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AND ELSEWHERE IN THIS  
REPORT ARE OWNED BY  
FHI STAFF MEMBERS AND  
COME FROM DEVELOPING  
COUNTRIES. THIS SIMPLE  
ROCK CARVING FROM THE  
AFRICAN COUNTRY OF  
ZIMBABWE DEPICTS A  
MOTHER, FATHER  
AND CHILD.

**DEAR FRIENDS,**

Family Health International is undergoing an important metamorphosis during this final decade of the 20th century. Even as we expand in our traditional roles for fostering better reproductive health, we are entering into new areas of work that will help us prepare for the clear challenges of the coming century.

We continue to devote most of our attention to the needs of developing countries. In a world of changing economic and political realities, we believe FHI is morally obligated to share its expertise in a variety of new venues where the needs exist. During the past year, for example, we have added former Soviet Union countries and Vietnam as new places where we work, providing technical assistance on a variety of family planning matters. FHI is expanding its work in the United States with efforts to help curtail the spread of the human immunodeficiency virus (HIV). For the first time, we are adapting HIV prevention strategies used successfully in developing countries for application in the United States.

Our mandate to improve reproductive health in the international arena can only mean greater challenges for us in the years ahead: the HIV epidemic already has an estimated 14 million victims worldwide, yet the hope for a cure during this century seems remote; the world's growing population

continues to add 95 million more mouths to feed each year,

threatening the quality of life in all countries; and the number of women who will die this year alone from pregnancy-related causes is an appalling and unacceptable 500,000, according to the World Health Organization's estimate.

These stark reminders give all of us at FHI a deep sense of urgency and commitment to our work. We must not only adapt our programs for use in new cultural settings, but we must also find additional financial resources from a variety of donors to help us carry out that work. Success will





Children in Thailand

also hinge upon the continuation of our strong collaborative ties with a worldwide network of investigators, government health ministries and sister organizations. Their invaluable partnership is deeply appreciated.

During 1991 and 1992, we continued to receive most of our support from the U.S. Agency for International Development (A.I.D.), allowing us to make a vital contribution to our nation's family planning and HIV prevention programs in developing countries. In the area of population, we have adjusted our focus to meet A.I.D.'s new emphasis on countries with the greatest need for family planning. Our HIV prevention work in developing countries has expanded substantially and will continue to do so under a new five-year commitment with A.I.D. that began in 1991.

Providing better family planning options by developing and introducing new contraceptive drugs or devices, as well as improving upon existing methods, remains an important item on our long-term agenda. The slow but essential process of gathering clinical data on contraceptive safety and efficacy, both for experimental and existing methods, is fundamental work at FHI. In addition to our contraceptive development cooperative agreement with A.I.D., we received a \$1.3 million grant in 1992 from the National Institutes of Health to continue work to develop and evaluate a thermoplastic condom prototype. Also in 1992, the Andrew W. Mellon Foundation of New York provided FHI \$630,000 in a three-year grant, part of which will be spent to examine drugs that may one day be used widely for non-surgical female sterilization. In support of the above, FHI plays a significant role in researching and disseminating information about a variety of contraceptive-related issues, such as acceptability, use, cost and quality of services.

Significant changes in the makeup of our board have taken place. After 14 years of service, Dr. Sharon L. Camp ended her board membership in 1992. Dr. Camp served as board chair from 1979 to 1982. She is a senior vice-president of Population Action International in Washington, responsible for that organization's public education, media and policy advocacy work.

Dr. Viveca Odland, who was elected to the board in 1989, resigned at the beginning of 1993 to accept an appointment as chair of the board's Population Advisory Committee, a newly-constituted panel whose members are neither directors nor officers of FHI. Dr. Odland is an associate professor of obstetrics/gynecology at University Hospital, Uppsala, Sweden.

Dr. Malcolm Potts, a professor at the University of California, Berkeley, and FHI president emeritus since 1990, left our board in 1991. Also leaving the board that year was Brig. Gen. Alexander B. Andrews, U.S. Air Force (retired), a businessman and attorney of Raleigh, N.C. He served more than 10 years on the board and was its secretary from 1982 to 1990. Dr. King K. Holmes, director of the Center for AIDS and Sexually Transmitted Diseases Research at the University of Washington, Seattle, Wash., concluded his four years of service as a board member in 1991 when he became chairman of the board's AIDS/Sexually Transmitted Infections Advisory Committee.

Four members have joined the board in recent years. In January 1993, the board elected as a director Dr. Ursula Lachnit-Fixson, a specialist in obstetrics/gynecology and a trustee for Schering Research Foundation, Berlin, Germany. Also elected to the board was Dr. Wilbur James Gould, professor of otolaryngology at New York University, Columbia University and New York Medical College and founder of the Ames Vocal Dynamics Laboratory in New York City.

In the fall of 1992, Dr. Harry Woolf became a board member. He is former director of the Institute for Advanced Study, Princeton, N.J. and currently serves as a professor-at-large for the institute. Joining the board in 1991 was John L. Ganley of Georgetown, S.C., a former FHI executive vice-president and former chief executive of Clinical Research International (CRI) based in Research Triangle Park, N.C.

We are indeed grateful for the devoted leadership our former and current board members have given to FHI and for the many achievements resulting from their commitment. The challenges for FHI during the remaining years of this century are both monumental and ever-changing. The partnership we treasure with all our friends will help us greatly as we strive to meet those important goals.

Torrey C. Brown, MD  
Chair/Chief Executive Officer

Theodore M. King, MD, PhD  
President/Chief Operating Officer

# COUNTRIES WHERE FHI HAS WORKED



## EUROPE/NORTH AMERICA

Austria  
Belgium  
Canada  
Denmark  
Finland  
France  
Italy  
Netherlands  
United Kingdom  
United States  
Yugoslavia

## LATIN AMERICA

Antigua  
Argentina  
Barbados  
Belize  
Bolivia  
Brazil  
Chile  
Colombia  
Costa Rica  
Dominica  
Dominican Republic  
Ecuador  
El Salvador  
Guatemala  
Haiti  
Honduras  
Jamaica  
Mexico  
Panama  
Peru  
Paraguay  
Saint Lucia  
Trinidad and Tobago  
Venezuela

## AFRICA

Botswana  
Burkina Faso  
Burundi  
Cameroon  
Cape Verde  
Central African Republic  
Chad  
Congo  
Côte D'Ivoire  
Egypt  
Ethiopia  
The Gambia  
Ghana  
Guinea-Bissau  
Kenya  
Lesotho  
Malawi  
Mali  
Mauritania  
Morocco  
Mozambique  
Niger  
Nigeria  
Rwanda  
Senegal  
Somalia  
South Africa  
Sudan  
Swaziland  
Tanzania  
Togo  
Tunisia  
Uganda  
Zaire  
Zambia  
Zimbabwe

## MIDDLE EAST/ASIA/PACIFIC

Australia  
Bangladesh  
People's Republic of China  
Fiji  
Hong Kong  
India  
Indonesia  
Iran  
Jordan  
Kazakhstan  
Kyrgyzstan  
Korea  
Malaysia  
Nepal  
Oman  
Pakistan  
Philippines  
Singapore  
Sri Lanka  
Taiwan  
Thailand  
Turkey  
Vietnam  
Yemen

Since it was founded more than 20 years ago, Family Health International has become a world leader in promoting sound family planning practices and better reproductive health, including prevention programs to curtail the spread of the acquired immunodeficiency syndrome (AIDS), especially within developing countries.

FHI is committed to helping families have access to the best contraceptive methods to achieve the appropriate number and spacing of children, preventing the spread of AIDS and other sexually transmitted diseases and improving maternal and child health. Our work focuses on these areas: developing, introducing and evaluating contraceptive methods; encouraging provider and consumer practices that improve contraceptive efficacy, quality of care and access to health services; and helping developing countries to build their own capacity for controlling the AIDS pandemic.

A MAYAN MOTHER  
BREASTFEEDS HER  
INFANT IN THIS  
CONTEMPORARY  
CERAMIC  
STATUETTE  
FROM LATIN  
AMERICA.



Headquartered in North Carolina, FHI was established in 1971. Its original mandate was to conduct clinical trials to introduce contraceptive methods to less developed countries. While this remains a vital part of FHI's work, our non-profit organization has expanded dramatically into a variety of related areas, including research and technical assistance in other aspects of reproductive health and numerous training programs that promote family health.

Since its creation, FHI has worked in more than 90 countries. In cooperation with the U.S. Agency for International Development (A.I.D.) and other donors, FHI concentrates its efforts in priority countries where programs are expected to have the most impact, while continuing to provide technical assistance to other countries. FHI has established offices in Asia and Africa, and works closely with a variety of in-country organizations.

**NEW INITIATIVES**

Our responsibilities in preventing the spread of the human immunodeficiency virus (HIV), which leads to the fatal AIDS, have grown substantially in recent years. We are also broadening our funding base within A.I.D. and from other donors, including private sources, to address other important needs.

An independent entity called the Foundation for International Family Health was established in 1991 to manage assets gained when FHI sold its majority interest in Clinical Research International. Resources from the foundation are supporting new initiatives, such as our recently established Maternal and Neonatal Health Center, AIDS prevention work in the United States and family planning activities in Vietnam and in central Asian countries of the former Soviet Union.



*Women with their children in Vietnam, site of a planned FHI study*

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In collaboration with leading health institutions in Hanoi and Ho Chi Minh City, FHI sponsored two seminars on contraceptive technology in Vietnam during February 1993. More than 250 physicians attended the sessions, which featured five international speakers. Funding from Population Action International helped underwrite the seminars. Vietnamese health officials visited our U.S. headquarters in 1992 and 1993 to discuss other joint family planning projects.

Although most of FHI's activities take place in developing countries, the organization's expertise is being called upon more frequently within the United States and other industrialized countries. We welcome these new challenges, which are often complementary to our work elsewhere in the world.

For example, FHI's work to encourage the correct use of oral contraceptives in other countries led to our efforts within the United States to develop and promote standardized, simplified instructions for oral contraception. An estimated 200,000 U.S. women using the pill have unwanted pregnancies each year, many of them because they failed to understand complicated or incomplete pill instructions. In 1992, the U.S. Food and Drug Administration adopted FHI's simplified instructions, requiring the new wording for all new formulations of oral contraceptives containing estrogen and urging pharmaceutical companies to use the instructions for pills currently on the market. Companies have indicated they will do so.

Also in the United States, FHI is providing assistance to a community-based project for HIV prevention in Belle Glade, Fla. That work calls upon our expertise gained from many years of developing prevention strategies in other countries.

And in our home state of North Carolina, where reducing the infant mortality rate is considered an imperative goal among state leaders, we are contributing our expertise to the North Carolina Governor's Commission on the Reduction of Infant Mortality in a study planned for 1993. Through our Maternal and Neonatal Health Center, we will analyze the state's health records and related data in an effort to seek new strategies for reducing infant mortality.

**KEY LEADERSHIP**

In 1991, FHI came under the leadership of Dr. Theodore M. King, who became our president after 14 years of leading the Johns Hopkins Program for International Education in Reproductive Health (JHIPIE/GO).

Two other key leaders within FHI have assumed new responsibilities. Dr. Roberto Rivera, who previously headed our Division of Clinical Trials, was appointed to the newly created position of Corporate Director for International Medical Affairs in 1992. He is focusing on FHI's collaborative work with national and international agencies, identifying projects of interest that may be supported by our technical expertise.

After a year's sabbatical with the World Health Organization's Safe Motherhood Programme, Dr. Judith Fortney returned to FHI in 1992 to become Corporate Director of Scientific Affairs. Her responsibilities include directing our new Maternal and Neonatal Health Center.

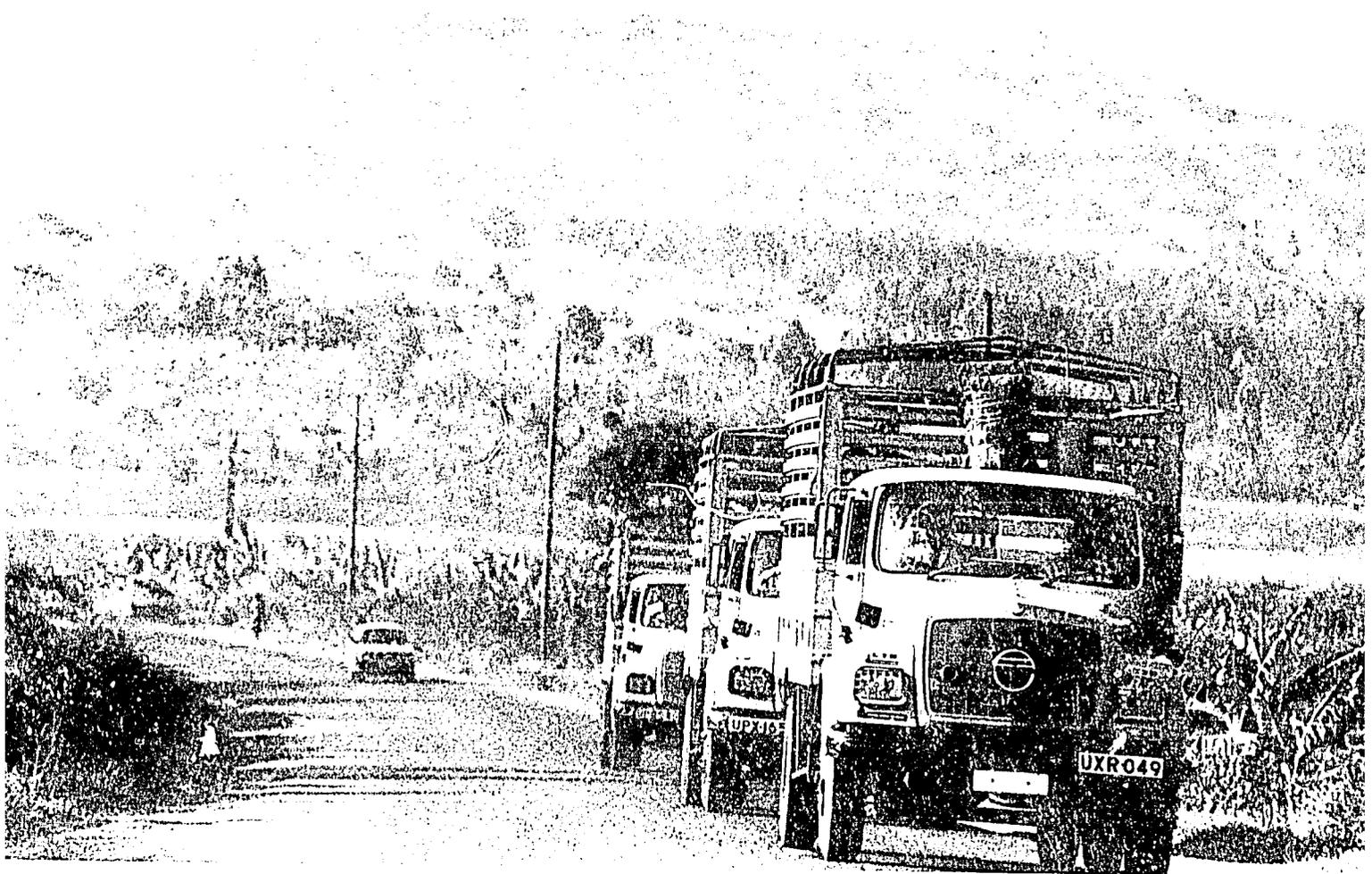


Jerry Markatos



*FHI's Technical Advisory Committee, which reviews our reproductive products and provides technical guidance, are (from left, top left): Dr. Lucile Akers, chair; Dr. Robert Seaman; and Judith Fortney. (from left, bottom left) Dr. Michael Hupert and Dr. Deborah Anderson, back row; and Dr. Eric Martinez, Manager; Dr. Willard Campbell; and Dr. William DeGruccio.*

*Because some African truck drivers have a high risk of HIV exposure, the disease often spreads along truck routes such as this one in Uganda.*



Under FHI's organizational structure, Dr. Howard Miller, senior vice president, oversees divisions involved with contraceptive research and development. Jo Ann Lewis, our senior vice president for population programs, oversees divisions that are involved with population issues, programmatic research, overseas development and information programs. Alfredo Pérez is senior vice president for management, including responsibilities for our human resources office and private sector initiatives. Robert Hughes is controller and vice president for administration. Our corporate director for medical affairs is Dr. Thomas Petrick.

At our Arlington, Va. offices near Washington, Dr. Peter Lamptey is vice president for FHI's AIDS programs and William Schellstede is executive vice president, with responsibility for Washington programs.

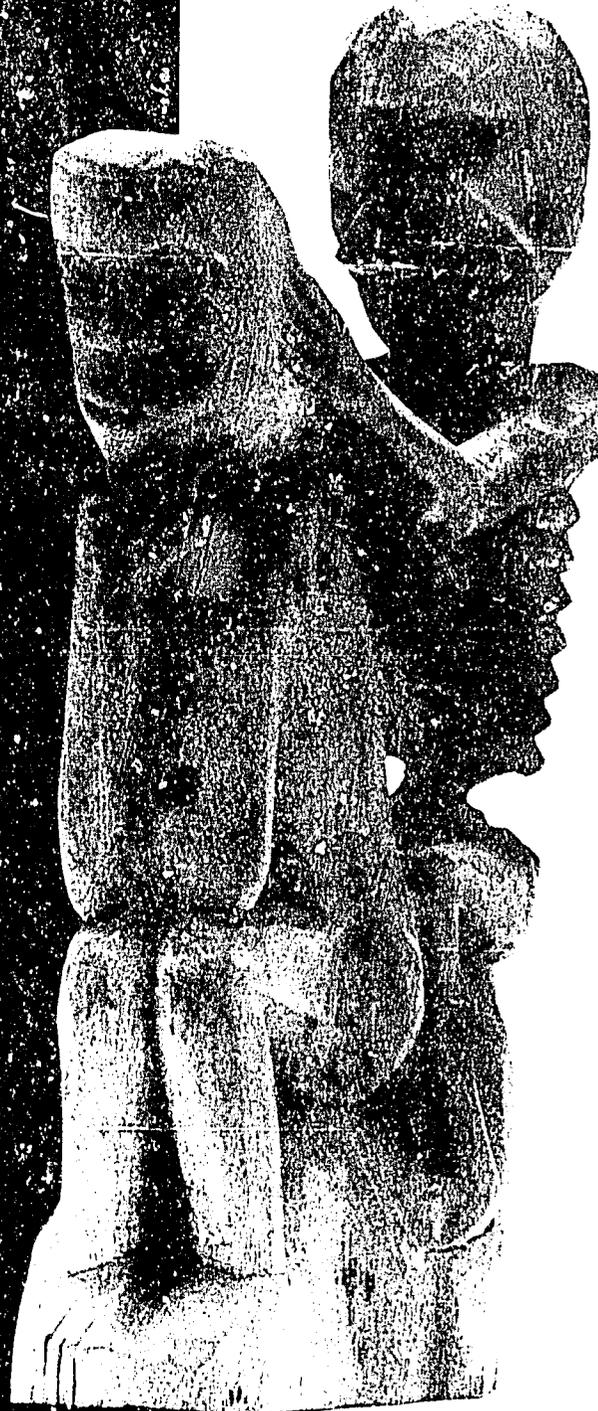
Elsewhere in this report are profiles of our new president and of the people who direct our divisions. This biennial report highlights the contributions of our division directors, whose conscientious leadership in implementing our day-to-day activities plays a crucial role for much of our success.

At least 14 million people worldwide, including 1 million children, are infected with the human immunodeficiency virus (HIV). By the year 2000, the number of people infected with HIV, eventually leading to AIDS, will rise to between 30 million and 40 million, according to the World Health Organization (WHO).

Developing countries are hardest hit by the AIDS pandemic, with two of every three of the world's HIV-infected population living in sub-Saharan Africa. Hard-won gains in economic and social stability in many developing countries are threatened by the burdens this disease is already imposing.

Because FHI has long been a world leader in promoting better reproductive health, especially within developing countries, our involvement with AIDS was a natural extension of our previous work. In recent years, we have provided assistance with the design, implementation and support of more than 250 prevention projects in 35 countries in Africa, Asia, Latin America and the Caribbean.

A WOOD CARVING BY  
COLOMBIAN ARTIST  
JUAN DE LA CRUZ  
SAAVEDRA SHOWS A  
THINKING MAN WITH  
DEATH.



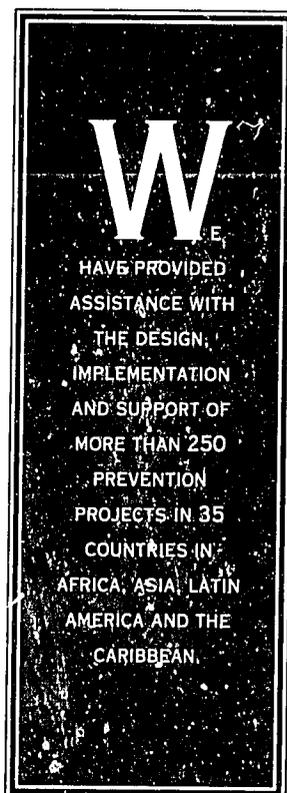
This work has given us vital insights into the most effective strategies for curtailing the spread of AIDS. It is clear that only a well-integrated, large-scale and carefully targeted effort will succeed. In 1991, we were awarded a five-year, \$168 million cooperative agreement from A.I.D. to begin such a broad-scale approach within specific countries. This new effort by the United States, called the AIDS Control and Prevention Project (AIDSCAP), is the largest investment by any government for international work to slow the spread of HIV.

The AIDSCAP approach combines three of the most successful strategies resulting from our experience with earlier projects: encouraging people to change their behavior when that behavior exposes them to HIV transmission; improving treatment and prevention of other STDs that enhance the spread of HIV; and making affordable, acceptable and high-quality condoms readily available.

#### **WORKING SINCE 1987**

FHI's work with HIV began in 1987 with funding from the American Foundation for AIDS Research (AmFAR) and from U.S.A. for Africa. Later that year, FHI's AIDSTECH Division was established under a five-year, \$40 million cooperative agreement with A.I.D. At the time, it was one of the largest cooperative agreements between a government and a private organization to combat HIV in the developing world. The AIDSCAP effort builds upon lessons learned through AIDSTECH.

AIDSCAP is headquartered in the Washington area. In order to be more responsive to needs in developing countries, regional AIDSCAP offices have been established for Latin America, Asia and sub-Saharan Africa. Country offices have been established in 13 countries.



Consistent with FHI's long-standing commitment to help developing countries find ways to help themselves, we work closely with governments and other organizations to build their own resources for combating the spread of HIV. Like other FHI programs, our HIV prevention projects focus on key countries where coordinated efforts with other organizations will have the greatest impact.

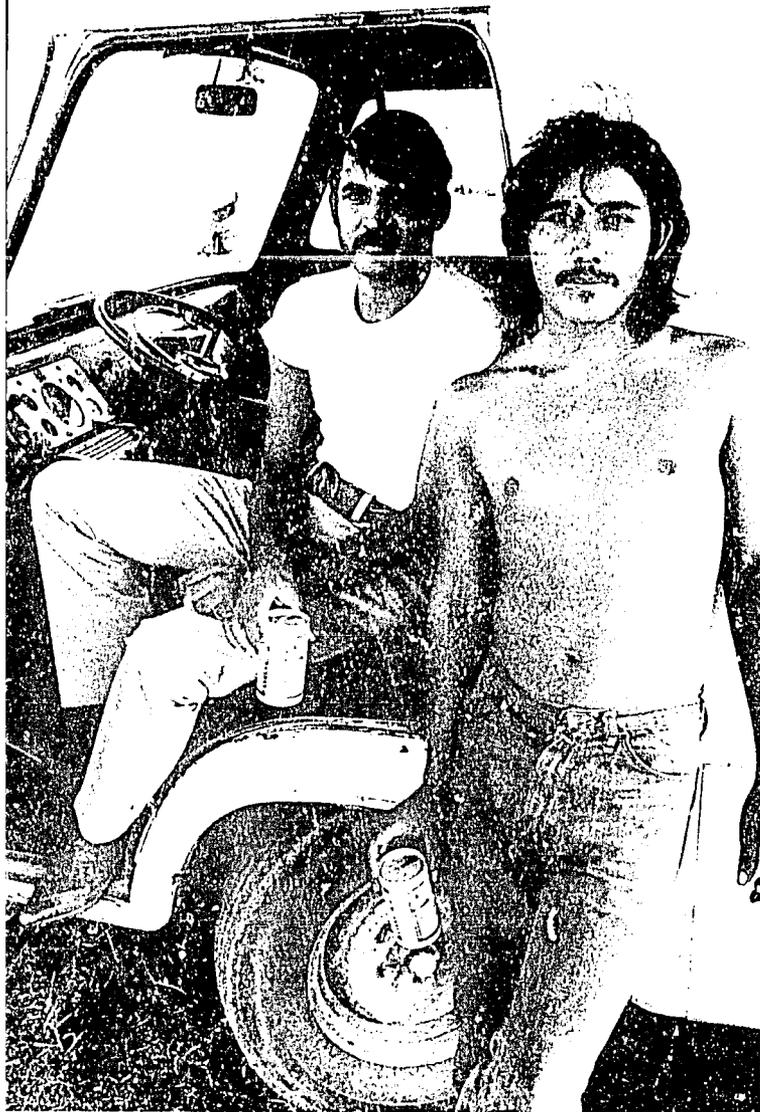
FHI is developing large-scale programs in Brazil, Cameroon, Dominican Republic, Ethiopia, Haiti, India, Jamaica, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Thailand and Senegal. FHI also provides technical assistance to other countries upon request. Nine other organizations contribute their expertise to AIDSCAP. They are the Center for AIDS Prevention Studies (CAPS), the University of California, San Francisco; John Snow, Inc.; Ogilvy Adams & Rinehart; Population Services International (PSI); the

Program for Appropriate Technology in Health (PATH); Prospect Associates; the Institute of Tropical Medicine, Antwerp, Belgium; the University of North Carolina at Chapel Hill; and the University of Washington in Seattle, Washington.

#### **CHANGING BEHAVIOR**

Since HIV is spread primarily through sexual transmission, FHI concentrates on changing behaviors that place people at risk. Encouraging people to reduce the number of their sexual partners and to use condoms are key aspects of preventive efforts. Our work also focuses on providing better treatment and control of other sexually transmitted diseases, many of which facilitate HIV transmission.

Each month, our efforts currently provide HIV prevention messages to thousands of people and distribute millions of condoms. Increasing condom use in many of these programs is being achieved through "social marketing," in which traditional marketing techniques are used to address a public health problem. Although the social marketing programs are subsidized, they can help developing countries recover some of the costs of HIV programs, thus making them more sustainable. Social marketing techniques include promotional campaigns and price subsidies.



John Moses

*Two men in Haiti. The man on the left is holding a condom, one of the many distributed through FHI's program in 1992.*

Examples of social marketing programs funded by FHI and conducted by other organizations include the following:

- **IN BURKINA FASO**, a social marketing program led to the sale of nearly 4.5 million condoms to distributors for the year ending August 1992, the most successful start-up of any condom social marketing program in Africa. More than 100 wholesalers and an estimated 1,800 retailers were involved in the distribution of these condoms in cities, frontier towns and mining sites.
- **IN ZAIRE**, a social marketing program that began in 1987 dramatically increased condom sales, with nearly 10 million sold in 1991. Even after donor support was withdrawn in 1992 because of political unrest, 7 million were sold. The project paved the way for providing condoms through a variety of new outlets, including bars, small shops and hotels.

■ **IN THE CARIBBEAN ISLAND NATION OF HAITI**, where the HIV epidemic may already have infected as much as 15 percent of the urban populations, more than 1.1 million condoms were sold from August 1991 through September 1992. The effort included the creative use of radio and television advertising.

### USING PEER EDUCATORS

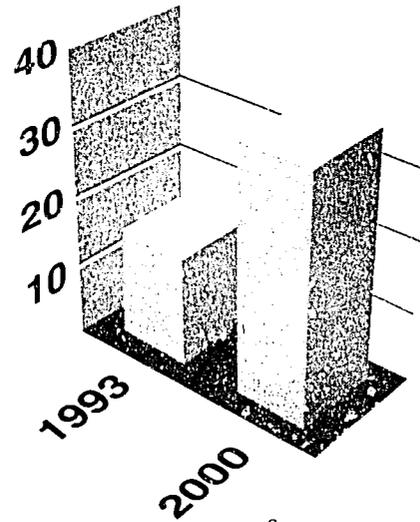
FHI uses many approaches to reduce high-risk behaviors. One such approach is to train people exposed to high risk who in turn teach their peers, a process called "peer education." Prostitutes and their customers, truck drivers, factory workers and students are examples of such groups. A similar approach is educational programs to reach people at risk where they work or socialize. FHI has supported programs to train employers, farmers, taxi drivers and bar owners to provide HIV education and to distribute condoms to their employees and customers. Yet another approach is to distribute condoms through health centers, including STD and family planning clinics.

FHI has supported many projects using peer educators to disseminate information and distribute condoms. These have proven especially effective with prostitutes, whose life-styles frequently place them outside the reach of traditional health services.

Under the MIDSTFCH project, which ended in 1992, 48 million condoms were distributed in more than 20 countries and FHI trained 5,200 peer educators. Here are just a few examples of that work:

- **IN THE WEST AFRICAN COUNTRY OF CAMEROON** between 1989 and 1991, prostitutes trained as peer educators accounted for 19 percent of all sales for the more than 1.1 million condoms distributed countrywide through social marketing. The percentage of people infected with chlamydia, a sexually transmitted disease, declined by more than half between 1989 and 1991.
- **IN OLONGAPO, PHILIPPINES**, the proportion of prostitutes who encourage their clients to use condoms rose from 24 percent in 1990 to 51 percent in 1992, while the proportion who said their clients never used condoms dropped from 31 percent to 10 percent. More than 1,400 peer educators have reached an estimated 36,000 people through this effort.
- **AFTER AN INTERVENTION PROGRAM IN ZIMBABWE**, the proportion of prostitutes who said they always encouraged the use of condoms rose from under 10 percent to nearly 60 percent. In the city of Bulawayo, nearly 100 peer educators were trained during the first year of the program.

## WORLDWIDE HIV INFECTIONS (BY YEAR, IN MILLIONS)



Source:  
World Health Organization

### TREATING OTHER STDs

STDs, especially those causing genital ulcers, have been shown to increase the chance of HIV transmission by as much as 50 times in a single act of intercourse. In addition to supporting STD centers and evaluating therapies, FHI uses a variety of innovative approaches to make STD remedies more readily available. The marketing of inexpensive antibiotic kits in Cameroon is one example. The Cameroon project will use the commercial distribution system to ensure the availability of appropriate antibiotics.

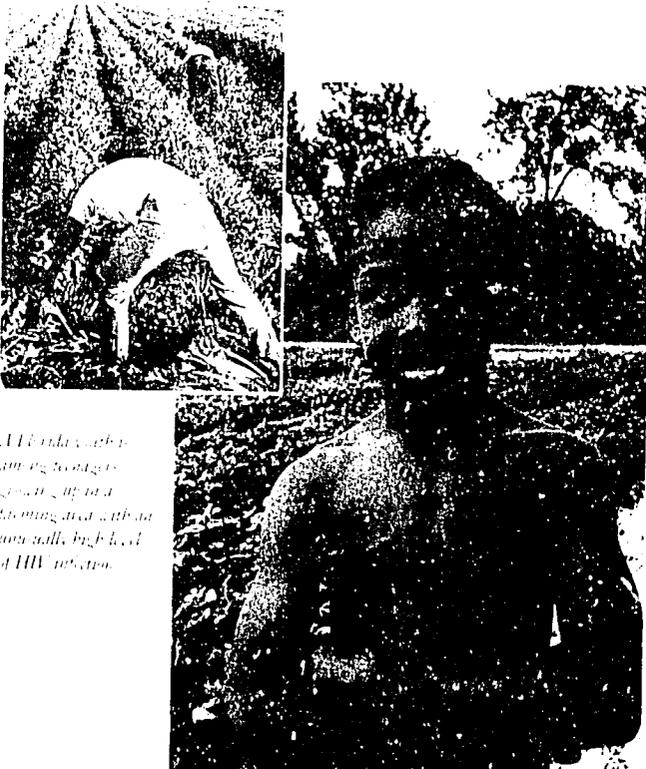
Other FHI initiatives include the following:

- FHI HAS IMPROVED STD TREATMENT IN BURKINA FASO AND THE CARIBBEAN by training health workers to treat STDs using treatment algorithm charts, basing the treatment given on a patient's symptoms rather than requiring expensive laboratory testing.
- IN THE DOMINICAN REPUBLIC, an FHI-supported clinic is distributing comic books among prostitutes to correct common misunderstandings about STDs. Through simple stories involving street-wise women, vital health information is explained in comics circulated among this high-risk group.

### TRANSFERRING FHI'S INTERNATIONAL EXPERIENCE TO THE UNITED STATES

The HIV epidemic in the United States is beginning to resemble the pattern of HIV transmission in the countries that FHI has traditionally served. Infection from heterosexual transmission among women and ethnic groups, many from cultures or countries where FHI has worked, is increasing rapidly.

FHI has begun offering its international experience to assist in combating the epidemic in the United States. As one example, in 1992 we began work in HIV prevention in Belle Glade, Fla., where peer education is being adapted to address the needs of African-American and Haitian youth engaged in high-risk behaviors. This work is being done in conjunction with the Community Foundation of Palm Beach and Martin Counties and the Carl S. Brumback Health Center in Belle Glade, with a grant from AmFAR.



John McGehee

HIV risk is high among teenagers living in a farming area with an unusually high level of HIV infection.

## POLICY AND COSTS

FHI seeks to educate policy-makers to support intervention programs aimed at people who practice high-risk behaviors. Collaborative planning, technical assistance, conferences and computer-based modeling to show how the epidemic may spread are among the tools used in this effort.

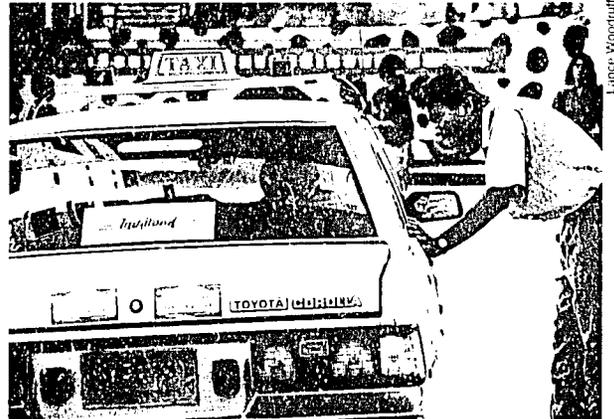
HIV has an average incubation period of 10 years. If policy-makers are to make sound decisions today, they must have a clear understanding of how the spread of HIV is likely to affect their communities years into the future. FHI has helped develop several computer-based models with this objective in mind.

A simple model merely forecasts the number of AIDS cases based on a given level of HIV infection. More sophisticated models, such as the one developed by the U.S. Department of State's Interagency Working Group on Computer Modeling of AIDS (iwgAIDS), recreates the epidemic inside the computer, taking into account HIV risk factors and possible interventions. With this model, decision makers can compare various "what if" scenarios. FHI helped develop SimulAIDS, a model that complements the iwgAIDS approach while being quite different from it. SimulAIDS specifically forecasts transmission scenarios for African cities. It can help answer such questions as:

- How rapidly will the epidemic spread?
- Which intervention strategies will be most effective?
- What are the relative costs of prevention programs versus the future costs of treatments?
- Will HIV have a greater impact than other diseases, such as malaria or measles?



*In Bangkok, Thailand, a malaria-treating company's physician dispenses AIDS education materials to an employee and a taxi driver, an AIDS prevention message.*



*Lance Woodruff*

Another program called the AIDS Impact Model, developed by The Futures Group in collaboration with FHI, can present results from either simple or complex models in a graphic, easy-to-understand format for use in presentations to policy-makers and others. It can show the impact of the AIDS epidemic on a number of sectors, including child and adult mortality, health care costs, hospital bed utilization, population growth and the labor force.

Computer modeling can provide reasonable estimates of the impacts of the AIDS epidemic. FHI has helped model the epidemic in Burundi, Cameroon, Haiti, Kenya, Malawi, Thailand and Uganda.

## ENSURING SAFE BLOOD SUPPLIES

Blood transfusions may be responsible for up to 10 percent of HIV infections in some countries. Screening blood for transfusion is often the first step a government takes to control the spread of HIV. Since 1987, FHI has assisted 19 countries to ensure safe blood supplies.

FHI also helped train health care providers by conducting workshops on blood transfusion. Often blood transfusions are administered unnecessarily or without weighing the risks. Relatives of HIV or AIDS patients and paid donors carry a higher risk of HIV infection than volunteers, for example. Educating blood donors about HIV is important in persuading high-risk donors not to give blood. Since 1987, AIDS/TECH completed 26 blood transfusion prevention projects in 17 countries.

This work has helped establish the protocols and necessary systems used by several developing countries today to ensure the safety of their blood supplies. With these quality assurance programs already in place, other countries will be able to adopt the procedures to begin their own sustainable programs for assuring safe blood supplies.

### SUPPORTING RESEARCH

A wide variety of research to improve programs to control the spread of HIV is part of our work. This effort includes research to evaluate the effectiveness of intervention projects to determine which components should be replicated or expanded. Also included are studies involving high-risk behaviors, which help evaluate approaches that may help modify these behaviors. Other work involves epidemiological research on HIV, especially concerning the role of STDs and the effectiveness of condoms and spermicides in preventing them.

This research yields practical results. An FHI study of 273 prostitutes in Cameroon, for example, has shown that the spermicide nonoxonyl-9 (N-9) may provide protection against HIV infection for women. Another study of discordant couples in Zambia who used both spermicides and condoms has indicated that spermicide reduces the infection rate in women, but not in men.

It is clear that condoms offer effective protection against HIV infection. An FHI analysis of unpublished data and of studies performed by others illustrates dramatically the level of protection. The analysis showed that when condoms were used regularly by discordant couples, in which one partner was HIV-infected and the other was not, only one in 40 of the uninfected partners contracted HIV from their mates. For those who did not use condoms, the risk was much greater — one in every four partners contracted HIV from their mates.

Human behavior can be modified, including such sexual practices as using condoms. Experience has shown that communities can deliberately change overall sexual behaviors in order to reduce the spread of HIV. Yet our understanding of sexual practices is limited, especially as practices are influenced by community and culture. To improve strategies that change sexual behaviors, FHI's AIDSTECH Division established a research program to study these behaviors. In a continuation of this initiative,

AIDSCAP is testing effectiveness, acceptability and sustainability of new interventions to reduce high-risk sexual behavior, improve condom use and reduce sexually transmitted diseases.

In Zimbabwe, for example, people at high risk of getting AIDS are being interviewed to learn more about how their attitudes and experiences affect their decisions to use condoms. In Jamaica, research grants underwrite work by the University of West Indies and the University of California at Los Angeles to examine social and cultural factors that influence the sexual behavior of high-risk groups. And in Botswana, similar issues are studied in an FHI-funded AIDS educational program for women conducted by the University of Illinois and the University of Botswana.

**I**F POLICY-MAKERS ARE TO MAKE SOUND DECISIONS TODAY, THEY MUST HAVE A CLEAR UNDERSTANDING OF HOW THE SPREAD OF HIV IS LIKELY TO AFFECT THEIR COMMUNITIES MANY YEARS INTO THE FUTURE.



*A Child, her mother and infant are both infected with the AIDS virus.*

Jane Boone/IC: Hollnagel/Hoogt Impact Visuals

FHI is committed to developing and introducing a broader range of safe, effective and acceptable methods of contraception.

As U.S. pharmaceutical companies have generally withdrawn from contraceptive development, FHI has become one of only a few North American organizations developing and testing new contraceptives for approval by the U.S. Food and Drug Administration (FDA). FHI has also continued to assist developing country programs to introduce currently approved contraceptive methods in their own countries.

In coordinating clinical trials for new contraceptive devices or methods, FHI works closely with a number of related agencies, including the World Health Organization (WHO), the Contraceptive Research and

DCARVING  
A SCENARIO  
TO THE  
AN ISLAND  
A WOMAN IN  
ASSISTED  
IND BY A  
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Development Program (CONRAD), the Population Council and the Association for Voluntary Surgical Contraception (AVSC). We have also developed an extensive network of international investigators. Over the past 20 years, FHI has worked with more than 260 clinical research centers around the world.

### NEW CONTRACEPTIVE CHOICES

In 1992, FHI prepared submissions for FDA approval of two new contraceptive products — a male thermoplastic condom and a variation of a device used for female sterilization. We also contributed to an FDA submission for approval of a female condom.

**THERMOPLASTIC CONDOM.** FHI is developing a male condom made of thermoplastic material instead of latex, the material used in most condoms today. Thermoplastic condoms appear to be at least as strong as their latex counterparts and offer important advantages. They promise a longer shelf-life than latex condoms, which deteriorate rapidly in the storage conditions often found in developing countries.

Unlike latex condoms, thermoplastic condoms do not deteriorate when used with oil-based lubricants. FHI research has shown that oil-based lubricants can cause a 90 percent decrease in the strength of latex in as little as 60 seconds, potentially leading to failure both as a contraceptive and as a protective device against AIDS and other sexually transmitted diseases.

The thermoplastic condom is drawing interest for potential use in the United States. In 1992, the National Institutes of Health awarded FHI \$1.3 million to support four years of clinical trials and acceptability studies of FHI's condom prototype.

Another form of thermoplastic condom, designed to be easier to put on and consequently more appealing to use, is at an earlier stage of development. In addition to finding more durable and more appealing devices, pilot projects are defining manufacturing processes that may



*Children find places to play in a crowded Bangkok neighborhood.*

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U.S. PHARMACEUTICAL  
COMPANIES HAVE  
GENERALLY  
WITHDRAWN FROM  
CONTRACEPTIVE  
DEVELOPMENT.  
FHI HAS BECOME ONE  
OF ONLY A FEW  
NORTH AMERICAN  
ORGANIZATIONS  
DEVELOPING NEW  
CONTRACEPTIVES.

lead to low-cost ways of mass production in developing countries.

**FEMALE CONDOM.** The female condom, studied by FHI under the trade name Reality, is made of polyurethane. Reality is licensed by Wisconsin Pharmaceutical from Chartex (UK) for distribution in the United States. It resembles a large male condom with a flexible ring at either end, one fitting inside the woman much as a diaphragm does and the other anchoring the device outside the vagina. While women can control a variety of methods that provide effective contraception, use of a male condom for protection against AIDS and other sexually transmitted diseases requires partner cooperation. A female condom would give women an option for self-protection.

In cooperation with CONRAD, FHI conducted clinical and acceptability trials of the female condom involving more than 350 women in the United States and other countries. The female condom has been introduced in Europe by Chartex. In 1993, the U.S. FDA approved the device for marketing in the United States.

**FILSHIE CLIP.** FHI has submitted a Premarket Application (PMA) for FDA review and marketing approval of the Filshie Clip, a device for female sterilization developed by Femcare, Ltd., UK. This clip is used to pinch the Fallopian tubes closed. Because it is narrower than other devices currently used to close the tubes, it may do less damage to the tubes. Thus, reversing the sterilization later may be easier. FHI conducted clinical trials involving more than 9,000 women in 20 countries to evaluate the clip.



*FHI's Carol Jeanes discusses the female condom. FHI conducted clinical trials for this new contraceptive, which was approved in 1993 for use in the United States.*

Among other products being investigated are injectable microspheres (NET-90), which are small, biodegradable spheres of norethindrone injected into the body that deliver this contraceptive hormone for 90 days; and biodegradable NET implants (Annuelle), which are expected to provide a year of contraception as norethindrone is released from small pellets implanted in a woman's forearm.

**INTRODUCING CONTRACEPTIVES**

FHI conducts clinical trials with existing contraceptives to provide local data to national family planning programs and carries out a range of other activities to improve the planning and introduction of contraceptives. In addition to introducing local providers to new methods, these activities help country programs to select an appropriate mix of methods. Some examples of that work include:

**NORPLANT.** Developed by the New York-based Population Council, Norplant was the first new major hormonal contraceptive marketed in the United States since oral contraceptives were introduced three decades ago. It consists of six match-size Silastic capsules implanted in a woman's upper arm. The implants deliver a continuous supply of progestin and provide highly effective contraception for up to five years.

**F**HI TAKES SAMPLES OF CONDOMS DIRECTLY FROM MANUFACTURERS TO ENSURE THAT PRODUCTS MEET A.I.D. STANDARDS. ALSO, SAMPLES ARE TAKEN PERIODICALLY FROM WAREHOUSES OVERSEAS, WHERE CONDOMS CAN OFTEN DETERIORATE IN ADVERSE CONDITIONS.

FHI has sponsored Norplant trials involving about 7,000 women in 11 countries. These trials have been instrumental in securing marketing approval for Norplant in Haiti, Nepal, Senegal, Singapore and Sri Lanka. Approval is pending in Egypt, El Salvador, Ghana and Pakistan. The Population Council used FHI data to support its FDA application to allow Norplant use in the United States, which was approved in December 1990. It is likely that other countries will grant approval in the next two to three years. FHI continues to work with programs in many of these countries to plan and carry out activities aimed at broadening the use of Norplant.

With funding from the Andrew W. Mellon Foundation and Ford Foundation, FHI is participating with WHO and the Population Council in a nine-country post-marketing survey of women's health and satisfaction with Norplant. The five-year project also seeks to identify any problems associated with removal.

**COPPER-BEARING IUDS.** Until the 1970s, all intrauterine devices (IUDs) were "nonmedicated," that is, they contained no copper or hormones. A second generation of IUDs developed since then contain copper. Copper-bearing IUDs have proven to be safer and more effective. Problems with bleeding and other undesirable side effects have diminished.

Among this second generation of IUDs is the Copper T 380A, also known as the TCU 380A, developed by the Population Council and first marketed in 1982. In 1991, FHI completed an extensive study of the TCU 380A, two earlier copper-bearing IUDs and the Lippes Loop, a nonmedicated IUD. From 1985 to 1989, clinical trials involving some 10,000 women were conducted in 23 developing countries. While the other copper-bearing IUDs proved highly effective and generally safe, the TCU 380A clearly had the best record with regard to accidental pregnancies, continuation rates and device life-span. The TCU 380A is currently the IUD most commonly used for postpartum contraception.

**PROGESTIN-ONLY ORAL CONTRACEPTIVES.** FHI is studying the issue of when breastfeeding women should begin using progestin-only contraceptives. Unlike oral contraceptives that contain estrogen, progestin-only pills do not reduce lactation and are thus the recommended oral contraceptive for breastfeeding mothers. Women who breastfeed frequently with few supplements are naturally protected against pregnancy for at least six months if they do not resume menses. In many developing countries, the only time women receive medical care is during pregnancy and immediately following childbirth — the only practical time to provide adequate counseling about oral contraceptives. In FHI's study, one group of women begins taking the contraceptive six weeks postpartum and another group starts at six months or at first menses, whichever comes first. Contraceptive effectiveness and continuation rates are among the outcomes that are being evaluated. The study involves about 2,000 women in Asia, Africa and Latin America.

**RELATED ACTIVITIES.** Extensive experience with introductory clinical trials, particularly with Norplant, serves as a basis for FHI's contraceptive introduction program. Our experience with clinical trials, including evaluations of copper-bearing IUDs, also dovetails with FHI's emphasis on postpartum contraception. As part of this initiative,

FHI is helping programs in several countries to evaluate the safety, efficacy, acceptability and cost implications of immediate postpartum insertion of IUDs.

FHI also provides extensive quality assurance for condoms distributed by A.I.D. in the developing world. FHI takes samples of condoms directly from manufacturers to ensure that products meet A.I.D. requirements, which are based upon standards set by the American Society for Testing and Materials (ASTM) and the International Organization for Standardization (ISO). Also, samples are taken periodically from warehouses overseas, where condoms can often deteriorate in adverse storage conditions. In 1991, A.I.D. spent \$43 million to buy and distribute nearly a billion condoms. FHI testing for quality assurance that year resulted in recommendations that about 6.3 million condoms be withdrawn from distribution, including many in storage that had been purchased in previous years.

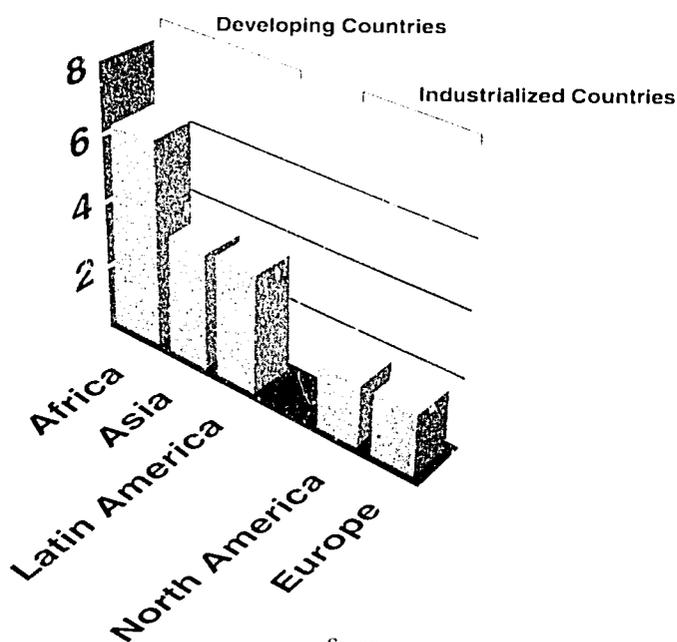
Future studies will seek ways of predicting more effectively when condoms will fail or break. FHI also is expanding its contraceptive quality assurance program to include the testing of other products, including oral contraceptives, spermicides and IUDs.

#### IMPROVING ACCESS TO CONTRACEPTION

There are many safe and effective methods of contraception. However, they must be available, affordable and acceptable, both for users and for the health community that provides them. FHI has long been committed to promoting a wider choice of contraceptive options in developing countries by introducing and encouraging acceptance of alternative methods.

A crucial element for improving access to contraceptives is the removal of practices or policies that are unnecessary barriers to the provision of contraceptive methods. This problem is global in nature and encompasses many obstacles to the availability and use of contraceptives, including legal, economic or programmatic constraints. FHI in 1992 developed a strategy to address the specific problem of medical barriers to contraception. This work, part of a comprehensive effort by A.I.D. to identify medical barriers and develop new tools and interventions to help overcome them and to improve quality of care, is being coordinated with similar activities under way by other organizations, including AVSC, The Futures Group, the Program for International Training in Health (INTRAH) and Population Communication Services.

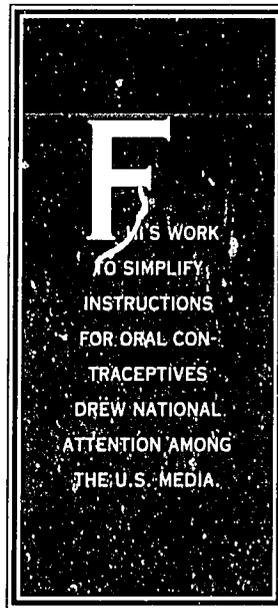
**FERTILITY RATES**  
(AVERAGE NUMBER OF CHILDREN EACH WOMAN  
WILL BEAR DURING HER LIFETIME)



Source:  
United Nations,  
WORLD POPULATION PROSPECTS, 1990

Medical barriers are practices and policies by health providers, officials or policy-makers that unnecessarily restrict access to contraception and other reproductive health services or discourage people from using these services. Examples of medical barriers include the following:

- Inappropriate eligibility criteria impose arbitrary restrictions on who may use a method. For example, providers in many countries follow guidelines that require a woman to have four children prior to sterilization.
- Unwarranted contraindications, outdated information or incorrect perceptions among providers often prevent women from obtaining desired family planning assistance.
- Many programs, especially in Latin America, recommend as many as five follow-up visits within 12 months after insertion of an IUD, even though most women have few problems, if any.
- Specialist physicians only are allowed to insert an IUD or Norplant in many countries, even though studies have shown that trained nurses and midwives can do these procedures safely.



and failure to promote the lactational amenorrhea method (or LAM) as a contraceptive alternative. The Togo Ministry of Health and Population officially endorsed the conference's recommendations for ways to overcome these problems.

A 1991 conference in Senegal drew attention to policies that required extensive diagnostic laboratory tests before a woman would be allowed to use oral contraceptives. Research supported by FHI in Senegal showed that such systematic laboratory testing was not only unnecessary but discouraged many women from using the pill.

At the request of family planning officials in Niger, a contraceptive technology conference was held in 1991 in that country. Recommendations included ways to simplify access to oral contraceptives both in urban and rural areas and to train midwives to provide better counseling. Seminars in 1992 were conducted in Egypt, Jordan and

Jamaica. Conferences were conducted in early 1993 in Vietnam and Kazakhstan, a part of the former Soviet Union.

## CONTRACEPTIVE TECHNOLOGY UPDATE

### SEMINARS

For 20 years, FHI has organized contraceptive technology update seminars around the world to furnish better information on family planning to providers and policy-makers, as well as to introduce new contraceptive methods and practices. A primary goal of these seminars is to change, by consensus, long-standing practices that are unnecessary — procedures that have become barriers to family planning.

Such seminars have been held recently in the West African countries of Senegal, Niger and Togo. At the 1992 Togo conference organized in conjunction with INTRAH, more than 180 participants concluded that obstacles to effective contraceptive use included a poor mix of available methods, with heavy reliance on injectable contraceptives; an undefined national policy on providing contraceptive services to clients under age 20;



*Participants talk during a break in a 1993 FHI contraceptive technology seminar held in Almaty, Kazakhstan, part of the former Soviet Union.*

## **SIMPLIFYING THE USE OF ORAL CONTRACEPTIVES**

FHI is involved in several efforts to improve the use of oral contraceptives (OCs). Used correctly, oral contraceptives are nearly 100 percent effective. However, surveys in developing countries report failure rates as high as 20 percent. Instructions that are difficult to understand can lead to misuse and failures. Differing instructions from one brand of pills to the next can add to the confusion. If use effectiveness of pills were improved by just one percentage point worldwide, 630,000 unwanted pregnancies would be prevented each year.

Studies in Colombia and Egypt, as well as the United States, show that many women do not understand how to use the pill correctly. As a result of those studies, the FDA asked FHI to propose simplified and standardized instructions for the most common forms of oral contraceptives, those that use a combination of estrogen and progestin. Following a public hearing to review proposed changes, the FDA in 1992 asked manufacturers to adopt new wording in patient package inserts for all existing and new oral contraceptives combining estrogen and progestin that are distributed in the United States.

FHI's work to simplify instructions drew national attention among the U.S. media, including an appearance on ABC's "Good Morning America" by an FHI expert who directed the research. Several major newspapers, including *The Washington Post* and *USA Today*, also covered the issue. Meanwhile, FHI is testing simplified instructions for combined oral contraceptives in Mexico and is planning a multi-country project to test effective ways to encourage use of the new instructions in other developing countries. At the request of the FDA, FHI is drafting simplified instructions for progestin-only pills.

## **IMPROVING SERVICE DELIVERY**

As part of our overall effort to increase access to good quality, affordable family planning services, FHI is working with major international family planning service organizations, including WHO, A.I.D., and its cooperating agencies, International Planned Parenthood Federation (IPPF) and the United Nations Population Fund (UNFPA). One goal is to promote consistent service guidelines for local programs and to encourage cooperation among the agencies.

One project documented the service delivery guidelines issued by eight international family planning organizations. It found inconsistencies in program



*Mother and her child in Bangkok*

guidelines, such as those for prescribing oral contraceptives. FHI has produced a catalog of program guidelines to promote local guidelines that are consistent, accurate, up-to-date and easy to use.

With severely limited resources at the local, national and international levels, the cost of family planning programs is clearly a barrier to service delivery. FHI is working on several projects that address this issue. For example, in collaboration with the Population Council, FHI is studying the costs and safety effects of reducing follow-up visits for IUD users recommended by family planning agencies in two Latin American countries.

In Ecuador, the current regimen used by Centro Médico de Orientación y Planificación Familiar (CEMIOPLAF) includes visits at eight days, five weeks, three months, six months and one year. A study is assessing the cost and safety effects of substituting a more flexible schedule. The results may suggest how to reduce costs, both for clients and the program, without compromising quality of care. A similar study is under way in Mexico with the Mexican Institute of Social Security.



Source: B. B. F. F.

*Health providers and policy makers participate in a 1992 contraceptive technology seminar held in Jordan.*

#### **QUALITY OF CARE**

To help A.I.D.'s population program improve the quality of care provided by family planning services, FHI conducted extensive interviews with several service delivery agencies that work with A.I.D. Our survey found that these agencies have long focused their activities on improving services for their clients.

The study documented numerous ways in which such agencies are continually assessing quality of services, as well as specific activities they do to improve their programs. The development of better guidelines, improved training activities and the production of educational materials are just a few of the ways agencies are working to provide better quality of care for their clients.

FHI has also cataloged methods of assessing quality of care so that other organizations and local family planning programs may use them to improve their own programs. As part of FHI's effort to improve quality of care, a system used successfully by private industry for improving the quality of products and services has been translated into procedures that are more applicable to the needs of family planning agencies. Called "Service Quality Improvement," the process has the potential to enhance and revitalize family planning programs.

In yet another example of this work, FHI responded to concerns raised in Bangladesh about the access women have for removal of the subdermal implant, Norplant. The 1991 study showed that the quality of services available to clients was generally good. Study findings helped shape training of providers, emphasizing the need for adequate client counseling and appropriate access to removal services.

#### **BETTER HEALTH FOR MOTHERS AND INFANTS**

The well-being of mothers and their infants is closely linked with family planning at FHI. Helping families in the developing world choose the appropriate number and timing of their children's births is one of the most important ways to promote good reproductive health. Cultivating good maternal and infant health encourages smaller family sizes that are more in keeping with such limited resources as food, fuel, shelter and available jobs.

Proper spacing of childbearing also protects the health of both mother and child. A baby born less than two years after a sibling's birth faces more than twice the risk of dying in infancy than a baby born after a longer interval, according to *Child Survival: The Role of Family Planning*, an FHI monograph published in cooperation with IPPF, with partial funding from UNEPA.

"Contraceptive use can improve child survival; child survival can increase the demand for family planning," the monograph says. "Resources and efforts concentrated in

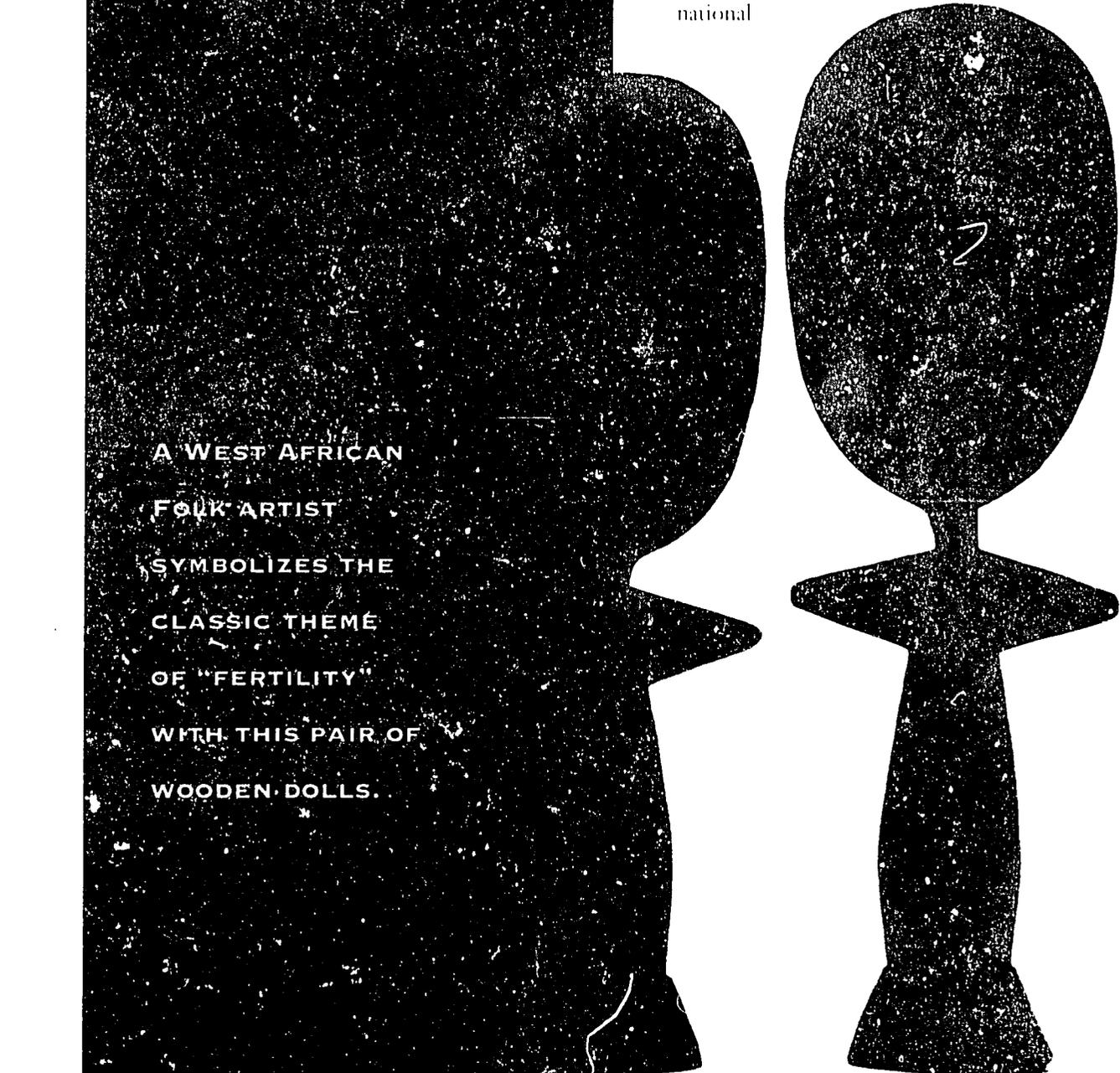


Helping nations address their own reproductive health needs is a cornerstone of FHI's work. In this spirit, FHI works to strengthen organizations and programs to help them conduct high quality research and carry out interventions aimed at addressing specific reproductive health concerns. This strategy also helps disseminate findings more effectively, since it encourages local policy-makers to transform abstract research into meaningful public practice.

Biomedical, epidemiological and programmatic work on reproductive health is a part of the effort. Building country programs also involves implementing and evaluating health programs, as well as strengthening the capacity of organizations to deliver services that impede the spread of AIDS.

By providing data on the most acceptable, the safest and most effective methods of family planning, in-country researchers can help national

A WEST AFRICAN  
FOLK ARTIST  
SYMBOLIZES THE  
CLASSIC THEME  
OF "FERTILITY"  
WITH THIS PAIR OF  
WOODEN DOLLS.



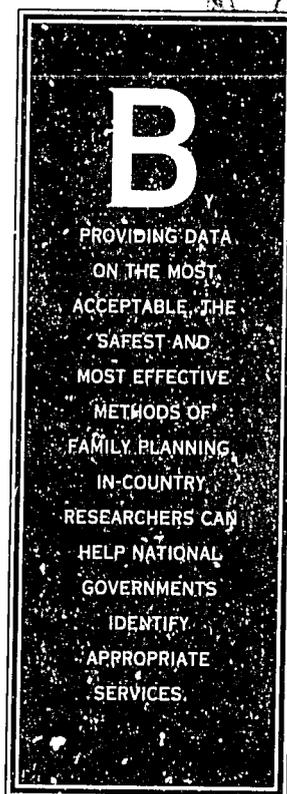
governments identify appropriate services for a region or for groups with special needs. These institutional development efforts not only help translate research into policy, but also into meaningful action.

### **BUILDING LOCAL CAPACITY**

The origins of our institutional development program can be traced to the India Fertility Research Program (IFRP), created with the help of FHI in 1973 to address widespread public concerns about IUDs. Clinical trials and related work helped many people accept this safe and dependable contraceptive method. While FHI's financial support was phased out by 1979, the India program continues to operate. Numerous affiliated centers throughout India, ranging from rural clinics to sophisticated medical centers, participate in IFRP's work.

Over the past two decades, FHI has provided extensive help to strengthen research and management capacities of professionals at 15 health organizations in 12 countries. The organizations which have received FHI's intensive support are known as Family Health Research Centers (FHRCs). FHI has also worked in many other countries through a network of researchers, health care providers and institutions where, as part of collaborative research and program intervention projects, we provide technical assistance, training and financial assistance.

FHI has a long-term commitment to working in partnership with health research organizations, assisting them to function effectively after external support has been phased out. FHI views its intensive support for institutional development as long-term, but not permanent. A number of FHRCs have "graduated," although they continue to be eligible for support on a project-by-project basis.



*A Tanzanian journalist who attended an FHI journalist training workshop interviews a mother about her health care needs.*

### **CURRENT WORK**

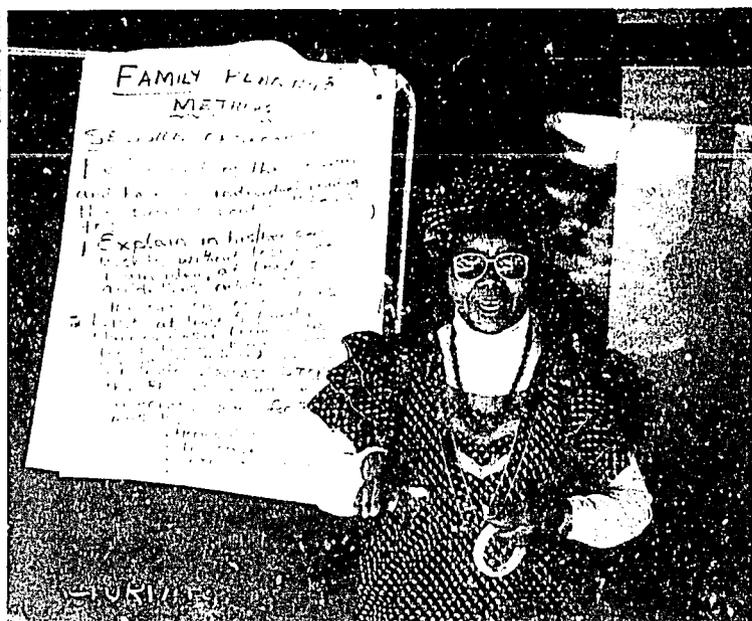
During 1991 and 1992, FHI provided support for family planning institutions in Bangladesh, Indonesia, Egypt, Sri Lanka, Mali, Mexico, Niger, Thailand and Kenya. FHI has also worked with the National Population

Council of Egypt, a government agency, to strengthen its capacity to manage programs and research. FHI works with many national programs and grassroots organizations in many countries to strengthen capacity to do AIDS prevention work.

Just a few examples of recent activities include the following:

- **IN INDIA**, with funding from the United Kingdom's Overseas Development Administration, FHI in conjunction with International Planned Parenthood Federation (IPPF) funded two pioneering AIDS projects. Both projects used peer educators to distribute information and condoms. The Madras Health Information Project focused on working-class men at high risk of contracting AIDS. The Bombay Male Health Information Project worked primarily with homosexual men and established the first newsletter in India providing information on HIV, STDs and alternative sexual practice.
- **IN KENYA**, FHI is helping the University of Nairobi to build a contraceptive and reproductive health research program within its Department of Obstetrics and Gynecology. Assistance includes workshops, computer training and technical help to design programmatic research projects and improve scientific writing.

*A participant at an FHI journalist training workshop in Kenya leads a discussion.*



- FOR 16 YEARS IN BANGLADESH, FHI has supported the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERITT), the country's designated organization for introducing new contraceptive methods and devices. With approval from the government of Bangladesh, the World Bank is providing project funding to BIRPERITT in 1993, a move that will allow FHI to phase out its core support. BIRPERITT has been chosen by Bangladeshi health officials to introduce Norplant into the country. Using the FHI-supported Norplant clinical trials program as a model, BIRPERITT has launched an introduction program.
- A SRI LANKAN CONFERENCE in February 1992 drew FHIRC leaders from research centers in six countries, allowing them to exchange ideas and discuss common problems. Providing such forums is a vital part of FHI's strategy for local institutional development.
- AN INTENSIVE REVIEW of FHI's 15-plus years of experience in institutional development is the focus of a monograph on lessons learned, scheduled to be published in 1993.
- FHI STAFF ARE DEVELOPING an innovative evaluation tool for organizations committed to strengthening institutional development. This evaluation framework for assessing strengths and weaknesses of research and service organizations is being designed for use by funding agencies to use in on-site assessment visits or for self-assessments by the institutions themselves.

## INFORMATION AND TRAINING

Providing clear, appropriate and up-to-date information to health providers and policy-makers in developing countries is vital. Through international conferences, workshops, educational programs and a variety of publications, FHI communicates ways of improving reproductive health and contraceptive use, as well as new strategies for slowing the HIV pandemic.

Each year, FHI responds to thousands of requests from the international health community, local programs and journalists throughout the world for current information about a variety of reproductive health matters.

Training and education are vital elements in both HIV prevention and family planning. In Cameroon, for example, FHI worked closely with the National AIDS Control Unit and the AIDS Counseling Center to develop a training program as part of a national AIDS counseling system. In a related effort, 20 lab technicians in Cameroon were trained to teach their skills to others. As a result, HIV testing is performed at 70 sites throughout the country.

In family planning, FHI's contraceptive technology update seminars give health providers the most current information about new contraceptive methods, including an open discussion of concerns these new methods raise. The sessions also focus on how to improve access to existing contraceptives through changes in the way services are provided.

## PROVIDING A FORUM

Training assists health providers who are working on the front lines of the AIDS pandemic or with local family planning problems. FHI also provides international forums where key experts and policy-makers can explore evolving trends or methods in global terms.

To complement its emphasis on the lactational amenorrhea method (LAM), FHI in recent years has developed a broad strategy of promoting postpartum contraception. Although not new, many family planning programs have been slow to accept it. Since a 1990 international conference on postpartum contraception held in Mexico City, sponsored by FHI in collaboration with the Mexican Institute of Social Security and the Ministry of Health, meetings for policy-makers and providers in individual countries have been supported by FHI. National conferences have been held in Bangladesh, Indonesia, Nepal, Philippines and Togo. FHI has also distributed to family planning professionals a comprehensive guide in English, French and Spanish containing a slide show and resource papers for in-country presentations on postpartum contraception.

In 1991, FHI and the Population Council sponsored a two-week workshop in Indonesia to train staff from family



*FHI's Leticia Escobedo works with Mercedes Castell, a summer intern, at FHI's headquarters in North Carolina.*

FHI's institutional development activities provide technical assistance in:

- Institutional needs assessment and evaluation
- Research design and methodology
- Data collection and management
- Data analysis
- Scientific writing
- Information dissemination
- Computer training
- Strategic management and long-term planning
- Financial management
- Grant writing and fundraising
- Development and implementation of interventions

planning research organizations to use research that would help improve their programs. FHI, with support from the Andrew W. Mellon Foundation and A.I.D., also hosted an International Acceptability Task Force meeting at our North Carolina headquarters. The gathering allowed FHI and other organizations concerned with the introduction of new contraceptives and with sexually transmitted disease prevention to share ideas on cultural, social and health issues that influence acceptance of contraceptive methods at the country and local level. The 30 participants included representatives from WHO, IPPF, and the National Institutes of Health as well as researchers and health providers from Bangladesh, Brazil, Egypt, The Gambia, Mexico, Nepal, Nigeria and the United States.

FHI provides a variety of training programs covering a wide range of topics in many countries, in addition to



*FHI's library staff discuss ways to assist researchers. In addition to printed materials, the library has access to numerous electronic databases.*

many educational projects. In 1992, for example, FHI held workshops on conducting focus groups for Ministry of Health personnel in St. Lucia in the Caribbean and on crisis intervention and prevention counseling for family planning clinics in El Salvador.

FHI's AIDS prevention work has a strong emphasis on training. Our AIDS training work in more than 20 countries has covered a variety of topics, such as counseling, the development of educational materials for targeted audiences, strategies for HIV prevention education, program management and testing procedures for HIV antibodies. In Dominica, for example, 41 physicians and nurse practitioners received training about the treatment and prevention of sexually transmitted diseases. HIV counseling and education techniques have been the subject of other training sessions in that country and many others, including Bolivia, Cameroon, Ghana, Haiti, Kenya, Mexico, Niger and Nigeria.

### **INFORMATION DISSEMINATION**

In addition to training sessions and conferences, FHI produces a variety of publications designed to keep health care professionals and policy-makers well informed about family planning, maternal health and the best ways to fight the HIV epidemic. Individual FHI staff members also publish frequently in a wide range of professional and popular publications.

In a related effort, FHI provides technical assistance to journalists in developing countries to improve their capacity to report on important health trends, thus encouraging a more thoughtful and better informed dissemination of health news. Workshops for health journalists support an overall effort to increase public awareness about available contraception methods and related family planning matters.

In recent years, FHI has conducted journalism workshops in Senegal, Kenya, Tanzania and Indonesia, and supported the creation of networks linking journalists and sources of information on reproductive health. Journalists representing 77 publications and press agencies in 19 countries have participated in the workshops.

FHI's publications and media work activities include the following:

- **Network**, a quarterly health bulletin, is published in English, French and Spanish. Since 1990, FHI has tripled the circulation of **Network** to its current level of 30,000. This award-winning publication is provided free of charge to readers, who include physicians, health care providers and government health ministry officials.
- Important scientific papers are translated each year into French and Spanish for distribution in French-speaking Africa, the Caribbean and Latin America. In 1992, these translated articles were circulated to 3,600 physicians, research scientists and other medical personnel. Four papers were translated into Spanish and five into French, on such subjects as experience with Norplant contraceptive implants in Nigeria, contraceptive efficacy of the lactational amenorrhea method (LAM), prevention of IUD-related pelvic infection, oral contraceptive compliance and its role in the effectiveness of the method, and whether the benefits of breastfeeding outweigh the risk of postnatal transmission of HIV via breastmilk.
- Monographs on special topics are published periodically. Recent publications include **The Copper IUD: Safe and Effective**, which examines safety and performance aspects of copper IUDs; **Sexual Networking in a Provincial Thai Setting**, a look at how a select group of men and women in Thailand share multiple partners; a monograph on the important role of family planning on child survival entitled **Child Survival: The Role of Family Planning**; and a monograph called **Improving Family Planning: A Decade of Programmatic Research**, which explores such questions as acceptability of a contraceptive

method and how a clinic's operating procedures might influence use of a contraceptive.

- With 2,000 requests for information from health care professionals each year and about 200 inquiries from news media, FHI has become a clearing house for up-to-date information on reproductive health matters. As appropriate, FHI issues news releases and arranges press conferences to keep health journalists well informed. The goal is to educate policy-makers and the public about these important matters.
- Frequent mailings to a variety of health providers, policy-makers and others cover many topics. For example, bi-monthly mailings to AIDS researchers and health professionals in developing countries often provide the only source of AIDS literature available to the recipients, playing a vital role in keeping them informed about the latest developments in AIDS research.
- An FHI-produced film entitled *The Faces of AIDS* premiered in Dakar, Senegal, at the VI International Conference on AIDS in Africa in 1991. The film seeks to show the human side of HIV infection. English and French versions are being distributed to FHI-sponsored projects and general distribution is being arranged.



*Page proofs for FHI's quarterly health bulletin, Network, are examined in preparation for printing. Circulation has tripled since 1990.*

**M** ONTHLY  
MAILINGS TO AIDS  
RESEARCHERS  
AND HEALTH  
PROFESSIONALS IN  
DEVELOPING  
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LITERATURE  
AVAILABLE TO THE  
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### A NEW GENERATION

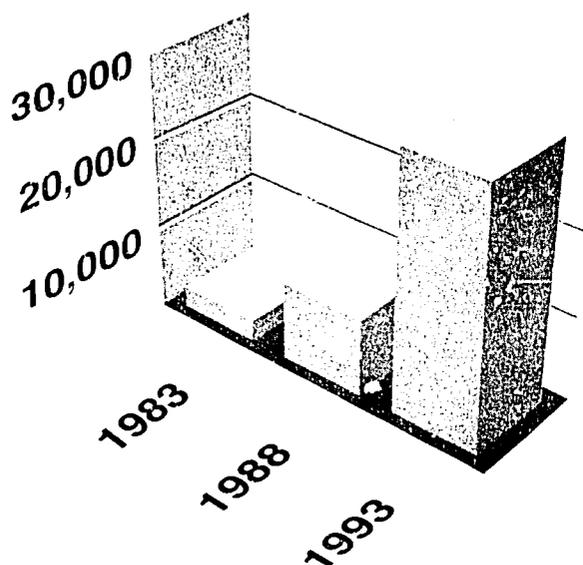
With support from the Andrew W. Mellon Foundation, FHI in 1991 initiated a postdoctoral fellowship in contraceptive technology. Our first fellow, Dr. Xu Jin-Xun from the People's Republic of China, is a research and science administrator at the Shanghai Municipal Family Planning Commission. Dr. Xu's training at FHI has prepared him to conduct clinical trials in Shanghai. As a follow-up to his training in the United States, FHI plans to support Dr. Xu in implementing a clinical trials research

study in China. A new Mellon grant will support postdoctoral fellowships for three more outstanding scientists from developing countries.

FHI also works closely with U.S. universities to provide internship experiences for graduate students in public health, the social sciences and related fields. In the last two years, we have had more than 20 interns from graduate schools including the University of North Carolina at Chapel Hill, Duke University, Tulane and the University of Michigan. In 1992, our interns included students from the Dominican Republic, Ecuador and Uganda who were studying in the United States.

FHI is committed to providing a good learning experience that not only enhances skill development, but also gives the interns an opportunity to contribute to an ongoing FHI research or technical assistance project. As interns, students work under the supervision of an experienced FHI researcher. Internship projects are varied. For example, interns have worked on such diverse projects as analyzing data from an AIDS prevention project among pharmacists in Mexico and testing a questionnaire to measure correct use of oral contraceptives in the United States.

### NETWORK CIRCULATION GROWTH (ALL LANGUAGES)





THEODORE M. KING

## PRESIDENT/CHIEF OPERATING OFFICER

**THEODORE M. KING**  
PRESIDENT

When Theodore M. King became president of FHI in 1991, he took over during a period of unprecedented growth in programs and staff. To meet the challenge of change FHI is facing, Dr. King brought with him more than 25 years' experience in international and domestic reproductive health. And while FHI's central mission remains the same, the corporation continues to grow and diversify under Dr. King's leadership.

"Our agenda remains pretty much unchanged," Dr. King says. "FHI's prime interest over the years has been in family planning, population and, more recently, AIDS. We have a strong public health orientation. We want to do everything we can to help developing countries to put in place the least costly programs that will improve the well-being of the greatest number of citizens. Public health is always less costly than curative medicine. That orientation should not change."

Before joining FHI, Dr. King held a number of key positions at Johns Hopkins School of Medicine and Hospital. Perhaps most significantly for FHI, he played a primary role in establishing the Johns Hopkins Program for International Education in Reproductive Health (JIPIEGO), one of FHI's sister cooperating agencies that receive major funding from A.I.D. From 1977 to 1991, he served as president of JIPIEGO. During that period, he also held other administrative positions at Hopkins: director of gynecology and obstetrics of the medical school and chief of gynecology and obstetrics at Johns Hopkins Hospital (1971-83), and vice president for medical affairs for the hospital and the Johns Hopkins care system (1983-91).

Dr. King's relationship with FHI is long-standing. JIPIEGO

pioneered the introduction of laparoscopic female sterilization, using a device called the Falope ring developed at Johns Hopkins Medical School under Dr. King's guidance. FHI conducted clinical trials of the Falope ring in developing countries. "The Falope ring is still a major approach to female sterilization in the developing world," Dr. King says. In the late 1970s, Dr. King also served as chairman of our Technical Advisory Committee.

At FHI Dr. King finds his efforts more focused than they were in carrying out his diverse responsibilities at Hopkins. "At Hopkins the focus was on research, education and clinical care for patients at the Hopkins Hospital," he says. FHI's focus is on the improvement of reproductive health in developing countries.

Still, there are strong similarities. "What I particularly like about the work at FHI is the opportunity to help people and to assist in the development of new information," Dr. King says. "These are the very same things I liked about the positions I held at Hopkins. My job is to provide a management environment where the staff can get on with their work. FHI staff are excellent people, dedicated to the well-being of economically deprived people throughout the world."

Dr. King holds a Ph.D. in physiology from Michigan State University and an M.D. from the University of Illinois School of Medicine in Chicago. Before joining the staff at Hopkins, he taught at the University of Missouri School of Medicine and chaired the Department of Obstetrics and Gynecology at Albany Medical College in New York. He has an M.S. in zoology from the University of Illinois at Urbana and a B.S. in biology and chemistry from Quincy College in Illinois.

His numerous publications include more than 150 articles in scientific journals and contributions to 36 textbooks and monographs.

## SENIOR STAFF

**THEODORE M. KING, MD, PHD**  
PRESIDENT/CHIEF OPERATING OFFICER

**WILLIAM SCHELLSTEDE**  
EXECUTIVE VICE PRESIDENT

**JOANN LEWIS, MPH**  
SENIOR VICE PRESIDENT OF POPULATION PROGRAMS

**HOWARD MILLER, MA, MD**  
SENIOR VICE PRESIDENT OF RESEARCH AND DEVELOPMENT

**ALFREDO PÉREZ, MBA**  
SENIOR VICE PRESIDENT FOR MANAGEMENT

**ROBERT HUGHES, MS**  
VICE PRESIDENT OF ADMINISTRATION

**PETER LAMPTEY, MBBS, DRPH**  
VICE PRESIDENT OF AIDS PROGRAMS

**JUDITH FORTNEY, PHD**  
CORPORATE DIRECTOR OF SCIENTIFIC AFFAIRS

**THOMAS PETRICK, MD**  
CORPORATE DIRECTOR OF MEDICAL AFFAIRS

**ROBERTO RIVERA, MD**  
CORPORATE DIRECTOR FOR INTERNATIONAL MEDICAL AFFAIRS

Following are profiles of our new president and FHI's division directors. This issue of FHI's corporate report highlights the contributions of our division directors, whose leadership plays a crucial role for much of our success.



PETER LAMPTHEY

## AIDS CONTROL AND PREVENTION

**PETER LAMPTHEY**  
AIDSCAP DIRECTOR, VICE PRESIDENT  
FOR AIDS PREVENTION  
PROGRAMS

For Peter Lamptey, FHI's work to control the spread of AIDS is a natural extension of the organization's efforts in other areas of reproductive health.

"Put very simply, the tools that we use in family planning, in nutrition, in maternal and child health and other public health areas are the very same that we use in AIDS work," he says. "In family planning, for example, you are trying to get people to change their behavior and to use contraceptives. These are essentially the same objectives for working with AIDS."

Dr. Lamptey has been at the forefront of FHI's AIDS programs since their inception. In 1987, when FHI received its first AIDS funding, he chaired a task force to examine our overall work in light of the AIDS epidemic. Later that year, A.I.D. awarded FHI a five-year cooperative agreement, which expanded into a \$40 million AIDS prevention program, and Dr. Lamptey was named director of the new AIDSTECH division.

As the AIDS pandemic has grown, so have FHI's programs to help control its spread. In 1991, A.I.D. awarded FHI a new agreement for \$168 million over five years whereby FHI established its AIDSCAP Division, with headquarters in Arlington, Va., and an Asia regional office in Bangkok, Thailand. As vice-president, Dr. Lamptey now oversees FHI's AIDS programs.

Working to control the spread of AIDS is one of FHI's central missions, and the organization plans to expand that commitment as resources become available. "AIDS is going to be with us for many years to come," Dr. Lamptey says. "The need for this work will only increase. It is a very serious health problem today and, unfortunately, will become an even more serious problem in the coming years."

A native of Ghana, Dr. Lamptey joined FHI in 1981 as head of FHI's Africa Regional Office in Accra, Ghana. He moved to FHI headquarters in North Carolina in 1983. For the 10 years before joining FHI, he taught public health at the University of Ghana and conducted research on primary health care in rural areas. He received his M.B.B.S. from the University of Ghana Medical School. He also studied public health at UCLA and received his doctorate in that field from Harvard University. His post-doctoral work includes studies at Massachusetts Institute of Technology.

## DEVELOPMENT OFFICE

**ARLENE MCKAY**  
DIRECTOR OF DEVELOPMENT

FHI relies heavily upon government funding. But it also seeks to broaden its financial base and looks for new opportunities to improve reproductive health in the developing world through projects the government might not choose to fund for various reasons. As director of development, it is Arlene McKay's job to find those opportunities. Since coming to FHI in 1986, she has been responsible for developing funding sources, coordinating research proposals and managing FHI corporate publications and public relations.

"I've been involved in international work for a long time, so I know that there are great needs," Dr. McKay says. "This is a responsive organization, so when new problems and challenges arise, we look at what the issues are, how to research them and how to solve them."

Often, such opportunities require seed money for work that later receives substantial government support. FHI's first funding for AIDS work, for example, came from private sources, the American Foundation for AIDS Research and U.S.A. for Africa, for projects in Ghana, Cameroon and Mali. "What that allowed us to do was to demonstrate that you can do AIDS prevention work successfully with people practicing high-risk behavior," Dr. McKay says. FHI built on that early experience to become a leader in the international effort to control the spread of AIDS.

Dr. McKay also serves as FHI's liaison with organizations in our home state of North



ARLENE MCKAY

Carolina. "I'm responsible for corporate relations locally, the things we do here in North Carolina to be a responsible corporate citizen," Dr. McKay adds. "And I chair FHI's internship committee. We have eight to 10 interns every year, mostly masters and doctoral candidates in public health. It's exciting to see these young people coming through and matching them with appropriate projects. That's been a rewarding program."

Dr. McKay holds a Ph.D. in psychology from Northwestern University. Her undergraduate degree in psychology is from the University of Miami and her masters in psychology is from Pennsylvania State University. She has worked extensively in Latin America and pioneered studies on the relationship between nutrition, health and early childhood education to the physical and psychological development of malnourished and economically deprived children.



**NANCY E. WILLIAMSON**

**CONTRACEPTIVE USE AND  
EPIDEMIOLOGY DIVISION  
NANCY E. WILLIAMSON  
DIRECTOR**

The former Program Evaluation Division used social science and market research to help agencies in developing countries solve specific problems related to contraceptive use. Under a 1993 reorganization, this unit became part of the new Contraceptive Research and Epidemiology Division.

"It's quite practical work," says Nancy E. Williamson, division director. "Methods have to be acceptable, available and cheap. We may have the most effective and safest contraceptive method, but it wouldn't be any good if people don't like it."

Some of the division's recent efforts include developing clearer instructions for oral contraceptives for the U.S. Food and Drug Administration. Other work includes evaluating social

marketing programs that encourage contraceptive use and studying the effectiveness of breastfeeding as a contraceptive method. The acceptability of postpartum contraception is part of the division's work.

"We can work wherever a programmatic need arises," Dr. Williamson says. "We're not just doing things that are intrinsically interesting to us. Our work is tailored to the needs of particular programs. We ask how we can make our assistance most effective. It's not the kind of work you would do at a university. It's rewarding because it has a use. I consider that worthwhile—it makes it worth coming to work in the morning."

→ Before joining FHI in 1981, she was an assistant professor of sociology at Brown University and later worked for the Population Council as resident evaluation adviser for the Bohol Maternal and Child Health/Family Planning Project in the Philippines. Most of her field experience is in Asia. Dr. Williamson holds a doctorate in sociology and an M.S. in public health from Harvard University. Her bachelor of arts degree in sociology is from the University of Michigan.

Dr. Williamson began a one-year sabbatical in 1993 to work as a technical advisor to A.I.D.'s Office of Health in Washington.



**LYNDA P. COLE**

**FIELD OPERATIONS DIVISION  
LYNDA P. COLE  
DIRECTOR**

FHI's mission is to improve reproductive health throughout the world. But how are efforts coordinated to ensure that FHI responds appropriately to what country programs need and want? Matching country needs with FHI resources is the primary role of FHI's Field Operations Division.

"It is a matrix system," says Lynda P. Cole, division director. "FHI has its mission and goals, and countries have their individual goals. We're involved in matching the two."

The role of the Field Operations Division, which was established in 1993, is to work closely with A.I.D. Missions and country-specific family planning programs. The division serves as a liaison between the countries and FHI.

Among the division's responsibilities are: serving as a clearinghouse for information on FHI activities in individual countries; providing regular feedback to the A.I.D. Missions on FHI programs; and providing back-up support and assistance to FHI field offices. In work that is not funded by A.I.D., the division is developing strategies for reproductive health and family planning programs in Vietnam and the Central Asian Republics.

"We are the interface with the field and the Mission programs," says Ms. Cole. "Our major emphasis is making sure there is a coordinated effort—that everything happens that needs to happen."

Ms. Cole brings to her role of field operations director more than 20 years of experience in international health and family

planning. She has worked as a researcher, manager and administrator, and her international experience includes work in Africa, Asia, the Caribbean and Latin America. Ms. Cole came to FHI in 1976 as a senior research analyst in FHI's Clinical Trials Division. She worked as project leader and associate director of Clinical Trials, managing many of FHI's large-scale multicenter trials.

Prior to becoming division director, she served as deputy director and associate director of FHI's AIDSTECH Division. Her duties included management of programs in the Eastern Caribbean and oversight of activities in information, education, communications, training and logistics, as well as managing the preparation of the final report. She received her master's degree in sociology and her bachelor's degree in mathematics from the University of Texas in Austin.

**POLICY AND RESEARCH UTILIZATION  
DIVISION  
SUSAN PALMORE  
DIRECTOR**



**SUSAN PALMORE**

"We're taking a grass roots approach, really," says Susan Palmore, director of policy and research utilization. "Increasingly, we are focusing our efforts around meeting the direct needs out in the field."

Ms. Palmore's division plays an active role in FHI's recent emphasis on removing barriers to the delivery of reproductive health care, such as medically unnecessary requirements for follow-up visits and clinical screening. The division has helped to convert FHI research into practice three ways: by building local capacity through training; by helping developing countries to incorporate current research into improving policies; and by distributing information through a broad range of publications, training workshops and other communications activities.

Contraceptive technology update seminars (CTUs) and other workshops provide up-to-date information to physicians and other health-care providers. FHI's quarterly bulletin called **Network**, monographs and the translation of important scientific articles from English into French and Spanish are an important part of the division's work. Ms. Palmore's division also holds workshops to train journalists in developing countries and to assist health care organizations to build their own capacity for scientific writing and communication.

"I really think FHI is on the cutting edge, because we link the clinical and applied research with programs," Ms. Palmore says. "That's something no other agency does in the way that FHI approaches this challenge. We're taking what we learn from research and helping programs to understand and incorporate these lessons into services as quickly as possible. I'm particularly excited about our new initiative to improve access to reproductive health services."

Ms. Palmore joined FHI in 1988. Previously, she worked with the East-West Population Institute in Honolulu, Hawaii, for 18 years, serving as a senior administrator from 1981 on. She holds an M.A. in political science and a B.A. from the University of Hawaii.



**BARBARA JANOWITZ**

**SERVICE DELIVERY RESEARCH  
DIVISION  
BARBARA JANOWITZ  
DIRECTOR**

Developing countries face tough decisions in providing people with contraceptive choices.

Barbara Janowitz's division helps countries decide how to get the most from what they can spend, by comparing the costs of alternative ways of providing family planning services.

"Family planning programs have to do what everybody else does when they go shopping," Dr. Janowitz says. "They have to make decisions about how to allocate their resources. You have to ask, 'Is this money being well spent?' Sometimes the answer is no."

Dr. Janowitz's division has examined the cost savings from reducing the number of recommended follow-up visits for women who use IUDs. The encouraging findings indicate that the number of visits in some clinics could be reduced without risking women's health, thus allowing resources to be used in better ways.

"We have an integrated strategy of looking at how family planning services are delivered, what they cost and what you get out of them," Dr. Janowitz says.

Forecasts of family planning costs often indicate a gap between the need for services and available funding from governments and other donors. The division focuses on ways to reduce or eliminate that gap.

One obvious way is to increase financial support from donors. Yet there are other alternatives that the division carefully evaluates on a case-by-case basis. Sometimes resources can be reallocated in a way that increases the number of people served without sacrificing quality. Increasing client fees or introducing new fees is yet another way to cover expenses, but clinic managers need meaningful analysis of how that may affect contraceptive use.

Since joining FHI in 1977, Dr. Janowitz has played a major role in designing research projects to evaluate maternal and child health, as well as family planning programs. She has also worked in AIDS prevention programs. She has worked in Bangladesh, Brazil, Ecuador, Ghana, Honduras, Kenya, Nigeria, Sierra Leone, Thailand and Zimbabwe. Her undergraduate work at City College, City University of New York, was in economics. She holds a doctorate in political economy from the Johns Hopkins University.

## RESEARCH AND DEVELOPMENT DEPARTMENT



ROSALIE DOMINIK

### BIostatistics Division ROSALIE DOMINIK DIRECTOR

Rosalie Dominik worked in health survey research at the Rand Corporation before she joined FHI in 1986. A keen interest in women's health brought her to FHI. "I was able to apply my knowledge of health research methods in the area of reproductive health by joining FHI," she says.

Her division helps researchers to design studies and provides independent statistical analysis of the results. "We consult daily with researchers about what data should be collected, then determine what statistical tests are needed to interpret the findings."

Two years ago, FHI strengthened its capacity to seek regulatory approval of new contraceptive methods by making all the analyses of clinical trials data the responsibility of the Biostatistics Division.

Since then, among the division's more important tasks have been analyses of FHI's clinical data for a thermoplastic male condom, a female condom and a new method of female sterilization.

But the division's work is not limited to clinical trials; it provides crucial support for the full range of FHI's research. "The variety of study designs and research questions present challenging and interesting problems for our analysts," says Ms. Dominik. The division also helps developing countries develop their own research capacity by providing training.

The Biostatistics Division's job is to provide technical support, but the results are very practical. "We help researchers to obtain answers from their data, and the results allow policy-makers, regulators and clinicians to make more informed health decisions," Ms. Dominik says.

Ms. Dominik's undergraduate work at Northwestern University was in human development and social policy. She holds two M.P.H. degrees, one from the University of California at Los Angeles in population and international health and one from the University of North Carolina at Chapel Hill in biostatistics.



CAROL A. CONNELL

### CLINICAL TRIALS Division CAROL A. CONNELL DIRECTOR

Carol A. Connell was named director of clinical trials in 1992. Her experience with FHI includes working with regulatory affairs and overseeing the reorganization of the Clinical Trials Division as its deputy director.

Among the goals of the reorganization was to remove potential bias arising from clinical trial researchers analyzing their own data and to adapt FHI's contraceptive research to industry standards.

As a result, FHI now has the capacity to carry out full-scale development of new contraceptives, from the earliest trials through regulatory approval. "By separating the clinical trial and scientific support groups, we were able to reduce bias and increase the scientific validity of our clinical trials," Ms. Connell says. "We're also better able to take advantage of people's skills by having them become more specialized."

As deputy director and now director of the division, Ms. Connell has overseen the clinical trials for new contraceptives. The division also conducts trials to assist with the introduction of currently approved contraceptives in developing countries and to address questions affecting particular groups, such as breast-feeding women.

This work is increasingly critical, because few commercial pharmaceutical companies are developing new contraceptive methods. "It takes an average of 10 to 20 years to develop a new

product and conduct clinical studies," Ms. Connell says. "It's a long and expensive process, and only 40 percent to 50 percent of products get approved. Ten years ago, 14 companies were developing contraceptives. Today there are only a few. FHI is one of the leading organizations doing this work."

Before joining FHI, she was manager of research data services for Knoll Pharmaceuticals in Whippany, N.J., where her work focused on clinical trials of cardiovascular drugs. Previously, she was supervisor of cardiovascular research at Overlook Hospital in Summit, N.J. She holds an R.N. degree and was educated at Fairleigh Dickinson University, the Hackensack Hospital School of Nursing and St. Joseph's College.



HOWARD PRICE

### MATERIALS TECHNOLOGY Division HOWARD PRICE DIRECTOR

As director of the Materials Technology Division, Howard Price oversees FHI's development of selected new contraceptives and manufacturing methods. The division also conducts extensive testing of condoms and oral contraceptives for A.I.D. and other agencies.



LANETA J. DORFLINGER

When Dr. Price arrived in 1992, FHI had several important new products at an advanced stage of development, including two thermoplastic condom prototypes. Helping to bring those products to market is a top priority for the division. "But we can't stop there," Dr. Price says. "We can't afford to rest on a limited technology base."

Through its work for A.I.D., the division is also responsible for assuring the quality of latex condoms that A.I.D. provides to many developing countries throughout the world.

Before coming to FHI, Dr. Price was director of advanced technology at Zimmer, Inc., a division of Bristol-Myers Squibb, Inc., the leading manufacturer of knee and hip replacements. Among his accomplishments was development of more durable hip replacement prostheses.

Coming to FHI was a natural transition. "I've spent my life teaching and working in the health care field," Dr. Price says. "There were two key factors. One was FHI's mission, the humanitarian work that is the whole theme of the organization. The other was the people, with their obvious capabilities in their own disciplines and their forthrightness. I think that the whole key to the success of an organization is that the people in it recognize that they depend on the success of everybody else in the organization."

Before his 11 years at Zimmer, Dr. Price was an associate professor of chemistry for 10 years at Marshall University. He earned his doctorate in organic chemistry from the State University of New York at Binghamton. He holds a B.A. in chemistry from Dickinson College and did postdoctoral work at Albert Einstein College of Medicine.

**REGULATORY AFFAIRS AND QUALITY ASSURANCE DIVISION**  
**LANETA J. DORFLINGER**  
**DIRECTOR**

FHI's capacity to develop new contraceptive methods includes the capability to seek regulatory approval from the U.S. Food and Drug Administration. Regulations are constantly changing, and the FDA has stepped up its efforts to ensure compliance. Consequently, the Division of Regulatory Affairs and Quality Assurance has played an increasingly important role at FHI.

Laneta J. Dorflinger came to FHI in 1991 as director of the division after working with A.I.D. and other cooperating agencies, including JIPIEGO. Her job is to ensure that FHI research complies with the rules of the FDA and other regulatory agencies and to oversee the preparation of applications to the FDA for conducting research and for approval of new contraceptives. In her first year, FHI prepared FDA applications for two new contraceptives: the male thermoplastic condom and a new device for female sterilization, and contributed to a third application for a female condom.

"This is a period when the FDA is radically changing the way it does business," Dr. Dorflinger says, "and we're being scrutinized in a way we have not been in the past. This division's job is to stay on top of all the regulations as they evolve and to help the organization adjust. From an intellectual perspective, it's always exciting."

FHI recently added a new program within Dr. Dorflinger's division to provide independent quality assurance for research projects. "A formal quality assurance program is new for FHI and for some of the pharmaceutical industry in general," Dr. Dorflinger says. The role of this division, both for regulatory

affairs and quality assurance, is to provide the organization with the assurance that the research we do is always of the highest possible quality and to facilitate the process of getting new contraceptives approved and to the market.

Before joining FHI, Dr. Dorflinger worked as an independent consultant in contraceptive development and introduction. From 1983 to 1990, she worked with A.I.D. in Washington, first as a fellow of the American Association for the Advancement of Science on loan to A.I.D., then as a biomedical scientist working directly for the agency. She holds a Ph.D. and M.S./M.Phil. in physiology from Yale University and did her undergraduate work at Lafayette College.



DAVID J. TERWEY

**SCIENTIFIC SUPPORT SERVICES DIVISION**  
**DAVID J. TERWEY**  
**DIRECTOR**

The information technology industry is evolving at an exciting pace, challenging professionals around the world to stay abreast with current trends. As director of Scientific Support Services, David Terwey's main focus is to oversee the growth and operation of FHI's state-of-the-art computer system.

"We try to emulate utility companies in that we must ensure that the system always works," Mr. Terwey says. "We run in excess of 99 percent availability 24 hours a day, seven days a week."

One of Mr. Terwey's recent challenges has been linking FHI's computers at our headquarters in Research Triangle Park, N.C. with our offices in Arlington, Va., and our new Asia regional office in Bangkok, Thailand. The hookup to Virginia was relatively straightforward. Bangkok has been more of a challenge. "In much of Asia, modern telecommunications is quite a new thing," Mr. Terwey says. Planning is under way for similar communication links with FHI offices in other countries.

Scientific Support Services also designs custom software tailored to FHI's special needs. "We try to use off-the-shelf software whenever possible, however some development is inevitable," he says. Even when commercial software is available, FHI's programmers can often create our own programs more cheaply than it would cost to buy software.

The division also provides training for FHI staff and research associates. Technical advice is never more than a phone call away.

Mr. Terwey first came to FHI as a programmer in 1973. In 1975, he led the effort to transfer our computer system to India. When he left in 1978, he was head of data processing. For the next 11 years, he held computer-related positions at private companies and at Moses Cone Memorial Hospital in Greensboro, N.C. In 1989, he returned to FHI in his current position.

He is committed to keeping FHI's scientific capacity on the cutting edge. "I'm interested in a challenge — and keeping up with technology that is changing so quickly is certainly a challenge," he says.

His B.A. in sociology is from Trinity University in San Antonio, Texas, and he has done graduate work in computer science at the University of North Carolina at Chapel Hill.

**OPERATING RESULTS 1992**  
**COMPARATIVE BALANCE SHEET**

	SEPTEMBER 30	
	1992	1991
<b>ASSETS</b>		
<b>Current assets</b>		<i>(Restated)</i>
Cash	\$1,784,044	\$1,551,161
Short-term investments	600,000	650,284
Receivable from federal government (unreimbursed costs incurred)	484,739	468,724
Accounts receivable	716,070	559,879
Prepaid expenses	379,834	197,543
Pension forfeitures	190,212	167,698
<b>Total current assets</b>	<b>4,154,899</b>	<b>3,595,289</b>
Restricted investments	—	1,289,537
Property and equipment		
Promotional materials	—	20,599
Medical and office equipment	505,136	396,651
Leasehold improvements	298,824	163,204
Software	114,522	88,285
Electronic data processing	1,267,056	686,119
Automobile	18,930	18,930
	2,204,468	1,373,788
Accumulated depreciation and amortization	(1,367,912)	(710,810)
<b>Net Value of Property and Equipment</b>	<b>836,556</b>	<b>662,978</b>
<b>Total assets</b>	<b>\$4,991,455</b>	<b>\$5,547,804</b>
<b>LIABILITIES AND FUND BALANCE</b>		
<b>Current liabilities</b>		
Accounts payable	\$1,095,476	\$792,865
Accrued salaries, payroll taxes and fringe benefits	836,371	719,990
Unearned income	303,660	506,750
<b>Total current liabilities</b>	<b>2,235,507</b>	<b>2,019,605</b>
<b>FUND BALANCE</b>	<b>2,755,948</b>	<b>3,528,199</b>
<b>TOTAL LIABILITIES AND FUND BALANCE</b>	<b>\$4,991,455</b>	<b>\$5,547,804</b>

**OPERATING RESULTS 1992**

**STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND BALANCE**

	CONTRACTS AND GRANTS			YEAR ENDED SEPT. 30, 1992	YEAR ENDED SEPT. 30, 1991 <i>(Restated)</i>
	GOVERNMENT	NON- GOVERNMENT	OTHER SUPPORTED ACTIVITIES		
<b>REVENUES</b>					
Contract and grant income					
Agency for International Development	\$33,441,015	—	—	\$33,441,015	\$20,908,949
National Institutes of Health	26,783	—	—	26,783	16,280
	33,467,798	—	—	33,467,798	20,925,229
Contributions	—	8,591	1,942,979	1,951,570	709,602
Income from services	—	772,926	—	772,926	1,564,302
Investment income	—	7,882	51,043	58,925	99,876
Rental income	—	—	442,592	442,592	356,381
Gain on sale of investments	—	—	1,941	1,941	15,616,046
Other	—	2,699	—	2,699	140,209
Fixed fee (deduction) income	(1,030)	(10,182)	11,212	—	—
<b>Total Revenues</b>	<b>33,466,768</b>	<b>781,916</b>	<b>2,449,767</b>	<b>36,698,451</b>	<b>39,411,645</b>
<b>EXPENSES</b>					
Program services					
Research and evaluation	26,741,359	491,889	1,872,062	29,105,310	17,482,094
Supporting services					
Service centers	582,395	149,184	4,523	736,102	849,519
General and administrative	6,143,014	140,843	55,896	6,339,753	5,329,949
<b>Total expenses</b>	<b>33,466,768</b>	<b>781,916</b>	<b>1,932,481</b>	<b>36,181,165</b>	<b>23,661,562</b>
<b>Excess of revenues over expenses</b>	<b>—</b>	<b>—</b>	<b>\$517,286</b>	<b>517,286</b>	<b>15,750,083</b>
Fund balance at beginning of year				3,528,199	3,488,579
Transfer from FHH to the Foundation				1,289,537	15,710,263
<b>FUND BALANCE AT END OF YEAR</b>				<b>\$2,755,948</b>	<b>\$3,528,199</b>

*The above financial statements have been audited by Ernst & Young and an unqualified opinion was rendered.*

## BOARD OF DIRECTORS

**Torrey C. Brown, MD (Chair)**  
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Department of Natural Resources  
State of Maryland  
Annapolis, MD

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Assistant Secretary General  
International Planned Parenthood Federation  
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