, Burundi, Cameroon, Kenya, Mali, Niger, and Zimbabwe. A.I.D.'s programs are designed to target STD interventions to core groups whose behavior puts them at high risk, urban/high density areas with high STD prevalence, and symptomatic individuals in urban/high density areas. These targets are selected for STD intervention because they represent the vector for spread of STDs to the general population and are thus the most efficacious intervention point. In most countries where resources for the diagnosis and treatment of STDs are extremely limited, A.I.D. encourages strategic interventions that target these high-risk groups. Where funds and medical resources are more plentiful, A.I.D. supports the introduction of broadbased diagnosis and treatment of STDs.

5.3 Constraints to Integration

Some of the most important constraints to integrating STDs into either HIV/AIDS prevention or family planning programs are related to the limitations of STD control activities. Perhaps the two most important limitations are the lack of low-technology methods for diagnosis and treatment (especially for women) available for use in low resource settings and the logistics and high costs of diagnostic supplies and treatments. Other constraints include a lack of trained personnel; the weakness or lack of referral systems, in combination with there being few functioning STD programs in existence; the difficulty of implementing partner notification systems; and the weak or nonexistent surveillance systems for identifying who has STDs and which STDs they have.

6. Host Country and A.I.D. Management Considerations and Project Design and Implementation Issues

6.1 Host Country Management Considerations

Host country management considerations concerning the integration of family planning and HIV/AIDS activities include the following:

- In most countries, much of the health sector activities are donor driven or funded. An effective integration of family planning and HIV/AIDS-related activities would therefore require the coordination and cooperation of multiple donor agencies, which has proven to be problematic in the past.

- Considerations regarding economic structural adjustment program may prevent changes in the MOH or civil service that would be required to run an integrated program effectively. This situation could arise because of restrictions imposed with regard to the establishment of new posts in the MOH or in reassigning personnel to new positions.

- In many countries, it is difficult to identify local organizations with the organizational and technical capabilities to implement either family planning or HIV/AIDS-related projects (e.g., Côte d'Ivoire, Tanzania, Zambia). Given this general organizational and infrastructural weakness and that many organizations are already functioning at or beyond their absorptive capability, integration could result in overloading the few viable and functioning organizations.

6.2 A.I.D. Management Considerations

USAID Missions

USAID management considerations concerning the integration of family planning and HIV/AIDS activities include the following:

- There is not a consistent, clear understanding at the missions (reflecting some differences in A.I.D./Washington as well) as to a) the continuing importance of population programs as well as HIV/AIDS programs; b) the readiness of A.I.D./Washington to accommodate both these priorities separately or in an integrated fashion in strategic planning; c) the flexibility of A.I.D./Washington and central project contractors to respond to host country initiatives and priorities; and d) the importance of elevating both population and HIV/AIDS concerns in policy dialogue with host country officials.

- There is an overall shortage of mission health, population, and nutrition officers throughout sub-Saharan Africa, as well as a shortage of technical backstopping capacity in A.I.D./Washington. Integration may place an additional management burden on missions in that A.I.D. Bureaus are "compartmentalized" and are not organized to facilitate an integrated approach. As integration is a new process, additional effort will be required to design and develop new integrated projects and programs.

- The design and monitoring of effective integrated projects requires a much greater knowledge about local capabilities and constraints than missions generally possess. This is one of the reasons many programs have been designed as vertical programs. Therefore, additional technical personnel with more knowledge of local situations would be required if integration is to succeed.

- There may be a tendency among USAID contractors, as well as Health, Population, and Nutrition Offices, to view an integrated project from their particular area of expertise, i.e., emphasizing either the population or the HIV/AIDS aspect of the project rather than implementing the project in its truly integrated form.

A.I.D./Washington

As A.I.D. continues to move toward a fewer number of "mega-projects" (those in which all activities are under the direction of one Cooperating Agency), integration becomes more of a necessity. Integrated projects will, however, require unprecedented levels of cooperation between the Bureau for Africa, the Offices of Population and Health in the Bureau for Research and Development, and field missions to resolve many issues, including the following:

- The question of who will pay for integrated programs (Office of Population or Office of Health core funds or Development Fund for Africa) and what mechanism and mix will be used for co-funding;

- The question of how funding will be attributed against separate earmarks and targets (even though the Development Fund for Africa provides greater flexibility, congressional targets relating to the fund still separate family planning and HIV/AIDS activities);

- The question of whether integrated programs will be compatible with A.I.D.'s existing system of strategic objectives and targets of opportunity under the "focus and concentrate" restrictions;

- The realization that the need to develop new indicators assessing program impact and the increasing pressure on missions to assess short-term "people-level impact" may deter the initiation of new innovative and integrated programs; and

- The question of how integrated programs will resolve the potential conflicts between A.I.D. priorities as determined by "AIDS emphasis countries" and "population priority countries."

In addition to the separate management considerations of A.I.D./Washington and the field missions, there may exist a basic conflict as to who will design and implement integrated projects. For example, as stated earlier, there tends to be a major difference in target groups between HIV/AIDS projects designed in the field and those designed by the Office of Health and its centrally funded contractors — with those designed by the Office of Health targeted toward high-risk core groups and those designed in the field targeted toward a more general population.

6.3 Project Design and Implementation Issues

The following issues need to be considered when developing an integrated family planning-HIV/AIDS program. The list is not exhaustive and therefore should not serve as a detailed "road map." It is

intended to highlight important issues that should be taken into consideration during the design process.

- Because of the "leading edge" nature of integrating family planning-HIV/AIDS activities, it will be important for missions to consult with Bureau for Africa/ARTS, Office of Health, and Office of Population staff with regard to the latest information and guidance before beginning design.

- The contractors chosen to implement programs should be those who are capable of carrying out both family planning and HIV/AIDS activities or those who are willing to work with other contractors in a coordinated and integrated manner.

- Special attention needs to be given to evaluation.

- It will be important for all project designs to include a focus on youth-oriented activities (or explain why such a focus is not included).

- All design teams, whether for family planning or HIV/AIDS projects, should include a person whose concentration has been in the other field so that areas of coordination can be included.

- For those programs that were initially designed with little or no coordination/integration of activities, there will be a need for a system of periodic reviews to identify places in which coordination could be expanded. This will require sufficient project flexibility to allow modification of activities during the life of the project. A step-by-step or "rolling design" approach would be most effective in overcoming obstacles and constraints as encountered.

- Although the "mega-project" type of project may appear to be easier to administer, a well-coordinated and integrated approach implemented by appropriate contractors, utilizing the comparative advantages of each, would be the optimal design.

- Project design will need to analyze the respective strengths and weaknesses of each program component (i.e., family planning and HIV/AIDS) so that complementarity can be achieved in implementation (see Appendix L for a checklist to assess family planning and HIV/AIDS programs' potential for integration).

- The use of the non-project assistance mechanism⁵ should be considered an appropriate approach in the integration of family planning and HIV/AIDS efforts, especially in promoting policy development and for ensuring coordination within and among ministries.

⁵Under this mechanism, a host government and USAID jointly agree to a set (or sets) of conditions precedent and to the dollar amounts to be disbursed to the government upon the successful fulfillment of the conditions precedent.

7. Constraints to Integration of Family Planning, HIV/AIDS, and STD Activities

7.1 Constraints at the Policy Level

- In most sub-Saharan African countries, the MOH is one of the weaker ministries and generally does not possess the institutional capacity to undertake the critical analyses required to design and implement successful integration of programs.

- There is often a gap in knowledge and understanding between local family planning and HIV/AIDS programs and the priorities of donor agencies. This can result in donors' imposition of inappropriate and sometimes unwanted activities on countries as well as missed opportunities to provide needed support for innovative local initiatives. A good example of this situation is the dichotomy between the apparent policy on HIV/AIDS prevention and control in A.I.D./Washington and that expressed in sub-Saharan Africa by host country personnel and staff at USAID missions. The A.I.D./Washington position focusing more on specific core group, high-risk target populations inhibits integration with family planning programs which target couples of reproductive age. The opinion in sub-Saharan Africa is that HIV/AIDS is much more affecting the general population, making integration with family planning more rational.

- Many donor organizations lack the flexibility within their bureaucracies to provide support across program lines, thus reinforcing the tendency towards maintenance of vertical programming structures within national programs.

- The policy commitment necessary to mobilize support for family planning or HIV/AIDS programs has not been forthcoming at the highest echelons of most national governments in sub-Saharan Africa.

- Existing family planning and HIV/AIDS programs are already short of both human and financial resources and most governments have few, if any, additional resources to contribute. Most health care providers have insufficient time for clients as it is without increasing their burden and further reducing the quality of services provided.

- Perceptions of family planning and HIV/AIDS solely as health issues, rather than as a combination of social, economic, and health issues, restrict the ability of these programs to draw support from other, often more affluent and influential sectors such as business and labor.

- In few sub-Saharan African countries have private sector organizations developed the strength necessary for effective family planning programs, to say nothing of their capacity to take on added responsibilities in HIV/AIDS programming.

- Economic structural adjustment policies hinder, if not prevent, implementation of the changes necessary to successfully integrate programs.

- The term "integration" carries negative connotations for some development professionals, particularly many of those working in family planning who have seen integrated

MCH/FP efforts give inadequate attention to family planning in the midst of competing health care priorities.

- Special interest groups (such as conservative religious organizations) in many countries can offer opposition to promotion of either family planning or use of condoms for HIV/AIDS prevention.

7.2 Constraints at the Programmatic Level

- Insufficient supplies of commodities and resources needed to operate either family planning or HIV/AIDS programs (e.g., condoms, pharmaceuticals, IEC, and transport) hinder successful program implementation and reinforce tendencies not to share resources across program lines.

- Limitations of in-country logistics pose critical problems even in the presence of adequate supplies.

- Although young people are a target group that could benefit greatly from integrated programming, neither HIV/AIDS nor family planning programs have developed effective approaches to this group. In large degree, this is also true of efforts aimed toward men.

- Integration may pose a threat to entrenched interests within bureaucracies, who might consequently resist such approaches or implement them half-heartedly.

- Insufficient behavioral research has been carried out in both family planning and HIV/AIDS prevention concerning community-level perceptions to allow the development of quality IEC that can motivate positive behavior modification. Integration of family planning and HIV/AIDS messages might only complicate this situation.

- It has been extremely difficult to develop valid evaluation protocols for measuring the impact of HIV/AIDS prevention activities. This lack of valid protocols may hinder integration. Similarly, the limitations of cost-accounting/cost-effectiveness analyses inhibit decision making for or against integration on these grounds.

- Western medical bias that restricts health services to delivery by medically trained providers inhibits the provision of services through existing community resources such as traditional healers, traditional birth attendants, and fieldworkers who are already in a position to reach and influence people. Many programs have had difficulty organizing sufficient training for either HIV/AIDS prevention or family planning programs. Adding the requirements for cross training in the other discipline could present an even greater challenge.

- Perhaps the two most important limitations to integrating STDs into either HIV/AIDS prevention or family planning programs are the lack of low-technology methods for diagnosis and treatment (especially for women) for use in low-resource settings and the logistics and high costs of diagnostic supplies and treatments. Other constraints include the lack of trained personnel; the weakness or lack of referral systems, in combination with there being very few functioning STD programs in existence; the difficulty of implementing partner notification systems; and weak or nonexistent surveillance systems for identifying who has STDs and which STDs they have.

- Referrals are an important component of integrated family planning and HIV/AIDS activities. Existing mechanisms for handling referrals are, however, minimal to nonexistent and in some cases there are no places to which people can be referred.

- The concentration of technical and economic resources in urban areas limits the ability and willingness of programs to make the effort required to serve people in rural areas, where the majority of the population in most sub-Saharan African countries lives.

- The technologies for contraception and for prevention of HIV/AIDS are not fully compatible. No policies have yet been developed to address the issue of whether two family planning methods should be used at once to ensure prevention of pregnancy and protection from HIV.

- Non-targeted, free distribution of condoms by either the organized HIV/AIDS or family planning programs can work against utilizing the resources of the private sector to promote condom use and availability.

8. Conclusions

Policy

1. A review of the estimates being made of the probable impact of the HIV/AIDS epidemic on demographic factors in sub-Saharan Africa suggests that the epidemic will have a tragic, and in some cases a drastic, impact on families and whole societies, with significant reductions in population growth rates and changes in demographic profiles. The consensus among most demographers is that although the impact of AIDS on future population growth will be significant — approximately one percentage point — the rate of growth will continue at a high level. In any case, population and family planning programs remain vital elements in achieving needed improvements in family health and welfare as well as being essential for economic development. Any lack of appreciation of this situation within the development community could further delay support for strong family planning programs in sub-Saharan Africa and could impede attempts to integrate HIV/AIDS concerns with those of family planning.

2. In order to avoid any delay of support for strong family planning programs or any impediment to integration of HIV/AIDS and family planning, it is important that A.I.D./Washington articulate a concise statement on the demographic impact of HIV/AIDS in sub-Saharan Africa that highlights the need to continue support for population/family planning activities, both for demographic growth and family health and welfare reasons.

3. Experience with successful efforts at integration of family planning and other maternal and child health concerns in Zimbabwe and Botswana suggest that *under the right conditions* definite benefits can be gained from integration of certain elements of HIV/AIDS programming with that of family planning.

4. Some degree of integration seems inevitable in any country in which the HIV/AIDS epidemic has begun to affect people's lives. The questions to be resolved are when, where, and how to integrate, and when a combination of effort will play a useful role in promoting program goals.

5. Effective integration will require strong policy support for both family planning and HIV/AIDS programmatic elements by government and private sector organization decision makers. This will need to include recognition of mutual benefits, the mutually supporting roles of each element, and the contribution that each must make to the other. This recognition must be articulated to and shared by all levels of personnel in the programs.

6. Dependence on donor assistance is impeding national commitment to both family planning and HIV/AIDS programs. Substantial policy dialogue is still required to secure the kind of commitment that is manifested by national investment as well as strong national leadership in program planning and implementation.

7. Successful integration of family planning and HIV/AIDS activities will require resolution of the dichotomy between the apparent policy on HIV/AIDS prevention and control in A.I.D./Washington which is perceived by field personnel to focus more on specific core group, high-risk target populations and that expressed in sub-Saharan Africa by host country personnel and staff at USAID missions which targets a broader, general population.

8. Integration of family planning and HIV/AIDS prevention activities must be selective, country and situation specific, and must emphasize coordination of efforts rather than a complete merging of program operations.

9. Country-specific decisions will largely be determined by the relative strengths or weaknesses of the policies and programs of a country's family planning and HIV/AIDS institutions and the stage of maturity of the programs. Realistic appraisals must be made of the need for increased financial, physical, and personnel resources required if increased activities are to be undertaken.

10. USAID missions in sub-Saharan Africa need more flexibility to be able to combine family planning and HIV/AIDS activities within one strategic objective and thus be able to support local initiatives towards integration.

11. Traditional methods of analyzing cost-effectiveness are not appropriate or adequate for dealing with integrated programs having non-integrated objectives.

12. Any form of integration that involves massive movement of resources, either human or financial, is more likely to weaken rather than strengthen program performance.

13. The contribution of the many private and international agencies and bilateral donors is not to be underestimated in what they bring either to family planning or HIV/AIDS programs. They are a source of expertise, innovative approaches, support in seeking policy change, and they provide important financial and human resources. They are generally amenable to integrated approaches and can be expected to be helpful partners and/or leaders in seeking areas for more integrated programming.

14. With the multitude of donors and Cooperating Agencies in family planning and HIV/AIDS programming, the requirements for coordination are apparent. There are instances in such countries as Uganda where, despite good efforts, the coordination required for effective integrated programming is yet to be developed. Coordination at its best will facilitate efforts and help to avoid duplication of effort. At its worst, it becomes restrictive and stifles initiative.

15. The present medical/health orientation of both family planning and HIV/AIDS programs is constraining their coverage and effectiveness in addressing these serious societal problems. This orientation needs to be countered by a recognition that both family planning and HIV/AIDS affect and are affected by socioeconomic conditions beyond the field of health such as the status of women, general poverty and deprivation, education, and job opportunities.

Programmatic

Service Delivery

16. It would be imprudent to depend on either the logistics, service delivery, or IEC capacity of present family planning programs in much of sub-Saharan Africa for substantial contributions to the HIV/AIDS program. Only as the family planning programs are strengthened in specific joint activities with HIV/AIDS can they make an effective contribution.

17. Those designing and implementing both family planning and HIV/AIDS prevention programs need to have an understanding of the local culture and need to be aware of the individual, familial, and societal pressures that affect an individual's sexual behavior. There is a need for increased involvement of African expertise, especially in this area.

18. A particular benefit of integration of HIV/AIDS and family planning activities would be a greater focus on reaching youth and men.

19. As an increasing percentage of those using anonymous HIV-testing centers are either couples or individuals attending the centers immediately before marriage, these centers appear to be a particularly useful location to include information and services for family planning.

20. Referral of clients for other appropriate services is a simple, yet potentially useful form of integration. In most settings, however, effective mechanisms for referrals are nonexistent.

21. HIV/AIDS and family planning programs both can benefit from efforts to establish and enhance service delivery capacity, such as introduction of family planning and HIV/AIDS prevention into workplace, social marketing, and other programs.

22. Traditional healers and traditional birth attendants represent a potential resource for provision of information and education about HIV/AIDS prevention and family planning as well as provision of condoms, given their prominence within African society. They could also play an important role in offering diagnosis and treatment of STDS, if given proper training. Lack of success by family planning programs to date in utilizing this resource should be recognized in developing experimental programs.

23. To be effective, both family planning and HIV/AIDS programs need to cultivate strong and positive relationships with the community. Services will reach more people if they are expanded beyond the confines of the clinic and taken into the community.

24. HIV/AIDS prevention programs have moved more aggressively than family planning to involve the community in the delivery of services. Integration would facilitate utilization of these channels for family planning.

25. Family planning programs stand to benefit from the community participation and outreach strategies being utilized by HIV/AIDS programs more than the latter benefits from the clinical services provided by family planning.

26. HIV/AIDS prevention and family planning activities clearly overlap in terms of reducing the risk of pregnancy for HIV-positive women. There are very different perspectives, however, between the two programs in terms of what constitutes effective contraception. The condom, which is the most effective method to reduce HIV transmission, is not considered a particularly effective method of family planning. The dramatic increase in condom use for HIV/AIDS prevention needs to be analyzed in terms of its potential to increase contraceptive prevalence.

Training

27. There is a tremendous need for more and better training of service providers in both family planning and HIV/AIDS. However, in times of economic structural adjustment, civil unrest,

drought, and the like, which are affecting most countries in sub-Saharan Africa, it is questionable whether this need can be met given the declining economic situation in most settings. It is important to be realistic in terms of what service providers can be trained to do under these constraints.

IEC

28. A combination of mass media and interpersonal communication which are related and mutually supportive would be the most effective means of creating general awareness of HIV/AIDS and fostering changes in behavior.

29. Although it would be both appropriate and useful to provide some level of integration of IEC programs for HIV/AIDS and family planning, it is not necessary that every message and activity within the programs be integrated.

30. Although it is important to design and target messages for specific audiences, care must be taken not to marginalize or stigmatize these target groups or create unfavorable reactions among other important target groups.

31. Drama and music have proven to be useful channels for IEC, for both family planning and HIV/AIDS prevention. They are highly appropriate in sub-Saharan Africa where the oral rather than the written tradition of sharing knowledge still predominates. They can also be particularly useful in areas where literacy is low.

32. It is frequently noted that HIV/AIDS has made it easier to talk about family planning. There is still a long way to go, however, towards dealing openly and frankly with issues such as sexuality and gender roles — especially in areas where conservative voices inhibit this discussion with youth as well as the advertising and public promotion of condoms.

33. IEC efforts are only effective when the services they promote are appropriate for clients' needs, readily available, and of good quality.

STDs

34. Although the importance of STDs is recognized (including the additional difficulty of diagnosis and treatment of female STDs), and a number of countries are attempting integration of STDs with family planning and HIV/AIDS activities at the policy level, little is actually happening in terms of services.

35. Although cost issues related to condom supply are being widely discussed, the lack of low-cost, easy-to-use methods of diagnosis and treatment of STDs has been largely ignored.

Commodities Supply/Logistics

36. There is no real knowledge to date as to how to project the need for condoms. Conflicting estimates are apparent at all programming levels. This key HIV/AIDS prevention and control element is receiving fragmented and inadequate attention from national programs and the donor community. The issue of how many condoms are required must be resolved in the context of urgent decisions as to who will buy them, from whom, and when.

37. More coordination and effective action are needed in condom distribution. This involves the identification of target groups and the establishment of appropriate cost recovery policies and distribution mechanisms. In-country supply channels are generally inadequate to handle greatly increased quantities. Condom coordinating committees, in which donors and distribution agencies discuss and decide policy, are one vehicle to help achieve increased coordination.

Social Marketing

38. Specific groups will always need free condoms, but many are best served through social marketing programs which can make products widely available at affordable prices, even to the very poor.

39. The potential for social marketing to link family planning with HIV/AIDS prevention is considerable. The advantages of using social marketing as a bridge between the two goes beyond a shared interest in the condom; important advantages also accrue in the overall policy environment and through improved outreach strategies, strengthened institutional capabilities, and increased cost-effectiveness.

Research

40. Both HIV/AIDS and family planning programs would benefit greatly from increased research in human behavior, particularly with regard to sexuality, gender roles, and the economic dependence of women.

Management

41. USAID management capability (i.e., numbers and qualifications of staff) is stretched to its capacity in most cases. Increased programming and that of an integrated nature developed through bilateral country programs will require more staff experienced in these areas.

9. Recommendations

Policy

1. The Offices of Population and Health and the Bureau for Africa should prepare joint guidance for USAID missions in sub-Saharan Africa which will

- clarify the present and potential demographic impact of the AIDS epidemic and emphasize continuing a strong population and family planning program, both for family health and welfare and demographic/macroeconomic development reasons;
- indicate the potential for integration of HIV/AIDS and family planning activities that should be examined on a country-specific basis;
- demonstrate how centrally funded projects can be used to implement integrated activities, as appropriate;
- clarify the way in which the Bureau for Africa will review project implementation documents to allow for flexibility for integration of HIV/AIDS and family planning activities within the context of funding, strategic prioritization, management considerations, and the limitations of present methods of cost-effectiveness analysis;
- resolve issues relating to the dichotomy drawn between target populations in HIV/AIDS and family planning programming; and
- elevate the priority to be given by USAID missions working with other donors in policy dialogue with host countries to efforts to secure greater national financial commitment and leadership for both family planning and HIV/AIDS programs.

2. Those designing projects either for HIV/AIDS prevention or family planning programs should carefully assess the potential for integration within these projects, articulating mutually supportive objectives. Only in exceptional cases should these designs attempt full integration of the two programs. They should initially focus on selective integration or coordination of specific activities in which joint action is clearly advantageous and in which mass movement of human or financial resources is not required.

3. In policy dialogue and project development, program leaders should look beyond the health rationale for support of family planning or HIV/AIDS programs and the health system for solutions. There must be greater recognition of the socioeconomic implications of both these problems and greater involvement in the solution of disciplines such as education, public finance, and social welfare, as well as the military, women's and youth organizations, and local government.

Programmatic

Service Delivery

4. Program designers seeking to maximize the potential benefits of integration should give first priority to those joint activities that lead programs outside of fixed facilities, involve the

community, and make services readily available and culturally sensitive through community-based activities (e.g., CBD, workplace programs, social marketing, utilization of traditional healers, and programs with youth organizations). African leadership must be fully involved in the design and implementation of the program to assure its sensitivity to local customs and responsiveness to local needs.

5. While not ignoring the particular needs of men and of women of reproductive age, highest priority in integrated programming must be given to developing more effective programs to deal with the needs of youth. This is clearly a high priority group both for HIV/AIDS and family planning programs and is the logical first order of business for integrated programs which can naturally deal with both program elements.

6. Program designers should also give attention to the potential for integration of family planning and HIV/AIDS activities both within clinics in the family planning program and within the fixed facilities of the HIV/AIDS program (e.g., counseling centers). At a minimum, this would involve greater attention to infection control in family planning clinics, the ability to answer simple questions about HIV/AIDS or make appropriate referrals, and the ability to take HIV/AIDS into consideration when explaining contraceptive options to clients. It would also include HIV/AIDS counselors being able to explain the benefits and general methods of family planning to HIV/AIDS clients and to make appropriate referrals. (Often the referral system itself will need to be developed.) To the degree consistent with local capabilities and available resources, these activities would also include attention to STD diagnosis and preventive treatment.

7. Collaborative efforts should be taken by family planning and HIV/AIDS program managers to include family planning in the services offered to the increasing numbers of couples who are making use of the HIV/AIDS anonymous testing centers.

Training

8. Regardless of the degree and complexity of integration planned, project designers must give attention to securing adequate numbers of and providing training for program managers and service delivery personnel. Since most HIV/AIDS and family planning objectives are associated with modifying human behavior, communication skills as well as technical skills must be given appropriate attention. Family planning service providers should be equipped with enough basic knowledge about HIV/AIDS to enable them to address their own concerns and those of their clients and to ensure they practice safe clinical procedures.

IEC

9. Those engaged in family planning and HIV/AIDS programming should initiate a dialogue to identify the points at which IEC campaigns could be mutually supportive. Not all messages should be integrated and target audiences will sometimes differ. There should, however, be considerable overlap especially in messages to youth. Those messages for target groups "outside the family" should neither stigmatize nor marginalize these target groups nor make concern for HIV and/or use of the condom something alien to the family setting. IEC interventions should empower people to make decisions and take action to modify their behavior.

10. Whether integrated or not, IEC campaigns should utilize both mass media and interpersonal communication in mutually supportive ways. They should also be based on careful

research on local perceptions and the realities of the individual and social pressures that determine sexual behavior. They should make use of culturally acceptable approaches such as music, community drama, and involvement of local celebrities and should develop innovative approaches to making counseling more effective in the African context, in which individuals rarely act on their own but within a broader familial and societal context.

11. In light of the serious nature of the population/family planning and HIV/AIDS issues, programs must take every reasonable action to assure frank and open discussion of human sexuality and the dangers posed for adolescents by pregnancy and HIV/AIDS. This discussion should always present the issues in ways compatible with the mores of the society and should include practical advice for those who may already be sexually active with one or more partners. For this group, access to publicized information about condoms and the ready availability of supplies must receive priority attention.

12. Program managers must assure that the development of adequate services accompanies the IEC programs that are promoting them. These services must be readily available and of such quality that the needs of clients who respond will be satisfied. The attention this requires to on the job training, supervision, and a good system of logistics should also assure that IEC materials are appropriately disseminated.

Research

13. A strong program of research should be developed, especially as the potential for integration gives more impetus to reviewing certain issues important to both family planning and HIV/AIDS. These areas would include behavioral, biomedical, and operations research as well as studies that are required more specifically for IEC and marketing programs. Attention must also be given to developing better tools for cost-effectiveness analyses and evaluations of integrated programs.

Commodities Supply/Logistics

14. The donor community, together with host countries, must give highest priority to finishing the work begun on rationalizing the projection of condom needs, purchasing the highest quality condoms at the cheapest price, delivering commodities, and developing adequate procedures for internal logistics and quality control.

Social Marketing

15. More emphasis should be placed on social marketing. Programs should be viewed as having important benefits for both family planning and HIV/AIDS prevention. The creation and development of HIV/AIDS prevention condom social marketing programs should be encouraged and assisted by family planning organizations. A total country policy should be developed related to pricing and to the targeted distribution of free condoms.

16. Social marketing should be viewed as a cost-effective service delivery mechanism. In developing these programs, however, such emphasis should not be placed on financial self-sufficiency that it leads to low sales and restricts the ability to reach low-income populations. All condom social marketing programs should price their lowest-price condom to be easily affordable to the target population.

STDs

17. Family planning programs should improve the STD and HIV/AIDS components in their curricula, service delivery guidelines, and training programs for service providers. Although additional diagnostics appropriate to the developing world are necessary for optimal assessment of reproductive tract infections, currently available techniques should be utilized whenever possible. Screening and treatment protocols should be developed per setting. If STD services are to be incorporated into family planning or into any primary health care service, logistics systems for supplies will need to be improved, and information management systems will have to be strengthened to include information about STD clients. Potential areas for integration of family planning into STD and/or HIV/AIDS prevention programs and vice versa include IEC activities, training, screening, and referral.

Management

18. If increased programming for HIV/AIDS and family planning is contemplated and especially if the programs are to effectively explore opportunities for integration in bilateral programs, A.I.D. must strengthen its staff, especially at the USAID mission level. Vacant positions should be filled, and new positions will probably be required in countries likely to increase their programming. Similarly, A.I.D. must continue to ensure a strong technical support capability in the REDSOs and in A.I.D./Washington to assist in the design and evaluation of these activities.

19. A.I.D. should continue to be supportive of the many private and international organizations that are in the family planning and/or HIV/AIDS programming arena. Increased demands for coordination of efforts are outweighed by the contribution these groups make through innovative approaches and their ability to work in areas that may be considered too sensitive for government support.

20. The donor community, together with host countries, should increase attention to coordination and information sharing, especially if there are to be attempts to bring two programmatic elements together that are often supported by different donors. Care should be taken, however, to ensure that coordination is facilitative and does not inhibit initiative.

Appendices

Appendix A

Scope of Work

Background

Projection models of the transmission dynamics of HIV/AIDS suggest that AIDS is capable of significantly reducing population growth rates over a few decades. The disease is also believed to have some impact on the dependency ratio of a population. Under this PIO/T, POPTECH will provide technical assistance for the development of a strategy and recommendations for the integration of AIDS activities into population/family planning (P/FP) programs.

Objectives

The objectives of this activity are to (1) assess the technical and administrative feasibility and program implications for integrating AIDS activities into established P/FP programs and (2) provide strategic guidance and practical, appropriate advice to USAID Missions in regard to ways in which P/FP programs can contribute effectively to deterring the spread of the AIDS epidemic.

Scope of Work

The contractor will provide a team of 4 specialists to conduct the study on the implications of the AIDS epidemic for P/FP programs. The team will be comprised of a Senior P/FP Advisor, a Senior Medical Epidemiologist, an Information, Education and Communication (IEC) Materials Development Expert, and a Health Care Planner. Specifically, the contractor will:

- review the literature on the demographic consequences of AIDS in developing countries (this includes centrally funded activities as well as bilateral);
- advise on the extent to which AIDS prevention and control activities can and should be incorporated into family planning programs;
- develop ways in which AIDS information, education and communication (IEC) can be incorporated into different components of P/FP interventions;

- identify lessons learned from P/FP programs which are also relevant for HIV/AIDS prevention and control activities;
- propose approaches to involve family planning providers in AIDS prevention goals with P/FP contraceptive goals; and,
- propose policies, directives, guidelines, and strategies to REDSO/WCA for stimulating the development of complementary activities with regard to HIV/AIDS and P/FP programs in Africa.

Methodology

The team will interview key U.S.-based personnel involved in P/FP and HIV/AIDS (2 days in AID/W) as well as World Health Organization (WHO) staff in Geneva (2 days). The team will visit four (4) African countries which have existing family planning programs and/or a serious HIV/AIDS problem to gather relevant information through document reviews, in-country interviews and site visits. At the completion of each country visit, team members will brief the bilateral USAID Missions on their analysis of the situation and issues. Countries suggested for team visits are Zaire, Mali, Uganda, Rwanda, Cote d'Ivoire, and Malawi (subject to mission interest and concurrence). REDSO/WCA will inform the contractor of specific countries chosen at least 30 working days prior to commencement of the study.

Reporting Requirements

The team will spend approximately 5 full weeks in the field (AID/W, Geneva, four African countries) before returning to Abidjan where the remaining time will be spent writing the draft report. A six-day work week is authorized. All team members will participate in drafting the report during week 6, and the team leader will finalize the draft report before leaving Abidjan. A copy of the draft report will be submitted to REDSO/WCA/HPN Officers and the HIV/AIDS Advisor prior to the team leader's departure from Abidjan. REDSO/WCA staff will provide comments to POPTECH within 30 working days after receipt of the draft report, and POPTECH will edit, finalize and provide REDSO/WCA with 10 copies of the report within 30 working days of receipt of REDSO's comments.

The report, which is to be written in English, must address all the items listed under the Scope of Work section of this PIO/T. Annexes to the report should include, but are not limited to, a bibliography, names and addresses of persons contacted and interviewed during site visits, and copies of any relevant policy papers/guidelines currently being followed/proposed by countries visited.

Team Composition and Qualifications

1. Senior P/FP Advisor (Team Leader)

Graduate degree in public health or related field and a minimum of ten years experience in identifying, implementing, managing, and evaluating P/FP programs/projects in less developed countries, preferably in Africa. In-depth knowledge of USAID procedures, demonstrated leadership/management abilities and French fluency (S-3/R-3).

2. Senior HIV/AIDS Medical Epidemiologist

Graduate degree in epidemiology. A minimum of ten years experience in identifying, implementing and evaluating medical epidemiology programs and a minimum of 5 years experience in HIV/AIDS, preferably in Africa. In-depth knowledge of mathematical and projection models and French fluency (S-3, R-3).

3. IEC/Materials Development Expert

Graduate degree in communications or education or related field and a minimum of 10 years experience in the development and evaluation of health education materials and programs. Previous experience with HIV/AIDS and/or P/FP IEC programs and materials development is very desirable. French fluency (S-3, R-3).

4. Health Care Planner

Graduate degree in public health, health financing and economics or related field and a minimum 10 of years experience in planning and developing health care programs and systems in less developed countries. Previous experience in P/FP programs and/or HIV/AIDS and the ability to work in French.

Appendix B
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Appendix C

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Appendix D

Relevant Observations from Interviews with Staff of A.I.D. Offices of Population and Health, Bureau for Africa, Family Health International, and World Health Organization

Washington, D.C.

R&D/POP

R&D POP personnel expressed considerable concern for the spread of HIV/AIDS as well as interest in the possible contribution family planning programs could make in its prevention and control. At the same time, R&D/POP staff had some reservations as to how effective this participation/collaboration/integration might be in practice. Concern was expressed that family planning might be "swallowed up" and essentially ignored in a more integrated approach as has often been the case with the integration of family planning services with maternal and child health services. Several problems of a more technical nature were also mentioned:

- Family planning has had more success in reaching married women than the prime targets for HIV/AIDS campaigns — adolescents, commercial sex workers, and men with high risk life styles (i.e., many sexual partners).
- Although concern for married women as innocent victims is valid, they are probably not the population on which most emphasis should be applied in seeking to control the AIDS epidemic.
- The most obvious interface between family planning and HIV/AIDS interventions is in condom distribution. To date, however, this has been one of the weaker family planning methods due to effectiveness, cost, and acceptability considerations. Nevertheless, the recent rapid increase in condom use in Zimbabwe and Zaire were cited as examples that demand for this method is increasing in the light of the AIDS epidemic.
- Family planning may have had modest success in helping women choose a family planning method, but actual counseling on sexual practices has not been its strong point . . . nor do family planning programs have sufficient and adequately trained personnel to do enough quality counseling to have any real impact on the spread of AIDS.
- Family planning clinics should be concerned with improving the quality of clinical care to protect clients and service providers from HIV/AIDS infection. The risks of infection are relatively small, however, and the numbers involved are so limited that such improvements will have little impact on the overall spread of the HIV/AIDS epidemic.
- With the exception of a modest impact on the spread of STDs through condom distribution, family planning programs have had only limited experience with STDs. The technology for diagnosis and treatment has been more time consuming and costly than most family planning programs can afford. Even with recent advances in technology, this may still be the case for most family planning programs. Not all R&D/POP personnel are confident that the limited control of STDs to be obtained through family planning clinics — which in turn may have only a narrow impact on AIDS — would be a cost-effective approach either to improving the family planning program or effecting AIDS control. R&D/POP staff with more of a woman or client oriented approach than a public health approach urged more attention to this issue.

Among the management considerations cited, the following appeared most critical:

- Despite some progress in coordination with WHO/GPA and various other bilateral donors and NGOs, the progress in predicting growth in demand for condoms and in preparing to meet that demand has been limited. Although A.I.D. continues to meet approximately 70 percent of the present demand, some critical problems are associated with this issue. R&D/POP funds are inadequate to meet an increased demand for condoms; apparently R&D/Health funds for AIDS are inadequate for condom purchase; the AIDSCAP project has no provision for the purchase of condoms; apparently only limited Africa Bureau Development Fund for Africa (DFA) funds can be used for the purchase of condoms; the WHO/GPA decision to not assume a more aggressive role in condom procurement has not been accompanied by the development of national level procurement procedures adequate to meet the need; A.I.D. has no comparative price advantage since world market prices are significantly lower than US procurement; A.I.D. is not enamored with the quality of testing done by the regional laboratories supported by WHO/GPA and PATH in West Africa; and substantial problems remain to be addressed in logistics management for actual distribution of the condoms.
- The country prioritization exercises being carried out by several bureaus and projects within A.I.D. add a substantial complicating factor to any discussion of coordination/ integration. R&D/POP's Population Priority Countries strategy which focuses on those (20) countries worldwide likely to have the greatest impact on world population growth is not fully compatible with Africa Bureau priorities for population/family planning programs. Nor are either of these strategies fully compatible with the status of the AIDS epidemic in various countries or the priority country list established by AIDSCAP.
- R&D/POP personnel perceive the reduction of technical personnel at the regional bureau and country levels to be a further impediment to more coordinated and integrated programming. R&D/POP suggestions for a simplified management project centrally funded like the previous Family Health Initiatives project or the SEATS project are not consistent with Africa Bureau present policy emphasis on the development of bilateral projects at the USAID level.

Even with the constraints mentioned above, R&D/POP personnel could see definite benefits to be gained both by the AIDS and the population program through the "integration" of selected interventions.

- Although little is to be gained from integration of family planning and AIDS at the family planning clinic level, there can be considerable benefit for both parties in other areas. The AIDS epidemic has given impetus to a more frank and open public discussion of sexuality and contraceptives/condoms and a willingness to pursue more community-based and social marketing approaches including method-specific mass media IEC, promotion, and advertising.
- More should be done and is being done by the OPTIONS project to model and demonstrate the demographic consequences of AIDS and the continuing need for population programs. The AIDS epidemic has, however, served a useful purpose in elevating the public policy dialogue and achieving such policy objectives as eliminating import taxes on condoms/ contraceptives in some countries.
- The AIDS campaign can serve as a vehicle to move family planning messages and services toward audiences it has previously had some difficulty in reaching, such as adolescents, workplace clients, and men in general.

R&D/Health

R&D/Health personnel stated general agreement with a presentation by Family Health International (FHI) staff which emphasized the potential for collaboration of family planning and HIV/AIDS programs. Both R&D/Health and FHI have more confidence in potential family planning clinic contributions to AIDS control through STD control, counseling, and improved family planning clinical safety procedures than does R&D/POP. FHI also suggested a strategy for high prevalence HIV/AIDS areas that might be questioned by R&D/POP since it included de-emphasizing IUDs and promoting condoms over other family planning methods unless the client is clearly at low risk of HIV infection. FHI does, however, have reservations about going as far as one IPPF position that involves full integration of family planning and HIV/AIDS and would make family planning workers "development" workers. FHI did not see a large demographic impact to be gained from adding HIV/AIDS to family planning programs but did recognize the importance to family planning in improving the quality of care.

Both FHI and R&D/Health stressed points with which R&D/POP appeared to agree — the need to promote condom use more aggressively, especially through social marketing and other community-based approaches; the desirability of educating family planning providers about AIDS, AIDS prevention, and correct condom use; the need to coordinate condom commodity needs, warehousing, quality control, and distribution for both AIDS prevention and family planning; and the need for family planning to work closely with AIDS prevention organizations.

R&D/Health called attention to the interdisciplinary work being done on a revised A.I.D. AIDS policy statement that should be available by December 1992

R&D/Health suggests that partnership with AIDS activities (including STD control) would give family planning a more client-oriented "needs" focus making it more attractive to clients and society. At the same time, R&D/Health recognizes some problems in achieving more collaboration. For example, the AIDSCAP project does not target married women (primary clients for family planning) since its targets are high risk transmitters (commercial sex workers, employed men away from home, STD patients who are usually men, and youth which would include girls¹). The R&D/Health AIDS budget (about \$90 million annually including \$23 million to WHO/GPA) has few funds available to pay for the "AIDS activities" that might be carried out by family planning programs.² Solutions have not been found for the future purchases of anticipated increases in condom requirements. Initial purchases of STD drugs can be made by AIDSCAP but future requirements are not covered.

Research being carried out in computer modeling suggests that condom distribution is the strongest intervention presently available in AIDS prevention and control, changed sexual behavior the second strongest, STD control a weak intervention, and that a 50 percent effective vaccine would be stronger than all the rest. More work is needed on models to indicate what level of condom use by whom will be needed to have an impact on AIDS in different situations. At present, inadequate experience and data are available to establish targets required to achieve and measure impact. The University of Illinois and the Bureau of the Census may have better information in 6 to 12 months.

More research is required on the possible impact of AIDS on fertility and on the "coping mechanisms" couples or individuals may use in the face of death or potential death of a partner or child through AIDS. Efforts are

¹Experience in project design in the field by one of the team members suggests that targeting youth is not one of AIDSCAP's strong emphases.

²An exception may be the contribution R&D/Health has given to IPPF/Western Hemisphere to fund AIDS-prevention activities in addition to its family planning programs.

being made to develop cross-over measurement of AIDS concerns through R&D/POP-sponsored DHS surveys. DHS, however, has primarily surveyed women who are not the prime targets of AIDS interventions.

Africa Bureau

The Africa Bureau placed considerable emphasis on the problems encountered in meeting AIDS and family planning priority requirements in many countries of Africa due to conflicting priorities: R&D/POP's Population Priority Countries strategy, child survival priorities, and AIDSCAP's priority list. Additionally, DFA's emphasis on economic reform, democratization, and private sector development which leaves little room for "electives" adds a further complication. The US Congress's emphasis targets of 10 percent of the annual \$800 million DFA for population, 10 percent for health, and 5 percent for AIDS helps to keep the money available. The programming process is chaotic, however, especially in light of the shortages of health, population, and nutrition (HPN) officers in Africa (a figure of 26 needed was stated). Nevertheless, the Africa Bureau maintains a strong emphasis on bilateral project development. It is not actively seeking mechanisms through bureau, REDSO, or R&D projects which might simplify USAID planning and management responsibilities but are perceived by the Africa Bureau as diminishing USAID responsibility for making hard choices in program development.

The Africa Bureau has considerable interest in pursuing the integration of family planning and AIDS, including the development of comprehensive projects. One bilateral project could include both emphases if they are perceived as having some real bridging points and not just both put together for cosmetic bureaucratic purposes. The "analytic agenda" of the Africa Bureau Office of Analysis, Research, and Technical Support (ARTS) needs to include review of the concept of family planning including broader reproductive health interventions.

Emphasis was given to the need for AIDS activities to be specifically supportive of family planning in order to "sell" both concerns to USAID directors, host country leaders, and a public which previously may have rejected open discussion of sex and contraceptives/condoms.

FHI AIDSCAP

AIDSCAP staff expressed interest in developing some kind of collaboration/cooperation between their project's AIDS activities and family planning, even though this is not a part of the AIDSCAP mandate. To date, none of AIDSCAP's field visits have dealt with this potential. Project staff recognize the problem of target groups not being the same, the need not to overburden village field workers, and the potential for undermining momentum built for family planning in some situations. At the same time, the potential for coordinated actions exist, and add-on AIDS activities could be paid for out of the buy-in, from core costs, through a private voluntary organization (PVO) competitive grant or a research grant mechanism in the project. AIDSCAP could also receive a regional bureau buy-in for this type activity.

AIDSCAP emphasized this project's difference from others which are reactive to a great number of country needs. AIDSCAP is designed to focus primary attention on 10 to 15 priority countries worldwide, although some attention (largely technical assistance) can be given to other associate countries. The project has a number of criteria for choosing priority countries "not the least of which is a willingness to buy in to the project." Much of this non-technical rationale is forced on AIDSCAP by the nature of its five-year \$168 million contract which has only \$68 million core funding and \$100 million expected from buy-ins. AIDSCAP admits that the buy-in requirement precludes selection on the basis of greatest need or greatest potential for impact on AIDS.

The three major AIDSCAP programmatic thrusts are

- to increase acceptance, usage, and availability of condoms (largely through social marketing, although there is no clear picture of who will buy the condoms for the project);
- to change sexual behavior including partner reduction; and
- to prevent and treat STDs.

WHO/GPA Briefing

On September 9, 1992, three team members met with several senior GPA/Geneva officials to discuss issues relating to the integration of MCH/FP and HIV/AIDS activities, in general, and specifically GPA's policy toward such integration. The discussions indicated strong support for such integration, in the general sense, at GPA headquarters. Indeed, it was stated that integration was essential for several reasons including the following:

- The main target group for HIV prevention is youth, which is also a key target group for pregnancy prevention;
- Resources can be maximized by integrating activities and taking advantage of every opportunity to educate people about HIV/AIDS;
- MCH/FP projects focus on the family which is adversely affected by the AIDS epidemic;
- MCH/FP programs cannot continue to function during the AIDS epidemic as they did before the epidemic;
- As the demand for condoms continues to increase, there is a growing need to coordinate condom supply and logistics between MCH/FP and HIV/AIDS programs;
- HIV/AIDS information must increasingly reach women, who constitute the key MCH/FP target audience;
- Given what is believed to be the important role between STDs and HIV infection, efforts regarding reproductive health need to be integrated with HIV/AIDS activities;
- Common areas exist in national policy development, and AIDS-related policy development can help to strengthen MCH/FP policies in many countries;
- Strengthening social marketing is key to coordination of family planning and HIV-prevention activities; and,
- Common infrastructure development could occur if there were better coordination between the programs.

Specific areas of needed research common to MCH/FP and HIV/AIDS programs include

- Questions concerning breastfeeding by women who are HIV positive or at high risk for infection;
- Identification of reasons why HIV-positive women continue to become pregnant at the same rate as HIV-negative women;
- Investigation of the amount (in general and by target group) of condom use needed to reduce the transmission of HIV at the national level;
- The impact of HIV infection on pregnancy outcome; and,
- The efficacy of spermicides in preventing the transmission of HIV.

GPA is presently developing joint programs with the family planning and MCH divisions within WHO/Geneva, and stated that it was working closely with UNFPA and The Population Council on condom supply and logistics. GPA is also developing policy guidelines concerning the role of MCH/FP in AIDS control.

It was clear from the discussions that the question of integration was only being dealt with at headquarters level, and that, to date, little if any effort has been devoted to the practical issues of the integration of day-to-day activities on the country or community level. Nor does there appear to have been any serious consideration of financial questions concerning integration in a time of increasingly limited resources.

The discussions highlighted that GPA's approach to integration will continue to follow its MOH-dominated focus. The target of GPA's integration efforts will be at MCH/FP clinics and other formal "western" health facilities, rather than at the traditional community level. Potential contributions by community pressure and traditional healers in this effort do not appear to have been considered.

Possible exceptions to the MOH-dominated approach within GPA/Geneva are the promotion of social marketing activities and the use of NGOs/PVOs to implement projects.

Constraints to effective integration were also noted, including

- The reluctance on the part of MCH/FP programs to become involved with HIV/AIDS activities as AIDS is seen as a "dirtier" area of concern; and
- The reluctance on the part of individuals directing programs to give up any of their "turf" in order to effectuate an integration of programs.

Appendix E

Program Profiles: Zimbabwe, Uganda, and Botswana

Zimbabwe Country Profile

A. Overview

1. Population/Family Planning

Zimbabwe has a population of 11 million with 47 percent of the population under 15 years. Seventy-five percent is considered to be rural, and the urban growth rate is in excess of 6 percent per year. The crude birth rate is 40 per 1,000 and the crude death rate is 9 per 1,000 (8 per 1,000 between 1985-90). The population growth rate is 3 percent (3.2 percent between 1985-90).

The TFR decreased from 7.3 in 1970 to 6.1 at present. Forty-three percent of married women are currently using contraception, the highest use in sub-Saharan Africa. In 1988, 96 percent of women reported having heard of at least one modern contraceptive method and 98 percent of men knew of the pill and condom. Use of modern methods has risen from 14 percent in 1980, to 27 percent in 1984, and an estimated 36 percent in 1988. Eighty-five percent of women using modern methods are using oral contraceptives.

Despite high contraceptive prevalence, however, Zimbabwe still has high fertility and population growth. A significant gap remains between knowledge of contraceptive methods, which is very high, and use of modern methods even among women who desire to delay or terminate childbearing.

2. HIV/AIDS

In the first quarter of 1992, 273 AIDS-related deaths were reported; in the second quarter, the number was 556. The greatest number of deaths were in the 0-4 age group (157), followed by those aged 30-39 (129) and 20-29 (111). In AIDS-related complex (ARC) cases, as well as in seroprevalence, however, the 20-29 age group has the highest rates.

In the 15-29 age group, women have a higher number of AIDS and ARC cases as well as higher seroprevalence rates. In the 30-39 age group, however, men have higher rates.

The total number of AIDS cases reported through the first quarter of 1991 totaled nearly 7,000, and it is estimated that the reporting system records only 30-40 percent of actual cases.

During the second quarter of 1992, a total of 1,509 new cases of AIDS was reported. This represents a 30 percent decrease in the number of cases from the first quarter. However, the decrease is attributed to the shortage of HIV-screening kits in the second quarter.

The number of reported ARC cases fell from 4,536 in the first quarter of 1992 to 3,533 in the second quarter. This decrease is also attributed to the shortage of HIV-screening kits.

Data from ante-natal clinics reflect high seroprevalence levels. Urban areas throughout Zimbabwe record that 25-40 percent of women attending ante-natal clinics are HIV positive. Official Government of Zimbabwe statistics indicate that there are 650,000 HIV-positive individuals in Zimbabwe.

HIV is increasing child mortality figures. Mortality rates for children under one increased from 23.6 to 31.8 per 1,000 live births between 1989 and 1990. Of infants dying at Harare Hospital in 1991, 50 percent were HIV positive.

The MOH reported 249,155 new STD cases during the first quarter of 1992. This was 37,202 cases fewer than the fourth quarter of 1991. It must be remembered, however, that 75 percent of STD cases are seen by traditional healers and are therefore not reported by the MOH.

B. Organization of Programs

1. Population/Family Planning

The Zimbabwe National Family Planning Program includes several ministries, NGOs, donors, and private providers. The Zimbabwe National Family Planning Council (ZNFPC), a parastatal under the MOH, is responsible for the design and coordination of family planning activities.

ZNFPC headquarters are located in Harare with administrative offices in all provincial capitals which operate provincial mobile and stationary clinics at district levels. Activities at the community level are mainly carried out by CBD workers. Coordination with the MOH takes place at each level and supervision of facilities is shared by the MOH and ZNFPC. ZNFPC units in Harare include medical/clinical, CBD, youth advisory services, training, IEC, evaluation and research, and management and administration. The training, IEC, and evaluation units have no provincial counterparts.

ZNFPC supplies approximately 25 percent of users of modern methods through its CBD workers and clinics. The largest provider of family planning services is the MOH system, comprising MOH and municipal clinics, as well as district and rural clinics. The MOH is estimated to have about 1,200 facilities which, in 1990, provided approximately 44 percent of family planning services. In 1986, the MOH began to integrate family planning services into general MCH and primary health care services. In addition to services available through the public sector, an increasing number of commercial, workplace-based, NGO, and church affiliated groups are offering family planning services.

ZNFPC's role is changing. It will become less operational and function more as a resource for family planning expertise and as a facilitator for family planning activities. ZNFPC wants to increase the potential for program sustainability by recovering 25 percent of contraceptive costs and 10 percent of clinical costs, as well as transferring costs from the public to the private sector by increasing the private sector's share from 5 to 17 percent.

Although ZNFPC has a strong infrastructure with senior-level individuals who have been with the organization for more than 20 years, many of these individuals are now leaving, and ZNFPC is probably overextended in terms of the amount of activities its qualified personnel can implement. In addition, due to the Economic Structural Adjustment Programme (ESAP), ZNFPC cannot fill vacant positions and 25 percent of ZNFPC headquarters positions are presently vacant. The continued sustainability of ZNFPC is also an issue given budgetary cuts resulting from ESAP-caused budgetary reductions and resource shifts to negate the effects of the current drought.

In 1989/90, the Government of Zimbabwe provided 62 percent (Z\$10,300,000) of the total funding for family planning, excluding donated contraceptives. The government currently funds between two-thirds and three-quarters of family planning activities and the rest are funded by donors including the World Bank, USAID, UNFPA, GTZ, the Danish International Development Agency (DANIDA), the Norwegian Agency for Development Cooperation (NORAD), and the Netherlands. USAID provided \$1.7 million worth of oral contraceptives (10,260,000 cycles) in 1991. However, USAID's provision of pills is being phased out, and the current USAID project paper assumes that Zimbabwe will be totally self-sufficient in procurement of pills from non-donor sources within three years.

USAID/Zimbabwe's \$14 million family planning project (1990-95) will seek to diversify methods, expand private sector involvement, and enhance the sustainability of family planning activities. The Government of Zimbabwe/World Bank Family Health Project II (1992-96) will be funded with a World Bank loan (\$25 million) and co-financed by the European Economic Community (\$1.6 million), DANIDA (\$3.8 million), NORAD (\$12.6 million), Netherlands (\$3.3 million), and the Overseas Development Agency (British) (\$3.3 million). Only \$7.4 million of this money is for family planning, however, with almost \$19 million going to the upgrading of rural hospitals.

2. HIV/AIDS

The AIDS Coordination Program (ACP), a unit in the MOH, has developed a Medium Term Plan which guides HIV-prevention activities. The budget for the national AIDS program is US\$5,640,084 (1992) and \$4,921,384 (1993). The AIDS program is decentralized with most activities being conducted on the provincial or district level.

The National AIDS Council, which was established in 1990, is charged with making policy concerning HIV/AIDS. It does not yet have legal status or funding, however. It is composed of representatives of all ministries, the Office of the President, the Attorney General, churches, business, the medical aid societies, and traditional healers. ZNFPC is not represented on the National AIDS Council.

A large number of organizations are working in the area of HIV/AIDS. A directory published in 1992 identifies 33 such organizations. The majority of these groups focus activities in and around Harare, and few have substantial expertise in HIV prevention.

1992 HIV-related activities funded by donors included

CIDA	\$ 88,000	IEC and traditional healers
DANIDA	1,500,000	Supplies and reagents
EEC	300,000	STD pilot project
NORAD	250,000	Undesignated
ODA	695,000	Undesignated
SIDA	500,000	IEC (SIDA also provides funds directly to various NGOs)
UNDP	500,000	Improvement of project management
UNFPA	710,000	Condoms
UNICEF	unknown	Youth

USAID's contributions include

Total US\$ obligated for AIDS activities 1987-90	\$6,957,801
Total local currency	1,369,000
Total (US and local currency) completed	7,870,026
Total (US and local currency) ongoing	456,775

USAID/Zimbabwe is presently designing a five-year HIV-prevention project.

C. Description of Activities

1. Policy Development

The AIDS epidemic has helped to improve the climate for policy development relating to family planning in many areas including

- Helping to remove duties on contraceptives (although contraceptives are now on the list for available foreign exchange, there remains a 20 percent tariff); and,
- Making it easier to discuss issues concerning sex and contraception with individuals and through the media.

Work remains to be done in several areas of both family planning and HIV-prevention, however, including

- Making youth a priority and removing government restrictions on effectively targeting youth to prevent pregnancy and HIV infection;
- Lessening church opposition to the effective promotion and distribution of condoms; and,
- Reducing television and radio advertising rates for public service (family planning and HIV-related) announcements.

2. Training

Training can be coordinated in many areas. For example, family planning service providers at all levels should be trained to provide STD and HIV-related information, and AIDS educators should learn about family planning. ZNFPC has begun to integrate STD and HIV into its family planning curricula. The demand for this additional training comes mainly from clients who want information about STDs and AIDS.

A major constraint exists with regard to the effective provision of HIV-related information by family planning service providers in that these providers are already overworked with insufficient time to provide each client information in a meaningful way. The financial constraints imposed by ESAP and drought relief bring into question the ability of the family planning program to expand its educational services significantly beyond its present activities. These constraints may require the development of good screening and referral systems between family planning, STD, and AIDS services rather than their complete integration. Nevertheless, all services could have IEC materials on FP, STD and AIDS available for their clients.

3. IEC

ZNFPC, MOH, and the AIDS Coordination Program all have separate IEC/health education units. Coordination of IEC activities has begun on a limited basis. For example, the IEC Unit at ZNFPC has established a working relationship with the MOH Health Education Unit and the ZNFPC Media Unit will be used on 70-30 basis by MOH-ZNFPC. The IEC Unit of the AIDS Coordination Programme (ACP) could be integrated into this loop. Although these activities are occurring on the national level, a significant move is under way to coordinate the development of IEC materials on the provincial and district level. The major issue is to upgrade the IEC capabilities at the local level especially in the areas of male motivation, youth, and parent education. In general, the IEC activities of both family planning and ACP are weak, and an opportunity exists for strengthening the IEC skills of family planning and ACP personnel.

HIV-related IEC has had little impact in motivating behavior modification. Although the integration of family planning and HIV messages may decrease the stigma associated with condoms, this may not necessarily produce a positive result if messages continue to promote AIDS as something to be ashamed about.

4. Biomedical, Behavioral, and Operations Research; and Surveillance, Monitoring, and Evaluation

Practical, focused behavioral research in both family planning and HIV prevention is urgently needed, especially with regards to youth.

AIDS educators in the workplace appear to have been successful at educating their peers, at least as judged by the decrease in STD rates at their workplaces. Further operations research in this area could multiply its utility and encourage integration of HIV/AIDS and family planning activities.

Surveillance, monitoring, and evaluation of family planning, HIV, and STD prevention activities can be coordinated or integrated in several ways. Common indicators include condom distribution and sales and HIV and/or STD and teen-age pregnancy rates. Programs can be monitored using health information system data and information about behavior change, etc., can be collected via KAP surveys.

Additional research needs common to both family planning and HIV-prevention are described in Appendix K.

5. Service Delivery

The ZNFPC Five-Year Strategy is being revised to include breastfeeding and HIV-prevention activities. A significant portion of the discussions concerned the integration of HIV-related service delivery into existing family planning programs, especially through the family planning clinic and CBD system. The integration of family planning activities into the MOH HIV-prevention system was discussed less and may not be practical at this time.

The business community including the Commercial Farmers' Union, National Transport Council, and David Whitehead has established many HIV-prevention programs in its workplaces and the potential exists for family planning to be incorporated into these activities.

Additional routes of non-traditional service delivery include working with women in high-density neighborhoods replicating the Bulawayo model of HIV/AIDS programs for commercial sex workers and youth.

Alternative routes of service delivery could be considered for family planning, HIV, and STD prevention activities including working with traditional healers and traditional birth attendants.

6. Social Marketing

Although a large potential for social marketing exists, the SOMARC project has only distributed about 2.5 million condoms per year and projects it will sell 4 million this year, in contrast to the 38-40 million distributed by the government's family planning programs. Even though demand in Zimbabwe is relatively high in relation to other African countries, little has been done to increase that demand in the commercial sector.

The SOMARC mandate from A.I.D./Washington was originally only to deal with family planning issues. This has recently been expanded to include HIV prevention. SOMARC previously targeted only men, they are now also targeting women. SOMARC sells condoms for Z\$1.80/3 through 1,500 outlets.

7. Commodity Supply and Logistics

The supply of commodities, especially condoms and clinic supplies such as gloves, needles, and syringes, is a major issue for both family planning and HIV-prevention programs. The inadequate supply of HIV-testing kits has, among other things, called the surveillance system into question.

Condoms are in continual short supply or in threat thereof. This is a drain on ZNFPC, which could be focusing on other activities.

Condoms will be supplied through 1994 by ODA and UNFPA; after that, the source of supplies is unknown. USAID will provide no more condoms.

8. Government of Zimbabwe and USAID Management Considerations

The many players in the areas of family planning and HIV in Zimbabwe often have their own agendas, and their activities need to be better coordinated. This need is well recognized, but the practicalities of accomplishing the goal are less well understood.

D. Perceptions of Advantages/Disadvantages Related to the Integration/Coordination of Family Planning and HIV/AIDS Activities

In general, it was stated that the coordination/integration of family planning and HIV-related activities is a good thing and should be promoted. Indeed, it was stated that such coordination has already frequently occurred on the local level in response to the demand from the communities.

The family planning program intends to make a greater effort in targeting men and youth. It was stated that these are two areas in which both programs should concentrate.

E. Constraints to Successful Integration/Coordination of Activities

The major constraint to the successful integration of family planning and HIV-related activities is the shortage of qualified personnel which is in part due to general economic conditions and further compounded by structural adjustment restrictions. Because of these complications, it is doubtful that governmental organizations can move beyond their present activities in a meaningful way.

Effective family planning and HIV prevention also involves improving socioeconomic conditions including water supply and sanitation and improving the status of women as well as formal health-sector activities. Given the present economic conditions, it may be difficult to improve socioeconomic conditions in the short- and medium-terms.

Although youth is the best point of intervention for both family planning and HIV-prevention activities, both the church and the government have been, and appear to continue to be, opposed to targeting effective interventions to this group.

F. Conclusions

In Zimbabwe, the integration of family planning and HIV-related activities appears to be occurring at the community level. This is in contrast to the national situation in which policies and programs remain vertical and separate.

Many areas of potential integration exist. Four areas of highest priority which can have the greatest impact are

- **Condom promotion and distribution including social marketing;**
- **Targeting men in efforts related to both family planning and HIV prevention;**
- **Increasing efforts directed toward youth to prevent HIV infection and teenage pregnancy; and**
- **Increasing the involvement of traditional healers to provide HIV and family planning related services.**

Uganda Country Profile

A. Overview

1. Population/Family Planning

Uganda is a least developed country with about 16.6 million people and an annual population growth rate of 3.7 percent. Approximately 90 percent of the population is rural, and 80 percent is engaged in agriculture. The per capita gross national product is \$220. Assuming that the current annual growth rate of 3.7 percent does not change, the population will double in 19 years.

Fertility in Uganda is high; current estimates put the TFR at 7.4. The crude birth rate is 52 per 1,000 per year. Infant mortality is estimated at 96 per 1,000 live births. The maternal mortality rate is estimated at 400-500 per 100,000 births while the crude death rate is 15 per 1,000 per year.

Uganda has a very young population; about 48 percent is under 15 years. Persons older than 64 represent about 4 percent of the population, resulting in an extremely high overall age dependency ratio.

The contraceptive prevalence rate is estimated at 5.5 percent, with 2.7 percent for modern contraceptives. Eighty-four percent of women have knowledge of modern family planning methods, and 70 percent have favorable attitudes to family planning methods. Contraceptive discontinuation rates are high: pill 15-20 percent, IUD 10-40 percent, and Depo-Provera 5-7 percent. The reasons for non-use of contraceptives include objection on the grounds of religion, poor access to and availability of contraceptives, husband disapproval, high cost of services, and health contra-indications.

The national attitude toward family planning is ambivalent. Concerns are expressed in many quarters that access to family planning services encourages promiscuity.

2. HIV/AIDS

Recent estimates indicate that about 10 percent of the population (approximately 1.5 million people) is infected with HIV. As of July 1991, almost 25,000 cases of AIDS had been reported to the MOH. Most AIDS epidemiologists, however, believe that the number of reported cases represent as little as 15-20 percent of the actual number of AIDS cases. Conservative estimates on the cumulative number of adults with AIDS in Uganda by the end of 1991 were 180,000, of whom over 142,000 have already died. During 1991 alone, nearly 50,000 adults died of AIDS.

The current estimate for the disease doubling rate is about 8-12 months. Thus, it is estimated that in 1995 there will be 534,000 cases. During the same period, pregnancy-related deaths attributable to AIDS among women are expected to push up the maternal mortality rate at least threefold from 4 to 13 per 1,000 births.

The majority of reported AIDS cases (83 percent) are young adults in the age group 15-40 years. Although there is almost a 1:1 sex ratio among the reported cases, more females are reported among the under 30-year old patients. If reflective of AIDS cases in the country, these data suggest that women become infected at a younger age than men.

In the period 1990 to 1995, almost half a million seropositive babies will be born with HIV infection; nearly a quarter million children are expected to become infected with HIV; and approximately 208,000 deaths in children are forecast due to AIDS during that period. Most of the AIDS deaths will be those in the young to mid-adult range who will invariably leave orphans. No reliable estimates or projections have been made, but as many as a million children could already be orphaned as a result of AIDS.

B. Organization of Programs

1. Population/Family Planning

Government activities for family planning are implemented through the MCH/FP division of the MOH. Available statistics indicate that Uganda has 1,443 health service delivery points — hospitals, health centers, dispensaries, maternity units, and aid posts. The MOH offers only limited family planning services, and few clinics stock contraceptives or provide more than token advice on family planning. Only about 10 percent of all service delivery points offer any MCH/FP services. In 1989/90, recurrent expenditure on health was 3.2 percent of the total government budget. In 1991/92, the figure rose to 4.05 percent.

The bulk of MCH/FP services are provided by NGOs. It is estimated that NGOs run about 20 percent of the health units but provide about 40 percent of the health services.

The local IPPF affiliate, the Family Planning Association of Uganda (FPAU), provides family planning, staff training, and IEC services nationwide. The FPAU provides 33 percent of the family planning services in the country. Other local NGOs include the Protestant Medical Bureau, the Catholic Medical Bureau (only natural family planning methods) the Pentecostal churches, the Uganda YWCA, the Islamic Medical Association, and the Seventh Day Adventist churches.

2. HIV/AIDS Prevention and Control

The AIDS Control Program, coordinated through the MOH, began in 1986. The program has been successful in reducing transmission of HIV through blood products and in creating a high level of awareness of the means of HIV transmission. This high level of awareness has not, however, been matched by significant changes in high risk social behavior.

The Government of Uganda recently established the National AIDS Commission (ACP) to coordinate a multisectoral AIDS strategy.

AIDS prevention and control activities are implemented by a large number of local and international agencies. A recent survey showed that a minimum of 15 agencies work in a given district, with one district having 66 agencies.

3. Donor Support of Family Planning and AIDS Prevention Programs

Donor support for family planning and AIDS prevention activities comes from a large number of multilateral, bilateral, government, and private sources. In the family planning arena, major donors are UNFPA and USAID. Major funding agencies for contraceptive procurement are USAID, UNFPA, and IPPF.

The UNFPA program committed \$16 million in 1988 for a comprehensive population program. Its five-year program focuses on basic data collection and analysis; population dynamics; population policy formulation; maternal and child health and family planning; population and family life information; IEC; and on issues concerning women, population, and development. UNFPA-supported programs are active in 13 districts. UNFPA supported AIDS prevention activities are incorporated in safe motherhood sensitization seminars and IEC activities which are implemented at the sub-county level in five pilot districts. The UNFPA program is scheduled to end in December 1992. Planning for the new country program is in progress.

The bulk of USAID assistance to family planning is provided through the Expanded Family Health Services Project, which began in 1989. The project purpose is to strengthen the capabilities and willingness of the government, voluntary organizations, and the private sector to formulate family planning policies and programs. It has six inter-related components: population policy activities, research and analysis, training and support for services, contraceptive and logistics management, IEC, and social marketing of contraceptives.

The project target is to increase the use of modern methods of contraception from current levels to 9 percent and to provide 180,000 couple years of protection (CYP) through commercial sales of contraceptives. A national population policy and a management information system are to be established before the end of the project.

The largest USAID-supported program is the AIDS education, prevention, and control program implemented by the Experiment in International Living (EIL). The project is a comprehensive effort involving both the government and the non-governmental sectors. It is designed as an umbrella project with EIL providing support to local NGOs to develop and manage HIV/AIDS prevention projects.

World Bank assistance began in 1987 with the First Health Project. This project supported safe motherhood initiatives (in collaboration with UNFPA) in three districts and MCH physical infrastructure rehabilitation projects countrywide. The Second Health and AIDS project, 1993-1997, is being developed.

WHO provides support through the provision of a chief technical advisor, who works in the MCH/FP division of the MOH. WHO is also the executing agency for the UNFPA-funded MCH/FP service delivery program in the MOH. WHO assists the MOH in the fight against HIV/AIDS through the WHO/GPA program.

The large number of projects, both in the family planning and AIDS prevention sectors, precludes a comprehensive listing of NGO activities. The following lists some of the more important activities, with special attention paid to those projects which already attempt/achieve integration of family planning and HIV/AIDS.

- GTZ implements a community-based primary health care program with a maternal health component in the Kabarole and Bundibugyo districts. GTZ also implements the Engabu condom social marketing program. HIV/AIDS and family planning programs are being partially integrated at the service delivery level.
- AVSC supports training in surgical contraception under an agreement with the MOH at Makerere University. HIV prevention information is integrated in the training curriculum.
- Pathfinder International supports the Family Life Education Project, which aims at strengthening family planning service delivery and personnel training programs in the Busoga and East Ankole Dioceses. Programs concentrate on CBD service delivery. Coordination with AIDS prevention activities takes place at the district level.
- SEATS provides financial and technical assistance to FPAU, Ministry of Labor, Islamic Medical Association, Uganda Private Midwives Association, and the MOH. Plans exist to assist the Seventh Day Adventist churches to include family planning in their health care delivery system.
- CEDPA provides financial and technical assistance to the YWCA's Health Improvement Project. CEDPA addresses youth in an integrated family planning/AIDS prevention communication program.
- CARE Uganda implements reproductive health projects through integration of family planning services in 50 government service delivery points. Projects include AIDS IEC, personnel training, and CBD activities.
- World Vision has projects with a broad range of services including public health with MCH/FP components and counseling for persons with AIDS.
- The African Medical and Research Foundation in Kenya implements primary health care projects which involve training of CBD workers, traditional birth attendants, and the integration of STD control.

Coordination Mechanisms

Coordination takes place at both the formal and informal levels. At the formal level, meetings are chaired by the Ministry of Finance and Economic Planning during which government and donors exchange views on the economy and discuss program implementation. Meetings regarding family planning and AIDS prevention issues are chaired by the MOH and the National AIDS Commission, usually on a bimonthly basis.

Informal coordination takes place through monthly meetings chaired by the World Bank and under the auspices of the resident United Nations coordinator. Since 1991, donor agencies engaged in supporting health activities meet on a quarterly basis, with agencies taking turns to convening and chairing the meetings. UNFPA holds regular bimonthly and biannual meetings at the central and district levels during which agencies and NGOs discuss programs and coordination issues.

Donor Levels and Trends

About 70 percent of the MCH/FP budget is donor supported. This reliance on donor support is similar for AIDS prevention and is not expected to change in the near future.

C. Description of Activities

1. Policy Development

Strategic policy issues include the following:

- The official policy of the MOH is to implement community-based health services and health promotion through a primary health care approach. However, because of vertically funded programs by the international donor community and minimal MOH and government budgetary support, the primary health care approach has not been put into operation.
- A multisectoral strategy for HIV/AIDS prevention and control has been developed. The implementation of this strategy was to be facilitated by the establishment of the National AIDS Commission, a prime ministerial level coordinating body, which provides representation throughout all relevant sectors of the government, (i.e., not just the MOH). Although this level of coordination is appropriate and badly needed in all countries, the effectiveness of this coordinating body in Uganda has been limited and is currently being evaluated by the World Bank, WHO, and other donors.
- At the MOH level, strategic planning includes the integration of AIDS prevention and family planning. Actual efforts to integrate or consolidate MCH with family planning and HIV/AIDS with STD control at the community level are limited.

Operational policy issues include the following:

- The restriction on brand name advertisement of condoms for HIV/AIDS prevention purposes necessitates the "quiet promotion of condoms" to support national AIDS control efforts. ~~This restrictive policy severely hampers the effective implementation of the AIDS control program.~~
- Operational procedures, which require the performance of a pelvic examination prior to prescribing oral contraceptives, limit access and acceptance of this effective contraceptive method.
- Reliance by programs on a fixed health facility approach to health services delivery severely limits outreach and effectiveness of national health delivery and health promotion efforts.

2. Training Programs

The training needs on both the family planning and HIV/AIDS side in Uganda are immense. Years of civil disruption have decimated the cadre of service providers within the MOH structure. Training for family planning was begun in 1984 under the FHI I project by INTRAH. This resulted in development of a training curriculum. Under the FHI II project, seven staff members were established as a training department within the MOH; the department now has only three staff members. Government salaries are low and skilled people seek jobs elsewhere. Initial training activities were focused at the central level, but this approach has not been effective in meeting the need for trained medical staff in the rural areas where most of the population lives. Current training efforts are seeking to establish a cadre of trained staff at the district level who can serve as resource personnel and provide supervision in their areas. Due to the limited number of staff available, plans are to focus on just a few districts — nine in the Western region. Support for training activities is being provided by USAID and UNFPA with technical support from INTRAH.

A standardized curriculum for MCH/FP has been developed. At this point, there is no integration. Other programs within MOH, such as Expanded Program on Immunization and AIDS, do their own training. The only AIDS-related component in the family planning training now is on protection from infection.

On the NGO side, FPAU is the main resource in the country. Under the SEATS program, it is training the family planning staff of the workplace and Islamic Medical Association projects as well as FPAU's own workers. FPAU has done some TOT training on AIDS for its staff; however, FPAU believes its counselors are still not able to provide effective counseling on HIV/AIDS. They know little about AIDS beyond the need to keep instruments sterile. No AIDS materials are available for use by FPAU staff.

FPAU has just started a pilot CBD program and is moving into the area of community outreach. It now has a staff of approximately 70-80 field educators working in the rural areas to follow up clients and refer people to the clinics for services. FPAU hopes eventually to train them to provide contraceptives.

AIDS organizations, on the other hand, do not have to be concerned with the provision of clinical services. Therefore, training for their workers has focused on communication skills, counseling, and community outreach.

In terms of potential integration, there is a clear need for the inclusion of HIV/AIDS in the training of family planning service providers so that they can at least provide their clients with accurate information and refer them for needed services. Family planning programs need to address, on a program-by-program basis, whether they want to move into the broader area of HIV/AIDS counseling. Given the low level of interpersonal counseling skills and the lack of training resources, such an approach may be impractical at this time.

On the other hand, a number of HIV/AIDS programs have indicated their interest in including some family planning elements in their programs. This could range from providing information on the health benefits of effective contraception for mothers and children to actually offering methods other than the condom. Since their staff are already being trained in counseling and interpersonal skills, the addition of family planning information to their portfolio may not be too difficult. It could also be an effective way to advise a much larger number of people about the health benefits of family planning.

3. IEC

IEC activities in support of family planning in Uganda are still at a very early stage of development. A predominantly rural population, years of civil strife, and the influence of conservative religious factions have resulted in a "quiet" approach to provision of services until recently. The FPAU provided services at a restricted number of clinics and contraceptives were available through the MOH's MCH/FP program. Given the breakdown in the medical system within the country, however, most of these services were only available in major hospitals and a few health centers. Most IEC materials, generally in the form of posters and some

motivational and method-specific materials, were produced and many, in both Swahili and English, have been brought in from neighboring Kenya.

The government was one of the first to openly address the AIDS problem in the country and quickly began an IEC campaign to create awareness among the population. These efforts were in one sense successful in that awareness of HIV/AIDS is quite high. However, almost no time was devoted to developing a strategic IEC plan nor was there time to carry out pretests of local knowledge, attitudes, and practice. Evaluations of the early media efforts indicate that many Ugandans could not really identify with the messages. Also, given the conservative attitude of the government, it was necessary to stress monogamy and abstinence as the principal means of combating AIDS — something that was perceived as unrealistic by most Ugandans. Use of condoms cannot be promoted in the media.

At the same time the media campaign was being carried out, a District AIDS Mobilization Project (DAMP) was launched. DAMP's objectives were to mobilize government and administrative machinery and the general public at the local level to take an active role in the prevention and control of HIV/AIDS. The program promoted abstinence, monogamy, and condom use. The project was designed by the Health Education Division of the MOH in collaboration with the ACP and was implemented through a series of three-day training seminars for health workers, councilors, and government staff at different levels. An evaluation of the project reported that although course participants acquired useful knowledge, little action resulted. Issues of sexuality and social behavior were omitted. In addition, women were consistently under-represented in these training sessions.

Based on the evaluation of the HIV/AIDS mass media and DAMP initiatives, the ACP has redesigned its IEC strategy. Current efforts focus on training of community leaders — women, youth, and religious leaders — to work within their communities. Communication skills are an important component of this new project, and new materials more specifically targeted to different audiences are being developed. DAMP hopes to be able to develop materials for low-level literates and to produce materials in local languages. A major constraint is availability of funds. ACP provides materials on AIDS to the NGO community in Uganda. Although ACP is located within the MOH, materials are not distributed through the MOH system at this time.

The intense interest in IEC in support of the HIV/AIDS activities has actually served as a catalyst for action on the family planning front as it has created a more open climate for discussions of reproductive health issues, especially condom use. New initiatives under way include a Population Communication Services-supported project with FPAU to produce/procure a range of materials including radio spots, handouts, flip charts, posters, etc. Through the SEATS project, FPAU will also be providing training that includes IEC to projects operated by the Federation of Ugandan Employees and the Islamic Medical Association. All these efforts have some focus on AIDS, but HIV/AIDS is not fully integrated into the training curriculum.

As new IEC family planning and HIV/AIDS activities get under way, there will be many opportunities for collaboration and integration. Dialogue between IEC staff in both sectors would be useful and should be encouraged. In addition, a great deal of interesting research has been and continues to be carried out that should be incorporated into the design of new strategies. Uganda is made up of diverse regions and cultures and as most of the population is in the rural areas, community involvement in design as well as operation of programs would be most beneficial. Some specific areas that should be explored include targeting specific groups such as men, youth, religious leaders, and women's organizations; addressing issues of sexuality, economic dependency, and relative powerlessness of women within the local context; and use of local languages, local terminology, and humor as a means of personalizing messages. One step has been the publication of the "Ekanya Shocked into Sense" comic book about AIDS. The book is written in English, however, and would need to be translated into local languages to reach a wider audience. In a country with a high rate of illiteracy, especially among women, there is also the need for simple print materials about HIV/AIDS and family planning methods. The need for clear, easy-to-comprehend instructions for condom use has been emphasized by a number of organizations.

With greater responsibility for IEC activities moving to the district level, the need not only for effective training in communication but the means to follow up and support field staff should be underscored. Integration should not mean overburdening staff so that they cannot effectively support either family planning or HIV/AIDS activities. Likewise, production of effective IEC materials will be meaningless unless effective distribution channels are established so that workers have the resources they need to do their jobs.

4. Biomedical, Behavioral and Operations Research and Surveillance, Monitoring and Evaluation

Potential research issues include the relationship between an individual's HIV status and his or her attitudes concerning family planning and adolescent sexuality and behavior.

Work testing the feasibility of using traditional birth attendants and traditional healers to inform about and/or deliver condoms in Ugandan communities should be continued. In lieu of ethnographic research, interventions and IEC efforts must be designed by and for local communities.

Ongoing research concerning attitudes and beliefs about condoms needs to be complemented with some condom quality control studies.

A large demand appears to exist in Uganda for female-controlled methods that will provide protection against HIV. Acceptability and efficacy trials with the female condom and other female controlled methods should be considered.

If referral systems between AIDS, STD, and family planning services are established, their effectiveness will need to be assessed.

Ongoing research in Uganda on STD diagnosis and treatment is very important. This includes the research on male and female perceptions of their reproductive physiology, health, and sexuality.

More information regarding potential contraceptive interactions with HIV acquisition, transmission, and disease progression is urgently needed. Research on these issues is being carried out throughout the world and more information should be available on these issues with time.

Common indicators for monitoring family planning and HIV and/or STD programs are contained in health information systems, and for evaluating them there are KAP surveys, condoms sales, STD reinfection rates, and teenage pregnancy rates.

5. Service Delivery (Clinical and Non-Clinical, Public, and Private)

In Uganda, it appears that because of their vigor and extension AIDS programs have more to offer to any effort to integrate/coordinate family planning and HIV/AIDS activities than do those of family planning. Program leadership attitudes vary, but service providers express a genuine interest in making the connection between family planning and HIV/AIDS. Many AIDS counselors recognize that for those at high risk of HIV infection, or those who already have tested HIV positive, an additional pregnancy represents a significantly greater risk for the AIDS client, the outcome of the pregnancy, the future of a potentially orphaned or HIV-positive child, and the health and economic welfare of the extended family. Counselors and their leaders, however, express the need for more training in family planning before they can effectively add this component to their work with HIV clients.

The same interest in and some experience with discussing AIDS with family planning clients is expressed by family planning providers. They, too, indicate the need for more training related to AIDS if they are to be accurate and effective in their messages. They do not expect to do comprehensive counseling on AIDS in their provision of family planning services. They could, however, provide basic information, help clients to understand the implications of AIDS in making a choice of contraceptives, and make referrals for further

counseling or support services for AIDS. Clinics, which are not a large supplier of condoms at this time, could do more in this regard.

Family planning providers have sometimes increased their attention to sterile procedures in the face of risk to themselves or their clients of the spread of the HIV virus. In the FPAU program, in which there has been an emphasis on the IUD, disposable gloves have been made available as well as inexpensive bleach solution for decontamination, disinfectant for cold sterilization, or autoclaving equipment for boiling instruments. The requirements for sterile procedures, the cost and logistics implications, and the potential for undue apprehension on the part of the client calls into question the requirement for a pelvic examination before initiating hormonal contraceptives. Emphasis in the family planning program on hormonal contraceptives and to a lesser degree the IUD are somewhat in conflict with the emphasis on the condom of the AIDS control program.

With the exception of the GTZ basic health services project in two health districts, few formalized efforts have been made to combine AIDS and family planning service delivery. In fact, the manager of a large tea estate reported that family planning workers come to the estate from time to time, AIDS control workers come at different times, and neither promotes the interest of the other. Nevertheless, the ad hoc practical experiences of "integration" by service providers give promise that more can be done in the future. The GTZ experience demonstrates that the road to more unified programming is not easy. Despite having both AIDS and family planning emphases in its program for more than two years, only in the last six months has it been able to bring the two components together in practical planning exercises; the family planners must continue to be a "squeaky wheel" to gain adequate attention in the vigorous efforts at AIDS prevention. This appears due to leadership perception of the relative importance of the two facets of the program, male dominance in some aspects of programming objectives, ambivalence over the role of hormonal contraceptives as they relate to HIV transmission and progression, MOH policy, training programs which limit expansion of community-based family planning services, and the general weakness of the family planning services in the two districts served by the project.

Although more vigorous and well supported than the family planning activities, the AIDS preventive services (condom distribution along with counseling) are also only dealing with a small proportion of the population, often through fixed facilities which are limited in number or strength of program.

The areas in which the integration of family planning and AIDS service delivery is more likely to be productive in the future are in efforts that would allow both programs to work together on the community level. The expanded effort would have the advantage of being largely new territory for both AIDS and family planning. Their mutually supportive objectives could be identified in initial planning, and benchmark progress indicators could include indicators common to both. They could be funded to achieve both purposes. Although program managers would be accountable for progress in each of the objectives, the two concerns could be essentially integrated at the service delivery/client level. Strong emphasis on the use of the condom for these target populations regardless of whether for family planning or AIDS control purposes would obviate much of the concern over the appropriateness of hormonal contraceptives in the presence of HIV/AIDS. The programs could be designed jointly to assure that appropriate approaches were made to particular target groups but in such a way as to not offend other audiences.

Social marketing, discussed below, should play an important role in increasing access to condoms and in vitalizing the participation of the private sector. The approach should address the concerns of both family planning and AIDS control and not be narrowly identified as one or the other.

6. Service Delivery through Social Marketing

Two condom social marketing projects exist in Uganda. Their products are the Protector and Engabu condoms. Unpackaged condoms are also sold by the FPAU and some EIL subgrantees directly to consumers

at clinics, project sites, and through CBD workers and community health workers. Unpackaged condoms can also be found in drug stores and in the informal commercial sector.

The Protector condom is distributed through Armtrades, Ltd., operating under a subcontract to the SOMARC II program. Armtrades is an indigenous pharmaceutical distribution company. The company employs 20 full-time promoter/salesmen to promote and distribute Protector. Technical assistance to Armtrades is provided by the SOMARC regional manager, based in Harare, who visits the company every two to three months.

The consumer price of Protector is Ush 150 (US\$ 0.05 each) for an envelope containing three Ansell blue/gold condoms. Protector is sold primarily through private clinics, pharmacies, and drug stores. An estimated 1,000 retail outlets carry the product.

Sales of Protector began in August 1991. Total sales for the year ending July 31, 1992, were 1,107,829 pieces. Sales for the months of August and September 1992 average about 80,000 pieces a month. Target groups are consumers in the C and D (lowest) economic classes.

Religious and governmental opposition to Protector mass media promotional activities surfaced shortly after the beginning of the campaign, requiring the suspension of all radio, television, and some print advertising. The suspension remains in effect today. A "quiet" promotion of condoms has now been adopted as government policy, encouraging brand promotion at the point of purchase only and providing more widespread forms of health education about condom use.

The Engabu condom is distributed by GTZ as part of its comprehensive primary health care project in the Fort Portal region. The project acts as the distributor, selling the condoms directly to local retailers and to consumers through project personnel. The consumer price is Ush 100 for an envelope containing 5 condoms. Although the economic target groups for Engabu are similar to those of Protector, the brand is positioned with a regional flavor, being designed especially for "Ugandan conditions." The launch of Engabu was preceded by several articles in the national press which created unfavorable publicity and delayed the shipment of the condoms to the project site. Sales of Engabu began only recently. No sales statistics are available.

Unpackaged Panther, no-label, and Sultan condoms are sometimes found in retail shops and in town markets. Estimates of quantities distributed are not available. Consumer prices range from Ush 20-50 per piece. Anecdotal evidence suggests that many condoms intended for free distribution end up being sold in the commercial sector.

Condoms in commercial shops are not evenly available. In Jinja, Protector seemed only available at selected drug stores. In Fort Portal, both Protector and Engabu were fairly widely distributed. In both areas, retailers were selling the condoms way above the suggested consumer price, with Protector selling at between Ush 250-500 per packet of three and Engabu selling at 300 per packet of five. When questioned on the purchase price of Protector, most retailers indicated that they purchased the product from resellers at prices of between 150-200 Ush per packet of three (the suggested retail purchase price is Ush 105 per envelope). Armtrades is negotiating with CARE, EIL, and FPAU to use their distribution networks to sell Protector. The company is also attempting to increase distribution through greater use of existing commercial wholesale channels.

7. Commodity (Condom) Supply and Logistics

Condom supply and distribution channels are complex and service providers have exceeded the responsive capacity of organizations managing condom supplies. A condom policy has yet to be adopted, supply shortages and stock-outs at the service level are frequent, storage space is inadequate, the multiplicity of agencies and organizations involved in MCH/FP and AIDS prevention programs makes the distribution system cumbersome and inefficient, record keeping systems are not fully operational, and training is needed at all levels of the logistics management system. This system will be sorely tested in 1993, when the number of condoms required is estimated to be 20.5 million units, doubling the amount required for 1992.

8. Host Country and USAID Management Considerations

Because of the large number of international donors providing assistance in the health and population sector in Uganda, effective coordination of programs (both service delivery and research) is difficult, at best. UNDP is thought to be "too bureaucratic and too burdensome because of formality requirements" to facilitate this multisectoral coordination.

Supervision and oversight of national AIDS and MCH/FP programs is inadequate. This is particularly critical if programs are to be integrated through a primary health care approach.

If USAID/Uganda is to integrate HIV/STD and MCH/FP activities, a project authorization which allows a flexible approach is needed. The project authorization should be broad enough in scope to allow inputs from "compartmentalized" central projects as needed.

D. Perceptions of Advantages/Disadvantages Related to the Integration/Coordination of Family Planning and HIV/AIDS Activities

Most of those interviewed evinced a recognition of the close relation between family planning and the AIDS epidemic. This was generally expressed in terms of family health and welfare.

Service providers generally stated that the question of whether programs should be integrated is irrelevant. At the client level, these two problems are already joined and clients must receive help in both areas.

MOH officials noted the need for integration at the service delivery level, with some continuing separation of programmatic thrusts at higher organizational levels. What should not be integrated is accountability; someone must be identified to be responsible for achieving the goals in each program area.

The need to involve the community more in the program (both as providers and recipients of services) and in becoming more responsible for the health status of the community was seen as essential. Greater outreach beyond static facilities was also seen to be needed.

To date, there has been little formal integration of family planning and HIV/AIDS activities in Uganda. However, almost all the people interviewed expressed interest in some level of collaboration. Those working in family planning were well aware that their workers need to be knowledgeable about AIDS when counseling their clients. The need to educate service providers about the use of sterile procedures also was well acknowledged. On the HIV/AIDS side, considerable interest was shown in including information about, if not provision of, family planning methods other than the condom to clients as a means of protecting the health of women and children.

Two different perspectives on integration were expressed by different religious organizations offering health care. The Islamic Medical Association has started a clinical family planning program (that does not include an IEC component) and is running two pilot HIV interventions in the community. From the association's perspective, it has been easier to convince religious leaders that condoms should be promoted for HIV/AIDS prevention (and that this will not encourage promiscuity) because use of condoms is sanctioned in their religion for family planning. The Catholic Hospital at Kivulu, on the other hand, is informing its clients about the use of the condom for prevention of HIV/AIDS as a health measure even though condom use cannot be promoted for family planning.

E. Constraints

The following are constraints to achieving more coordination or constraints in either AIDS or family planning programs that might be addressed more effectively by better coordination:

- Inadequate government commitment as expressed in budgetary allocations — Both family planning and AIDS prevention and control activities are still donor driven and donor financed.
- Difficulty of coordinating activities with so many different donors and different projects addressing AIDS and family planning.
- Bureaucratic constraints as funding is often made available for narrowly defined purposes. Although this may be useful to assure attention to essential program areas especially in initial stages, there comes a time when purposes of overall program efficiency require more flexibility to assure greater integration.
- Inadequacy of training of personnel both in family planning and AIDS prevention in order for them to be able to pursue these mutually supportive objectives effectively.
- Misconceptions by program leaders related to either family planning or AIDS.
- Substantial breakdown of the public sector infrastructure for delivery of health services over the past two decades.
- Lack of appropriate management systems for logistics, supervision, monitoring, and evaluation in the public sector.
- Ambivalence of program leaders with respect to the use of hormonal contraceptives in the presence of HIV; insufficient attention paid to the concepts of relative risk in determining program policies.
- Inability of programs to advertise — the requirement for "quiet promotion."
- Inability thus far to demonstrate to the private commercial sector that it is in its best economic interest to support the objectives of family planning and AIDS control both financially and with a sound workplace policy.
- Religious, cultural, and ethnic beliefs and attitudes including a conservative attitude toward frank discussion of sexuality especially with youth, the status of women in the home and society, etc.
- Lack of experience on the part of health and family planning programs in reaching and influencing behavioral patterns of youth.
- Remaining stigmatization and fear related to AIDS and AIDS infected clients — marginalization of AIDS-infected population, connotation of guilt making it more difficult to deal with prevention of AIDS between marriage partners.

F. Conclusions

There is less to be gained for the AIDS program from efforts to integrate AIDS activities into the present weak family planning efforts. There is considerably more to be gained both for AIDS and family planning if components of family planning were more formally included in AIDS counseling and informational services. This could produce a more comprehensive approach to dealing with clients, could contribute to preventive actions, and could reduce the burden on caregivers.

Improving the potential for mutual benefits within the present family planning and AIDS control structures will require cross training of service providers to make them minimally competent in the other area of concern. It will require upgrading and revision of the general IEC program of both program areas to clarify and address specific targets with appropriate messages that are mutually supportive of (or at least not antagonistic to) the

two objectives. It will require further study and policy decision making to clarify the role of contraceptives other than condoms in the face of a high prevalence of HIV infection; it will require a full supply of and improved logistics for condoms. It will require a policy change with regard to hormonal contraceptives which maximizes their availability at the community level and minimizes apprehension on the part of providers and clients due to physical examination requirements. If pelvic examinations are to be required and/or IUDs are used or male or female sterilization provided, increased attention is required to assure sterile procedures and an adequate supply of commodities.

Achieving a real payoff from more integration will require policy change that produces greater explicit financial and moral support from the government. It will also require some joint decision making by family planning and AIDS leadership to identify the areas especially in non-clinical, non-static facility, community-based programs in which joint programming can be carried out. This would imply a more aggressive approach to youth and workplace services, with a special emphasis on the private sector and on social marketing.

The uneven availability of condoms in the public, private, and commercial sectors suggests that current distribution policies and supply networks could be improved. The Protector social marketing campaign is capable of doing much more, but Protector's relatively high price, the lack of full-time marketing management, and the failure to utilize existing commercial and project-based distribution networks fully all work against realizing the full potential of this project. The potential for national distribution of the Engabu brand should be explored, as well as the possibility of providing marketing assistance to GTZ project personnel.

Greater emphasis on social marketing should take place while free distribution of condoms in the public sector is scaled back and focused more on target groups with the greatest need. NGOs, both local and international, should be encouraged to sell the social marketing brands using project, clinic, and CBD and community health worker distribution networks.

Botswana Country Profile

A. Overview

1. Population/Family Planning

According to the 1991 census, the current population of Botswana is estimated at 1.3 million. The rate of population growth is 3.5 for the period 1981-1991. Analysis of the census figures is currently under way at the Central Statistical Office; until this analysis is completed, the extent of any decline in fertility cannot be identified. At the current rate of growth, the doubling time for the population is 20 years. Since high fertility leads to a high proportion of children, the dependency ratio is nearly 100 percent.

Population density is low at the national level (2.3 people per square kilometer), but the pressure on arable land is great (population density on arable land was 307.3 per square kilometer in 1986). The urbanization process that is taking place indicates, along with other factors, that Botswana has a population problem. The urban population is 23.9 percent of the total and some urban areas and rural settlements have increased above this average national rate. Gaborone and Jwaneng have experienced the highest rates of growth, 5.4 percent and 12.8 percent respectively.

The economy in Botswana is financially strong but the labor market situation is such that only 20 percent of the population aged 15 and over has access to jobs. Income distribution is unequal: the poorest 40 percent of the population earns 11 percent of the total national income while the richest 20 percent earns 62 percent.

The MCH/FP services are offered through 520 operational district hospitals, health centers, clinics, and health posts by the MOH and the Ministry of Local Government, Lands, and Housing. According to the 1988 DHS, the modern method contraceptive prevalence rate was 32 percent among women in the childbearing ages. Modern methods, particularly the pill and injectables, have been replacing the use of traditional methods which have decreased from a prevalence rate of 9.2 percent in 1984 to 1.3 percent in 1988. Condom use was limited at the time of the DHS. It could have been expected that the HIV/AIDS program would have increased condom use, but there is no evidence of this. The distribution-based method mix shows a reduction in the percentage for condoms from 15 percent in 1988 to 11 percent in 1990 despite the increase in units distributed to clients in those years, 2.1 and 2.7 million respectively.

2. HIV/AIDS

The HIV epidemic is of relatively recent onset in Botswana, with significant spread in the population only since the mid-1980s. Early surveys in 1984 and 1985 detected no HIV seropositivity among the Basarwa population nor among terminally ill patients in several hospitals. The percentage of HIV seropositive blood donors increased from 0.9 percent in 1987 to about 9 percent in early 1992, a tenfold increase in five years. Several HIV seroprevalence studies, using non-standardized techniques, were conducted among pregnant women in Botswana between late 1990 and early 1992. These studies indicated that the HIV epidemic already had reached significant proportions in urban areas (Gaborone and Francistown, 6 percent and 8 percent, respectively), in a semi-urban area (Molepolole, 6.1 percent), as well as in a rural community surrounding a mining town (Orapa/Boteti, 7.5 percent). These data suggest that the distribution of HIV infection in Botswana is not limited to the major urban areas nor is HIV spread solely along the main truck route from South Africa to neighboring Zambia and Zimbabwe.

The Botswana National AIDS Control Program (NACP) conducted a systematic collection of HIV prevalence information at three selected sites (Gaborone, Francistown, and Maun) during February-April 1992 on antenatal clinic patients (which the WHO proposes as the best proxy for HIV prevalence in the 15-49 year old or sexually active population), male STD patients, and tuberculosis patients. The results of this HIV sentinel surveillance survey indicate that HIV seroprevalence rates have doubled from late 1990/early 1991 to

early 1992. About one out of six pregnant women in Gaborone (14.9 percent) and one out of four (23.7 percent) in Francistown are now infected with HIV. HIV prevalence is 12.7 percent in Maun, a semi-urban area which is the country's main tourist center and a major growth point in northern Botswana. Only 350 cases of AIDS had been reported in Botswana as of June 1992.

STDs are a major health problem, accounting for 6-7 percent of all public sector out-patient visits. The HIV prevalence rate in Gaborone is significantly higher among men with another STD than among women seeking antenatal care. Whereas the peak age-specific HIV prevalence among women is among the 20-24 year olds, men with STDs have their peak age-specific prevalence 10 years later (ages 30-34). As seen elsewhere in Africa, the female to male HIV infection ratio is approximately 1:1.

A July 1992 NACP report concluded that the "HIV epidemic has been explosive in Botswana and has now reached catastrophic proportions." Factors found to contribute to the rapid spread of HIV in Botswana include high rates of other STDs in the population (estimated annual 1989 incidence rate of 8.5-12.7 percent in 15-49 year olds), early age of first sexual activity, multiple sexual partner behavior, and the high mobility of the population which implies work-related separation of partners over long periods of time.

B. Organization of Programs

1. Population/Family Planning

Two ministries are responsible for the health care system in Botswana, the MOH and the Ministry of Local Government, Lands, and Housing. National policies and supervision of the entire system are the main responsibilities of the MOH. This ministry also runs nine district hospitals. The Ministry of Local Government, Lands, and Housing is responsible for the supervision of the 15 district health teams in charge of running 15 primary hospitals, 169 health clinics, 308 health posts, and 665 mobile stops. Mining companies operate three hospitals, and three more hospitals are operated by missions. This health service network is well distributed: 85 per cent of the population lives within 15 kilometers of a health facility.

The provision of family planning information, services, and supplies is an integral part of the MCH Unit of the Primary Health Care Department. Family planning services are provided in some form at all levels of the government health system, which is by far the largest provider in the country.

Besides the governmental effort, some NGOs recently started or are about to start some family planning activities. Religious missions and private companies operate facilities with family planning included. The Botswana Family Welfare Association, which was established in 1988, provides information, education, and counselling at the community level. The YWCA provides information on family planning in its mothercare center for adolescent mothers.

An inter-ministerial steering committee was previously charged with the coordination of institutions involved and activities performed in population and family planning. The recently created Council on Population and Development with government leadership, which includes non-governmental representation, is expected to be effective in implementing and coordinating population and family planning activities throughout the country. Prevention of HIV/AIDS is recognized as a priority issue in population/family planning, a fact that is underscored by the participation of the director of the NACP as a member of the council. In addition, a Reference Group, including the ministries mentioned above plus the Central Statistical Office, has been provisionally established to assure effective coordination in implementing the USAID-funded Botswana Population Sector Assistance (BOTSPA) project. The council will probably incorporate the program and the Reference Group may eventually disappear.

Botswana's family planning program has been successful in that about 32 percent of the women in the reproductive ages practice contraception. Despite this relatively high prevalence rate, the discontinuation rate

is running at about 50 percent in this pill-dominated program and the population growth rate, 3.5 percent, is one of the highest in the world.

2. HIV/AIDS

In Botswana, the integration of family planning programs and HIV/AIDS prevention programs has evolved as a logical extension of an integrated primary health program. The government, USAID, and other donors have learned from previous experience and earlier debates on the issues and have moved ahead to develop integrated programs.

In developing an integrated program, issues of collaboration and coordination are paramount. The responsibility for coordinating HIV/AIDS and family planning activities has been placed at a high level of the government. In the case of HIV/AIDS, the NACP was established to coordinate the participation of the Ministries of Finance and Development Planning; Health; Local Government, Lands, and Housing; and Education. This is to assure that policy, financial, and operational issues will be addressed from the perspective of the overall program.

Activities are starting or about to start, and there are some indications that they can have a great impact on both the fertility rate and AIDS, given the commitment of the government and the infrastructure offered by the MCH/FP program and the commercial sector. The population of Botswana is small but easy to reach, and the country has demonstrated the ability to provide contraceptives to a large proportion of the general population. The social marketing program has the potential for success, and the family planning association also has the ability to supplement the distribution of condoms efficiently within its projected CBD program.

C. Description of Activities

1. Training Programs

Assessments of both family planning and AIDS programs in Botswana underscore the need for training of personnel. Lack of skilled staff is one of the major constraints to effective delivery of services in both sectors and, therefore, an impediment to integration of family planning, AIDS, and STD activities.

From the highest levels of the MOH down to the family welfare educators, the system is severely understaffed. For example, the health education unit in the MOH has seven positions, but only three are currently filled. Skilled people are quickly lured to the private sector where salaries are higher and they are not faced with frequent transfers.

At service delivery points, nurses provide most services as doctors are at a premium. Since nurses are in short supply, however, family welfare workers, who are supposed to educate the community about health matters, are being pulled into the clinics to help provide clinical services. Surveys among the nurses themselves have revealed that although many have received training in IUD insertion, few feel qualified to do it. Guidelines, standards, and procedures for providing family planning and STD services exist, but most providers are not familiar with them and do not use them.

Family planning service providers also lack training in counseling and interpersonal communication so that they are poorly qualified to help clients make informed choices. With plans in the works to integrate STD diagnosis and treatment and HIV/AIDS education and prevention throughout the MCH system, the need for training of all service providers in counseling and interpersonal communication skills becomes a critical factor.

To date, it appears that two training approaches have been employed: sending selected staff abroad for specialized training and holding workshops for selected groups. The idea behind both strategies is that those attending the training will then go back to their posts and train their colleagues. The little in-service training that exists is usually didactic not skills-based and rarely includes family planning.

As there is also a dearth of well-trained people in the private sector, it will not be possible to turn to the NGO community for assistance in this area.

USAID's new project will include third country and on-the-job training at district level. The initial aim will be to provide as many MCH/FP service delivery points as possible with a minimum number of better-trained personnel and to begin the process of skills transfer from supervisors to service providers. As the training schedule permits, either during the project or after, additional trainees will be selected. They will include midwives and medical officers from hospitals.

Expected outputs of these training efforts include a central training section to provide effective training to service providers and supervisors; at least 480 service providers, primarily from district level; a training information system to track on-the-job performance; at least 105 managers and supervisors familiar with the training program.

2. IEC

An 1991 evaluation of USAID's population project (Bertrand, et al) reported that, "The lack of a clear IEC strategy, using established communications channels to reach segmented target audiences, is generally acknowledged as the most serious gap in the government's population program." To date, there has been little promotion of family planning through the media. Botswana lacks its own television production capability, but has a large radio listenership and a well-established print media. The literacy rate in Botswana is high, actually higher for women than men. Most people, however, continue to receive family planning information from clinics. Due to the heavy workload in most clinics, and the lack of appropriate training, health education activities are minimal. The MOH has a cadre of trained community-level family welfare educators who are supposed to educate the community about health matters, including family planning. As mentioned above, due to the shortage of nurses, most of these family welfare workers have been pulled back into the clinics where they are assisting nurses in providing clinical services rather than doing IEC. Therefore, counseling and information services are minimal to non-existent in most clinic settings.

The MOH operates an IEC production unit that produces pamphlets, posters, and radio programs. The quality of work done by the MOH production unit is reported to be high, although it is often backlogged due to shortage of staff and the mandate to serve all the programs operated by the MOH. Print materials have been developed for both literate and semi-literate audiences, although there are significantly more of the former than the latter. (No IEC materials have been produced on STDs.) The main problem is that these materials are not readily available in the clinics. There is no established mechanism for distributing IEC materials. Unused materials are piled up in storage areas and most service providers do not know that they exist.

Outside of the government program, a few NGOs have become active in family planning IEC. Botswana does not have a strong tradition of NGO involvement, so these groups do not represent an existing source of expertise. Botswana has a high rate of teenage pregnancy and a number of these groups are focusing their efforts on young adults, including the Red Cross Society, the YWCA and the Botswana Family Welfare Association (BOFWA), an IPPF affiliate formed just three years ago. All these programs are attempting to provide young people with family life education both in and out of school. Some programs, such as BOFWA, provide condoms on request. The YWCA's PACT project trains students to run family life education workshops for their peers in secondary schools. They include information on family planning, including contraceptives. AIDS information and prevention is stressed. Students would like contraceptives to be made available in the schools so they could avoid the potential embarrassment of seeking services at clinics or even in pharmacies where they may encounter family or friends.

The Ministry of Education has mandated that family life education be included in the school curriculum as part of the biology courses in secondary school. However, because no questions on the material are given on examinations teachers do not feel compelled to teach the units. BOFWA is trying to work with the teachers

to make them more comfortable in dealing with the subject. BOFWA is also working with parents, to make them more receptive to the curriculum.

There is now an emphasis on presenting family life education material as part of the primary school curriculum as sexual activity starts early in Botswana (sources at the YWCA who work with adolescent mothers report that girls are often sexually active by age 9 or 10) and many students drop out of school after primary school, when they are about 12 years old. Efforts to reach out-of-school youth have been less successful. Efforts are being made to work with groups of young people attending evening schools or involved in study groups.

Little has been done to reach men with family planning IEC. A leaflet was developed to accompany condoms sold in vending machines. This program has been discontinued, however. One program specifically targeting men is the workplace program (one component on family planning is supported by UNFPA and another for AIDS has been funded by USAID). The program operates primarily through the training of peer educators in the workplace.

Another approach to reaching men is through the Botswana Defense Force, which has its own health care system that provides services to families as well as military personnel. Condom use is now being promoted by the military, but this has happened primarily in response to the threat of AIDS.

Overall, IEC activities in support of family planning in Botswana remain weak and little technical capacity exists within the private sector. One of the initiatives of the USAID-funded program is to strengthen the capacity of local NGOs to provide technical assistance in areas such as IEC and training.

In terms of HIV/AIDS, initial IEC activities focused on moralistic campaigns in support of monogamy which kept the messages at arms length from the reality of people's lives. Materials stressing the importance of keeping to one partner were not only not reflective of the reality in Botswana, especially given the difference in the sex ratio with women significantly outnumbering men. They were, in fact, misleading in the case where one partner was already infected with HIV. Few people took the message seriously at that time as few personally knew anyone who had died of AIDS.

Botswana's current realization that AIDS poses a serious threat to the health and economic development of the country has led to action. As family planning activities are already integrated into MCH services, it seemed logical — on the part of the government — that the prevention of AIDS should be integrated into the MCH/FP program. Although AIDS activities in Botswana are under the direction of the NACP, most HIV/AIDS IEC activities continue to be carried out through the same MOH channels that support family planning.

HIV/AIDS-related IEC efforts have progressed in that messages are now more appropriate and are highly visible on billboards, posters, bumper stickers, etc. Radio programs and spot announcements are on the air and there are plans to use folk media, including drama.

With the integration of AIDS education into the MCH/FP system, AIDS activities will face the same constraints noted above for family planning. Clinics and health posts lack materials and service providers have limited skills in communication, which will be even more important when dealing with AIDS and STDs.

As is the case with family planning, the health system is not proving to be the best mode for reaching groups such as youth and men. These activities are being picked up by the private sector. In addition to groups already involved in family planning, several groups have been formed to deal exclusively with the issue of AIDS, including the business community. These include the Botswana Red Cross Society and Teachers Against AIDS.

The Botswana Defence Force has involved platoon leaders in the dissemination of HIV/AIDS information to their units. In addition, one member of each platoon is being trained as a peer counselor. Condoms are being promoted and are being made readily available to members of the armed forces.

Integration of family planning and AIDS activities in Botswana is already a national policy. In terms of IEC as other service delivery components, it will only be successful if the existing system is sufficiently strengthened and if materials developers and service delivery staff are given sufficient training, supervision, and support. Many of these issues are being addressed in the new USAID program for Botswana.

To date there has been little involvement of the business and commercial sectors in IEC activities for HIV/AIDS. This is partly due to a tendency to look to the government to take care of such things in this small and relatively prosperous country.

3. Social Marketing

A social marketing of condoms program is scheduled to begin in Botswana in November 1992 under the direction of Population Services International (PSI) with funding from USAID. In the past, the government had not shown interest in establishing a contraceptive social marketing project for the sale of contraceptives. With the advent of the AIDS epidemic, however, and the resulting emphasis on the use of condoms to prevent the spread of HIV, it has decided that there is a place for such a project.

Condoms are currently available without charge through MOH MCH/FP outlets. The brand distributed by the government, Sultan, is not very popular — people say that they smell funny and often break. Those who can afford to do so purchase better-quality condoms in pharmacies. The MOH sees the social marketing project, which will offer better quality condoms at subsidized prices, as filling the gap between the free commodities available within the health system and the more expensive brands available commercially.

In order to implement the project, PSI will establish a new local NGO affiliate in Botswana. PSI will manage the program through this affiliate with the intention of transferring management responsibility to the local program within five to seven years. The initial agreement with PSI will run for a period of three years and will then be evaluated to determine the future direction of contraceptive social marketing (CSM) activities in Botswana.

The objectives of the CSM project, over the three-year period, are to 1) sell over 2 million condoms; 2) achieve a broad distribution in all urban and commercial centers including workplaces, bars, hotels, kiosks, and market stalls; 3) train and develop a local distributor; and 4) carry out an aggressive promotion and advertising campaign.

PSI will carry out consumer research and, based on the results, will determine brand name, packaging, and type of promotion to be used. PSI will also carry out a baseline KAP study with regard to condom use. The condoms for the program will be supplied by the government.

Monitoring and evaluation research activities will be a part of the project. They will include 1) product inventory status, 2) number and location of outlets, 3) sales, and 4) expenditures and revenues. PSI is aware that the efficiencies of scale that are possible in large markets cannot be realized in the case of Botswana because of its small population. Thus, the project will be designed to reduce costs wherever possible.

4. Condom Supply and Logistics

Contraceptives were originally provided by USAID, UNFPA, and the Government of Botswana. UNFPA stopped the provision of contraceptives in 1991, except for Depo-provera. USAID began phasing out of contraceptive procurement in 1987. As of May 1992, the government purchases all contraceptives (with the

exception of Depo-provera). The amount of condoms introduced into the country has increased from 1.2 million units in 1990 to 4 million in 1992.

Hospital clinics and health posts have enough contraceptives to meet current levels of demand, but lack of supervision, transport problems, and poor calculation of monthly needs have resulted in over- and under-stocking and expiration of some commodities.

D. Perceptions of Advantages/Disadvantages Related to the Integration/Coordination of Family Planning and HIV/AIDS Activities

Some of the constraints within the system that could affect successful implementation of an integrated program include the following:

- A lack of skilled staff throughout the public sector from ministry level to family health workers.
- Few service providers currently possess effective counseling and interpersonal skills. These skills will be essential if these workers are to deal effectively with the issues of HIV/AIDS prevention and diagnosis and cure of STDs. The lack of these skills may also be a factor in the low continuation rates in the family planning program.
- Most of the financial support for family planning is currently being provided by international donor agencies. The willingness and ability of the government to assume a greater share of the cost of these programs will be an important consideration in their long-term viability.
- The NGO community in Botswana is relatively young and is not in a position to provide much in the way of expertise to the national program.
- Private sector resources (i.e., the business and commercial sectors) have not been tapped for public relations and financial support. In a country like Botswana, which is relatively prosperous, the private sector could play an important role in promoting and sustaining an integrated program.

The experiences of the earlier USAID BOTSPA project and the Botswana AIDS in the Workplace Project funded by the A.I.D. Africa Bureau's HIV/AIDS Prevention for Africa (HAPA) project had led to the development of an amendment in the new BOTSPA project which will support an integrated approach to STD/HIV prevention and MCH/FP. This project is "on the leading edge" of current public health thinking with regard to HIV/AIDS prevention and control. For this reason, it is paramount that aggressive monitoring, evaluation, and impact assessment of the project be initiated as soon as possible.

Appendix F

The Demographic Impact of the HIV/AIDS Epidemic on Sub-Saharan Africa

Introduction

The continuing spread of the AIDS epidemic throughout sub-Saharan Africa has increasingly led to a discussion of the demographic impacts of the disease. The issue is of key importance for several reasons including the following:

- Rapid population growth in sub-Saharan countries is a major hindrance to the economic and social development of those countries;
- The AIDS epidemic has a disproportionate impact on the economically productive segments of society (i.e., the 20-35 age group) and the better educated and wealthier. Thus, the disease does not follow the usual pattern of targeting the weaker segments of society (i.e., the young and the old);
- It is frequently stated by senior host country officials as well as by senior-level representatives of donor organizations that the AIDS epidemic will take care of the population problem;
- Programs to reduce fertility and population growth require a better understanding of the epidemic's impacts for planning these programs;
- Sub-Saharan Africa is the fastest growing region in the world in terms of population, with an estimated doubling time of 23 years (from mid-1989) and with approximately half its population presently under the age of 15 years; and
- In order to adequately target interventions, national HIV-prevention programs need to know the ongoing and potential demographic impacts of the disease in their respective countries.

The issue of the demographic impacts of AIDS needs to be placed in an historic context. During the early years of the epidemic, it was commonly stated that the epidemic would take care of the population problem in sub-Saharan Africa. The pendulum then swung back to the position that the epidemic would have no significant impact on the population problem, and that the AIDS epidemic and positive population growth rates would continue to be seen together.¹

Projection Models – General

A number of mathematical models have been used to assess the impacts of the AIDS epidemic on sub-Saharan Africa's population growth and the results have not been totally consistent, in large part because of the unknown future trends of the epidemic. It must also be noted that models have been based on current data, mainly surveys of HIV seroprevalence and the number of reported AIDS cases. HIV and AIDS reporting throughout sub-Saharan Africa is recognized as being very inadequate.

Anderson, et al., have been the leading proponents of the possibility of negative population growth. They have modeled the epidemic to produce a negative growth rate within 30-60 years (using an initial growth rate of 4 percent). However, in this model, HIV-prevalence rates rose to 50 percent at the time population growth rates became negative.

Bongaarts' work finds that population growth rates would not decline by more than half. The major difference in these two scenarios is that Bongaarts' HIV-prevalence rates level off at 20 percent of adults and never attain the high rates used by Anderson.

Way's work² based on the iwgAIDS model (the Department of State's Interagency Working Group)³ simulates that in a typical African country. The Bureau of the Census projection (over a 25-year period -- 1990-2015) finds HIV prevalence increasing from under 4 percent to over 16 percent of the total urban adult population, and rural HIV prevalence increases from 0.5 percent to about 5 percent of the adult population, a tenfold increase. The initial population is 5.5 million with 20 percent living in urban areas.

Population growth is assumed to decline from 2.8 percent to 2.2 percent over a 25-year period due solely to demographic trends. With an HIV-prevalence rate reaching 8 percent in the adult population, the population growth rate would decline to 1.8 percent. In 2010-2015, the population grows at 1.5 percent per year as compared with 2.3 percent in the absence of AIDS. Due to the large excess of births over deaths, total population continues to increase, but the increase is reduced by more than 500,000.

"Thus, even with a relatively severe AIDS epidemic (e.g., 25 percent of sexually active adults infected) reaching into both urban and rural areas of the country, total population growth rates may decrease by only about 1 percentage point . . . Since modeling results show that birth rates may be little affected by the epidemic, African countries should continue to have strong positive growth rates, despite the presence of an AIDS epidemic."⁴

Although other issues are involved, the major difference between these predictions is predicting the future level of HIV infection. One assumes that, as seen in other epidemics, adult seroprevalence will plateau well below 100 percent. The question remains at what point below 100 percent. It had previously been stated that adult seroprevalence levels had plateaued in many urban areas. With the possible exception of Kinshasa, this appears to be no longer absolutely correct, although the rate of increase has slowed.

In addition, longer-term projections must estimate not only new HIV infections, but also changes in behavior. Given that our present knowledge concerning behavior and its motivating factors is extremely weak, it is questionable whether one can adequately predict future trends in behavior.

The increasing seroprevalence in many rural areas is mirroring the previous epidemiologic curve of urban areas. Thus, although unknown, it may not be out of the realm of possibility that the seroprevalence levels will eventually, in the mid to distant future, be closer to 50 percent than 8 percent of the adult population.

Most of the models (with the exception of Anderson) assume a leveling off or plateauing of HIV prevalence even if no behavior change takes place. "These plateaus occur as certain high-risk groups become saturated."⁵ However, the epidemic has gone beyond "high-risk" groups in most sub-Saharan African countries. Therefore, even if a leveling-off does occur, it may occur at rates significantly higher than those predicted which concentrate on the spread of HIV through high-risk groups.

Projection Models -- Specific Countries

A number of attempts have been made to project the demographic impacts of the AIDS epidemic within specific countries. This section discusses three such attempts: Kenya, Uganda, and Rwanda.

Kenya

The demographic impact of AIDS in Kenya has been investigated by AIDSTECH/FHI⁶ and by The Futures Group⁷.

The FHI projection, while still in draft form, predicts that instead of a growth rate of about 3.15 percent in the year 2000 (assuming a medium fertility rate), the growth rate would be 2.6 percent (assuming 0.8 percent incidence) or 2.35 percent (assuming 1.4 percent incidence) with seroprevalence rates leveling off by the year 2000. Under a very high scenario (incidence of 2.1 percent), population growth would decrease to about 2 percent. The FHI projection also concluded that due to the higher seroprevalence in urban and peri-urban areas, the greatest impact would be seen in those areas.

Stover and Johnston assumed a current HIV prevalence of 3 percent increasing to 8 percent by the year 2000. They recognized that this was a conservative estimate. Using the DemProj model⁸ together with various standard demographic projections provided by the Long Range Planning Division of the Kenyan Ministry of Planning and National Development, they predicted that HIV infection would increase from about the present 700,000 HIV-positive individuals to over 1.4 million in the year 2000 and 1.9 million by the year 2010. Infection would be concentrated in the young adult population with approximately 44,000 HIV-positive newborns per year by the year 2010.

Stover and Johnston's projection predicts that the population would grow from a present 22.6 million (1989) to approximately 40.4 million, rather than to 45.3 million without the impact of AIDS. Thus, although there are a great number of deaths due to the disease, the overall population still grows significantly. The growth rate would decrease from 2.8 to 2.1 percent by the year 2010. However, this means that the population is still growing by approximately 850,000 people per year. Stover and Johnston predict that the "population will double in size in the next 25 years even with a severe AIDS epidemic."⁹

The TFR was 6.7 in 1989 and the projection assumed a continued decrease to 5 in year 2000, and 4.2 in year 2010. "[T]he assumed reduction in the fertility rate causes about as much decline in the rate of population growth as does AIDS."¹⁰

Uganda

The demographic impact of the AIDS epidemic in Uganda has been investigated by the World Bank¹¹ and The Futures Group¹².

The Futures Group assumed a declining TFR from 7.35 in 1988 to 4.0 in 2008 and to 2.5 in 2028. It also assumed an increase in adult HIV seroprevalence from 9.3 in 1988, to 15 by 1998 at which point it levels off.

With these assumptions, population growth rate decreased from 2.8 in 1988 to about 1.0 in 2008 and 0.5 in 2028. The growth rate did not become negative even after 40 years. It should be noted that in this projection the major impact in decreasing growth was due to the declining TFR. If the model was run assuming no AIDS, the population growth rate would still have decreased to 1.5 by 2028.

To follow up this point, a second scenario was run with the same assumptions except that TFR was kept constant. In this scenario, the population growth rate initially declined from 2.8 in 1988 to 2.5 in 2003. However, the rate then increased to 3.2 in 2028.

Similarly, the World Bank model projects that even with the AIDS epidemic, population growth rates will remain above 3 percent, although AIDS-related mortality could reduce population growth by 0.5 percent annually.

Rwanda

The demographic impact of the AIDS epidemic in Rwanda has been investigated by The Futures Group¹³.

Rwanda has a reported population of about 7 million (1991 census) and has the highest population density in Africa. The average number of children per women in approximately 7.6 and the rate of natural increase is estimated at 3.1 percent per year. This leads to a doubling time of the population of about 23 years.

The projection used two scenarios: the first assumed a 3 percent HIV prevalence in 1992-1997, increasing by 1 percentage point per year until 2007 in which it levels off at 6 percent; the second scenario increased infection rates by 3 percentage points every five years until leveling off at 12 percent. Fertility was projected to decline gradually from a TFR of 8.0 in 1992-1997, to 3.41 in 2037.

The results show that in the first scenario, the population will continue to grow while the growth rate declines to 2.1 percent per year. In the second scenario, the annual growth rate declines to 1.9 with an overall population doubling time of about 35 years.

Additional Questions

There are a number of additional questions relating to the demographic impact of the AIDS epidemic including the following:

Impact on total fertility rates: Although anecdotal evidence suggests that some women may want to have as many children as possible before they die, others may decide to stop producing children so as not to leave them orphaned.¹⁴

Impact on the age of marriage: The age of marriage may be lowered as men seek younger women who have not yet been exposed to HIV.

Infant and child mortality: Stover and Johnston project an increase in infant mortality of 11.5 percent by the year 2010 (61 without AIDS; 67 with AIDS); and an increase of 32.6 percent in child mortality (95 without AIDS; 126 with AIDS). Bureau of the Census projects that by the year 2015 infant mortality will increase by more than 20 percent, and mortality in under-fives will increase nearly 50 percent.

Dependency ratio¹⁵: It is often stated that the dependency ratio will be significantly affected by the AIDS epidemic. However, Stover and Johnston predict that the dependency ratio will be little affected by the epidemic. In Kenya, they predict the ratio to increase only 1.8 percent by year 2010 (75.8 without AIDS; 77.2 with AIDS). The rationale, in part, being "that AIDS kills not only young adults but also infants and children."¹⁶ They recognized, however, that by the year 2010, there would be over 1 million orphans.

Similarly, World Bank projections for Uganda find that "the dependency ratio is affected only very slightly because of the offsetting effects of pediatric and adult AIDS deaths."¹⁷

The Bureau of the Census, however, found that the impact on the dependency ratio would be more significant and projects that, in their model described above, the dependency ratio would be 83 in the no AIDS scenario, 88 in the projected scenario, and 89 in the amplified scenario.¹⁸

Potential changes in societal behaviors as the sex ratio becomes more heavily weighted in favor of males due to increased female deaths¹⁹: Although WHO has suggested a sex ratio of 1:1²⁰, it appears that more women are being infected and dying than men. Although the usual population pyramid for an entire country in Africa is fairly symmetrical, in urban areas it is pronounced due to the migration of young men (18-35) in search of work. In much of East and Southern Africa, the male:female population ratio in the 20-35 age group is around 1.5:1. In general, urban HIV prevalence is highest in men aged 25-35 and women aged 15-25 due to the tendency in Africa (and throughout most of the world) for relationships to be formed between older men and younger women.

This is a result of who mixes with whom. Modeling has shown that HIV will spread much faster when sexual relationships are formed across age cohorts than if relationships remain only within a cohort.²¹ Nevertheless, the distorted population pyramid results in an overall ratio of 1:1.

Even assuming overall male:female infection rates to be equal, the impact on the number of women dying would be greater since they are infected earlier. Nevertheless, the age-specific population is not the same as there are more younger people than older throughout Africa. This means that there are more younger women infected as there are always more women aged 15-25 than men aged 25-35. Thus, women are not only dying earlier of AIDS, there are also more of them dying. The future demographic effect of this situation is a progressively decreasing ratio of females:males in the older reproductive age groups as the present cohort of teenagers enters into their twenties and thirties. The pool of available equal-age female partners for men in their thirties and forties is shrinking, further increasing pressure for the formation of unequal-age partnerships.²²

The AIDS epidemic is now spreading throughout much of the rural area as economic migrants continue to move back and forth between the urban and rural environments. "However, as the epidemic spreads into the larger rural population, the absolute size of the most severely affected younger female population is larger than the size of the older adult population, which eventually results in a higher number of infections in women."²³

Nevertheless, recent surveys from Côte d'Ivoire show a 2:1 male:female ratio of infection.²⁴ This difference may be related to the stage of the epidemic the country is in.

Sub-national variations: In general, the models do not investigate sub-national variations in infection and death rates. However, variations within country are extremely important as they affect such factors as local labor shortages and internal migration patterns.

Of greater importance, however, is the need to know patterns of sub-national variation so that adequate interventions can be designed and implemented. For example, the iwg model predicts that by 2015, the number of infected persons in rural areas will exceed those infected in urban areas. Therefore, national HIV-prevention programs need to begin to target rural areas to a much greater degree than at present.

Conclusion

In general, the consensus follows the position summarized in the following statement by May and Stover: "The only circumstances that would lead to negative population growth would be replacement level fertility combined with national adult HIV prevalence levels of 15 percent or more. The largest contribution to reduced population growth rates in these situations is reduced fertility not increased mortality due to AIDS."²⁵

It is important, however, to differentiate population growth on a national level from that of selected age groups. The impact of AIDS will be more substantial than the general population numbers would suggest. Deaths from AIDS are concentrated in groups that are generally considered to have lower morbidity and mortality, i.e., those in the early adult years. Therefore, the population age structure may be significantly different as a result of the epidemic.

The Bureau of the Census projects that the excess urban mortality for those aged 30-50 due to AIDS will be 6 to 7 times. Nevertheless, it must be noted that a death at age 20 has greater consequences for a country than a death at age 50-60.

Finally, it can be concluded that both family (and extended family) welfare and general socioeconomic development factors will be influenced unfavorably by both AIDS and the expected continuing rapid population growth. Consequently, irrespective of the degree to which they are integrated, it will be imperative to maintain and increase support of programs both to prevent and control the spread of HIV/AIDS infection

and to bring rapid population growth rates into balance with the capacity of individual families and the society to absorb and productively utilize greater numbers.

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Endnotes

1. For example, a recent WHO estimate predicts that Africa's overall population growth rate of 3% will be reduced by .5, resulting in an average annual rate of 2.5%. WHO, "Update on AIDS" Weekly Epidemiologic Record, Nov. 29, 1991.
2. Way and Stanecki: The Demographic Impact of and AIDS Epidemic on an African Country: Application of the iwgAIDS Model, CIR/BUCEN, 1991.
3. The iwg model includes a variety of behavioral factors; marriage formation and dissolution, patterns of sexual contact, turn-over rates, condom use. However, one can question whether there is sufficient accurate information concerning the individual and societal pressures which determine one's sexual behavior to facilitate the model's accuracy.
4. Underline in original. Way: HIV/AIDS in sub-Saharan Africa, p.9.
5. Stover & Johnston, p.1.
6. AIDSTECH/FHI: An Assessment of the Health and Economic Impact of AIDS in Kenya, Draft Document, 1992.
7. Stover & Johnston: The Demographic Impact of HIV/AIDS in Kenya, 1992.
8. DemProj is a demographic projection model that incorporates an AIDS component.
9. Stover and Johnston, p.5.
10. Stover and Johnston, p.3.
11. World Bank: Uganda: The Economic Impact of AIDS.
12. May and Stover: The Impact of HIV/AIDS on Population Growth in Central Africa: The Cases of Uganda and Rwanda.
13. May and Stover.
14. Dr. Susan Allen is presently conducting research in Kigali on women's fertility-related decision making given HIV/AIDS.
15. The dependency ratio equals the number of dependents (children under the age of 15 and adults over the age of 65) per 100 adults.
16. Stover & Johnston, p.4.
17. World Bank: Uganda: The Economic Impact of AIDS, p.16.
18. Way: Demographic Impact of HIV in Less-Developed Countries, p.10.
19. Most of the following discussion is taken from DeCosas and Pedneault: The Demographic AIDS Trap for Women in Africa: Implications for Health Promotion.

20. In Uganda, Berkley et al have found a sex ratio of 1:1.4. Berkley et al.

21. Anderson, R: The Transmission Dynamics of Sexually Transmitted Diseases: The Behavior Component, Presented at the Seminar on Anthropological Studies Relevant to the Sexual Transmission of HIV, Denmark, Nov. 1990.

22. DeCosas and Pedneault, p.7.

23. DeCosas and Pedneault, p.2.

24. Benoit et al.

25. May and Stover, p.12.

Appendix G

A.I.D.-Supported Programs for HIV/AIDS Prevention and Control in Sub-Saharan Africa¹

Introduction

The urgency and magnitude of the AIDS epidemic have resulted in a significant mobilization of national and international resources. All countries in sub-Saharan Africa have National AIDS Control Programs (NACP) based in the Ministry of Health. The NACPs have developed, in conjunction with WHO/GPA, Medium Term plans which are operationalized into practical intervention projects. Most countries have been operating under these plans for 3-5 years.

The NACPs were established as vertical programs within the MOH, but act as independent organizations. Frequently NACPs are housed in buildings separate from the MOH and their budgets are totally donor supported. With few exceptions (Ethiopia), the costs for HIV/AIDS-related activities have been borne, and continue to be borne, almost totally by the donor community.

On an Africa-wide basis, the largest donors have been international agencies and foundations, the United States, the Scandinavian countries, and Germany. The United Kingdom, Canada, Switzerland, Netherlands, Italy, the former USSR, Belgium, Finland, Japan, and others have also funded HIV/AIDS prevention activities. A.I.D. has been pre-eminent among the donor community in its commitments and efforts to confront the AIDS epidemic in sub-Saharan Africa.

Overview of A.I.D. HIV/AIDS Prevention and Control Programs in Sub-Saharan Africa

A.I.D. has obligated approximately \$100 million for HIV/AIDS prevention in Africa since 1986. Funding has been used for monitoring HIV/AIDS; increasing government and public awareness; assisting African countries with the development and implementation of AIDS prevention programs; and conducting applied research aimed at improving preventive measures. A major constraint to providing assistance is that investments in HIV/AIDS control are limited by the interests and policies of African governments. Other constraints include government absorptive capacities for preventive health care and competing public health priorities. Therefore, A.I.D. has tailored its response to specific country situations, emphasizing interventions ranging from heightening the awareness and commitment of governments to combat HIV/AIDS to increasing the use of condoms and changing sexual behavior. A.I.D. project activities have emphasized community-based education programs focused on changing attitudes and behavior.

A.I.D. Policy and the HIV/AIDS Strategy for Africa

A.I.D.'s 1987 Policy Guidance on AIDS put forth the following four principles to guide all A.I.D.-supported prevention and control activities:

- increase the awareness of policy makers of the impact of HIV/AIDS on their societies;
- focus on prevention of the infection;
- create sustainable programs; and
- emphasize continual program monitoring and evaluation.

¹This is excerpted from an A.I.D. document.

In response to a recent directive from the A.I.D. administrator, the agency is in the process of reviewing and updating the Policy Guidance on AIDS. The update should be completed by October 1992.

Currently, the strategic approach of A.I.D.'s HIV/AIDS prevention activities focuses on

- reducing the sexual transmission of HIV;
- concentrating resources in key countries;
- developing public-private sector partnerships;
- conducting community-based approaches/interventions; and
- expanding knowledge about sexual behavior and applying that knowledge toward the design of more effective interventions.

The Bureau for Africa's HIV/AIDS strategy is built around the following key elements:

1. Promoting a **regionwide approach**, because the HIV virus honors no national boundaries. The scale and type of A.I.D. country programs are most influenced by
 - estimated current prevalence of HIV;
 - probable potential for transmission of the disease, determined by
 - prevalence of other known sexually transmitted diseases;
 - the size and proportion of the urban population;
 - government (or other indigenous) commitment and capacities; and
 - USAID mission capacity to design and manage a program.
2. Concentrating on applying current knowledge to **prevention measures**. Basic research and/or treatment activities are not funded.
3. Emphasizing **surveillance** so that the spread of HIV/AIDS can be monitored. A.I.D. is working closely with the U.S. Bureau of the Census and other agencies in conducting surveillance activities.
4. Emphasizing **African leadership** in defining the scale of the problem and the most appropriate prevention and control measures. An indicator of host government commitment is the official budgetary level (with attribution to either or both host government and donor) for HIV/AIDS prevention.
5. Supporting the **leadership role of WHO/GPA**, while maintaining effective and appropriate support for USAID mission-sponsored bilateral HIV/AIDS activities in-country.
6. Concentrating on **targeted interventions** using all accessible organizations in Africa, including existing USAID contractors and grantees, other U.S. Government agencies, and other U.S.-based and indigenous non-governmental organizations.
7. Promoting **integration of HIV/AIDS interventions** into any ongoing USAID-sponsored health, population, and nutrition activities in-country.
8. Providing funding and technical assistance for programs to encourage **sexual abstinence by adolescents and marital monogamy** and discourage "high risk behavior." Also providing condoms for some national programs.
9. Seeking to mobilize private and voluntary sector institutions to encourage sustainable interventions at the grass-roots level.

A.I.D.'s Evolving HIV/AIDS Program in Africa

As AIDS has reached serious proportions, A.I.D.'s strategy for addressing the problem has evolved to meet changing priorities. Initial efforts in 1987 were limited, and resources were channelled through WHO. In late fiscal year 1987, a major centrally administered AIDS Technical Support Project (ATSP) was initiated by the Bureau of Research and Development (R&D) (formerly the Bureau for Science and Technology) to provide technical support on a worldwide basis. The AIDS Technical Support Project (ATSP) employed three major Cooperating Agencies for implementing HIV/AIDS interventions: Family Health International (AIDSTECI), the Academy for Educational Development (AIDSCOM), and the Centers for Disease Control.

In June 1988, the Africa Bureau's Regional HIV/AIDS Prevention in Africa (HAPA) project was established to expedite support of mission initiatives in the prevention and control of the HIV/AIDS epidemic in Africa. This umbrella project was designed to complement and supplement existing A.I.D. HIV/AIDS resources and to provide rapid and flexible assistance to African USAID-supported interventions. The HAPA project has financed subprojects carried out by host country government entities, private voluntary organizations, and other private sector institutions capable of implementing AIDS-related activities in African countries. USAID missions that anticipate the need to expand country AIDS prevention programs are expanding their HIV/AIDS activities within the framework of their bilateral development programs, either by developing and implementing their own tailored HIV/AIDS projects or by integrating HIV/AIDS components into existing or new bilateral health and family planning projects and, where appropriate, other development programs.

Key interventions that were provided by the central and regional mechanism included IEC programs; increased access to condoms; STD control and counseling; applied, operations, and behavioral research; training; epidemiologic surveillance; and acquisition of diagnostic tests and related laboratory equipment. Technical expertise to assist USAID missions in the design, development, and evaluation of HIV/AIDS subprojects has also been provided.

The initial approach to HIV/AIDS prevention used a "target of opportunity" strategy, implementing a wide range of small projects to gain information on what works at a time when AIDS was still a very sensitive issue for many countries. Prevention activities were started wherever possible, using diverse interventions, frequently by working on blood supply issues — which were politically less sensitive.

Emphasis countries in Africa initially were chosen for AIDS prevention programs using such criteria as urban HIV and STD prevalence, urban population size and percentage, host country absorptive capacity and receptivity, U.S. foreign policy interests, and USAID mission support.

A mid-project review of the central ATSP project in 1989 and a program assessment of the regional HAPA project in 1991 resulted in an agency consensus to keep the full-service cafeteria approach for supporting HIV/AIDS prevention and control. The state of the science was not ready to support, nor were the A.I.D.-recipient countries ready to accept, a comprehensive focused program.

In early 1991, after extensive internal and external technical reviews and analysis of lessons learned from the first four years of AIDS prevention activities, A.I.D. re-designed the central ATSP and amended the regional HAPA Project. The ATSP was re-designed to provide a new mechanism to address the growing need for more comprehensive prevention programs in the face of an expanding HIV/AIDS epidemic. This was done by R&D in collaboration with the regional bureaus, missions, and other A.I.D. operational and policy divisions. This was an agency-wide effort and was developed over a period of almost a year.

Under the re-designed ATSP, a cooperative agreement was established with Family Health International (FHI), to develop the new AIDS control and prevention project (AIDSCAP). FHI and its subcontractors will design and implement comprehensive HIV/AIDS prevention programs in collaboration with USAID missions.

All agency HIV/AIDS activities in Africa support the evolving agency policy which dictates that the inputs from A.I.D. and WHO/GPA are complementary. WHO provides coordination and planning and A.I.D. supports in-country implementation. A.I.D. policy also addresses the mandate to provide more support for PVOs and NGOs.

Progress to Date

A.I.D. has funded AIDS prevention and control activities in 39 African countries. As the agency gained experience in HIV/AIDS prevention and control, the following activities became key elements: monitoring HIV/AIDS; increasing government and public awareness; assisting African countries with the development and implementation of AIDS prevention programs; and conducting applied research aimed at improving preventive measures.

Under the ATSP project, AIDSTECH and AIDSCOM implemented activities in over 30 countries in Africa. Many of these activities will be continued and expanded under the AIDSCAP project. To date, AIDSCAP has assisted USAID missions in the design of comprehensive AIDS programs or provided technical assistance in 13 countries and is beginning major program implementation in four of these (Ethiopia, Nigeria, Senegal, and Malawi).

The Africa Bureau, through the HAPA project, has supported projects in 20 countries (Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Ghana, Kenya, Malawi, Mali, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Uganda, Zaire, Zambia, and Zimbabwe). The HAPA project engaged more than 21 implementing agencies which have utilized established in-country institutional capabilities (such as PVOs/NGOs) for implementing intervention-oriented assistance.

Community-based PVO/NGO/university activities have been successful in serving as capacity-building instruments for those entities desiring to enter into the HIV/AIDS prevention and control arena in Africa. Among the activities was the very successful condom social marketing program in Zaire and the filming of the highly acclaimed Ugandan AIDS video, "It's Not Easy." The latter is being used Africa-wide as an educational tool for AIDS prevention and has been translated into several other languages. Other successes include an instrumental role in identifying the strong association between HIV infection and occurrence of other sexually transmitted diseases; determining that several technologically appropriate simple diagnostic tests for HIV are suitable for use in austere laboratories and clinics in Africa; and pioneering a private sector AIDS-in-the-Workplace approach to AIDS prevention.

Host country Ministries of Health, including those in Uganda, Zaire, Zambia, Zimbabwe and Botswana, have co-funded A.I.D. activities through local currency generating programs, among other means. PVOs and other grantee/recipients (including Save the Children, CARE, Project Hope, World Vision, Experiment in International Living, Population Services International, Johns Hopkins University) have contributed at least 25 percent of the cost of the activities. The CDC, Bureau of the Census, WHO, UNDP, UNICEF, and World Bank have provided extensive collaborative support and coordinate closely with A.I.D.

Measuring Program Impact

As the entire international scientific community is currently developing appropriate measures of HIV/AIDS program impact, the use of process indicators (such as monitoring the number of condoms sold) is currently the most available means to measure HIV/AIDS project performance. Knowledge, attitudes, and practice (KAP) surveys (which have been funded in several countries) assess the impact of educational programs by providing a measure of the degree of awareness raised (rather than an actual change in sexual behavior), which will lead to a lowered risk of HIV infection. Despite the long latency of HIV infection, these indicators may provide, either directly (such as by measuring changes in HIV seroincidence in sentinel populations) or indirectly (such as by measuring changes in the incidence of other STDs, using STDs as a proxy for HIV), a measurable assessment of HIV/AIDS program impact. A.I.D. is leading the international community in these

investigations, and as appropriate assessment indicators are validated, they will be incorporated into HIV/AIDS activities in Africa.

To assess more precisely the outcome of HIV/AIDS prevention activities, USAID has tested a series of practical HIV prevention program indicators to evaluate program status and to monitor program results over time. During the summer of 1991, USAID (in collaboration with the CDC and WHO) conducted a pilot test in Jamaica of a preliminary list of indicators that USAID and WHO/GPA will consider adopting as standardized measures of program progress worldwide. As a next step in this process, the indicators will be tested in several African settings. This validation process is extremely important and will lead to an unprecedented capacity to measure the people-level impact of prevention activities, providing comparability across programs, intervention strategies and settings.

Programs to monitor the incidence and prevalence of HIV/AIDS are a basic and important component of HIV/AIDS prevention and control strategies. Through the Center for International Research of the U.S. Bureau of the Census, the HIV/AIDS Surveillance Database has been maintained and utilized for epidemiologic and demographic analysis and modeling of the HIV/AIDS epidemic in Africa. This database, initiated and funded by A.I.D., is the premier international compilation of all available published and unpublished data on the seroprevalence and epidemiology of HIV/AIDS in Africa. The database has provided important information for use in HIV/AIDS resource allocation decisions which use epidemiologic criteria and is being expanded to include similar information on other sexually transmitted diseases in Africa.

A.I.D.'s Future Response

For the foreseeable future, HIV/AIDS will remain a major problem, probably of crisis proportions in some areas, in Africa. Political leadership and governments in most of Africa now recognize the dimensions of the HIV/AIDS epidemic and its growing adverse impact on development, and are organizing efforts toward prevention and control. Increasingly, bilaterally supported programs in maternal/child and reproductive health and family planning play a critical role in mobilizing local efforts and resources for HIV/AIDS prevention and control. Additionally, innovative approaches should be considered for incorporating HIV/AIDS prevention activities, as appropriate, into other, non-health and population sector mission programs, such as education, human resources development, private sector, agriculture, and other development sectors (e.g., AIDS-in-the-workplace, social marketing, and training activities.)

A.I.D.'s policies and strategies have been tested in the field. They are proving to be appropriate and effective in assisting African countries to implement their National AIDS Control Programs. A.I.D. has collaborated closely with the CDC in the past and plans to continue this relationship, especially in such areas as the diagnosis and treatment of STDs, HIV/STD program planning and management, and program monitoring and evaluation. A.I.D. plans to continue to work through WHO/GPA and through increased bilateral programs. This approach permits maximum flexibility to respond to differing situations, and to adjust approaches based upon actual experience in Africa.

A.I.D. is targeting the equivalent of 5 percent of the Development Fund for Africa for HIV/AIDS prevention and control activities in fiscal year 1992 as Congress has recommended, and is planning similar levels for fiscal year 1993. This represents a major expansion in A.I.D.'s HIV/AIDS program in Africa. A.I.D. is exploring program expansion possibilities within its country strategies, further building upon its three-pronged approach for HIV/AIDS programming in Africa.

First, the A.I.D. Africa Bureau and its missions in Africa are increasing collaboration with the central Research and Development Bureau projects, especially the AIDS Technical Support Project, exploring ways in which they can expand services to Africa in a cost-effective and efficient manner using a combination of DFA and central bureau resources.

Second, opportunities are being explored to establish additional bilateral HIV/AIDS programs rather than continuing to rely largely on an Africa Bureau regional project approach. The regional HAPA project has been extended through fiscal year 1993 to assist USAID missions in the development of their bilateral HIV/AIDS programs. USAID missions will then be required to implement their own tailored bilateral HIV/AIDS programs and will receive technical assistance from Cooperating Agencies of the Bureau for Research and Development. This will allow A.I.D. to provide more comprehensive assistance to selected African governments within the framework of bilateral programs.

Third, efforts are being increased to identify opportunities to expand A.I.D. health and family planning programs, as well as mission programs in other development sectors, to incorporate or enlarge HIV/AIDS education and prevention components. This will allow A.I.D. to integrate its HIV/AIDS program into ongoing and new preventive health and family planning efforts, which are largely focused at the community level. For example, recently in Ghana, a \$5 million HIV/AIDS component was integrated into the USAID Family Planning and Health bilateral project. Similar project activities are currently under way in Malawi and Côte d'Ivoire.

This progression toward "bilateralization" is intended to ensure a flexible and responsive use of mission resources for designing and developing their bilateral HIV/AIDS projects, based upon what they have learned about HIV/AIDS through earlier implementation of agency HIV/AIDS prevention and control activities. It should be pointed out, however, that many missions in West Africa have had little or no experience in HIV/AIDS prevention and control to date because of the relatively low level of attention paid to HIV/AIDS by their host governments (due to the less severe epidemiologic situation thus far in that region). Many of those countries are probably now at the same point on the HIV epidemic curve where countries such as Uganda, Zambia and Tanzania, were in 1985-86. Those missions will require additional time to identify and fund appropriate implementing agencies, learn which interventions work best in their settings, and then develop bilateral HIV/AIDS projects.

Coordination of Central, Regional and Bilateral Projects in Africa

The Africa and R&D Bureaus have collaborated over the past year to identify agency AIDS emphasis countries with comprehensive HIV/AIDS programs as a major component of their development portfolios. In fiscal year 1993, 24 African missions will program resources for HIV/AIDS prevention activities; 10 have made AIDS prevention a strategic focus of their programs. A sub-set of these AIDS emphasis countries are designated as AIDSCAP priority countries whose programs will be designed and implemented by AIDSCAP. A.I.D. will designate 15 AIDSCAP priority countries worldwide for implementation, presumably 7-8 in the Africa region.

The newly designed AIDSCAP results, in part, from the findings of an internal review of A.I.D.'s existing AIDS prevention programs and is predicated on the following lessons learned:

1. It is possible to prevent HIV infection on a limited basis;
2. Increasing demand for and access to condoms has been a key part of success to date;
3. A.I.D. has had the greatest success with NGOs and PVOs, which can mobilize rapidly and respond to the current crisis;
4. Treatment and diagnosis of STDs play a major role in prevention and control of HIV infection;
5. A.I.D. has not had an impact on HIV infection at the national level because of lack of concentration of resources;
6. There is a need to learn more about communications for behavior change and sexual behavior, especially in Africa, in order to prevent and control HIV; and

7. **A.I.D. has learned about the critical importance of multiple reinforcing channels of communication aimed at changing knowledge and attitudes toward sexual behavior, as a prelude to behavior change.**

AIDSCAP has three goals: 1) improved design, implementation and evaluation of HIV prevention and control programs; 2) improved knowledge of sexual behavior and application of this knowledge to communications strategies for behavior change; and 3) a policy reform program.

Improved HIV Prevention Programs: Major interventions in this category include 1) behavior change, including reduction of the number of sexual partners, 2) increased access and use of condoms, and 3) improving diagnosis and treatment of STDs.

The project will train both public and private service providers, as well as appropriate individuals and groups (e.g., traditional practitioners) who may be in a position to provide information and influence behavior. The project will also establish an internal capacity for training and retraining of service providers. The project will use two principal approaches to increase access to condoms: 1) contraceptive social marketing programs, and 2) public-private sector partnerships for the marketing and provision of condoms.

Improved Communication Strategies for Behavior Change: Research will be undertaken to improve understanding of sexual behavior, and findings will be applied to communication strategies aimed at changing behavior. This will be a major element of the AIDS strategic plan developed for priority countries (see discussion of priority countries below). The project will include subagreements which will fund approximately six leading behavioral scientists and/or their institutions to conduct intensive research in communications for behavior change. The researchers will assist in planning and implementing the country's strategic plan for behavior change.

Policy Reform: AIDSCAP, using computer-based simulation models, will provide critical information needed to convince policy makers that AIDS is a serious problem. The project will also provide accurate information concerning the potential development impact of the epidemic and the effectiveness of control and prevention activities. The models are designed to respond to questions such as the following: How many AIDS cases will there be in the future? Will AIDS have a greater impact than other diseases such as malaria and measles? What are the relative costs of prevention programs compared with future costs of treatment? What are the relative effects of different intervention strategies?

A full-scale program includes the entire range of program components including the provision of IEC interventions; behavior research and evaluation; logistics; counseling; surveillance and monitoring; training; and commodities (medical equipment and drugs for the treatment of STDs). Once a country is determined to be an AIDSCAP priority, a strategic plan for the prevention and control of HIV/AIDS will be developed by an FHI technical assistance team, the USAID mission, and the host government. A resident advisor and technical assistance staff will then be placed in the field to assist with implementation of the national strategic prevention plan.

Country prioritization for Africa is still in progress. First year AIDSCAP priority country candidates currently under discussion with USAID missions, host governments, and the Bureau for Africa include Malawi, Tanzania, Nigeria, Senegal, Rwanda, and Ethiopia. Final AIDSCAP priority country selection will be based on the following criteria:

1. mission commitment to program HIV/AIDS activities
2. potential HIV transmission (HIV and STD levels)
3. population size and distribution
4. country commitment
5. country capacity to respond
6. availability of bilateral funds
7. availability of other donor funds

The project will provide technical and other forms of assistance to all non-priority countries requesting such help on a resource-permitting basis. The technical assistance staff will be responsible for maintaining a consultant roster with expertise in the three priority areas: STDs, condom access, and condom demand/partner reduction, as well as in other areas that are frequently requested such as IEC, counseling, evaluation and surveillance, and epidemiology.

To facilitate decentralized field-based decision making, and to contribute to in-country capacity for HIV/AIDS control and prevention, the project has established three regional offices for Africa, Asia, and Latin America and the Caribbean.

Appendix H

Projection Methodology for Condom Requirements

Three models have been developed to estimate the number of condoms that will be required for an effective HIV/AIDS prevention program. Two approaches are used in these models: 1) one approach seeks to provide protection for a certain proportion of the urban male population, and 2) one approach seeks to protect a proportion of all coitus that occurs in the population.

Two models use the first approach. Model 1, proposed by WHO in 1991, considers two steps to forecast the needs for condoms for a new HIV/AIDS prevention program. The initial estimate takes a proportion of the urban population of males for whom a coital frequency is applied. A wastage of 0.1 and a safety stock of 0.5 is added. The proportion of males may come from surveys, family planning service records, etc. A coital frequency of two per week is suggested. Future estimations will be made based on the program capacity to motivate users and to distribute condoms, and coital frequency may be taken from available local data. Although this is an easy-to-use model, it overemphasizes the amount of coitus since it assumes that married and single people have the same coital frequency, therefore the number of condoms that should be used may be also overestimated.

Model 2, developed by Way and Stanecki, introduces a new concept: the impact that a level of condom use can have on the HIV/AIDS epidemic. The U.S. Bureau of the Census model to assess the impact of condom use on the HIV/AIDS epidemic, on which Model 2 is based, concludes that the HIV prevalence rate would stabilize at slightly above the current level by the year 2015 if 15 percent of the urban male population between ages 15 and 64 use condoms in all coitus. Lower levels of condom use among this same risk group would allow the prevalence of HIV/AIDS to increase tremendously. Higher levels of condom use could reduce HIV prevalence below current rates.

In Model 2, the proportion of urban males that should use condoms in the AIDS prevention program is predetermined according to the desired impact. Another assumption is that married and single men have different coital frequencies per year, 100 per married man, which include 10 extramarital relations, and 60 coitus per single man. Different proportions of coital frequency that should be protected can be assumed within the model according to characteristics of the community. The lowest estimate of this model, assumes that all intra-marital coitus is completely safe and that it is only necessary to protect the others.

Model 3, which uses the second approach, is a sophisticated computerized model developed by Mario Jaramillo which takes into consideration differentials in sex behavior urban and rural men, married and single men, faithful and unfaithful husbands. It also considers specific target groups: high risk husbands, commercial sex workers, and high risk single men; prevalence of condom use and coital frequency among those groups is also taken into account.

This model produces a set of 23 tables containing all the assumptions and projections of relevant populations, condoms required, and cost to the donor providing the condoms. Urban-rural breakdown is provided in the output of the model. These projections are made for five consecutive years.

The model requires the input of many parameters but the built-in default values for those parameters make the model easy to use on a preliminary basis. Changes of these values can be introduced when reliable data are available.

The estimated needs of condoms by the three models for the current population of sub-Saharan Africa, assuming that 15 percent of the urban male population will use condoms in Models 1 and 2 and using the default parameters in Model 3, are as follows:

First Approach	Model 1	450 million	minimum* amount 150 million
Second Approach	Model 2	377 million	
	Model 3	123 million	

* Assuming that all coitus within wedlock is totally safe, this model does not include wastage.

The cost for the lower estimated need of 123 million condoms, is \$6.7 million. This figure is more than double the money allocated by USAID for purchasing condoms.

During year 1991, 242 million condoms were supplied by all donors to the countries of Sub-Saharan Africa of which 156 million (65 percent) went to 14 countries having the highest contraceptive prevalence rates or being the biggest in population size. Estimations of the three models for these countries show that the differences between amount supplied and the estimated figure are very big for models one and two. These differences become bigger when Zimbabwe and Tanzania, which were supplied in excess, are not considered (see table below). There is no evidence that the condoms in those countries were used, on the contrary there are some indication that they may not have been used. The case of Zimbabwe is a good example: The specific prevalence from the DHS survey (1988) for condoms, 1.2 percent, does not match the level of prevalence obtained from CYPs generated by the condoms supplied in that year, 9.6 percent. Although the DHS is not a very reliable measure of condom use, this amount of difference is a matter of concern. Condoms in this country were provided free of charge to users which may have substantially influenced the degree to which they were actually used.

**Comparison Of Condoms Supplied To Fourteen Selected Countries
With Estimations Of Three Models
(Figures In Million Of Units)**

		14 African Countries *	12 African Countries **
First Approach	Model 1	496.1	442.6
	Model 2	268.3	239.4
Second Approach		116.8	107.2
Supplied ***		187.8	126.3
First Approach Difference with M-1		- 308.3	- 316.3
Difference with M-2		- 80.5	- 113.1
Second Approach Difference		+ 71.0	+ 19.1

* Including Cote d'Ivoire, Ghana, Nigeria, Senegal, Ethiopia, Kenya, Madagascar, Mozambique, Tanzania, Uganda, Zimbabwe, Cameroon, Zaire, Botswana.

** Excluding Tanzania and Zimbabwe.

*** Annual average of condoms supplied by all donors during 1990 and 1991.

In conclusion, it is important to note that a good deal of helpful work is being done to improve the capacity of programs to project needs for condoms. On the other hand, it is clear that present approaches are a long way from producing a definitive, dependable methodology. Present models require more testing with experience in a situation of apparent rapid change in condom demand. Additionally, greater attention must be given to attempts to measure actual condom use as well as distribution, especially as use may be affected by shifts toward more sales as compared to free distribution.

Appendix I

Brief Review of Experience with Family Planning and HIV/AIDS Social Marketing in Africa and Other Relevant Locations

Social marketing utilizes commercial marketing techniques and the resources of the local private sector to sell contraceptives and essential health products. The intent is to make urgently needed health products widely available and affordable to lower income groups. Prices are subsidized by donors or governments to keep retail costs down. The first social marketing program began in India in 1967. Today, over 40 programs exist, providing protection to more than 10,000,000 couples.

The advantages of using the private sector as a vehicle for service delivery are numerous: First, little additional infrastructure is needed, as social marketing projects use existing commercial wholesale and retail networks to sell their products. In every country, there are thousands of retail outlets — grocery stores, pharmacies, bars, hotels, kiosks, boutiques, street vendors, company canteens — which can serve as distribution points. Second, the use of commercial marketing techniques has proven to be an extremely effective means of generating demand. Advertising and promotional campaigns disseminate information about products, generate an understanding of the need for them, and inform customers about prices and the locations where the products can be purchased. Third, social marketing supports the development of the local economy by fostering industry and service capabilities (e.g., market research, advertising, commercial distribution, and manufacturing). Finally, reliance on the private sector is a cost-efficient method of service delivery; less expensive, for example, than either full service clinics or community-based distribution projects). While local governments and health ministries are increasingly unable to cope with the growing demands of providing family planning and preventive health care services, social marketing is now seen as a vital part of a process which leads to comprehensive primary health care.

The most important components of social marketing include pricing, research, promotion, placement (distribution), and the product. Prices are generally low enough to ensure affordability by target groups (low income consumers) but high enough to avoid perceptions of low product value and to encourage cost recovery. There is often a delicate balance between the competing needs of low prices and cost recovery; however, most available data suggests that there is a strong negative correlation between high consumer prices and high per capita sales. Market research helps determine price points as well as consumer preferences for products, packaging materials, and the efficacy of advertising campaigns. Tracking studies, focus groups and consumer and retailer intercepts are all tools which are used to plan, monitor, and evaluate social marketing programs. Profit margins for commercial intermediaries (distributors, wholesalers, and retailers) are held to industry norms (or higher) to encourage commercial interest in product distribution. Promotion takes a wide variety of forms: point of purchase materials, interpersonal and entertainment programs, and where local regulations permit, brand-specific mass media advertising. When IEC and motivation campaigns are combined with condom social marketing, the results have been dramatic (see below). Distribution is usually handled by existing networks of consumer goods and pharmaceutical distributors. In many programs, local sales staffs are augmented to permit targeted sales to high risk groups and to permit retailer training in product knowledge and the dissemination of AIDS prevention information.

Products marketed in social marketing programs include condoms, spermicides, oral contraceptives, IUDs, and injectables. Other health products, such as oral rehydration salts, are marketed to combat diarrheal dehydration. New products, such as STD treatments, will soon be launched in selected test markets.

Social marketing programs are usually managed by non-governmental organizations, e.g., family planning associations and commercial distributors. New organizations, some with an AIDS prevention mandate, have also appeared recently. Technical assistance provided by the two main U.S. social marketing organizations,

Population Services International (PSI) and The Futures Group, focuses on management assistance and the transfer of skills and technology to partner groups.

Until about five years ago, most social marketing programs concentrated on family planning. Large, established family planning oriented programs still produce the bulk of worldwide protection: programs in India, Bangladesh, Pakistan, and Egypt together produced 6,549,677 CYPs in 1991. The Bangladesh Social Marketing Company sold contraceptives in 1991 providing 1,439,492 CYPs; this accounts for over 9 percent of married women of reproductive age and over 40 percent of all couples using contraception.

In sub-Saharan Africa, the growing awareness of the need to stimulate demand for condoms, and to insure their widespread availability to groups at high risk of contracting the HIV/AIDS virus, has led to a dramatic growth in AIDS prevention social marketing programs.

The pioneer African AIDS-prevention social marketing program was begun in Zaire in 1987 by PSI. Originally designed as a pilot project for three of Kinshasa's 24 health zones, the project quickly and convincingly demonstrated the feasibility of condom social marketing for AIDS prevention. Sales of Prudence condoms and Graine vaginal tablets started in November 1987. By mid-1988, sales has exceeded all prior condom distribution efforts. Total sales for 1990 reached 8 million condoms and increased to 18 million in 1991. Since the suspension of USAID/Zaire programs in October 1991, the condom social marketing program has demonstrated its institutional sustainability by continuing to sell condoms at a rate of 2/3 million per month. In July 1992, monthly condom sales again exceeded 1,000,000 units.

In 1988, the project, in collaboration with the government's national AIDS Committee and with USAID funding, initiated, developed, and implemented a mass media campaign designed to support AIDS prevention activities in the country. Messages conveyed in print, and by radio, television, and local theater groups were directed to at-risk population groups. The messages, designed to create awareness of the ways in which HIV transmission is preventable, encouraged adoption of safer sexual behavior. Collaboration with the host country National AIDS Committee was instrumental in assuring culturally appropriate messages development (broadcast and print in all five national languages), obtaining official approval of all messages, and obtaining free airtime. A project-associated research activity has documented behavior change by Zairians. In the first two and a half years of the mass media campaign, PSI's condom social marketing project saw a 1,000 percent increase in annual condom sales.

The success of the Zaire program has spawned many new African AIDS prevention social marketing programs. Between 1987 and 1991, over a dozen new programs were started. Today, condom social marketing programs exist in Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, Malawi, Mali, Nigeria, Rwanda, Togo, Uganda, Zambia, Zaire, and Zimbabwe.

As part of the centrally funded SOMARC II project, The Futures Group is currently implementing a dual message condom campaign in nine African countries.¹ Market research carried out in over 13 countries indicated that there were great similarities in all countries regarding condom image and condom use:

- Overall, condoms have a very negative image and people are embarrassed or ashamed to admit their use.
- Condoms are not seen as being acceptable for use within marriage, but rather only with prostitutes.
- Condoms are often associated with disease rather than thought of as being an acceptable method of family planning.

¹The following is drawn from *Integration of HIV/Family Planning Messages at the Consumer Level* prepared by The Futures Group/SOMARC Project.

It was agreed that in order to increase condom use, the primary task was to change the image of the product overall. It was also found that men often saw discussing condoms as a method of family planning as being positive. They liked the idea of saying they were using condoms for family planning because it was socially acceptable behavior, whereas admitting that they were using them for STD/AIDS was embarrassing. Therefore, it was concluded that there had to be a dual strategy integrating HIV prevention and family planning.

"Protector" was chosen as the name of the condom to be used in the campaign because it had proven to be the most motivating in programs SOMARC had implemented over the years and because it was the obvious choice for combining a dual HIV/family planning message, as "protection" could be the common theme. The package design, which had been tested throughout Africa, is a photograph of a young, healthy, upscale, and generally well-off African couple, thus conveying the image that this is a product that could be used within marriage.

Market research was undertaken to evaluate the name and package design. Most responses were above the 70 percent level in stating that the image on the packaging indicated that the product was probably of a high quality. Responses were generally over 80 percent positive with regard to the question of whether the product would be for use in marriage. Responses were also generally over 80 percent positive with regard to whether the respondent would personally use the product.

A media campaign was developed with the following objectives:

- to communicate sending dual message of protection: condoms should be used for family planning as well as to prevent AIDS/STDs;
- to convey an image that Protector condoms are a high-quality product;
- to associate the use of the condom with positive behavioral attributes such as "wisdom";
- to change the image of condoms from negative to positive; and
- ultimately, to make condom use an acceptable part of everyday life.

The campaign used the African tradition of a storyteller/wise man who recounts the adventures of two men as they begin their journeys through adult life. The wise man counsels them to protect themselves, with one of the ways being to always wear Protector condoms. The young man who uses the condom has a happy, healthy life with the size family he can provide for. The young man who does not use the condom becomes sick and ends up with a large family he cannot support. The campaign slogan is, "Be wise, always wear Protector condoms."

Over 90 percent of those responding to an evaluation questionnaire on the television campaign found the slogan to be appealing and that the idea of protecting yourself was appropriate. Responses also indicated that consumers did understand the dual message and its importance. Results from the radio campaign on these questions were essentially the same; in addition, generally 90 percent of the respondents indicated they would personally use the product.

Appendix J

Brief Review of Experience with Family Planning and HIV/AIDS IEC Activities in Africa and Other Relevant Locations

Introduction

Family planning programs in Africa are at a "younger" stage of development than their counterparts in other regions of the developing world. Although family planning services in most countries were initially clinic based, those in Africa tended to remain so until fairly recently with government services, where available, generally relegated to the role of poor relation within the broader MOH structure. This was due in part to the combination of indifference, if not outright pro-natalist attitudes, on the parts of most African governments towards population issues and continued high levels of infant mortality.

The 1980s saw a turnaround in attitudes of most African nations towards the need for family planning as burgeoning populations and economic austerity threatened to swallow up the fruits of development long before they ever reached the table. In this more supportive climate, new approaches to service delivery and innovations in the provision of IEC, many based on the experiences of programs in other parts of the world, began to proliferate across the continent, with a host of international institutions providing support technical assistance to both government and private family planning efforts.

Some of the lessons that have been learned in the process, in Africa and in other parts of the world, may be helpful in the development of IEC initiatives in support of HIV/AIDS prevention programs in Africa, as the target audiences of both programs overlap: women of reproductive age, men, and youth. On the other hand, since family planning efforts in the past have more consistently targeted women, the emphasis on reaching men and youth for prevention of HIV/AIDS may result in new and better approaches to working with both men and young people and in breaking down communication barriers between the sexes and across generations. In addition, the urgency of tackling the AIDS epidemic may actually be helpful in creating a more open climate within countries, and internationally, for discussion of issues such as sexuality, gender, and the economic dependency of women.

Some Specific Experiences from Family Planning and HIV/AIDS IEC

The importance of involving the target audience in the design of any IEC activity — from media campaigns to counseling guidelines — cannot be underestimated. This approach would have been considered novel within the family planning field not that many years ago, however, and there are still all-too-many instances of its being ignored. For example, when Zimbabwe launched an HIV/AIDS awareness campaign in 1988, they made use of some European and American training materials. The result was a perception on the part of the Zimbabwean nurses exposed to the materials that AIDS was a disease that only affects homosexuals. Other campaigns, such as Uganda's "Zero Grazing" ads, seemed a discrete way to deal with the issue of marital fidelity to sensitive policy makers. It was quite confusing to the general public, however, who were unable to understand the connection between grazing your cow and getting AIDS. In most countries, concern about what will be perceived as "acceptable" or "unacceptable" is generally much more acute among bureaucrats and the elite than among the majority of the population.

IEC activities, including mass media, can be effectively utilized to provide people with facts about family planning or HIV/AIDS; but to move in the direction of behavior change, those facts must be able to help people make decisions and take action. For this to happen, the facts must be perceived by the audience as being relevant to their lives. Facts are not helpful when they are used to threaten or create a climate of fear as this more often than not results in indecision and no action at all. For example, a 1991 evaluation of HIV/AIDS mass media in Uganda reported that, "Fear was by far the dominant emotion" generated by the

campaign and yet, "Despite this high level of fear, there is still considerable evidence of high risk sexual behavior." Ideally, IEC activities should serve as a means of empowering people — individually and collectively — to take positive action.

Since the mid-1970s, family planning programs have been turning to the private sector to take advantage of its expertise in advertising and marketing. The use of techniques such as focus group discussions, for example, have become common in the development of messages for mass media campaigns. The effectiveness of this strategy has been evident in the success of numerous social marketing programs developed in countries around the world. These efforts have considerably increased the accessibility and use of contraceptives. Most particularly, they have had a tremendous impact on the sale of condoms — which has relevance in terms of HIV/AIDS prevention when condoms are currently the sole source of protection outside of abstinence and monogamy.

The best IEC campaign in the world, however, will not be successful if the necessary services and supplies required to take action are not readily accessible. There are numerous examples, particularly in Africa, of people having been motivated to seek family planning services only to be faced with limited hours of service, contraceptive shortages, discourteous treatment, and the like. Similarly, there have been instances when an HIV/AIDS campaign has sought to increase the number of people requesting antibody tests, but has not had sufficient staff available to meet the resulting demand. Getting the dissatisfied client to "try again" will be even harder than motivating the person to take action in the first place.

In order to develop effective IEC activities, it has been demonstrated that it is most effective, and ultimately most efficient, to try out ideas in small, pilot projects and then to implement them on a larger scale. A common pitfall, however, has been the assumption that if it worked well in Zimbabwe, it will work in Zaire. It is necessary to design programs with the flexibility required to make whatever adjustments are necessary to carry out activities in a way that is appropriate to the local circumstances.

Like family planning, HIV/AIDS prevention programs are attempting to change intimate personal behavior that is also subject to a great deal of emotional, social, and even political pressure in terms of what is acceptable and what is unacceptable behavior — standards that usually are very different when applied to males and females. The life and death nature of the AIDS epidemic has emphasized the need for greater understanding of how these forces affect behavior so that programs can more effectively assist people to take the action needed to save lives. The availability of such knowledge will also allow family planning and STD programs to better meet the needs of their clients.

Although mass media can be very effective in increasing awareness, its potential to change behavior is greater when it is used in support of individual and group approaches at the local level. In addition, studies in several African countries (Kenya, Uganda, and Zaire) indicate that although most men indicated they had learned about AIDS from the radio or newspaper, the majority of women reported learning about the disease from other people. Therefore, if women are a target audience, other channels of communication may need to be employed to reach them directly. On the other hand, a number of studies have shown that sales of contraceptives tend to drop when advertising campaigns are discontinued, underscoring the mutually supportive roles that mass media and interpersonal communication should play.

There is ample evidence that entertainment can be an effective means of both reaching people with information and influencing behavior change. Popular songs, soap operas, and traditional theater are just some of the forms of entertainment that have been used successfully for both promotion of family planning and prevention of AIDS. In Zaire, the song recorded by the country's leading popular singer, known as the "AIDS song," is thought to be in large part responsible for a dramatic increase in condom use. In Mali, the effectiveness of a traveling theatrical troupe in presenting information and stimulating discussion about family planning is being evaluated by an operations research project to determine if it will have an actual impact on contraceptive acceptance. Use of entertainment may have particular application in Africa where the reach of

modern media, particularly television, is limited and where there is still a strong tradition of oral communication.

The involvement of celebrities also can increase awareness and understanding. In the United States, Magic Johnson's public disclosure that he is HIV positive probably did more to humanize the face of the AIDS epidemic for Americans, particularly young males, than any other single event.

The quality of the interpersonal relations between client and service provider have proven to be an important component in assuring that family planning clients accept and continue using the family planning method of their choice. However, the skills required to provide counseling for HIV/AIDS prevention will most likely be beyond the capacity of even highly competent family planning providers unless they are provided with additional training and on-the-job support from their peers and supervisors.

Members of peer groups usually make the most effective counselors and educators. Just as satisfied family planning users have proven to be highly effective in motivating their peers to adopt contraception, personal contact with people who have been able to use condoms successfully or with those who have already contracted AIDS can help motivate behavior change. Likewise, the most successful family planning programs for adolescents have been those in which information is disseminated by young people themselves.

Appendix K

Future Research Requirements

Work is being conducted on some but not all of the following issues, and more work needs to be done on most of them.

Mechanical and Chemical Barrier Methods and Spermicides

More research is needed to determine the acceptability, effectiveness, and safety of both chemical and mechanical barrier methods, especially female controlled ones, in reducing the acquisition of sexually transmitted diseases, including HIV, as well as in preventing pregnancy.

Ongoing research in this area includes research on the ability and efficacy of existing and new spermicides to act as microbicides to prevent STD and/or HIV transmission; on consumer preference; on the reliability of different sizes and brands of condoms; and studies on contraceptive sponges and the diaphragm.

Condom quality control seems to be a chronic problem and more research on condom quality control and local conditions is needed.

Research on mechanical and chemical barriers should occur in tandem with the development of new and improved barrier methods for both men and women. Promising new developments include a male polyurethane condom which is stronger and more resistant to heat, light, and oil-based lubricants than the latex condom and several versions of female condoms. Three types of female condoms have been developed, Women's Choice which is inserted like a tampon, Reality[®] which is inserted like a diaphragm, and a third which is a latex panty fitting over the opening of the vagina.

There is also a need for a method that protects woman against STD and/or HIV but allows her to become pregnant.

There is a continuing need for behavioral research on local attitudes and practices regarding condoms. This research should determine the cultural, social, and personal conditions that affect motivation to use (or not to use) condoms and other barrier methods among subgroups of the population (Germain, et al. 1992).

HIV-Contraceptive Interactions

Conclusive information regarding the relationship between contraceptive use and HIV is lacking. More information is needed on both the impact of different contraceptive methods on HIV transmission to women and on HIV disease progression in women.

In June 1990, WHO stated that "given the present state of knowledge, the use of latex condoms appears to be the best strategy for prevention of HIV transmission during sexual intercourse." Laboratory data indicate that sperm cannot pass through an intact latex condom and that sperm can be destroyed by an appropriate concentration of spermicide. Similarly, laboratory data indicate that HIV cannot pass through an intact latex condom and that, in vitro, HIV is inactivated by spermicidal compounds containing nonoxynol-9, menfegol, or benzalkonium chloride. However, epidemiological studies suggest that use of nonoxynol-9 may not be beneficial because of toxicity leading to genital lesions. Spermicides alone are not adequate to prevent sexual transmission of HIV. Their efficacy in preventing transmission in conjunction with barrier contraceptives such as the condom, the diaphragm, and the contraceptive sponge is being studied (WHO, 1990).

Although there is concern regarding a possible increased risk of HIV infection among oral contraceptive users, to date there is no clear evidence that oral contraceptives increase a woman's susceptibility to HIV infection. Few studies of the relationship between injectables and implants and the risk of HIV infection have been conducted and their impact on HIV transmission is either unknown or not well understood. Since there is no evidence that oral contraceptives, injectables, or implants protect against HIV transmission, steroid contraceptive users at risk of acquiring HIV or STD, should be advised to use condoms consistently.

The few unpublished studies on the relationship between IUD use and a woman's risk of HIV infection are conflicting. Again, the most important issue is that IUDs do not provide protection against HIV and/or STDs. Therefore, any woman who is at risk for STDs and/or HIV should be counseled to use condoms.

HIV and Reproductive Health and Reproductive Health Decisions

Ongoing medical research on HIV and reproductive health includes research on the fertility of HIV-positive women, on the impact of HIV infection on pregnancy outcome, and on the effect of pregnancy on HIV infection.

More community-based research is needed on the effects of seropositivity on reproductive decisions of HIV-infected women and men.

Research is also needed on the relative risks of methods which are more or less effective at pregnancy prevention and disease prevention.

Similarly, more information is needed on the use-effectiveness (for disease prevention and contraception), the cost-effectiveness, and the acceptability of the simultaneous use of two contraceptive methods in comparison with the use of one mechanical or chemical barrier method.

Sexual Behavior and Decision Making

More research is needed on sexuality, sexual behavior, and sexual decision making. Better data on sexual behavior and its relationship to STD and HIV incidence and prevalence are essential to understanding transmission dynamics, plotting spread, and devising control strategies. Information gained about the individual and societal pressures that drive sexual behavior can be used in interventions attempting to modify existing behavior.

Alternatives to penetrative sex need to be explored and, if locally acceptable, promoted.

Studies which specifically address the short- and long-term behavioral consequences of HIV and STD counseling and testing in different settings.

Gender and Power Issues

A better understanding of issues of gender and power that determine a woman's ability to adopt or negotiate safer sexual behavior, as well as male-female communication, is necessary for the development of appropriate messages and interventions.

Gender power relations, including the economic, social, cultural, and political roots of power imbalances between women and men, along with women's strategies to achieve self-esteem, should be assessed in the context of reproductive health (Germain, et al. 1992).

Strategies should be tested that are designed to enable women to control when and with whom they have sexual relations and to protect themselves against infection by practicing safer sex, especially negotiating condom use (Germain, et al. 1992).

Approaches for encouraging men to adopt sexual behaviors that are respectful of their own health and of women's health, dignity, and body integrity should be tested (Germain, et al. 1992).

Adolescents

Behavioral research on adolescent sexuality would benefit family planning and HIV/STD prevention programs. There is an urgent need for practical, focused behavioral research in both family planning and HIV prevention especially with regards to youth. This includes research on adolescent sexuality and sexual behavior. More needs to be learned about the individual and social pressures influencing the sexual behavior of adolescents in different settings including the reasons adolescents do or do not use condoms and the economic pressures influencing the issue of girls and boys providing sexual favors to older men and women in return for financial support.

Men

Approaches for involving men in family planning and STD and HIV control programs need to be developed and evaluated.

Infection Control

Infection control is an important issue for family planning, STD, and HIV prevention programs. Clients and providers must be protected from the potential risk of HIV and STD infection. Operations research is needed to develop methods for ensuring that procedures for infection control are consistently implemented.

Non-Traditional Methods of Service Delivery

Research is needed on ways to involve traditional healers in both population/family planning and AIDS/HIV prevention activities.

Service Delivery

Studies need to be done which compare and evaluate cost-effectiveness, effectiveness, acceptability, and quality of vertical versus integrated programs in the prevention and control of STDs and HIV and in family planning. Outcomes such as contraceptive acceptance and continuation rates, complication rates following IUD insertion and abortion, HIV seroprevalence rates, and incidence rates of fetal wastage (e.g., spontaneous abortion or stillbirth) and low birth weight may be some of the appropriate indices to be measured against the cost of such programs (Wasserheit, 1989). Other outcome measures include the impact of changes in clinic services on patient load, waiting times, provider-client ratios, availability of care, and the effect of services on specific outcomes (safer sex behaviors, reduction of STDs and unplanned pregnancy, reduction of infertility, ectopic pregnancy, adverse pregnancy outcomes, initiation and continuation of family planning, etc.) (WHO, 1989).

Obstacles to clients' (male and female) use of health care services should be assessed, and actions to remove these obstacles should be developed and evaluated.

The viability of providing HIV and STD information and services through the private and informal sectors should be assessed (Germain, et al. 1992).

Cost-sharing approaches to services should be designed and evaluated.

Referral Systems

Effective referral systems (for counseling, HIV and STD testing, STD treatment, and family planning services) will be very important in those countries, such as Uganda, where it may not be feasible or desirable to

integrate fully family planning and STD and HIV prevention activities. Operations research on ways to design and optimize the functioning of referral systems should be a top priority in such settings. Methods/tools for monitoring these systems and for assessing their effectiveness need to be fine tuned and/or developed.

Risk Screening

Early detection of STDs is crucial for controlling these infections and their after-effects or secondary results (such as pelvic inflammatory disease and infertility), particularly in women. Studies should evaluate the impact of STD screening on the prevalence of STDs in the community and on incidence of these after-effects or secondary results. Data should be collected both in high risk sentinel populations (such as commercial sex workers) and accessible clinic populations (such as antenatal, family planning, and maternal/ child health clinic attenders). These data will help define cost-effective target populations for screening programs in different countries.

Operations research is needed to determine an optimal approach for risk screening of clients.

Core Groups and Target Populations

Operations research is needed on the impact of specific services aimed at target audiences, and the effectiveness of various community channels and messages in reaching target audiences needs to be evaluated. Also, the question of whether targeting results in stigmatization should be further considered.

More research is needed on the characteristics of STD core groups in different societies, the role of sex trading in the overall transmission of STDs in different settings, the local patterns of sex partner selection, the factors responsible for sustaining the high prevalence of STDs within core groups, and the factors responsible for transmission of STDs from core to non-core groups.

STD Research

More research is needed on the effects of different contraceptives on reproductive tract infections.

Studies evaluating the efficiency and cost-effectiveness of prophylactic antibiotics for IUD insertion and termination of pregnancy should be continued.

The impact of HIV infection on the presentation, natural history, diagnosis, and response to therapy of specific STD needs to be further elucidated. Further research on the influence of specific STD diagnosis and treatment on HIV transmission and progression is also needed.

The effect of hormonal family planning methods on risk of acquisition and on the natural history of STDs should be further investigated. Also, more research on the effects of chemical and mechanical barrier methods and the use patterns of these methods on the risk of STD transmission needs to be conducted.

Studies should be conducted to determine the effect of condom distribution on the incidence of STDs, including HIV, in the community.

Work needs to continue on development of algorithms for the syndromic diagnoses and treatment of STDs, especially on ones for diagnosing STDs and reproductive tract infections in women. The efficacy and cost-effectiveness of syndromic diagnosis of STDs should be compared with algorithms based on etiological diagnoses. (The syndromic approach to diagnosis and treatment of STDs is based on groups of symptoms, referred to as syndromes, rather than on the causative agents involved. The etiological approach requires laboratory tests to determine the causative agent before diagnosis can occur.)

Research on the right type and dosage of particular drugs is crucial because inappropriate dosages can often increase the resistance of some STDs, particularly gonorrhea and chancroid, to traditional treatments. Antibiotics that are effective and safe during pregnancy are also needed.

Clinical trials of inexpensive therapeutic and prophylactic regimens for STDs should be conducted.

A mass treatment approach to STD control should be tested and evaluated.

Strategies for strengthening partner notification systems should be tested.

The efficacy and cost-benefit of partner notification should be evaluated in different settings through community intervention trials (WHO, 1989).

Economic Studies

The economic consequences to women if they demand and/or make changes in sexual practices should be assessed.

Integrated HIV/AIDS and family planning initiatives are likely to be under considerable pressure to evaluate themselves in economic terms. At the very least, integrated programs will be expected to achieve programmatic goals and objectives at least as cost effectively as their non-integrated predecessor programs with the same goals and objectives. Appropriate tools must be identified to assess their success.

Modeling and projection efforts designed to determine resource needs and costs of integrated versus alternative programs need to be continued. The likely costs and impacts of feasible actions and their cost-effectiveness relative to that of other health priorities or actions to improve women's health and public health should be modeled (Germain, et al. 1992).

Indicators

Appropriate indicators for monitoring and evaluating programs on HIV prevention and family planning and integration impact need to be developed and tested in the field.

Surveillance, Monitoring, and Evaluation

STD surveillance is the initial step in establishing national STD program priorities, in estimating the overall cost of STDs and their complications, in developing rational guidelines for treatment or prophylaxis, in establishing the potential for HIV spread, and in monitoring and evaluating the effectiveness of programs for STD control and HIV prevention (WHO, 1989).

WHO (1989) has made the recommendation that surveillance systems be established to monitor the prevalence of STDs in sample populations, treatment failures following use of standard treatment regimens, and antimicrobial resistance among STD pathogens. In addition, the incidence of adverse outcomes of pregnancy, ectopic pregnancy, cervical cancer, hepatoma, and the prevalence of infertility should be defined in different populations.

More information is needed about the incidence of STDs and HIV in the population. Better empirical data linking sexual behavior to incidence and prevalence measures of STDs are needed. Therefore, sex behavior surveys should be linked to serosurveys and tests for STDs and HIV. Coordinated disease and behavioral surveillance systems should be developed. Information gained can be used for designing educational and behavioral interventions and also for understanding the epidemiology of STDs including HIV within different communities.

Information about the incidence of reproductive tract infections and HIV among women attending prenatal care and family planning clinics and on relevant sexual behavior could be collected by adding a reproductive tract infection and HIV component to existing data collection instruments, such as the demographic and health surveys. The module would contain questions about recurrent and new infections, use of condoms for disease prevention, and number of sexual partners and would need to be complemented by physical exams and laboratory tests. One limitation of the DHS is that in its present form, it is only used to collect information about married women of reproductive age and information is needed about the rest of the population, especially adolescents.

Monitoring and Evaluation

Although there are common indicators for evaluating family planning and HIV and/or STD programs — such as changes in knowledge, attitudes, and practices as determined by health information system and KAP surveys and focus group data, condom sales, STD reinfection rates, and teenage pregnancy rates — new, more appropriate ones need to be developed and tested.

To facilitate the monitoring and evaluation of referral systems, record systems should be developed which will make providers accountable for screening, referring, treating, and following up with clients. Client/clinic records and referral center records should be monitored.

Evaluation of services should assess whether proper clinical procedures are being followed, the extent of providers knowledge about STDs/HIV and their relationship to different contraceptive methods, and providers' counseling skills.

As part of ongoing operations research, practical methodological approaches to evaluation of integrated family planning and STD and HIV control activities should be developed and assessed (WHO, 1989). Outcome measures include trends in STD morbidity, community-wide trends in knowledge about STDs and in risk behaviors (sexual, prophylactic, health care seeking, etc.) (WHO, 1989).

For the purpose of HIV/AIDS program evaluation and monitoring, WHO/GPA has developed a preliminary set of program performance indicators (PPIs). The preliminary list of PPIs includes measurements of condom distribution, condom availability, reported casual sex, reported number of casual sex partners, reported condom use with casual sex partners, STD clinical management, STD prevalence in women, and STD prevalence in men.

These PPIs will serve as surrogate measures of HIV/AIDS prevention program impact. More direct measures, such as HIV seroincidence, are perceived by A.I.D./Washington as being prohibitively expensive and difficult to obtain. As surrogate measures, they may also provide a partial basis for evaluating and monitoring integrated programs and should be supplemented with additional indicators of program performance relevant to specific program objectives.

Integrated programs will face the challenge of dealing with multiple and possibly non-commensurable outcome objectives. A single measure of program impact is unlikely to be adequate for program evaluation, and alternative strategies will need to be identified. Simple solutions to the problem of evaluating integrated programs in economic terms may not be adequate. An apparently simple approach could be the measurement of traditional family planning and HIV/AIDS prevention outcomes separately with separate attributions of cost. This dis-integration of combined programs at the time of evaluation could significantly obscure the unique benefits to be derived from program integration. If integrated initiatives are to be successful in establishing their efficiency and competing with alternative formulations for health promotion, considerable attention should be focussed on this issue.

Appendix L

Checklist for Assessing Family Planning and HIV/AIDS Programs' Potential for Integration

The following checklist is intended to help program policy makers and program managers to decide if their family planning and HIV/AIDS prevention programs can be integrated and, if so, in which activities. The checklist also provides guidance as to how much success is expected from integration of efforts according to the status, strengths, and current level of development of the programs.

The checklist has been divided in two parts: programmatic areas and indicators of success of the integration process. A score can be assigned to each section by recording the positive or negative answers to each item included. All items have an equal weight, since at present, there is not enough experience to assign differential weights to the items.

The list can be used whether HIV/AIDS prevention programs are to be integrated with family planning programs or vice versa. Most of items are self-explanatory. The first part relates to the knowledge that the managers have of the program. Consideration is given to the possible benefits, constraints or problems associated with the integration in each item. The activity or activities that can be integrated are reflected in the positive answers. If there are no positive answers in this part of the checklist, integration would be impossible.

The second part supplements the first. It gives a score to the integration process and, in so doing, predicts the possible outcome of integration by comparing the number of positive with the negative answers — the more positive answers, the greater the chances of success. Some items in this part are directly related to family planning while some others are more HIV/AIDS oriented. This is to allow for the possibility of integrating either one into the other.

Although the checklist over-simplifies the problems associated with integration of the two programs, it is a beginning. If answers to the checklist indicate that integration is not advisable or feasible, in all likelihood integration would be a failure. More in-depth consideration of the cultural, policy, and programmatic related issues would supplement the information provided by the answers to the items included in the checklist. The managers of programs should use their discretion and knowledge to judge how much additional information they need.

CHECK-LIST FOR INTEGRATING HIV-PREVENTION AND FAMILY PLANNING PROGRAMS			
	PART 1. PROGRAMMATIC	Y	N
1	Is it possible to establish a unified policy (AIDS-FP)?		
2	Is it possible to do IEC materials together?		
3	Is it possible to integrate clinical services?		
3.2	Counseling		
3.3	Contraceptive services		
3.4	Lab tests		
3.5	STD diagnosis/treatment		
3.6	Distribute IEC Materials		
4	Is it possible to integrate community outreach services?		
4.1	Condom distribution		
4.2	Distribution of IEC materials		
4.3	Referrals to clinics/centers		
5	Is it possible to distribute condoms through social marketing?		
5.1	Advertising condoms for FP/AIDS		
5.2	Sell condoms		
6	Is it possible to integrate training?		
6.1	Counseling		
6.2	Contraceptive management		
6.3	Lab techniques		
6.4	Communication/advertising		
6.5	Marketing		
7	Is there anything else the two can do together? Specify.....(project or activity)		
8			
	If Y=0 no integration can take place		

	PART 2: INDICATORS OF FUTURE SUCCESS	Y	N
1	Is the government supporting more than 30% of the FP/AIDS programs?		
1a	Is the government providing contraceptives?		
2	Does the program have strong management?		
3	Is the logistics system adequate?		
4	Is a person in charge of the program 100% of the time?		
5	Is this person (in 4) located at a high level of the organization?		
6	Is there an effective coordinating body of the FP/AIDS activities?		
7	Contraceptive Prevalence Rate Y>20% N<20%		
7a	HIV seroprevalence at antenatal clinics Y>15% N<15%		
8	Program is vertical.		
9	Program is more than 5 years old.		
10	Program has no shortages of staff.		
11	Is there a strong CBD program?		
12	Is there a social marketing program?		
13	Are the services (of the program) overburdened? (yes=N)		
14	Does program have adequate funding?		
15	Condoms can be sold with no restrictions.		
16	Condoms can be advertised openly.		
17	There are no legal/administrative barriers to importation of condoms.		
18	Is there a clear understanding of what the two programs do at community level?		
19	Is there an acceptance of the integration by both programs at all levels?		
20	Are the two programs flexible enough to facilitate integration?		
21	Do the major donors favor integration?		
22	Is the country under Economic Structural Adjustment Program? (yes=N)		