

DELIVERING INTEGRATED FP/HIV/STI SERVICES

Achieving More Together

January 22–26, 2001

Lusaka, Zambia

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NGO Networks for Health Project

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-Retroviral
BCC	Behavior Change Communication
CBD	Community-Based Distribution
CBO	Community-Based Organization
COPE	Community-Based Protection and Empowerment
CS	Child Survival
DFID	Department for International Development (United Kingdom)
DP	Dual Protection
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
FC	Female Condom
FHI	Family Health International
FIPP	Female Initiated Protection Paradigm
FP	Family Planning
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IGA	Income-Generating Activity
KAP	Knowledge, Attitudes, Practices
MCH	Maternal and Child Health
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organization
PATH	Program for Appropriate Technology in Health
PLWH/A	Person Living with HIV/AIDS
PVO	Private Voluntary Organization
RFP	Request for Proposals
RH	Reproductive Health
STD/I	Sexually Transmitted Disease/Infection
TOT	Training of Trainers
USAID	United States Agency for International Development
VCCT	Voluntary and Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
WHO	World Health Organization



BACKGROUND

The “Delivering Integrated FP/HIV/STI Services” workshop is part of NGO Networks for Health (*Networks*) capacity building activities for its PVO Partners: ADRA, CARE, PATH, PLAN International, and Save the Children/US). The aim of the workshop was to strengthen the integration of family planning services with HIV/STI programs to improve their quality, particularly in the design, implementation, monitoring, and evaluation of effective, community-based initiatives.

The workshop was hosted by CARE Zambia. The following individuals comprised the Workshop Planning Team:

Dr. Ron Mataya, Associate Director (Reproductive Health Specialist)
Adventist Development and Relief Agency (ADRA)
Silver Spring, Maryland, USA

Jaime Stewart, Program Officer, Reproductive Health
CARE, Atlanta, Georgia, USA

Irene Banda, Health Sector Coordinator
CARE, Lusaka, Zambia

Mavis Kachimba, Consultant
CARE, Lusaka, Zambia

Dr. Mike Negerie, HIV/STI Advisor
NGO Networks, Washington, DC, USA

Terry Elliott, Senior Program Officer
PATH, Seattle, Washington, USA

Kim Green, HIV Programs Coordinator
PLAN International, Arlington, Virginia, USA

Ronnie Lovitch, Reproductive Health Specialist
Save the Children, Westport, Connecticut, USA

Dr. Ekpo Ikwo, HIV/AIDS Advisor
Save the Children, Washington, DC, USA



I. INTRODUCTION

A. Welcome and Opening Remarks

Dr. Gavin Silwamba, Director General, Central Board of Health, Lusaka, Zambia

Barbara Hughs, Deputy PHN Director, USAID, Lusaka, Zambia

Katharine Kreis, Senior Technical Advisor, G/PHN/POP/FPSD, USAID, Washington, DC, USA

Dr. Gavin Silwamba expressed his appreciation for being invited to the workshop and welcomed participants to Zambia. “Working together to achieve more” is a very appropriate theme, and significant results are expected from the workshop. Leadership, accountability, and partnerships are key strategies in Zambian health care. This workshop is a milestone for CARE in Zambia; it will help improve on networking, sharing, and advocacy for the integration of family planning and STI/HIV programming. Whatever resolutions are made at the workshop, they must be relevant, workable, and implementable, and most of all, must involve community participation for sustainability.

Barbara Hughs welcomed participants on behalf of USAID Zambia. Integrated FP/STI/HIV services are critical, and the workshop provides an important opportunity to share knowledge and insights and reflect on experiences.

Katharine Kreis welcomed participants on behalf of USAID in Washington, DC. Integrating FP/HIV/STI services is a timely topic in light of the growing cohort of adolescents, limited resources, and issues in the field. The workshop provides a terrific opportunity for sharing experiences with Washington, DC staff to examine what issues are most relevant in FP/HIV/STI for implementation and resource allocation.

B. Workshop Objectives, Agendas, Case Studies

Facilitator Wilma Gormley, Training Resources Group, Alexandria, Virginia, USA

The objectives of the workshop are to:

- Increase awareness of innovations, best practices, and effective integration of family planning with HIV/STI program interventions.
- Explore practical and effective solutions to situations often encountered in the field through analysis of scenarios presented as case studies.
- Enhance links and networks formed among colleagues from different PVO Partner organizations within the region, leading to mutual support and opportunities for capacity building and joint programming.
- Capitalizing on this awareness, interested participants will develop proposals to access seed funds for delivery of innovative, community-based, and integrated FP/HIV/STI services using best practices and other information gathered during the workshop.



By attending the workshop, participants will develop skills in one or more of the following areas:

- Design, implementation, and evaluation of effective, integrated, community-based family planning and HIV/STI programs.
- Community mobilization, participation, and advocacy methods in response to family planning and HIV needs.
- Effective use of IEC/BCC approaches to reduce sexual risk of HIV acquisition and to improve contraceptive utilization.
- Implementation of VCT activities focusing on client counseling using clinics and sustainable community-based models for HIV prevention and fertility reduction.
- Strengthening linkages between HIV prevention, care, and support services.
- Implementation of effective STI detection and treatment services at the clinical level.
- Integration of dual protection counseling and education into community-based FP/HIV/STI services.
- Implementation of MTCT prevention, particularly through integrated infant feeding and counseling, and VCT activities at the community level.

The complete workshop agenda can be found in Appendix A. Each day of the workshop was organized around a different theme or themes:

Monday:	Introduction <i>and</i> HIV/STI Care to Prevention Continuum
Tuesday:	Integration and Delivery of FP/HIV/STI Services
Wednesday:	Field Visits
Thursday:	Behavior Change Interventions and Community Mobilization in Response to FP/HIV/STI Needs <i>and</i> Maternal to Child Transmission of HIV
Friday:	Dual Protection

The workshop included presentations and case studies. Attendees were encouraged to be active participants in the workshop, to keep time, to listen to each other, and to enjoy themselves. Over 60 participants attended the workshop, representing NGO Networks and its five Partner PVOs: ADRA, CARE, PATH, PLAN, and SAVE/US. Participants from LINKAGES, AVSC International, FHI/IMPACT, USAID, Columbia University, and other local and international NGOs also attended (see Appendix B for a complete list of participants).

C. NGO Networks and Partners

Dr. Mike Negerie, HIV/STI Advisor, NGO Networks for Health, Washington, DC, USA

NGO Networks for Health (*Networks*) is an innovative, five-year global health project created to meet the increasing need for family planning, reproductive health, child survival, and HIV/AIDS information and services in the developing world.

The five *Networks* partners are the Adventist Development and Relief Agency (ADRA), CARE, the Program for Appropriate Technology in Health (PATH), PLAN International, and Save the Children/US. Collectively, the partners reach more than 60,000,000 beneficiaries and have an



approximate annual budget of US\$900,000,000. The Networks project marks the first time that five large international NGOs have worked in partnership at the global level to share resources and technical expertise in the field of reproductive health.

Networks is based on the principle that enhancing PVO/NGO capacity to provide FP/RH/CS/HIV services and strengthening PVO/NGO networks will increase the quality, sustainability, access, and use of health information and services. *Networks* has its own management structure, but is “governed” by a Partnership Advisory Group (PAG) and the Networks Partnership Council (NPC). The PAG is comprised of senior health program staff from the five PVO Partners who provide operational guidance. The NPC is comprised of senior representatives (vice presidents) of the five Partners; this group sets overall policy and provides strategic guidance.

The vision of *Networks* is to empower and enable individuals, families, and communities to improve their health; to create innovative and enduring NGO partnerships; and to foster and support networks that enhance the scale and quality of FP/RH/CS/HIV programs. To achieve this vision, *Networks*'s strategic objective is the increased use of FP/RH/CS/HIV practices and services through enhanced capacity of PVO/NGO networks. In turn, four intermediate results have been determined:

- Sustained PVO capacity to provide quality FP/RH/CS/HIV services;
- Accurate knowledge and sustained behavior change at the community level;
- Expanded, sustained PVO/NGO networks to provide FP/RH/CS/HIV service delivery;
- Expanded service coverage through public/private and private/private partnerships.

To date, four focus countries have been chosen: Armenia, Ethiopia, Malawi, and Nicaragua. In Armenia (where the lead PVO is ADRA), three models for FP/RH/STI service delivery are being field tested, and networks are being formed in three regions of the country. In Malawi, Save the Children/US is implementing the “Umoyo Network,” and in Nicaragua (where the lead PVO is CARE), a subgrant has been provided to PVO/NGO partners to help improve the health status of communities affected by Hurricane Mitch. Ethiopia has been chosen as the fourth focus country, and PLAN International will be the lead PVO. *Networks* also operates in Vietnam in safe motherhood/newborn care activities and partner networking.

Documentation of health networks is planned or underway in Bolivia, Mali, Kenya, and Nigeria. Successful networks have been shown to have the following characteristics: a clear vision, facilitative leadership, agreed-upon mission and goals, high levels of ownership, sufficient time; effective governance, management, and operations; credibility, diversified funding, collaborative relations with members, government, and the broader development community; and mechanisms for monitoring and evaluation.



D. Overview of Contributing Factors for the Spread of HIV/AIDS in Southern Africa

Irene Banda, Health Sector Coordinator, CARE, Lusaka, Zambia

Zambia has a population of approximately 10,000,000. At independence, approximately 30 years ago, the population was only 3,500,000. The fertility rate, 3.1 percent at independence, is now 3.7 percent. The crude death rate has remained relatively steady despite HIV/AIDS at 18.3 per 1000. However, the infant mortality rate, always high, has risen in recent years, reversing gains achieved in the 1980's. Malaria remains the top killer of women, particularly pregnant women, in Zambia.

Colonization in Southern Africa left a legacy of mining; in Zambia, this was copper mining. A "hut tax" was imposed by the British colonizers, and since many Zambians had no money, this resulted in rural to urban migration as men sought to earn wages in copper mines and through urban work opportunities. When gold was discovered in Johannesburg, many Zambian men migrated to South Africa to work in the gold mines. Housed in hostels, they were not allowed to have their wives accompany them. Many turned to prostitutes. This situation combined with migrations, rural-urban settings, and to South Africa, contributed to high levels of STIs. Today, 17 out of 1000 Zambians have one or more STIs. Nineteen percent have gonorrhea, 13 percent have syphilis, and 4.9 percent have herpes. Twenty-five percent of urban Zambians are HIV positive, compared with 13 percent of those living in rural areas. Overall, Zambia's HIV prevalence rate is 19.7 percent. In 18 percent of couples, both partners are HIV positive. Thirty-four percent of couples are discordant, with one partner infected.

All CARE Zambia programs, from those focusing on water and sanitation to those on refugees, have an HIV component, and there is a major integrated reproductive health program. Reducing STI/HIV rates cannot be achieved in isolation.

E. Testimonial

Community Representative Brigitte Syamevwe of Lusaka, Zambia, discussed her "health journey" as a woman living with HIV.

Brigitte Syamevwe is a married woman with eleven children. Both she and her husband are HIV positive. Mrs. Syamevwe discussed the traditional, cultural situation of women in Zambia, explaining that most women are powerless to insist on safer sex. "The meaning of a woman's life," she said, "is the meaning given to it by her husband." Many women feel that they must have as many children as their husband wants in order to secure their marriage.

Mrs. Syamevwe became pregnant unexpectedly while she was HIV positive. She visited a CARE clinic and was able to get counseling about HIV and pregnancy, and joined a women's reproductive health support group. After considering abortion, she decided to keep the baby; she took AZT during her pregnancy and opted for a cesarean section and formula feeding. Her baby has tested negative for HIV. Mrs. Syamevwe contrasted this positive experience with one that



occurred nearly twenty years earlier. Then she had visited a local clinic, was given glucose for her baby, but, intimidated by the nurse, was afraid to ask how to administer it. Ultimately, this lack of information led to the death of her baby.

Mrs. Syamevwe urged care providers to help make women more responsible for their own health by giving them information on basic hygiene and health issues. She asked that workshop participants listen to the felt needs of their clients, and expand programs targeted at men. “Women need to know that they have a right to health,” she concluded.



II. HIV/STI CARE TO PREVENTION CONTINUUM

A. Designing, Implementing, Monitoring, and Evaluating Effective Strategies for STI Care

Dr. Yves LaFort, Institute of Tropical Medicine, STI/HIV Research and Intervention Unit, Antwerp, Belgium

Sexually transmitted infection is a public health problem in and of itself, and STIs enhance HIV transmission. There are two major ways to control STIs: Prevention of infection through safe sexual behavior, and early and prompt treatment of infected individuals.

A1. The Piot Model

When people are infected with an STI, many never manifest symptoms. Of those who do, many do not seek treatment. Of those seeking treatment, not all will seek appropriate or effective treatment (some will self-treat, or visit traditional healers). Even when individuals do visit a clinic, not all are effectively treated. Ultimately, only a small percentage of individuals with STIs are effectively treated. This phenomenon is called the Piot Model.

There are interventions that can increase effective STI care. For more effective treatment, improved STI case management is needed. To increase care seeking, interventions include improving symptom recognition and increasing access to care. For a-symptomatic individuals, increased screening and presumptive treatment of high-risk groups is needed.

A2. Improving STI Case Management, Care Seeking Behavior, and Management of Asymptomatic Cases

Improving STI case management requires political commitment and the development of standardized guidelines. Adequate supplies of drugs and other materials is crucial, as is comprehensive training and supervision of caregivers. A cross-sector approach that links STI care with other curative health services and reproductive health services is also critical.



tools exist. The WHO/UNAIDS indicators have serious limitations—they are time consuming and expensive, geared towards clinics with a high number of STI cases, and vulnerable to subjective interpretation. Another problem is that each indicator has several criteria.

Alternative indicators exist. One of these is a combination of improved recording and a health care provider interview. In this way, evaluators can review specific cases with health care providers with the help of recorded information. STI as a biological marker for project evaluation is complex and must be used carefully. It is important to keep in mind that there is no direct linear relationship between HIV incidence and sexual behavior, and costs of periodic population surveys are very high.

B. Expanding and Strengthening VCT Services as a Tool for HIV/AIDS Prevention, Care, and Support

Dr. Gloria Sangiwa, Senior Technical Advisor, HIV/VCT, Family Health International (FHI), Arlington, Virginia, USA

HIV counseling involves a confidential dialogue between a client and care provider aimed at enabling the client to cope with stress and make personal decisions related to HIV/AIDS. Voluntary Counseling and Testing (VCT) is the combination of two activities—counseling and testing—into a service that amplifies the benefits of both. VCT is a voluntary preventative service; it is not diagnostic.

Prevention and care reinforce each other and promote community acceptance of HIV/AIDS, decrease stigma, and encourages PLWH/A to practice preventive behavior. VCT is an important entry point for both prevention and care. VCT facilitates behavioral change, enables people to plan for the future, reduces the stigma of HIV/AIDS, provides referrals for care and support, and can reduce mother to child transmission.

B1. Benefits of VCT

From the implementers' perspective, the benefits of VCT include the client's right to know; relief of anxiety associated with uncertainty; ability to plan for the future for the majority that are not infected with HIV; early referral to clinical care and support for those who test positive; and risk reduction through effective counseling. From the client's perspective, VCT alleviates anxiety; increases awareness and knowledge through accurate information and correction of misconceptions; increases clients perception of their vulnerability to HIV; creates community level peer educators; and reduces stigma.

Men often seek VCT to confirm their negative status, in contrast with women who often seek testing to confirm their positive status. Men also seek VCT to regain their partner's trust and show their commitment to a relationship, while women will use the opportunity to address other reproductive health concerns. Couples often seek VCT as a premarital requirement of certain religions, to discuss reproductive concerns, and to plan for children.



For those who test positive, there is important information that VCT counselors can pass onto clients, even if anti-retrovirals (ARVs) are not available to them. For the client who is HIV positive with no symptoms, preventative tuberculosis therapy should be considered. For the client who has TB, CTX prophylaxis should be considered. All HIV positive individuals should be counseled to take care of their health and to seek medical advice immediately for even minor illnesses. In addition, clients should be advised to maintain their weight by eating a balanced diet, take precautions to prevent diarrhea diseases, and exercise regularly. Clients should be advised to practice safe sex to prevent infecting their partner or reinfecting themselves. Finally, clients should be advised how to protect their unborn child if they or their partner is pregnant.

B2. Barriers to VCT

Barriers to VCT in the developing world include scarce economic resources and competing priorities; lack of access to drug therapies and psychosocial care; lack of access to services; fear of being tested; concerns that confidentiality will be breached; and the stigma associated with being seen at a VCT site. Women cite their primary barrier to VCT to be their spouse or partner. For men, the primary barrier is their own anxiety.

B3. VCT and Behavioral Change

An efficacy study conducted in Kenya, Tanzania, and Trinidad has shown that VCT is effective in promoting behavioral change, is cost effective, and is a viable component of a comprehensive HIV prevention strategy. The study also found that behavior change was significantly greater among individuals who went for VCT versus those who received general health information, and STD incidence rates validated reported behavioral change. Studies from Congo, Rwanda, Thailand, and Uganda supported the above findings.

B4. Evaluating VCT Programs

Service delivery of VCT can be evaluated through counselor reflection forms, exit surveys, use of an independent observer, laboratory studies, supervision and monitoring of staff, and follow-up staff training. It is also important to assess barriers related to the geographical location of sites, hours of operation, cost, and so forth. Impact can be evaluated through randomized studies, pre- and post-test client surveys, and behavioral surveillance studies.

B5. Integrating VCT

There are several advantages to integrating VCT into existing health facilities. VCT can become a routine event that is likely to be more anonymous than at stand-alone VCT sites. At the same time, VCT services will be more sustainable, and medical referral will be facilitated. Effective VCT services must be accessible, confidential, convenient, and affordable.

VCT programs should be implemented in two phases. The first phase—assessment—may take as long as four to six months and involve defining the site criteria, conducting a needs assessment, and selecting sites. In the next phase—implementation—staff are trained and operational guidelines are developed. At this time, IEC materials and a multi-media campaign is developed and launched. An effective, sustainable VCT program will provide high quality, client-oriented services and foster project ownership at sites.



C. Questions/Answers—FHI Panel

Dr. Yves LaFort, Institute of Tropical Medicine, STI/HIV Research and Intervention Unit, Antwerp, Belgium

Dr. Gloria Sangiwa, Senior Technical Advisor, HIV/VCT, Family Health International (FHI), Arlington, Virginia, USA

Q. How effective and sustainable are integrated FP/STI/HIV programs? What is the affect on family planning?

YL: HIV epidemic is a crisis, and a sector wide approach is necessary in the long term, although short- term solutions may be through vertical integration.

GS: At the same time, there is a great deal of common ground between the components. Need to clearly define integration—integrated services with dedicated staff, or one person expected to counsel on all.

Q. What does VCT cost? What does STI treatment and care cost?

GS: VCT costs approximately \$13/client in Uganda, and \$18 in Kenya. Rapid test kits are inexpensive (\$2-3); most costs are labor related.

YL: STI care is costly compared to, for example, immunization programs. STI programs must be evaluated in terms of cost/benefit.

Q. Is VCT affordable? What happens to people after they are tested?

GS: VCT is expensive. However, it can be accessible if appropriate resources are allocated by government, donors, and others; cost should not be a barrier given the importance of the issue. VCT cannot stand alone—there must be care and support groups to which to refer clients, regardless of their status.

Q. How did the VCT research project work and what happened after it ended?

GS: To create demand for VCT, the researchers used a media campaign—posters, radio, and so on. After the research project ended and demand had been created, the researchers returned to the donors for continued support. STI and family planning services have since been added.

Q. What is the community component in the two VCT programs in Rwanda and Kenya?

GS: Theatre and drama are used, as well as informal community resource people.

Q. What about VCT for adolescents?

GS: In Kenya, those under 18 years are not allowed to be tested, as legally they cannot give informed consent. Those 16-18 years can be counseled. One-third of all clients are between ages 18-24. Some centers target youth (ages 18-24), as counseling needs are different.

Q. Is there a danger of having donor-driven VCT at the expense of other necessary activities, such as testing for a safe blood supply?

GS: Priorities need to be clearly defined and impact potential must be evaluated. At the same time, situations and needs within each country differ and must be considered.



Q. What do we consider successful VCT?

GS. If a client opts not to be tested, that does not indicate failure. Counseling in and of itself is a powerful tool.

D. Case Study Presentations and Group Work

“Circle of Hope Project, Uganda,” Penina Ochola, Regional Health Advisor, PLAN, Nairobi Kenya

“Community Based Options for Empowerment,” Chifundo Kachiza, COPE Program Manager, Save the Children/US, Lilongwe, Malawi

D1. Circle of Hope/PLAN Uganda

PLAN Uganda works in four districts (Luwero, Tororo, Kamuli, and Kampala) and is partnered with various NGOs and government bodies. PLAN International has been working in Uganda since 1992, successfully implementing HIV/AIDS awareness education, VCT, post-test clubs, home-based care (HBC), and mobile clinics.

Objectives: The Circle of Hope project started in 1998, and targets children, youth, adults, and guardians living with and affected by HIV/AIDS. The Circle of Hope Project includes orphan assistance and succession planning strategies that aim to increase the number of children living with an adult caregiver; reduce psychosocial distress and uncertainty on the part of HIV positive parents; decrease incidents of physical abuse, stigma, property-grabbing, and neglect; increase use of wills to protect legal rights of orphaned children; increase school enrollment of orphaned and vulnerable children; and improve the health status of orphaned and vulnerable children

Activities: HIV care and support services are linked with family planning through an integrated health care infrastructure. Mobile community clinics offer a wide range of services including family planning and reproductive health, which allow women to seek a number of services at one time to avoid stigma. Condoms in general are promoted for their dual protection benefit. The Circle of Hope project is designed to expand this prevention to care continuum by addressing the educational, social, and emotional needs of children affected by HIV. PLAN strives to work with children before they have been orphaned, helping HIV positive parents to prepare their children's future by developing income generation projects, arranging access to health care and education, scheduling counseling, and making legal provisions for the transfer of property.

Results: The Circle of Hope project has improved access to education for children affected by HIV/AIDS (increased numbers of orphans are enrolled in schools), and has improved their health status (increased clinic attendance). Caseworkers and counselors report decreased incidents of abuse, stigmatization, property grabbing, neglect of orphans, as well as reduced psychological distress on the part of HIV positive parents. More children are living with adult caregivers and are protected by a will. Indirect results include increased use of VCT services, an increase in the number of condoms distributed, and reduced numbers of new HIV infections.



D2. COPE/SC Malawi

The Community-Based Options for Protection and Empowerment (COPE) project began in 1995 and is currently being implemented in four districts in Malawi, benefiting a target population of more than 36,685 and 212,282 direct and indirect beneficiaries respectively. COPE collaborates with many international and local NGOs as well as government bodies.

Objectives: COPE's objectives are to strengthen community capacity to prevent and mitigate the impact of HIV/AIDS on children and their families; strengthen the capacity of the government of Malawi to lead and sustain effective community-based responses to the needs of children and families affected by HIV/AIDS; strengthen the capacity of community-based institutions and organizations to provide and support community care for children and their families affected by HIV/AIDS; review and document program processes and disseminate findings and lessons learned; and advocate at the national, district, and local levels for policy development and change to benefit children and families affected by HIV/AIDS.

Activities: COPE's key interventions include: Identifying, monitoring, assisting, and protecting orphans and other vulnerable children; providing home-based care and psychosocial support; fundraising and income generation, community HIV/AIDS education, establishing community gardens, and community mobilization.

Results: Over the course of the COPE project, more than 200 Village AIDS Committees have been established, and communities are caring for their orphans and chronically ill. Care providers have been trained and are being called to neighboring villages to provide services and teach basic care skills. Some communities are buying basic drugs on their own. Most villages have youth committees that engage in HIV prevention as well as care for orphans and the chronically ill. Communities have established communal gardens whose produce is given to orphans and the chronically ill. More than 23,000 orphans have been registered and assisted, and communities have raised more than \$20,000. The project has also developed HBC kits that include drugs and other supplies.

Numerous lessons have emerged from the COPE project. As no single approach is effective for all communities, directly affected community members need to be equally involved in planning, implementation, and evaluation of activities. HIV/AIDS programming should focus on mobilizing communities to fill the gap traditionally provided by the extended family. At the same time, food security is a major need; agricultural assistance is not enough to meet the needs of those in dire circumstances. COPE has also shown that ensuring quality HBC requires standardization of resources, increased monitoring, increased availability of HBC supplies, and participatory training.

D3. Discussion

Participants were divided into five groups to discuss an assigned case study. Participants were asked to look at best practices and examine issues related to incorporating VCT into the programs. Below is a summary of the five groups' discussions:



	Best Practices	Incorporating VCT
Circle of Hope/ Uganda	<ul style="list-style-type: none"> ·Community focused ·Design based on in-country best practices ·Continually working to improve program ·Fighting stigma through post-test clubs ·Political commitment combined with local resources ·CBOs play a big role; community mobilization ·Involving HIV positive individuals and their families ·Linkages to medical services and psychosocial support ·Promotes hope as opposed to despair ·Integrated approach ·Preparation and education of children ·Child focus ·Post-test clubs, support groups 	<ul style="list-style-type: none"> ·VCT is already integrated
COPE/ Malawi	<ul style="list-style-type: none"> ·Listening to and designing program based on community needs; community-based ·Baseline survey done prior to design ·Participatory methods and partnerships ·Community mobilization ·COPE's role as facilitators and/or implementers depending on communities' needs ·Village AIDS Committees actively involved in record-keeping ·Multi-sectoral approach ·Flexible in addressing communities' needs 	<ul style="list-style-type: none"> ·Existing project is entry point for VCT ·Could use existing partnerships as referrals for VCT ·Could use Village AIDS Committees to establish post-test clubs, psychosocial support ·Need to conduct training ·Need equipment, logistical support, resources; examine cost sustainability ·Need linkages for care and support referral



III. INTEGRATION AND DELIVERY OF FP/HIV/STI SERVICES

A. Application of Family Planning+ Initiative and Request for Proposals

Dr. Marge Koblinsky, Director, NGO Networks for Health, Washington, DC, USA

“Family Planning+” is a new funding initiative through *Networks* aimed at PVO Partners. The initiative offers an opportunity for PVO Partners to build their capacity in implementing quality FP/RH programs. This may mean adding on a new family planning program component, strengthening an existing program with a family planning component, or expanding the impact of an existing integrated FP/RH initiative.

Specifically, the objectives of the FP+ Initiative are to:

- Improve, expand or initiate the integration of family planning programming into on-going field programs (be they health or non-health programs);
- Initiate the integration of family planning with safe motherhood or HIV programs; or,
- Improve, expand or initiate adolescent sexual and reproductive health programs.

Five million dollars is available and approximately 6 - 10 projects will be funded. The funding parameters for applications are as follows: 1) one PVO Partner with one or more local partners at \$150,000–\$300,000 (2 years); 2) two or more PVO Partners plus one or more local partners at \$200,000–\$700,000 (two years).

Proposals will be reviewed in three rounds: proposals submitted by January 31, 2001 will be reviewed by February 15; proposals submitted by February 15 will be reviewed by March 1; and proposals submitted by March 15 will be reviewed by March 31. Scoring will be based on strategic planning (50 points), specific plans for partnering (20 points), and technical competence (30 points).

Those intending to submit a proposal are strongly encouraged to go to their USAID mission for like funding, or co-mingling with private sources. At a minimum, missions need to concur with the program even if they do not provide funds. Country offices should apply through their home office point person as outlined in the detailed Request for Proposals (RFP) that was distributed during the session.

B. Integration of HIV/STI Prevention and Services in Family Planning

Julie Becker, Program Manager, EngenderHealth (formerly AVSC International), New York, USA

Dr. Stephen Wanyee, Program Manager, EngenderHealth, Nairobi, Kenya

EngenderHealth focuses on voluntary surgical contraception, post-abortion care, STI, and informed choice/clients’ rights. EngenderHealth, originally hospital based, is now moving into communities.



B1. Agenda

The agenda for the four-hour session was as follows:

- What is Integration?
- Advantages and Challenges of Integration
- If, How, and What to Integrate
- Interventions Cost Exercise
- Working with family planning providers on HIV and STI
- Integration Programming Case Study

B2. What is Integration? Brainstorming Exercise

Participants were asked to brainstorm their ideas on what integrating FP/HIV/STI services entails.

Following are the participants' responses:

- Talking/providing services to women about FP/HIV/STI at the same time in the same place (clinics, communities, workplaces, schools)
- Increase demand for services
- Condom promotion
- Involving men in services
- Caring for people as a whole human being
- Changing policies
- Skill development training
- Program planning—regional, national level
- Cost effective
- Service structure
- Long-term sustainability
- Expanded resources and supplies
- Monitoring and evaluation

Integration occurs at three levels: National/policy, service delivery/facility, and community. Integration involves a shift to a more holistic approach to sexual and reproductive health. Integrated services focus on risk perception, dual protection, and relationships and partner communication. Gender relations, poverty, and social norms are factored into client counseling. A broader definition of safe or safer sex is considered: “The freedom to enjoy sexual relations without fear of pregnancy, disease, or abuse of power/sexual coercion/violence.”

Several FP/STI/HIV service provision scenarios were presented, and participants discussed the level and quality of integration in each. The scenarios illustrated increasing degrees of integration.

B3. Small Group Brainstorming

Participants were divided into small groups to brainstorm answers to three questions. Responses are summarized below:



Group 1: Advantages: What does integration of STI/HIV prevention and care contribute to RH programs? How does it benefit RH objectives?

- More informed client choice
- Improved access to services
- May reach broader population in general
- Decreased cost for the client
- Less likelihood of missed opportunities
- Decreased cost per client and decreased opportunity cost
- Decreased drop out rate
- Increases possibility of confidentiality
- Improved quality of services
- More holistic for clients and staff—more responsive to client needs
- Increased potential for community involvement
- Clients get counseling opportunities that they otherwise may not have had

Group 2: Advantages: How does integration of HIV/STIs in family planning contribute to HIV/STI prevention and care efforts? How does it contribute to combating the HIV epidemic?

- Cost effective
- Better way to reach women
- Better way to bring men to FP+ services
- Increased condom use and improved information of FP/STI/HIV prevention
- Stimulates partnership and communication
- Easier to access FP+ services
- Help in reducing stigma about HIV
- Brings people at high risk for services
- Family planning providers have counseling skills in both FP/HIV/STI

Group 3: What are the challenges and barriers to implementation of integrated programs?

- Time of provider to add on more responsibilities
- Perception of provider to having the add-on service
- Cost—supplies, resources
- Space
- Provider skills
- Integration of different services targeting different clients
- Equipment
- Buy in of community leaders
- Risk of diluting family planning program
- Provider resistance
- Client resistance
- Resistance at national level
- Upsetting routine of the clinic
- Supervisor not sensitive to integration



B4. “If,” “How,” and “What” to Integrate: Cautions and Critiques

Women are at high risk for HIV and STIs. Forty-six percent of new HIV infections occur in women, and in sub-Saharan Africa, more than half of all adult infections are in women. STIs in women can have numerous negative consequences, such as pelvic inflammatory disease, cervical cancer, and increased HIV transmission.

Women are more vulnerable to HIV/STIs for biological and social reasons. Biologically, women have a larger mucosal surface area of exposure. There is also more virus in semen than in vaginal secretions. Young women, and women exposed to certain traditional practices (e.g., female genital mutilation) are more prone to microlesions, which increase transmission. Socially, women are more likely to accept pain and discomfort. Due to economic dependence on men, women often experience limited control over sexual decision-making, and may lack sexual knowledge. Integrating HIV/STI services into family planning is critical given that family planning services are often the only contact women in developing countries have with health programs. At the same time, family planning clients can be an important link to male partners who may be core transmitters.

If integration is desired, objectives must be clearly defined. Individual projects and programs must determine what their niche is and where they can have the greatest impact. In choosing “how” and “what” to integrate, key approaches include: Focusing on prevention first, knowing STI prevalence, addressing women’s interrelated needs using a gender sensitive approach; involving men, including a mother to child transmission (MTCT) component, addressing provider biases against condoms, and increasing the focus on sexuality in family planning.

Integration will require training of family planning providers. Trainings need to address condom biases, promotion of dual protection, and condom demonstration; sexuality knowledge, comfort, and values; risk perception, integrated counseling skills, gender relations, and stigma and discrimination.

B5. Cost Exercise

Participants were given cards describing integrated FP/HIV/STI activities and were asked to group them into one of three categories based on cost: Lower, medium, or higher. Below is a chart of activities by estimated relative cost:

Lower Cost	Medium Cost	Higher Cost
<ul style="list-style-type: none"> ·Allowing men to participate in family planning counseling sessions with their partners ·Providing couple’s counseling on relationships, sexuality, HIV/STI, and pregnancy prevention ·Encouraging female family planning clients to discuss HIV/STIs with their partners 	<ul style="list-style-type: none"> ·Encouraging female clients to bring their male partners for STI treatment ·Offering dual methods as an option to all family planning clients ·Distributing HIV prevention pamphlets to family planning clients ·Displaying HIV or STI posters 	<ul style="list-style-type: none"> ·Integrating STI/HIV prevention and sexuality in the MOH family planning counseling training curriculum ·Conducting a media campaign on dual protection ·Establishing policies and systems for partner notification (national level) ·Establishing VCT services



<ul style="list-style-type: none"> ·Suggesting that female clients refer their male partners for HIV counseling and testing ·Informing family planning clients about STI signs ·Promoting condoms for dual protection within family planning services ·Showing HIV/STI prevention videos in the clinic waiting room ·Generating a referral list for HIV/AIDS support and care services ·Generating a list of referral services for STI testing, counseling, and treatment ·Providing individual counseling on condom negotiation ·Conducting condom demonstrations with all family planning clients ·Improving family planning staff attitudes towards condoms through training and discussion ·Conducting group discussions on HIV/STI risk and partner communication in clinic waiting rooms ·Creating a private space for counseling ·Organizing an educational event at a family planning clinic for World AIDS Day ·Providing condoms in clinic waiting rooms so that people can take them without asking 	<ul style="list-style-type: none"> in a family planning clinic waiting room ·Conducting community education workshops on sexual and reproductive health ·Providing HIV/STI education in clinic waiting rooms ·Providing penis models for condom demonstration to all family planning providers ·Training CBD workers to do condom demonstration and AIDS education ·Providing educational materials on HIV/AIDS to CBD workers for distribution ·Training family planning providers in STI recognition and referral /infection prevention/standard precautions ·Providing free samples of condoms to family planning clients ·Training family planning staff in sexuality/ basic STI/HIV prevention/integrated counseling skills ·Developing a participatory community project to address sexual and reproductive health concerns ·Working with a school to conduct integrated sexual and reproductive health education ·Providing syphilis testing to all antenatal clients ·Providing specialized counseling about breastfeeding for HIV infected pregnant women ·Providing specialized family planning counseling for women who know they are HIV infected ·Training TBAs in how to protect themselves from infection 	<ul style="list-style-type: none"> ·Developing a logistics system for ordering, storing, and distributing condoms ·Developing job aids for integrating HIV/STI prevention/family planning counseling ·Providing STI syndromic management services ·Providing laboratory based STI diagnosis and treatment services ·Setting up STI testing labs ·Adding pelvic exams to family planning services for women seeking hormonal methods ·Offering VCT to all antenatal clients ·Conducting STI screening for women seeking IUDs
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The exercise illustrated that many services are already integrated, and that the majority of activities are not as expensive as perhaps initially assumed. There are a whole range of activities that can be undertaken as steps towards integration that are of low cost. Clinical activities having higher costs associated with them.

B6. Case Study: Programming for Integration

Participants were given a case study to read: A sub-district hospital wants technical assistance in integrating STI/HIV services within reproductive health services at the facility and in the wider community. Participants were provided with basic information regarding observations of:

- 1) The Facility (STI services, staff training, counseling, antenatal care, waiting room, educational materials, discussion with the chief medical officer)
- 2) Family Planning Counseling Services (new clients, physical exam for family planning clients, IUD services, and returning clients)
- 3) Community (health posts, CBD program, pharmacists/traditional healers, NGOs, schools, TBAs, and community feedback)

Based on this information, participants were split into three groups: Clinic, counseling, and community. Each group generated a list of problems observed and recommendations regarding integration of FP/STI/HIV services. The table below summarizes participants’ responses:

	PROBLEMS IN INTEGRATION	RECOMMENDATIONS FOR INTEGRATION
C L I N I C	<ul style="list-style-type: none"> ·Resistance of the chief medical officer ·Lack of application of training skills and knowledge ·Not following STI syndromic management ·Poor organizational management ·Inadequate use of the lab ·Inadequate information given during counseling ·Lack of drugs ·No follow-up training, on the job training ·Patients being referred to STI clinic from various parts of the facility/providers not using skills as expected ·Counseling focusing on FP, not on STIs ·Health education not client-oriented ·Waiting room not client oriented ·No pre/post counseling for women in AZT study ·Information dissemination inadequate 	<ul style="list-style-type: none"> ·Close follow-up and supervision of care providers ·Strategic planning ·Training of the chief medical officer to provide management support ·Improve waiting area, participatory health education, and counseling ·Strengthen syndromic management training ·Improve on drug availability for STIs ·Maximize lab use ·Improve STI services in order to cater to women (integrate into MCH)



C O U N S E L I N G	<ul style="list-style-type: none"> ·Lack of privacy and respect for privacy ·Nurse bias towards injection ·Poor interpersonal skills exhibited by nurse ·Risk factors evident but not addressed ·Not much HIV education · Clients ’ engaged to try condom application ·No promotion/counseling on dual protection ·Lack of standard protocol ·No systematic risk assessment ·Focus on family planning service for return clients ·Inadequate diagnostic instruments/nurse training ·Lack of conviction/ownership of HIV issues 	<ul style="list-style-type: none"> ·Reinforce the necessity of privacy in family planning services ·Promote understanding of the integration mandate among service providers ·Provide comprehensive training to service providers ·Providers with adequate practice ·Develop counseling protocols ·Set up group discussion/sensitization techniques ·Ensure availability of basic instruments
C O M M U N I T Y	<ul style="list-style-type: none"> ·No education/counseling about HIV/STI prevention ·Not offering dual protection message ·Sustainability—social marketing ·Social marketing messages—HIV only, not adolescents ·Existing services not meeting all community members’ needs (esp. adolescents and men) ·Disparate programs/services for FP, STI, and HIV ·Donor (vertical) funding ·Nurses aren’t trained in syndromic management ·Quality of care questions regarding STI treatment 	<ul style="list-style-type: none"> ·Coordinate logistics of supply and support of condoms ·Introduce DP training/counseling for clinics and CBDs ·Integrated FP/HIV/STI education in schools ·Social marketing of dual protection message ·Training for traditional healers, pharmacists, TBAs ·Better coordination between peer education groups ·Consistent community participation, planning, and self-assessment regarding RH ·Integration of RH programming/planning within different community structures ·Advocacy with church and other local groups

B7. Integrated Counseling

Integrated FP/HIV/STI counseling is based on the principle of informed choice. Informed choice is an individual’s well-considered decision based on available options, information, and understanding. Integrated counseling is more than providing clients with additional information. Rather, the GATHER model (greet, ask, tell, help, explain, and return visit) is utilized. Counselors work with their clients to determine individual circumstances and risks. Needs are explored and information is given to address gaps in a client’s FP/HIV/STI knowledge. At the same time, clients are taught skills in condom use (through demonstration and practice) and sexual negotiation.



C. Case Study Presentations

“SIDA in Exodus,” Dr. Aliou Sani, Health Advisor, CARE, Niamey, Niger
“One Stop Shop—Meeting the Needs of Adolescents in Kawangware, Kenya,” George Kahuthia, Program Officer, and Dr. Grace Miheso, Assistant Program Officer, PATH, Nairobi, Kenya
“SAFE II—The Sports Health and AIDS Footballers Education Program,” Popo Matsoara, Reproductive Health Care Coordinator, CARE, Lesotho

C1. SIDA/CARE Niger

The SIDA in Exodus project began in 1993 and targets migrant workers traveling from Niger to Abidjan in the Ivory Coast, as well as their sexual partners (women in villages and sex workers).

Objectives: The goal of SIDA in Exodus is to reduce high-risk sexual behavior in the target population by 60 percent. To achieve this goal, SIDA in Exodus aims to increase HIV/AIDS knowledge; stabilize STD prevalence through increased access to care and prevention services; increase capacity of public and private partners regarding HIV/STI education; increase condom distribution; and increase self-protection practices among women as advocated by religious and women leaders.

Activities: Key project activities include IEC at bus stations and other transport areas; training health workers in HIV/STI diagnosis, treatment, and prevention; and condom distribution.

Results: A significant number of IEC materials have been developed; however, no reduction in high-risk sexual behavior has been observed in the target population. Factors contributing to the failure of the project include the social-cultural environment; lack of permanent technical support; inability to create a visualization of the reality of AIDS; and the lack of a local branch of the project in Abidjan.

C2. One Stop Shop/PATH Kenya

The One Stop Shop project began in 1997 and targets adolescents in Kawangware, a slum in Nairobi. Kawangware has a high population density with an estimated population of more than 300,000—50 percent of whom are youth below 25 years of age. Four organizations collaborate on the project: Kabiro Health Care Trust, Family Planning International Assistance, Pathfinder International, and PATH Kenya.

Objectives: The goal of the project is to provide integrated reproductive health care information and services to adolescents and youth in one convenient place in Kawangware. The project aims to identify the needs of Kawangware youth and test ways to encourage youth to use existing and newly developed services through the “one stop shop” concept.

Activities: Interventions include involving youth in program design, implementation, and evaluation; training providers to care for the special needs of adolescents; promoting community advocacy and outreach activities to support youth development; promoting positive adolescent sexual behaviors and encouraging youth to visit clinics; and incorporating microenterprise and income generation activities to meet the holistic needs of youth.



Results: An evaluation conducted in 1999 found that youth perceive the One Stop Shop project as “educative, practical, acceptable, and empowering.” Youth knowledge of sexual issues has improved and in-school girls report that life skills training has enabled them to become more assertive when pressured by boys. There has been a drop in youth pregnancy and an increase in demand for condoms. At the same time, the project is working to become more “girl-friendly” and reduce stigma associated with visiting the clinic.

C3. SAFE II/CARE Lesotho

The SAFE II: The Sports Health and AIDS Footballers Education Program began in 1997 and was completed in December 2000. In collaboration with Populations Services International and the Society for Family Health, the CARE project targets youth aged 15-25 years living in the lowland border areas of Lesotho.

Objectives: The goal of the project is to improve the sexual health of youth aged 15- 25 years by decreasing or stabilizing HIV, STI, and pregnancy rates.

Activities: The project implements 23 sports (football and netball) tournaments annually. Each player in the tournament participates in a two-hour session on HIV/STI education. Approximately 250 youth are educated at each tournament, and more than 17,500 youth have attended the sessions. The sessions use small group work to cover HIV/STI facts and use a risk game to promote discussions. Peer educators are recruited from these sessions, and more than 160 youth have received a four-day peer educator training. Peer educators conduct outreach at the community level, focusing on behavioral change. Condom social marketing is also a key component of the project, and the project aimed to sell more than 60,000 condoms per month.

Results: An October 2000 project evaluation by DFID found that an outstanding peer education manual had been developed and that peer educators had been successfully trained. Pre- and post-test surveys found high levels of knowledge and appropriate attitudes.

C4. Case Study Discussion

Participants were asked to keep the following questions in mind while listening to the case study presentations:

- In the description of this project, in what ways are the messages around FP/STI/HIV integrated?
- In what ways are the programs and services integrated?
- Within the context of this project, what more could be done to integrate messages or programs and services?

At the close of the session, all participants regrouped to share what they had learned about integrating FP/HIV/STI services. Following is a summary of responses:

- Need to be clear on what and why we are integrating and how resources will be used
- Need to carefully document the results of integration and the impact on FP, HIV, and STI services
- Integration needs to occur at all levels, including national/policy level
- Integration is a more appropriate and holistic way to deal with clients



- Integration is probably cost effective
- Partnership is essential to integration
- Need to go beyond integration to ensure that services are ‘user friendly’ for different target audiences
- Need to be aware of stigma issues at all levels—from planning to implementation, to monitoring and evaluation
- Less likely to have missed opportunities with integration
- Integrated services are probably more sustainable and anonymous
- Communities should be involved from the planning stages
- Need to be flexible and adapt to the given context
- Integration will be challenging in the school setting
- Need to look after the reproductive needs of men as well as women
- Need to address gender inequities
- Need to provide development activities (IGAs) as part of integrated programs for youth

D. Strategies for Emergency Contraception Introduction in Africa

Siri Wood, IEC Program Officer, PATH, Seattle, WA, USA

This optional, evening presentation covered three main areas: 1) basic information about emergency contraception (EC); 2) steps to follow for strategically introducing EC work in a given setting; and 3) examples of various EC introduction programs in Africa.

EC prevents pregnancy after sex. Emergency contraception can be achieved by taking high doses of the hormones contained in birth control pills within three days (72 hours) of unprotected sex, or by inserting an IUD within 5 days (120 hours) of unprotected sex. The presentation focused on emergency contraceptive pills (ECPs).

According to the World Health Organization, there are no absolute contraindications for ECPs nor are ECPs believed to have any clinically significant impact on any pre-existing medical conditions. ECPs do not protect against STIs, nor do they interfere with an established pregnancy; that is, they do not cause abortion. The Emergency Contraception Consortium was formed in 1995 and currently has more than 20 member agencies internationally. The mission of the Consortium is to promote the availability and appropriate use of hormonal methods of EC around the world.

Providing ECPs in advance of when they are needed (advance-of-need prescribing) has many benefits. The sooner after unprotected sex that ECPs are taken, the more effective they are. Access barriers are reduced and studies have shown that women are not likely to use ECPs repeatedly or use them in place of other contraceptive methods. However, there are many common misperceptions surrounding EC. Many believe that ECPs are “abortion pills,” that they encourage irresponsible behavior and adolescent sexual activity, and that they reduce reliance on other contraceptive methods, such as condoms.



Introducing EC can be achieved by using the following framework:

- *Assess user needs and service capabilities:*—Is there a perceived need? What service outlets are preferred? What misinformation exists? What distribution mechanisms are preferred and what training is needed? Is an EC product registered and available? Who can provide ECPs?
- *Build support for EC introduction:*—Involve government and communities at the outset; emphasize EC as a standard of care; select a dedicated product.
- *Develop a distribution plan:*—Consider using family planning distribution sites, pharmacies, emergency rooms, and social marketing; ensure a consistent supply and appropriate access.
- *Meet information and training needs:*—Women need to know about ECPs in advance; providers need medical information, counseling information, and in-service training.
- *Introduce product:*—Inform women through the media, clinics, creative marketing; monitor and evaluate provider knowledge and skills, user experiences, contraceptive use patterns, and opportunities for service improvement.

Many lessons have emerged regarding the introduction of ECPs. Community members (including government bodies, religious groups, and so on) should be involved throughout the entire process. Appropriate distribution channels can be identified by implementing pilot projects. At the same time, providers must receive adequate training and clients must know about EC in advance. Product registration takes time and information about using regular birth control pills should be provided to ensure sustainable services.

The presenter cited examples from Population Council work in Zambia and PATH's efforts to introduce EC in Kenya. Discussion revolved around the lessons emerging from these projects.



IV. FIELD VISITS

Participants visited one of the following projects on Wednesday, January 24:

A. Chikankata Salvation Army Mission Hospital, Chikankata, Zambia

Chikankata Hospital is located 135 kilometers south of Lusaka on the edge of the Zambezi valley. Chikankata is considered one of the country's best hospitals and offers special services in home-based HIV/AIDS care, reproductive health, nutrition, growth monitoring, and care for children affected by HIV/AIDS. AIDS-related services are well integrated with family planning and reproductive health care, and providers receive a comprehensive training package.

A major AIDS program at Chikankata is the Community-Based Orphan Support Program (CBOSP). This project strengthens communities' capacity to care for orphans. Efforts include education and health services, income generation projects, HIV/AIDS prevention among vulnerable children, and referrals to agencies serving orphans.

B. CARE Integrated FP/RH/HIV Clinics, Lusaka, Zambia

The Zambia Community Family Planning Project (CFP) works to increase people's access to and use of quality reproductive health services to improve the lives of women and their families. At the clinic level, the project aims to improve reproductive health through awareness raising, training, supportive supervision, provision of equipment, and monitoring and evaluation.

The CFP project has been operating for five years; it originally focused on family planning, but its scope has been broadened to include reproductive health. The CFP project operates in seven districts and supports 39 clinics. Field visit participants had the opportunity to visit two Lusaka-based clinics, —Ng'ombe Health Center and Kabwata Health Center. At Ng'ombe, HIV/AIDS prevention strategies include IEC dissemination, individual counseling, and condom distribution in the community, peer counseling for youth, and campaigns to promote breastfeeding and male involvement. At Kabwata, MCH services are integrated with HIV/STI services. The center also disseminates IEC on reproductive health and has peer educators for youth.

C. Reflections on Field Visits

Participants were asked to keep the following questions in mind while observing the projects:

- Are HIV/AIDS and family planning services integrated? If so, how well has the project married the two? If not, would you recommend integration of these services in the project? What steps would you advise the project managers to take to ensure integration?
- Are the reproductive health needs of HIV positive women met? If so, how?
- How has the project approached community mobilization in its work? Do the surrounding communities feel they are part of the project and have a voice in it?
- Do you feel the project is sustainable? Why or why not?



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- What challenges has the project encountered in implementation and management? From your experience, what suggestions would you make to the project managers in addressing these challenges?
 - What best practices and lessons learned from this project can you take back to your community?

Participants were asked to share their reflections informally during the remainder of the workshop.



V. BEHAVIOR CHANGE INTERVENTIONS AND COMMUNITY MOBILIZATION IN RESPONSE TO FP/HIV/STI NEEDS

A. Behavior Change/Community Mobilization Stimulation

C.Y. Gopinath, Creative Director, PATH, Nairobi, Kenya

Siri Wood, IEC Program Officer, PATH, Seattle, Washington, USA

Participants engaged in a group simulation game activity that was based on the premise that when people express certain attitudes, we assume they have certain affiliations. For example, when we hear someone say, “Life is precious, you can make it but you can’t take it away,” we could assume they are against euthanasia, or when they say, “Life begins at conception,” they may be an anti-abortionist. The objective of the simulation was to provide a setting in which participants could look at the attitudes they hold and see how those attitudes influence their affiliations and assumptions about behavior change. The simulation game focused on three groups: Donors, PVOs, and the community.

The Setting: Somewhere in Africa. A small group is emerging because of particular beliefs they have. They call themselves Survivors, and carry explosives on their bodies wherever they go. There is a measure of sympathy for them in the community, though most people are very worried, as there have been periodic explosions in markets and on buses, resulting in death of innocent citizens. The Survivors have made it known that they are not a terrorist group; it just happens that they believe that carrying an explosive is like a talisman, and actually increases safety in public places. Given the proportion of Survivors in the overall population, it is estimated that three people in the room are members, and may be carrying bombs. If so, these bombs will explode in exactly two hours if the group does not succeed in identifying and disarming them before the time is up.

Round I: Participants were randomly assigned a color to represent one of three groups: Blue for “society,” yellow for “jury,” and green for the “bomb disposal squad” (BDS). Round I focused on the society group while the jury and BDS groups observed. Each member of the society group was asked to choose (silently) an affiliation, as a donor, and NGO/PVO, or a community member (in addition to three Survivors who may be present). Each person in the room was assigned an attitude to express regarding the Survivor “problem,” ranging from supportive, to fatalistic, to accusatory. Participants had three minutes to interview each other in pairs on their opinion of the Survivor situation and what steps they would take to resolve it. Three yes/no clarification questions were allowed by the interviewer or the group at large. At the end of the interview, interviewees assigned each other to a group—donor, PVO, community—based on the opinion they expressed.

Round 2: The yellow group, or “jury,” took notes on the Round I interviews. After all participants were assigned affiliations, the jury hosted an open house discussion to decide whether any individual had been assigned an incorrect affiliation and should be moved. The jury made all final decisions on placement, and reassigned a handful of individuals.



Round 3: The role of the green group, or “bomb disposal squad” (BDS) was to try to determine who had the bombs. They selected three individuals and explained their reasons for choosing them. The BDS was wrong about all three, falsely assuming that those with fatalistic attitudes or who were sympathetic to the Survivors were themselves Survivors. Two of the survivors had been thought to be donors, while one was assigned as a community member. After the Survivors were identified, the BDS negotiated with the Survivors in an attempt to disarm them.

Through the negotiations, a lot was learned about the Survivors’ underlying philosophy and reasons for carrying bombs. During the discussion, one Survivor surrendered his bomb, while the two remaining Survivors did not. At the appointed hour, they released small firecrackers to simulate a bomb going off.

A1. Discussion

After the simulation, participants discussed what they had learned. The major points raised during the discussion include:

- You can’t assume what a person is going to do based on the positions/opinions they express.
- Some felt at risk of being accused of being a bomber when they were not based on the opinion they expressed.
- People who spoke out about free choice or expressed religious opinions were thought to be Survivors.
- PVOs/NGOs rely heavily on community meetings to get opinions, but people may not express themselves honestly.
- People can be very passionate about their beliefs no matter how ridiculous they may seem to others.
- People may not be willing to express their true beliefs in a public setting if they feel they are not socially acceptable.
- People can get caught up in trying to solve a problem and rush for a solution—“the community is not doing anything so let’s go ahead and take charge.”
- When there is no consensus in a community it is difficult to express a “community voice.”
- People may not speak out for fear of being judged or for fear of that they lack competence.



B. Case Study Presentations and Discussions

“Child to Child Program Used to Enhance Integrated FP/HIV/STI Services,” Miriam Chipumbu, ADRA, Lusaka, Zambia

“Tang’ Project: Adolescent Behavior Change and Condom Promotion,” Mueni Lundi, Acting Project Manager, CARE, Nairobi, Kenya

“AIDS Surveillance and Education Project,” Renato Linsangan, Deputy Project Manager, PATH, Manila, Philippines

“Behavior Change, Care, and Support, and NGO/CBO Capacity Building,” Dr. Haidara Ousmane, Health Advisor, PLAN International, Bamako, Mali

B1. Child Survival/ADRA Zambia

The ADRA Child Survival project began in 1996 in Chipata and Chadiza districts in eastern Zambia. The project targets women of childbearing age (15-49 years) and children under five. The project collaborates with several international and local NGOs as well as various government ministries.

Objectives: The main goal of the ADRA-Zambia Child Survival Project is to improve the health of children under age five and women of childbearing age, thus reducing infant and maternal mortality rates.

Activities: The project helping communities to strengthen their capacity to address their own health issues. The project trains community health workers, traditional birth attendants, community leaders, neighborhood health committees, women’s groups, and Child-to-Child teachers.

Results: An evaluation conducted in 1999 found a significant increase in HIV/AIDS knowledge among all community members except out-of-school youth. In-school youth reported using condoms; however, men and out-of-school youth reported practicing casual sex without condoms.

B2. Tang’ Project/CARE Kenya

Tang’ (Luo for “be cautious”) is a 24-month pilot project with the goal of promoting safer sexual behavior among young people (aged 10-24 years). The project began in 1999 and is based in Gembe West Location of Mbita Division, Suba District.

Objectives: Tang’ aims to increase the use of appropriate HIV/STI prevention measures for adolescents by developing a district-level strategy to coordinate and manage HIV/STI interventions effectively; establish community-level support for HIV/STI strategies directed by youth; and improve knowledge, attitudes toward, and personal commitment to safer sexual behavior and better reproductive health.

Activities: Tang’ has been working through the District Intersectoral AIDS Committee (DIAC) to promote and facilitate coordination and collaboration of agencies involved in the sector at the district level. Tang’s intention is to formulate, together with other collaborators, a district-wide



strategy to address HIV/AIDS, which will be tested and evaluated. To facilitate community-level support, the project has established HIV/AIDS Understanding Training Sites (HUTS), which form the basis for the development of a communication strategy. The sites employ peer educators and are linked with a health facility for referrals. Central to Tang's community-level strategies is an examination of the cultural practices that can contribute to HIV/AIDS infection. Focus in this area is on the manner in which new and critical knowledge can be introduced within the existing cultural system.

At both the community and sector levels, the project emphasizes the treatment of STIs at the earliest possible opportunity. This includes educating young people on symptoms of STIs and a push for treatment at local clinics. This approach aims to portray the clinic as a facility that safeguards their privacy, confidentiality, and respect, to ensure the faster treatment of STIs. The project also makes a supply of condoms available.

Results: The project has only been operating for a short time, so a final evaluation has not yet been conducted.

B3. AIDS Surveillance/PLAN Philippines

The AIDS Surveillance and Education Project (ASEP) began in 1993 and targets female sex workers, male customers of sex workers, and sexually exploited children under the age of 16 living in eight urban areas.

Objectives: The goal of the project is to prevent the rapid increase of HIV/AIDS. Currently, less than 1 percent of the population of the Philippines is thought to be HIV positive. The project has four objectives: 1) to increase the knowledge, attitudes, and practices for STIs/HIV/AIDS prevention in high-risk groups; 2) to decrease policy and environmental/structural constraints to the prevention of STIs and the rapid increase of HIV/AIDS through advocacy efforts for the protection of the target populations; 3) to expand and strengthen linkages and resource partnerships with the government, NGOs, and other sectors in the community; and 4) to increase the NGO capacity in implementing community outreach and peer education.

Activities: To meet the first objective, Community Outreach and Peer Education (COPE) has been developed. COPE focuses on one-on-one interventions, such as risk reduction counseling, as well as group interventions, such as skills trainings and workshops. Another activity in place to meet the first objective is STD Syndromic Case Management (STD SCM). The second objective involves advocacy work and the adoption of laws and codes, such as the AIDS Law, Sanitation Code, Labor Code, and Convention on the Rights of the Child. To meet the third objective, partners are engaged in outreach, post-STD testing and treatment referral. Partners also collaborate with the Condom Social Marketing Organization and participate in monthly networking meetings. Finally, activities related to the fourth objective include peer educators, outreach posts, monitoring systems, project reviews, staff and volunteer development, and an annual behavioral monitoring survey.

Results: The 2000 behavioral monitoring survey showed an increase in condom use among female sex workers, a decrease in uncooperative partners, and an increase in refusal of



unprotected sex by female sex workers compared with 1999 data. In addition, two city ordinances have been passed that make condoms available in registered hospitality establishments; require AIDS/STD education for entertainers; upgrade existing regular medical examination requirements for entertainers; and restricts the hiring of minors by registered establishments.

B4. Behavior Change/PLAN Mali

The Mali AIDS Initiative is a comprehensive effort linking migration with prevention, care, support, and advocacy activities and integrating them into reproductive health programs, education, and livelihood efforts. The project began in 1995 and targets children, youth, girls/women, sex workers, migrants, truck drivers, and the general population. The project operates in five regional clusters in Mali.

Objectives: Project objectives are to build the capacity of local NGOs and communities through effective coalitions to ensure a strong, multi-sectoral, and sustainable Malian response to the impact of the epidemic; reduce discrimination and risk behaviors through effective, targeted behavior change communication; provide increased access to voluntary HIV counseling and testing; and expand access to care and support.

Activities: Project activities include targeted mass media behavior change campaigns, peer education, counseling, and outreach programs to vulnerable youth and high risk populations to reduce risky behavior among general and high risk populations. VCT, MTCT, and care and support interventions are combined with community-based interventions aimed at reducing stigma and decreasing high-risk environments. Strategies to engage political leaders, civil society, and communities to increase and decentralize the multi-sectoral response to the epidemic have been developed. Capacity building of local NGOs to increase community ownership and reduce the impact of the epidemic on the health sector is also underway. In addition, PLAN is establishing a comprehensive operations research, monitoring, and evaluation program to support and measure progress and inform stakeholders of effective approaches and best practices.

Results: Detailed results were not presented.

B5. Case Study Discussion Questions

Participants were divided into four groups for the case studies and discussion, which occurred concurrently. Due to time constraints, discussion summaries were not presented to the larger group. The following questions were used to guide group discussions:

1. What are the assumptions of attitudes that are underlying design and implementation of this project?
2. What attitude changes (clients and/or providers) occurred during the course of this project?
3. How would this project have been different if attitudes had been taken into account from the beginning?



VI. MATERNAL TO CHILD TRANSMISSION OF HIV

A. Prevention of MTCT of HIV: An Overview and the Ndola Demonstration Project Story

Mary Kroeger, Maternal and Child Health Coordinator, Wellstart International/LINKAGES, Washington DC

Nomajoni Ntembele, Resident Country Advisor, LINKAGES Project, Lusaka, Zambia

A1. Values Clarification Exercise

Participants were asked to agree or disagree with the following statements as an informal needs assessment for the presenters:

- There is no point in funding VCT in pregnant women if ARVs are not available.
- Condoms should be free and available in all high schools.
- Your husband/wife really loves you if he/she uses a condom with his/her girlfriend/boy friend.
- In Africa, breastfeeding is the major route of MTCT.
- In your own community or facility, if you yourself were going to have an HIV test, you could be sure of confidentiality.
- Donors should fund replacement feeds or formula for HIV positive mothers who chose not to breastfeed.
- I, myself, have been tested for HIV.

A2. Overview of MTCT

HIV has spread over time throughout Africa, and seroprevalence rates in pregnant women are far higher in Africa than in Asia, Latin America, or the Caribbean. Six hundred thousand children under age 15 were newly infected in 2000, 520,000 of whom reside in sub-Saharan Africa. As of 1999, a cumulative total of 13.2 million children age 14 and younger had been orphaned, 12.1 million in sub-Saharan Africa alone.

HIV/AIDS is not a gender-neutral disease. Women's lower socioeconomic status puts them at a disadvantage, and anatomically, women are at greater risk of infection than men are. At the same time, the 'predatory' behavior of men seeking younger and multiple partners increases women's risk. HIV/AIDS-infected women are ten times more likely to be physically abused, chased from their homes, and have their property inherited by their husband's relatives after his death. At the same time, HIV positive women are less likely to receive home care, and more likely to continue with heavy workloads and care for other ill persons even when they are ill themselves.

The risk of mother to child transmission (MTCT) is 5-10 percent during pregnancy, 10-20 percent during delivery, and 10-20 percent during breastfeeding when children are breastfed for two years. Reducing MTCT requires early, regular antenatal care. Essential antenatal care includes obstetric and medical history, a full physical exam, a nutrition assessment, STI screening, care for other infections, and malaria prevention and treatment. Antenatal counseling should cover VCT, infant feeding, nutrition, safe sex, delivery plan, family planning, and partner and family support.



During labor and delivery, MTCT can be reduced by keeping labor as normal as possible, minimizing invasive procedures, providing ARVs when available, and supporting breastfeeding if the mother chooses. Ambulation, nourishment, and oral hydration are important during labor, as is the presence of a support person. Strict adherence to infection prevention and the careful handling of blood is vital. Cesarean sections before the onset of labor can reduce the risk of MTCT; however, they are not always feasible in resource-poor settings.

Newborn care should also avoid invasive procedures such as suctioning the baby's mouth. If the mother chooses to breastfeed, exclusive breastfeeding should be encouraged. Breastfeeding up to six months reduces the risk of infant death even in HIV positive mothers. Studies have shown that exclusive breastfeeding for the first three months is associated with a lower MTCT rate than mixed feeding, while MTCT rates for exclusive breastfeeding and formula feeding are approximately the same during this period. Though this remains unproven, the theory behind this phenomenon is that formula irritates the infant's gut, making transmission more likely when mixed feeding is practiced.

The primary way to prevent MTCT is through HIV/AIDS prevention in mothers. Programs should address gender discrimination and promote interventions that are realistic in resource-poor settings. Breastfeeding should be supported and protected, and MTCT should be incorporated into safe motherhood, reproductive health, and child survival programs.

B. Ndola Demonstration Project

The Ndola Demonstration Project (NDP) is a case study in integrating infant feeding and HIV/AIDS interventions into maternal and child health (MCH) and community services. Funded by LINKAGES, NDP collaborates with the Ministry of Health, the National Food and Nutrition Commission, Ndola District Health Management Team, Hope Humana, HORIZONS, and the Zambia Integrated Health Program, with support from USAID.

Zambia has an established breastfeeding culture. Exclusive breastfeeding rates are 26 percent from 0-3 months, with early initiation rates at 98 percent. The mean duration of breastfeeding is 20 months. At the same time, Zambia has a high HIV prevalence rate, with 19.7 percent of the population infected. At this rate, 80,000 babies per year are estimated to be infected through MTCT. Ndola was chosen for the project due to its well-established district task force on HIV/AIDS, a wide framework for collaboration with NGOs, churches, CBOs, and so on, and the strong linkages between community groups and health services. Ndola also has a high HIV prevalence, with more than 40 percent of women ages 20-29 infected.

The objectives of the Ndola Demonstration Project are to:

- Strengthen the quality of MCH services (antenatal, labor, and delivery, postnatal, family planning, child health);
- Integrate counseling on infant feeding in clinics in communities in the context of HIV/AIDS;
- Introduce voluntary and confidential counseling and testing (VCCT) for HIV in clinics as an ongoing service;



-
- Strengthen community involvement in care and support;
 - Strengthen referral links between the community and health care services;
 - Monitor and document feasibility, experiences, acceptability, and costs of interventions.

Project implementation involved consensus and partnership building; assessment of health care facilities; rapid formative research; community assessment; baseline survey; facility enhancement for VCCT capacity; strategy for training; training and capacity building; and development of a monitoring and evaluation plan. Formative research methodology included focus groups, household interviews, detailed observation, and household feasibility trials. Key findings of the research indicated that the public is aware that HIV can be transmitted through breastfeeding; however, health providers incorrectly believed that transmission was as high as 50-75 percent. *Exclusive* breastfeeding is not common in Ndola, though women face social stigma if they do not breastfeed. Many households in Ndola lack food security, and the cost of replacement breastfeeding is high.

NDP developed a training strategy to integrate infant feeding and HIV/AIDS counseling into MCH services. The training strategy sought to improve the quality of MCH services and create an environment for integrated counseling. Community support systems were also established and referral systems strengthened. A training curriculum was developed and health care providers and community service providers were trained. On-the-job mentoring was found to be essential.

NDP advocates the following feeding recommendations:

- Promote exclusive breastfeeding among all HIV negative women and those of unknown status.
- Encourage and support HIV positive women who choose to breastfeed: to breastfeed exclusively for six months.
- Counsel HIV positive women who choose to replacement feed on the safe and appropriate use of infant formula; they will be expected to buy their own supplies.

To date, staff members have been trained in six demonstration clinics and community health providers in the catchment areas have been trained. Same-day VCCT is available in all six clinics, and 846 women have been tested and collected their results. One hundred and twenty-four men have been tested. All but one woman has chosen breastfeeding over replacement feeding. At this stage, plans are underway for scaling up the project in other districts in Zambia, and in other countries.



VII. DUAL PROTECTION

A. Setting the Stage for Dual Protection

Katharine Kreiss, Senior Technical Advisor, G/PHN/POP/FPSA, USAID, Washington, DC, USA

USAID is in the process of preparing ‘guidance’ on condoms and dual protection. The following presentation represents preliminary insights on the topic.

Dual method use is defined as using one contraceptive method to prevent pregnancy and another to prevent HIV/STIs. A primary method for pregnancy prevention is selected and condoms are added for HIV/STI prevention. Dual protection is the use of a condom (male or female) to prevent pregnancy and HIV/STIs. Dual protection is particularly important for sexually active adolescents, men who put their partners at risk, women who are at risk because of their partner’s high risk behavior, sexually active people in high HIV/STI prevalence areas, commercial sex workers, individuals or their partners who have HIV and/or an STI.

In reality, few married couples rely on condoms for contraception and many providers are biased against condoms. Family planning providers should begin promoting condoms and reaching out to men and adolescents in clinics and the community. Mass media messages need to be consistent. Provider attitudes towards condoms need to be changed to reflect the fact that condoms are, in fact, an effective method of contraception. Providers need to be aware of gender issues and power dynamics in decision-making and should promote true, informed choice.

Men need to be involved in family planning to promote gender equity. Men often play a dominant role in sexual decision-making and their responsibility regarding reproductive health is essential to curb the transmission of HIV/STIs. At the same time, women want their partners involved in family planning to support their contraceptive use and share responsibility, and want men to have a better understanding of reproductive health issues. Studies have shown that continued contraceptive use is twice as high when husbands are involved in counseling on family planning.

Violence against women has negative consequences for sexual and reproductive health, such as unwanted pregnancy, HIV/STI transmission, high-risk pregnancies, depression, and low self-esteem. Family planning personnel need to be trained to identify women who are victims of violence, provide reproductive health counseling, and refer to appropriate services.

More than one billion young men and women ages 15-24 are entering their childbearing years. Almost 50 percent of new HIV infections are occurring in this age group, which often lacks the comfort and independence to seek out reproductive health information. As such, family planning programs need to be friendly to adolescents. Communication skills need to be nurtured in youth and safe and healthy behaviors should be fostered.

Mass media campaigns and social marketing are to key to promoting dual protection. Equal attention should be paid to men, women, adolescents and their disease and pregnancy prevention



needs. Clients should be assisted in determining their actual HIV/STI risk and helped to make the best decision regarding dual protection.

Biomedical research is underway to improve male and female condoms by making them more accessible, acceptable, effective, attractive, and cheaper. Operations research is also being conducted to improve programs and provider attitudes. Best practices in condom programming stress benefits, empower people to change their behavior and attitudes regarding condom use, and provide easy access to condoms.

B. Promoting Dual Protection Within Family Planning Services: A Case Study From Nigeria

Dr. Joanne Mantell, Research Scientist, HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute/Columbia University, New York, USA; Senior Research Associate, New York Academy of Medicine, New York, USA

Dr. Eugene Weiss, Consultant, Association for Reproductive and Family Health, Ibadan, Nigeria

Dual protection is defined as simultaneous prevention of pregnancy and HIV/STIs. DP can be achieved by using a single barrier family planning method (for example, male condom), by the combined use of two methods (for example, IUD and female condom), or by the use of a non-barrier contraceptive along with mutual monogamy.

Integrating dual protection into family planning services is extremely important because of the substantial HIV/STI risk that results when men and women have multiple partnerships within and outside of marriage. Hormonal methods of family planning and the IUD provide no protection from HIV or other STIs. At the same time, family planning providers have done a poor job of promoting the male condom because many of them view condoms as less effective in preventing pregnancy than other methods.

B1. The Nigeria Dual Protection Project

The Association for Reproductive and Family Health, a reproductive health NGO in Ibadan, Nigeria, began a demonstration project on dual protection in early 1999 that is currently underway in six clinics (three government and three NGO). The HIV prevalence rate in Nigeria is approximately 6 percent, and a shift in HIV from high-risk populations to the general population has been observed. Contraceptive use is currently 7 percent nationwide, although this figure is as high as 25 percent in southwest urban areas such as Ibadan.

The operations research objectives of the project focused on client and service delivery issues:

- Increase family planning providers' skills in dual protection counseling and education;
- Increase initial and long-term dual protection practice;
- Improve understanding of clients' perceptions of their dual HIV/STI and pregnancy risks;
- Explore facilitators and constraints to dual protection practice;
- Evaluate the impact of adding an intervention involving male partners to dual protection services; and



- Develop and evaluate a system for monitoring achievement of dual protection objectives.

Phase I of the project involved piloting a dual protection counseling intervention, which included the introduction of female condoms into the contraceptive method mix. Phase II, scheduled to begin in February 2001, involves the development and testing of strategies to reach male partners of family planning clients.

Counseling

The effective integration of FP/HIV/STI efforts requires that family planning providers see disease prevention as their responsibility and provide counseling to promote condom use. Family planning education and counseling should be combined with counseling and education on HIV/STIs. To this end, the Female-Initiated Protection Paradigm (FIPP) has been developed.

The objectives of FIPP are to:

- Increase clients' HIV/STI knowledge;
- Help clients evaluate their personal vulnerability to HIV/STIs;
- Help clients make informed decisions that balance their pregnancy and HIV/STI prevention needs;
- Increase clients' skills in negotiating and using condoms; and
- Encourage male partners to support and practice dual protection.

A detailed and comprehensive Dual Protection Flip Chart was developed as a counseling aid. The flip chart, which was displayed at the workshop, covers a broad range of FP/RH/HIV/STI issues.

Training

A training program was developed for family planning clinic managers and providers. The trainings covered:

- HIV/STI clinical, epidemiological, and counseling information using local experts;
- FIPP concepts and components;
- Personal values and sexual comfort;
- Traditional Nigerian values/practices;
- HIV/STI risk assessment and counseling skills;
- Practice insertion, removal, and use of male and female condoms at home;
- Development of a repertoire of sexual and condom negotiation strategies for clients to use with partners; and
- Clinical field practicum to practice dual protection counseling.

All engaged in counseling role-plays as part of the training.

B2. Project Results: Phase I

An evaluation of the December 1999–August 2000 found that 'condom visits' increased from 2 percent to 15 percent in project clinics. Of clients taking condoms, 53 percent were using them



for dual protection. More than one-quarter of new clients were willing to try a male or female condom.

Most clients (77 percent) are married and monogamous; 85 percent are between 25-44 years of age. Ninety percent of clients have discussed family planning with their partner, and 61 percent have ever used male condoms. The evaluation found that there was a substantial increase in the number of providers discussing HIV/AIDS and other STIs and demonstrating condom use (with an emphasis on the female condom).

Qualitative research was also conducted to gauge women's perceptions of male partners' reaction to the female condom, which indicated that many men were accepting of the female condom, although some were resistant to their wives bringing it home. Women also indicated that they would like to have their husband attend family planning clinics with them. Focus groups with men indicated that they had mixed views toward the female condom and focused on what condom use implied about trust issues in the relationship.

Following are preliminary findings/observations and related recommendations from the evaluation:

Finding/Observation	Recommendation
The hierarchical concept of dual protection had to be simplified.	Keep dual protection simple; focus on male and female condoms.
Mutual monogamy is impractical as a dual protection category.	Keep mutual monogamy as a reporting category only.
Dual protection reporting is difficult.	Work out required reporting changes ahead of time and plan for a period of trial and error.
Among condom users, dual method use is as acceptable as single method use.	Dual protection practice should be promoted as both single and dual method.
Alternatives to male condoms for dual protection are important for married clients.	Introduce the female condom.
Many women are willing to try the female condom when offered free, but at least half do not continue use.	It is worthwhile to initially offer free female condoms. Even if not used, the idea of dual protection is introduced.
Providers tend to be arbitrary regarding who they think needs dual protection.	Conduct HIV/STI risk assessment and provide DP education to all clients.
IEC materials guide dual protection counseling, remind providers to cover essential topics, and can ground dual protection concepts in local culture.	Dual protection programs should ensure that culturally relevant flip charts, brochures, and other materials are available.
Providers are much less likely to deliver dual protection counseling to continuing as opposed to new clients.	Design separate protocol/clinical procedures for continuing clients.
Dual protection counseling requires a major change in provider behavior and attitudes.	Dual protection training needs to be substantial with emphasis on role modeling, feedback, and a supervised practicum.
Provider training on dual protection is inadequate	Plan for on-going monitoring, follow-up and



in and of itself to bring about changes in provider counseling.	technical assistance.
Providers identify male partners of clients as the biggest obstacle to dual protection practice.	Program activities aimed at males are needed.
Involving practitioners in dual protection design, training, and evaluation increases ownership and program success.	Each dual protection program should be adapted to the local setting.
Though dual protection counseling has not been delivered to all clients, providers have made a significant value shift.	Dual protection programs can be initiated widely, but will need a year or two before being fully implemented.

B3. Case Studies/Small Group Presentations

Participants were divided into four groups to discuss the following case studies. Responses are indicated below:

Group 1: Could the Dual Protection Flip Chart and Counseling Guidelines be used in the Lusaka clinics seen on the field visits on Wednesday? If not, discuss how you would go about adapting it to these settings? What would you do before introducing either the existing flip chart or the adapted one into ongoing clinic use?

- Time constraints
- Strategies for addressing dual protection issues for each client/triaging
- Protocols
- Flip chart is detailed—needs markers/tags
- Focus and reduce volume/content
- Separate flip chart for provider and client
- In-service training
- Too much information (absorption capacity of client)
- Target major issues depending on general assessment
- Sensitization followed by community-based, back-up service
- Provision of IEC materials for home use
- Pictures are crowded; make them more colorful and natural, some would make good posters
- Better layout
- On the positive side, the flip chart can improve client contact

Group 2: Are the Dual Protection Flip Chart and Counseling Guidelines adequate for use with males, either in individual settings or in a group setting? If not, discuss how you would adapt it for male education and counseling?

- Asses needs of male clients
- Pictures should portray men on the introduction page
- Pictures showing men doing counseling
- 7D, Step 2, Point 3—rephrase to reflect sexual relationships
- Other issues men said they were interested in should be added
- Adapt flip chart for use with men in settings outside the clinic



- More suited for couples than men alone
- Flip chart should be adapted/simplified for use in the community
- Could be more male-friendly if section on how couples can make condom use more pleasurable was included
- Need for more information on HIV counseling and testing
- Add guidelines for provider on how to use the flip chart depending on client

Group 3: Develop an outline for implementing a dual protection approach in Zimbabwe's community-based family planning services (assume they are currently only family planning services). Discuss what needs to be done, by whom, and in what sequence, and with what resources of assistance.

- Orientation of CBDs and providers and FP/RH community through Zimbabwe Family Planning Association
- Baseline survey to determine KAPs
- Stress participatory approach
- IEC/advocacy/social marketing
- Resource mobilization (funds, supplies, and technical assistance)
- Engage leadership—policy, advocacy, and sensitization
- Supplies and logistics systems
- Sustainability
- Retraining for CBDs; in-service training
- Facility assessment
- Adaptation of IEC and other materials
- Social marketing targeted at men and adolescents
- Mentorship, supportive supervision
- Review and revise health information systems
- Develop or adapt existing training models
- Monitoring and evaluation

Group 4: Develop an outline for a national plan for the implementation of a dual protection approach within clinic family planning services in a southern African country. Discuss what needs to be done, by whom, and in what sequence, and with what resources of assistance.

- Meeting with all stakeholders (donor, religious leaders, community leaders, political leaders, and so forth)
- Get support from donors
- Information passed to the district level and NGOs
- Situational analysis to examine demand quality, current messages, and other issues
- Counseling/capacity building for staff
- Dissemination of results for advocacy
- Policy development and allocation of resources
- Implementation—training of trainers, supervision and support, comprehensive training on integration, monitoring, and evaluation, and so on
- Resources



C. Overview of USAID Assistance in HIV

David Stanton, Senior Technical Advisor, HIV/AIDS Division, Global Bureau, USAID, Washington, DC, USA

In 1999, 36.1 million people were living with HIV/AIDS. There were 3,000,000 deaths from AIDS in 1999, and 5.3 million new cases. Cumulatively, 21.8 million people have died of AIDS.

USAID funding for HIV/AIDS focuses on prevention and mitigation. For 2001, USAID has \$330,000,000 for HIV/AIDS programming, \$280,000,000 of which is unrestricted. Approximately \$168,000,000 will be spent in sub-Saharan Africa, where the actual need is estimated at four billion dollars.

Internationally accepted HIV/AIDS targets for 2007 are to reduce HIV prevalence in 15-24 year-olds by 50 percent and to maintain prevalence rates below 1 percent among 15-49 year-olds in countries that already have low prevalence rates. Other goals are to increase access to programs that reduce MTCT, and to help local organizations provide basic care and support to HIV infected/affected adults and children.

USAID intends to help countries prioritize interventions, focus programs on vulnerable/high risk groups, and expand strengthen and adapt capacity to meet the HIV/AIDS needs of their populations. Three country designations have been developed: Rapid scale-up, intensive focus, and basic programs. The four rapid scale-up countries are Kenya, Uganda, Zambia, and Cambodia. These countries have been chosen based on the severity and magnitude of the HIV/AIDS problem, the potential for impact, and the existence of a conducive environment.

PVOs are essential partners in implementing USAID's HIV/AIDS strategic framework because of their independence, community reach, affiliation with local NGOs, and capacity for prevention, care, and support. As the HIV/AIDS epidemic continues to expand so must partnerships.

D. Closing Remarks

Dr. Marge Koblinsky, Director, NGO Networks for Health, Washington, DC, USA

Dr. Koblinsky thanked the organizing committee, CARE Zambia, and others who worked behind the scenes to make the workshop a success. Presenters were also praised for their innovative and informative presentations. A brief report of the conference will be produced and posted on the Internet, and a more detailed, comprehensive report will be produced for distribution.

Counseling is a major feature in all FP/RH/HIV/STI services. Good counseling allows for risk perception, imports skills to implement the decision, and improves quality of care. Key FP/RH/HIV/STI interventions, such as condom use and breastfeeding, are user-dependent and therefore effective counseling is key.



Behavior change at the community level is critical for supporting clinic-level interventions, as there is a strong interdependence between what happens in the clinic and what happens in the community. The case studies presented during the workshop showed evidence of an increase in knowledge regarding FP/RH/HIV/STIs, but far less evidence of increased condom use.

As such, partner PVOs need to improve what is happening at the community level. *Networks* would like to see a learning group formed among the partner PVOs to examine the case studies more closely and to disseminate lessons regarding behavior change efforts and increased behavior change (condom use).



APPENDIX I: WORKSHOP AGENDA

Monday, 22 January, 2001

INTRODUCTION

8:00-8:15	Registration	CARE, Zambia and Workshop Planning Team
8:15-8:30	Welcome and Opening Remarks	Dr. Gavin Silwamba, Director General, Central Board of Health, Lusaka Barbara Hughes, Deputy PHN Director, USAID, Lusaka Katharine Kreis, Senior Technical Advisor, G/PHN/POP/FPSD, USAID, Washington, DC
8:30-8:45	Workshop Objectives and Agenda	Wilma Gormley, Training Resources Group, Alexandria, Virginia
8:45-9:15	NGO Networks and Partners	Dr. Mike Negerie, HIV/STI Advisor, NGO Networks, Washington, DC
9:15-9:45	Contributing Factors for Spread of HIV/AIDS in Southern Africa	Irene Banda, Health Sector Coordinator, CARE, Lusaka
9:45-10:15	Testimonial	Brigitte Syamevwe, Community Representative, Lusaka

HIV/STI CARE TO PREVENTION CONTINUUM

10:30-12:00	Designing, Implementing, Monitoring, and Evaluating Effective Strategies for STI Care	Dr. Yves LaFort, Institute of Tropical Medicine, STD/HIV Research and Intervention Unit, Antwerp, Belgium
12:00-1:00	Lunch	
1:00-2:30	Expanding and Strengthening VCT Services as a Tool for HIV/AIDS Prevention, Care, and Support	Dr. Gloria Sangiwa, Senior Technical Advisor, HIV/VCT, FHI, Arlington, Virginia
2:30-3:00	Questions/Answers—FHI Panel	Dr. Gloria Sangiwa and Dr. Yves LaFort
3:15-5:15	Case Study Presentations and Group Work	“HIV/AIDS Care, Support, and Counseling” Penina Ochola, Regional Health Advisor, PLAN, Nairobi “Community Based Options for Empowerment” Chifundo Kachiza, COPE Program Manager, Save the Children, Lilongwe
Evening	Peer Educators Presentation	Youth HIV/AIDS Drama and Dance Group, Lusaka



Tuesday, 23 January, 2001

INTEGRATION AND DELIVERY OF FP/HIV/STI SERVICES

8:00-8:15	Review and Today's Agenda	Wilma Gormley, Training Resources Group, Alexandria, Virginia
8:15-8:45	Application of Family Planning+ Initiative and Request for Proposals	Dr. Marge Koblinsky, Director, NGO Networks, Washington, DC
8:45-12:00	Integration of HIV/STI Prevention and Services in Family Planning	Julie Becker, Program Manager, AVSC International, New York Dr. Stephen Wanyee, Program Manager, AVSC International, Nairobi
12:00-1:00	Lunch	
1:00-2:30	Integration of HIV/STI Prevention and Services in Family Planning	Julie Becker, Program Manager, AVSC International, New York Dr. Stephen Wanyee, Program Manager, AVSC International, Nairobi
2:30-4:30	Case Study Presentations and Group Work	“SIDA in Exodus” Dr. Aliou Sani, Health Advisor, CARE, Niamey, Niger “One Stop Shop – Meeting the Needs of Adolescents in Kawangware” George Kahuthia, Program Officer, PATH, Nairobi, Kenya Dr. Grace Miheso, Assistant Program Officer, PATH, Nairobi, Kenya “SAFE II-Sports Health and AIDS Foot-ballers Education Program” Popo Matsoara, Reproductive Health Coordinator, CARE, Lesotho
4:45-5:15	Preparation for Field Visit	Jaime Stewart, Program Officer, Reproductive Health, CARE, Atlanta, GA Daras Chirwas, Project Manager, Community Family Planning Project, CARE, Lusaka Dafton Siame, Program Manager, SCOPE- Orphans and Vulnerable Children, CARE, Lusaka
8:00-9:30	Strategies for Emergency Contraception Introduction in Africa	Siri Wood, IEC Program Officer, PATH, Seattle, Washington

Wednesday, 24 January, 2001

FIELD VISIT

7:00--	Group One: Salvation Army AIDS Home Based Care Activities, Chikancata Hospital, Chikancata	Group Leader: Mavis Kachimba, Consultant, Lusaka
8:30--	Group Two: CARE Integrated FP/RH/HIV Clinics, Lusaka	Group Leader: Doras Chirwas, Project Manager, Community Family Planning Project, CARE, Lusaka



Thursday, 25 January 2001

**BEHAVIOR CHANGE INTERVENTIONS AND COMMUNITY MOBILIZATION IN
RESPONSE TO FP/HIV/STI NEEDS**

8:00-8:45	Review and Today's Agenda	Wilma Gormley, Training Resources Group, Alexandria, Virginia
8:45-12:00	Behavior Change/Community Mobilization Simulation	C.Y. Gopinath, Creative Director, PATH, Nairobi Siri Wood, IEC Program Officer, PATH, Seattle, Washington
12:00-1:00	Lunch	
1:00-2:30	Case Study Presentations and Group Work	“Appreciative Inquiry Model Used to Enhance Integrated FP/HIV/STI Services” Miriam Chipumbu, ADRA, Lusaka “Tang’ Project, Adolescent Behavior Change and Condom Promotion” Mueni Lundi, Acting Project Manager, Tang’ Project, CARE, Nairobi AIDS Surveillance and Education Project” Renato Linsangan, Deputy Project Manager, PATH, Manila, Philippines “Behavior Change, Care, and Support, and NGO/CBO Capacity Building” Dr. Haidara Ousmane, Health Advisor, PLAN International, Bamako, Mali

MATERNAL TO CHILD TRANSMISSION OF HIV

2:45-5:15	Prevention of MTCT of HIV: An Overview and the Ndola Demonstration Project Story	Mary Kroeger, Maternal and Child Health Coordinator, Wellstart International/LINKAGES Project, Washington, DC, USA Nomajoni Ntembele, Resident Country Advisor, LINKAGES Project, Lusaka, Zambia
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Friday, 26 January 2001
DUAL PROTECTION

8:00-8:15	Review and Today's Agenda	Wilma Gormley, Training Resources Group, Alexandria, Virginia
8:15-8:30	Setting the Stage for Dual Protection	Katharine Kreis, Senior Technical Advisor, G/PHN/POP/FP/SA, USAID, Washington, DC
8:30-12:30	Promoting Dual Protection Within Family Planning Services: A Case Study From Nigeria	Dr. Joanne Mantell, Research Scientist, HIV Center for Clinical and Behavioral Studies, Columbia University, New York, USA; and Senior Research Associate, New York Academy of Medicine, New York, USA Dr. Eugene Weiss, Consultant, Association for Reproductive and Family Health, Ibadan, Nigeria
12:30-12:45	Overview of USAID Assistance in HIV	David Stanton, Senior Technical Advisor, HIV Division, Global Bureau, USAID, Washington, DC
12:45-1:15	Closing Remarks	Dr. Marge Koblinsky, Director, NGO Networks, Washington, DC



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