

THE WORKING GROUP ON REPRODUCTIVE HEALTH AND FAMILY PLANNING

Report from the meeting on
Innovations in Technology Introduction
February 10 & 11, 1998

Center for Health and Gender Equity
Population Council



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NEW APPROACHES TO TECHNOLOGY INTRODUCTION

Introductory Remarks

*Martha Brady
Director, Expanding Contraceptive Choice Program
Population Council*

The Working Group on Reproductive Health and Family Planning is co-sponsored by the Center for Health and Gender Equity (formerly the Health and Development Policy Project) and the Population Council. One of the main objectives of the Working Group is to stimulate debate and discussion on critical issues in reproductive health, particularly in light of the International Conference on Population and Development (ICPD) held in 1994 in Cairo. One such issue relates to practices in the field of contraceptive introduction, and the assumptions on which these practices are based. There are few subjects that generate as much interest or controversy. In the past, contraceptive technologies and their service delivery correlates were accepted as legitimate, largely autonomous subjects of inquiry. With the increasing adoption of a reproductive health perspective, these technologies are increasingly recognized as part of a broader system: one that takes into account user needs as well as the capacity of the service delivery system to provide new and existing technologies with appropriate quality of care. This meeting provides a valuable opportunity to review past efforts and to look to the future with new approaches.

Over the past several decades, the population field has witnessed an increase in the number of new fertility regulation technologies available to men and women around the world. Arguably this has made an important contribution to reproductive health. However, the availability of technologies has not, in all cases, matched well with the capacity of health systems to deliver them in a way that is safe, effective, and consistent with individuals' reproductive intentions.

Decades of investment in contraceptive development have led to new products and to considerable advances in introducing new technologies. Nevertheless, we have learned that the addition of a new method to an already stressed delivery system will not necessarily enhance, and may even impair, overall

program effectiveness. There is increasing recognition that specific initiatives and targeted interventions to improve the quality of services are needed in order to allow for the appropriate introduction and utilization of technologies. The process of introducing new technologies can provide a unique opportunity to improve the overall quality of services.

It is important to recognize that the word "introduction" has different interpretations. Within the pharmaceutical industry, one speaks in terms of "product launch". This "launch" is most often targeted to the medical establishment, as it is the providers who are viewed as the "consumers" or the "clients". In this context, the emphasis is on educating providers and raising awareness of the product.

In a broader sense, introduction involves the process by which contraceptive and other reproductive health technologies go from clinical testing to actual use by clients in various program settings. This process involves entire health systems, and subsystems within them (including local regulatory bodies, commodity procurement, logistics, management, training, supervision, etc.). In this sense, "introduction" is the interface between clients, technologies, and health systems.

The realities and circumstances that give rise to efforts to introduce contraceptive technologies are quite diverse. They may be donor driven; they may be prompted by economic considerations; they may be influenced by national concerns for achieving some desired contraceptive method mix; or they may be prompted by the desire to address some general reproductive health need. In any case, experience to date has demonstrated the importance of understanding the context in which people make sexual and reproductive decisions, and the ability of health systems to respond. This meeting will attempt to grapple with some of these issues.

The World Health Organization's Strategic Approach to Technology Introduction

Ruth Simmons
Professor of Health Behavior and Health Education
University of Michigan School of Public Health

I am honored to present an overview of the *strategic approach to the introduction of fertility regulation technologies* in the presence of so many of the people who helped develop and implement it. This approach was developed by the World Health Organization (WHO) in collaboration with several other agencies.

Naming the Approach

The approach developed by WHO has been referred to in different ways, each reflecting something quite essential. When we refer to it as the "**WHO approach**", we do so in recognition of the fact that WHO initiated it and provided the bulk of the financial support for its development and implementation. A number of other institutions have provided critical input from the very beginning, namely CEMICAMP, the University of Michigan, the Population Council, and the International Committee on the Management of Population. In particular countries, funding has also been provided by UNFPA, GTZ, and others. When we refer to it as the "**new approach**" to contraceptive introduction, we do so because it is innovative. We also want to signal that this methodology seeks to build on what has been learned from previous technology introduction efforts and to abandon what has not worked in the past. When we call it "**the strategic approach**", we highlight its significance as a major policy planning and decision-making tool. Today, I will refer to it as "**the quality of care approach**" to technology introduction, because it places quality of care and reproductive health needs at the top of the technology introduction agenda.

The Traditional -v- The Quality of Care (QOC) Approach to Technology Introduction

The QOC approach to technology introduction is more complex and intricate than its predecessors. It differs quite dramatically from conventional approaches, which focused on the actual technology of a single contraceptive method, its benefits, and the advances in modern science it represented (efficacy,

reversibility). These characteristics are certainly important. By highlighting them exclusively, however, previous contraceptive introduction efforts missed opportunities to investigate service delivery capacity, determine client and provider needs, and assess whether or not adding the new technologies would improve reproductive choice.

The QOC approach tries to ensure that reproductive choice is expanded by recognizing and emphasizing the long, arduous road which individuals—predominantly women—have to travel in order to control their fertility. The road, if you could see it, is not smooth. It is of poor quality, and it is very long. The QOC approach to technology introduction aims to make this road a little smoother and a little shorter by evaluating contraceptive introduction plans within the context of overall program strategy and client needs.

Key Elements Of The Approach

The approach has four major elements:

- It is informed by a systems framework.
- It seeks to answer three strategic questions.
- It has three major stages of activity (Stage I, Stage II, and Stage III).
- It is characterized by an emphasis on broad-based participation of stakeholders, including participants from women's health groups, NGOs, and research organizations—all of whom are stakeholders not usually included in the process of technology introduction.

These elements will be discussed in more detail below.

The Systems Framework

The notion underlying the systems framework is that policy choice related to technology introduction must be based on an integrated analysis of contraceptive technologies, program capabilities, and, above all, of user perspectives, user needs, and the social context of reproductive choice. While the technology is part of the systems perspective, the introduction of a single technology is not emphasized. Instead, an 'inventory' is taken of the method mix in a particular country. We ask about the methods available for groups defined by age, gender, lactational status, contraceptive intention, income group, and so forth.

Asking these broad questions about such groups and their particular needs for different technologies, the QOC approach tries to determine not only what methods are available within the system, but, just as importantly, the conditions under which they are provided.

At the same time, the approach considers user perspectives, user needs, and broad reproductive health and rights. It places users' perspectives in a wider framework that also encompasses gender, social structure, and cultural issues. From this broader perspective one can analyze the critical interface between user perspectives, user needs, and technologies. The systems framework also allows one to look at the interface between the user and the service system. How are people actually treated when they seek services? What is the quality of care they receive? What kind of information and counseling do they receive about specific contraceptive technologies and other reproductive health needs and services? Do people have access to care?

Finally, the systems framework enables evaluation of the capacity of a service system to provide quality care to people in need. Rather than looking narrowly at the client-provider interaction, the systems framework instead examines institutional determinants of quality and access. All levels of services are considered, including providers, facility management, and the larger program policy structure.

It is within this systems framework that consideration is then given to the strategic introduction questions which focus on the need to improve provision of existing methods, the need for method removal and the addition of methods currently not available within a service setting.

Three Stages of Activity

The first stage of the QOC approach to technology introduction is an assessment of the need for contraceptive introduction; the second refers to research focused on the improvement of reproductive choice; and the third stage promotes the use of findings from both the Stage I assessment and Stage II research for policy and program development.

Stage I: Strategic Assessment of Need

Stage I is particularly innovative because it argues that a national assessment should be conducted *prior* to making national decisions about the introduction of new methods. It includes a literature review, planning and dissemination workshops, and a field-based, interdisciplinary, and participatory assessment. The assessment is used to learn as much as possible about the technology mix in a country program, about service capacity, quality of care, user perspectives, and user needs. In the past, such assessments were not conducted. The WHO experience of introducing Cyclofem in five different countries indicated that organizing a series of field-based introductory trials in different nations, without a careful assessment, was not sound.

Assessments are intended to provide answers to the following three strategic questions:

- Is there a need for improved provision of existing methods?
- Is there a need to remove methods from a service delivery setting in cases where the safety or efficacy of these methods has not been systematically established, or in cases where they have been replaced by improved formulations or devices?
- Is there a need for the introduction of new contraceptive methods, and, if so, for what level of service delivery are they appropriate?

These three strategic questions must be asked prior to the decision to introduce new technology. For instance, when conducting service delivery research related to the introduction of Cyclofem in Indonesia, it was found that the Indonesian national program already provided two injectables, but was not distinguishing between the two. Consequently, the existence of two injectables within the service setting actually reduced reproductive choice. Thus the following question was raised: Why should one consider adding yet a third injectable to this system?

The philosophy underlying Stage I is that if a service delivery system does not have the capability to provide new methods with appropriate quality of care, introduction of new methods will not expand reproductive choice. Steps other than the introduction of new technology are needed first, namely

improved provision of existing methods, or even de-emphasizing, and hopefully removing, methods whose safety or efficacy has not been proven or which are simply outdated.

Assessments of the need for contraceptive introduction may lead to a variety of operational and policy changes and to research initiatives related to contraceptive introduction.

Stage II: Research

Stage II research entails the design and implementation of applied research focused on country priorities as established by the strategic assessment. This stage may entail research on the improved provision of methods already offered within a service-delivery setting, or on the introduction of a new method or methods, with attention to the technical, operational, and managerial changes required to ensure that these methods are provided with an adequate level of quality. Service delivery settings are studied in order to evaluate what adaptations are needed when innovations are introduced on a wide scale. Such research has included demonstration or pilot projects and user perspective and service delivery research within public sector settings. To the extent possible, projects have worked in routine settings and within existing resource constraints. Emphasis is on testing what an average service-delivery point is capable of doing. In earlier days, methods would be introduced in accessible, well-staffed urban facilities; consequently, these efforts would have promising results. The experience with Norplant® introduction in Indonesia was an especially tough lesson in how quality may exist in demonstration sites but not on a larger scale. Under the QOC approach, the endeavor is to avoid working in special, non-representative settings.

Both quantitative and qualitative methods are used; because of the need for in-depth understanding of program functioning, however, qualitative methods are particularly important.

Stage III: Use of Research for Policy and Planning

The primary objective of Stage III is the use of research results for policy and program development. Past experience has shown that the application of lessons learned is not assured by good assessments and research findings alone, but must be carefully fostered. The third stage of the approach focuses on initiatives intended to ensure that Stage I and Stage II lessons are heeded as service innovations are introduced and method introduction expands. A Stage III project may focus on improving the provision of existing methods, or on the introduction of new methods with special attention to necessary technical, operational, and quality of care reforms.

A Participatory Process

The QOC approach to contraceptive introduction involves a change in the process of policy choice, emphasizing country ownership, broad-based participation, and transparency of decision-making. Broad-based participation implies expansion from a relatively narrow group of decision-makers toward inclusion of other stakeholders from governmental and nongovernmental institutions representing multidisciplinary perspectives. The participatory approach also implies a commitment to an open process and widespread dissemination of information. Such a participatory process increases the likelihood that contraceptive introduction will abide by ethical principles and enhance reproductive choice.

Lessons Learned to Date

Brazil is the first of nine countries to implement the QOC approach to contraceptive introduction. Margarita Diaz will discuss this experience in some detail in a moment. We have learned a great deal from the process of implementing the approach in Brazil and in other countries. The experience has validated the reproductive choice and method mix focus of the approach, as well as its effort to place issues related to contraceptive introduction into the broader social, institutional, gender, and reproductive health context.

All of the country assessments have found a very skewed method mix. By closely examining national programs from myriad perspectives we have been able to see clearly that the reasons for a skewed method mix have to do with both the supply side and with broader social and institutional variables. Provider bias either for or against certain methods is powerful. During the Vietnam assessment, for example, it became apparent that providers generally believed that women in Vietnam were not capable of using the pill—an argument that has been widely used elsewhere. There also was a clear emphasis on long-acting methods. Some countries are subject to church proscriptions against modern methods. Husbands or other partners may like or dislike certain methods. In some settings, cost is a huge factor in developing the method mix. In Bolivia, for example, the IUD is emphasized among modern methods. The QOC approach helped us to see that while providers may offer a variety of explanations as to why they favor the IUD, the underlying motivation was cost: the health system does not have the money to pay for more expensive methods, and neither do users.

We have learned the importance of asking all the strategic questions. Focusing first of all on the question “Is there a need for better provision of existing methods?” is extremely powerful, because it places the issue of contraceptive introduction into a QOC perspective. The need to work on existing services was clear in all countries, as Margarita Diaz will illustrate with reference to Brazil. Asking whether there is a need to remove methods has also proved to be extremely important; often, there is a need to remove high dose monthly injectables or high dose oral contraceptives from service delivery settings. Answers to the first two strategic questions set the stage for the final question: “Is there a need to introduce new methods?” When this question was raised by the Vietnam assessment team, a long silence ensued. The team was aware that the Ministry of Health and the National Committee on Population and Family Planning, the two leading agencies conducting the assessment, had made a previous commitment to introduce Norplant®. Yet the team knew, based on what it had seen in the field, that the Vietnamese program did not have the capacity to ensure that this method would be introduced within a context of informed choice and quality of care. Because the team had taken a broad look at the service delivery

system and examined all methods and how they were provided, their work was persuasive in convincing national decision makers to reverse—at least temporarily—their decision to introduce Norplant®.

We have also learned that introductory research and the process of introducing new methods provide excellent opportunities for general quality of care improvements. In all instances where introductory research has followed Stage I assessments, it has not focused on the new method alone, but has sought to address the weaknesses that were found in the delivery of services more generally. Interventions have emphasized counseling and provision of balanced information, in addition to technical information, on *all* available methods, not only on the method that is being added.

One of the biggest problems we have faced in implementing the QOC approach is finding ways to sustain quality of care improvements. In some situations, political change interferes with the process. In Bolivia, for example, Ministry of Health staff at all levels—including service providers who had just been trained—changed with a new political regime. One of the images that comes to mind to describe our frustration with the Bolivian experience is the Greek myth of Sisyphus, who pushes the rock up the hill during the day, only to see it crash down at night.

The participatory process has proven to be a very powerful and important mechanism to help sustain these innovations. In particular, the participation of women's health advocates has been critical from the very beginning. While it was possible to ensure representation of women's interests, it also became clear that this is easier in some settings than in others. In Brazil and Bolivia, for example, there are many women's NGOs actively involved in the reproductive health field. Moreover, in Bolivia, reproductive health leaders in the government were particularly sympathetic to including such groups, because they themselves were actively reaching out to the NGO sector. But in countries like Myanmar and Vietnam, where the NGO sector is less developed, participation from outside of the government sector was unfamiliar. It was not immediately clear who the relevant groups were. In Vietnam, representatives from the Vietnam Women's Union, a government-sponsored organization, were included. Although the

Union is a governmental organization, it does not necessarily represent the same point of view as the Ministry of Health or the National Committee on Population and Family Planning. The Women's Union made extremely valuable contributions both to the assessment and to the subsequent research. In Myanmar, the Myanmar Maternal and Child Welfare Association, an NGO working closely with the government, participated in the assessment, providing its representatives with new insights into what their organization was and was not accomplishing at the village level.

In sum, we have concluded that the new approach to contraceptive introduction can indeed achieve improvements in the quality of reproductive health services in the public sector. In fact, I would argue that it provides a concrete methodology for attaining some of the objectives of the Cairo reproductive health agenda. However, implementation of the approach requires time and commitment. It is certainly not a quick-fix solution. While the approach has been developed with special reference to the public sector, it is time to consider its relevance for the private and NGO sectors as well.

DISCUSSION

Jose Barzelatto: I think that this work is an elegant demonstration of the spirit of Cairo. Should the strategic approach be framed as a systematic, periodic exercise—perhaps every three years—in every reproductive health service environment?

Ruth Simmons: I couldn't agree more that the approach should be used on a regular basis. In addition, we have made the approach very flexible, so it can be adapted to address not only contraceptive introduction issues, but also broader reproductive health concerns. In Bolivia, for example, contraceptive introduction was addressed within a broader reproductive health context.

Rachael Pine: Can you comment on the applicability of the entire framework to the introduction of other types of new technologies, for example manual vacuum aspiration (MVA) equipment? How would you adjust or change the analysis to accommodate that kind of process?

Ruth Simmons: In Vietnam, the issues of menstrual regulation and abortion were very important. However, because the assessment was so broad based, we felt that while we could touch upon these issues, we could not do justice to them. We decided to do a subsequent assessment to look specifically at the issues surrounding menstrual regulation and abortion. When considering applying the approach to other areas, the key is to determine which strategic questions must be asked.

Karen Beattie: The WHO Strategic Component Task Force is involved in an on-going discussion about the application of the approach to other reproductive health and more general health technologies.

Jim McMahon: Is there a strategy for Stage I assessments that is standardized for use in other countries? And, given that in almost every setting there is a need for improved provision of existing methods, how

do you decide whether to go forward with introducing new technologies or not? How is that decision ultimately made?

Ruth Simmons: The decision is ultimately made by the interdisciplinary team, after examining the full situation based on all primary and secondary data collected. The key is to weigh provider capacities against user needs and perspectives.

The Stage I assessment is currently being standardized. We recognize that there is a great deal of interest in conducting these assessments, yet there is often a limit in terms of available technical assistance, especially since we are a relatively small task force. One of the reasons we have been slow to produce a standard guide is that we fear that it will be received as a cookbook approach and that the importance of flexibility and team member participation in the development of context-specific questions and instruments will be downplayed.

Nesha Haniff: The methodology troubles me. While it is very logical and your intentions are excellent, I have found that unless this kind of study is funded from the outside it cannot be sustained by governments. If there were more feminist ministers in third world governments, and enough feminists outside of government working on this kind of concept, it might be sustainable. In reality we have to work largely with chauvinist ministers who have no concept of the importance of listening to the voices of service users, most of whom are women. I also wonder how well represented women's voices—the voices of the ultimate contraceptive users—really are. Thirty women out of fifty might enjoy using a particular method. The twenty who don't like it are very angry and very upset about it, and perhaps more likely to be heard. This should be considered.

Ruth Simmons: The issues of sustainability and funding are very important. The evaluation process helps to promote sustainable change by emphasizing local national ownership rather than expatriate technical participation. The process is always a learning tool. It *does* mean change; it *does* introduce a new set of expectations, ideas, beliefs, and values that are beneficial.

Case Study of Implementation: Brazil

*Margarita Diaz
Director of Training, Education and Communication
CEMICAMP, Brazil*

I would like to begin by thanking Ruth for her brilliant and thorough description of the WHO approach to technology introduction. Over the past four years, a Brazilian coalition has employed the three stage framework Ruth described in an effort to seek answers to the following strategic questions:

- Is there a need to introduce new contraceptive technology into Brazil's national health care delivery system?
- Is there a need to reintroduce or more appropriately introduce existing methods?
- Is there a need to remove methods that are currently provided?

Three Stages of Activity

Stage I

To begin Stage I of the assessment, we formed a multidisciplinary research team comprised of leaders from women's health advocacy organizations, the Ministry of Health (MOH), WHO, the University of Michigan, the Population Council, and CEMICAMP. The team began by conducting a comprehensive review and analysis of existing quantitative and qualitative studies of contraceptive service delivery.

The team then selected four sites for field visits. Because Brazil is so large, it was possible to choose sites with disparate economic and political situations, as well as varying capacities for providing accessible health care. Furthermore, each site was at a different stage of its implementation of the national health care program. The sites were Ceara, a relatively poor state that had previously received extensive external technical and economic support for its health program; Sao Paolo, a more affluent state; Mato Grosso, which lacks infrastructure; and the highly political Federal District.

The field visits had two main components: qualitative diagnosis of both private and public service delivery, and in-depth interviews with local civil and health authorities, service providers, and both current and potential contraceptive users.

A report summarizing the literature review and site visits of the Stage I assessment was presented and discussed in a national workshop sponsored by the MOH. The assessment revealed that although family planning is a high priority of Brazil's official women's health program, and contraceptive prevalence is around 70 percent, there are severe deficiencies in service delivery. Public sector health networks provide care of particularly poor quality. Although MOH guidelines recommend that state clinics offer a variety of modern contraceptive methods, tubal ligation and hormonal contraceptives—including high dose hormonal contraceptives, which are widely recognized as unsafe—were often the only 'options'. 'Choice' was further mitigated by severe constraints on the availability of and access to these methods. For instance, 80 percent of women using oral or injectable contraceptives had to buy them in pharmacies, where they are often expensive and dispensed without proper information or medical screening; those opting for tubal ligations had to pay for the procedure themselves. Some women were forced to have the procedure while undergoing a cesarean section, to ensure that it would be paid for. And while a few pharmacies did stock products labeled 'spermicide', the products were not actually contraceptives.

Based on these findings, we were able to establish priority areas for further work. The underlying theme for future work was to ***improve quality of care in state-sponsored health delivery systems.*** Removing inappropriate methods, such as high-dose oral contraceptives and high-dose injectables, was the top priority. Simultaneous improvements in the quality of care in public clinics would allow for broadening the mix of safe methods. Finally, the team concluded that new contraceptive technologies should only be introduced when service points adhered to minimum standards of quality.

Stage II

For Stage II, the team initiated a participatory action research project designed to improve the quality of reproductive health services through better utilization of existing methods, and, later, through appropriate

introduction of new methods. We selected a small city, Santa Barbara d'Oeste, which is located near Campinas and had previously asked CEMICAMP for technical assistance with quality of care improvements. Roughly 80 percent of Santa Barbara d'Oeste's 160,000 inhabitants consult one of the city's nine publicly-funded health posts and two health centers for care. Based on an informal assessment, the team found that the conditions of these services mirrored in many ways the results of the Stage I assessment. Santa Barbara d'Oeste was, therefore, an ideal location for the project.

Next, we designed a very systematic baseline evaluation in an effort to assess inventory, patient flow, time use of clinic staff, the client-provider relationship, and technical competence at the reception desk, among other factors. The evaluation was conducted at each facility. Interventions were then planned based on site-specific results. Some of the interventions we implemented based on the participatory diagnostic assessment were as follows:

- changing appointment schedules to make them more convenient to users
- inviting the community to make recommendations for improving clinic quality (including forming an executive committee comprised of local health authorities, women's health advocates, and health care providers)
- training staff to be client and gender sensitive and to focus more on client needs, less on technology
- training staff to work as a team
- increasing contraceptive options, including vasectomy and condoms
- implementing a functioning management information system
- ensuring supportive—not punitive—supervision
- reallocating physician time and training nurses to perform pap smears and breast examinations
- opening a referral center where men and women could receive reproductive health information and non-prescription contraceptives every day of the week
- opening a referral center for adolescents, which included a peer education program
- developing IEC material detailing contraceptive options and implementing educational activities in all health posts

One year into the project we began quantitative and qualitative evaluations. Exit interviews were conducted with clinic users. Notably, overall usage of the 11 sites increased by close to 20 percent each year for the first two years following the interventions, including a 50 percent increase in the number of consultations by men. Most interviewees noted significant improvements in the quality of care. Not one

interviewee said that the quality of services had worsened. The qualitative evaluation of the interventions also found the following:

- improvements in quality of care, including better client-provider interaction and expanded educational activities
- increased access to services (services were available to adolescents and men, and the system for making appointments was more efficient)
- 40 percent of family planning counseling was offered through referral centers rather than during appointments with gynecologists, allowing gynecologists more time to treat medical conditions
- initial increases in community participation and support (enthusiasm waned over time, perhaps due to elections and subsequent changes in clinic supervisors)
- little improvement in supervision
- improved contraceptive method mix, with all MOH approved methods available, though sometimes only through referral since not all posts have gynecologists on staff

In sum, we demonstrated that it is feasible to improve the quality of care of reproductive health services in resource-constrained public sector settings.

We learned that a participatory approach and sense of ownership by the community stimulates motivation and morale among staff, and is therefore crucial to improving the quality of services. Intensive external technical assistance also proved essential, and should optimally be employed for at least two years. In fact, we found that phasing out technical assistance was difficult and called into question the sustainability of our improvements. In particular, staff training must be continuous throughout the transition and ideally should integrate new supervisory techniques, while reflecting high levels of enthusiasm by researchers, managers, and providers.

Stage III

Stage III of the project was essentially a scaling-up of Stage II. A package of documents used in Stage II, including instruments, methodology, briefing papers, and training curricula, were introduced at a workshop and widely disseminated to other municipalities for use at all levels of the health system. Thus far, three other states have chosen to replicate our efforts, and are doing so with less technical assistance from CEMICAMP than was available in Santa Barbara d'Oeste. The MOH has also begun a series of policy

dialogues, both internally and with donor agencies. Clearly, the Ministry has realized that it is feasible to improve quality of care and reproductive choice, though doing so is by no means quick or easy.

Remaining Challenges

Efforts to introduce new technologies within a quality of care framework face many constraints. Effective community participation is essential. Involving women is a particular challenge since they are less likely than men to have been involved in municipal activities in the past. In Santa Barbara d'Oeste, women's health advocates recently dropped out of the executive committee because "we are interested in women's health, but we are not interested in being used by politicians for political reasons." In addition, official policy changes and staff turnover are frequent due to continuing political instability, causing an ineffective supervisory system, and ultimately leading to low motivation among personnel. Furthermore, the strategy employed requires research capacity that is not universally available, limiting its potential use. A simplified version should be developed. Most critically, we must ensure that the process is self-sustaining and can be replicated without external technical assistance and financial support.

DISCUSSION

David Grimes: Your portrayal of the poverty of the public sector in maintaining the pay and quality of personnel was a fine and true depiction. My question is, do you know what happened to the number of sterilizations in the Campinas area during the study period? You have described improvement in family planning services within the poor public sector. What, if anything, has changed with regard to the sterilization problem in the private sector?

Maggie Diaz: We do not have numbers detailing trends in tubal ligations. In the municipality we worked in, tubal ligations are not performed in any public sector setting. Instead there is an agreement with the private hospital. Tubal ligation is only included in the contraceptive method mix after a process of informed choice is undertaken by another service in Campinas (our service in the university). Vasectomy was part of the services, and during one year 150 vasectomies were performed. We want to investigate the level of informed choice of men selecting vasectomy.

Juan Diaz: A law was very recently approved permitting tubal ligation in the public sector. We have had no way to keep track of this forbidden procedure. Now, the public sector will have the opportunity to keep real statistics about tubal ligation.

Nesha Haniff: You spoke about rescheduling appointments, and what I have found—which is an important issue in quality of care—is that because nurses and clinic workers are very poorly paid and largely female, it is very difficult to get them to work at times that are not conducive to family life. It is difficult to get them to work in the evenings or very early in the morning.

Judith Bruce: Is there any way that some of the groups who participated in the process could develop some kind of standing relationship with a public service provider? That way, even when the energy and public sector interest surrounding the assessment decline, a committee of interested individuals will remain who can maintain contact with the clinic director and informally monitor services.

Ruth Simmons: Yes, we have tried to establish 'executive committees,' which we hope will continue to function.

Star Lancaster: You clearly had a dynamic increase in the use of family planning. Do you have a sense of the age group that this represented? I also wonder if women's groups in Brazil are still anti-sterilization. Has this climate changed at all?

Maggie Diaz: When we started, adolescents consulted with family planning services only after pregnancy. Since we opened the referral center for adolescents, their use of family planning prior to pregnancy has increased. The number of women using contraceptive methods at earlier ages has also increased. Male adolescents also come to the clinic, which offers information about sexuality as well as contraceptives.

Simone Diniz: With regard to the question on the women's movement's perspective on sterilization, the problem is one of abuse. Choice is not only an individual issue but also a social construct. The reason tubal ligation is such a prevalent contraceptive method in Brazil is because our options are so limited—tubal ligation was even illegal until just two weeks ago, yet was performed by all services in Brazil, private and public, and disguised as other medical conditions. Often, this surgery was performed without informed consent, and women paid for the procedure themselves. There was never discussion about male responsibility.

Adrienne Germain: I am very curious to learn the extent to which assessment teams debate the issues of STD epidemics—including HIV/AIDS—and how that relates to decisions about contraceptive technology. Do you look at related options, such as encouraging dual protection? In an environment with high rates of STDs, how do you think about the trade-offs between what are considered to be the more effective provider-dependent contraceptives and the barrier methods, which would protect women against infection? How does the availability of abortion as a back-up method figure into the equation?

Maggie Diaz: We are trying to incorporate STD components. It is a real challenge. For instance, married women do not perceive themselves as being at risk of STDs. It is not possible to accept the possibility of infidelity, especially in a Catholic marriage, and using condoms implies a lack of trust. We need to develop a way to reach these women.

Maryann Burris: I am having trouble wrapping my mind around the list of interventions costing nothing, or very little. I work in East Africa, so I wonder if the choices in the beginning had to do with the willingness by a government to provide resources, or at least redirection of resources in some way, so that from the beginning you have mapped out a way to ensure sustainability?

Juan Diaz: A lot of resources were put together for this exercise, but mainly, in the case of Santa Barbara, the issue was learning how to get more resources. In Brazil, health is not important politically, and is often an after thought in budgetary priority setting. One of the very important challenges was to learn, with local officials, how to get more resources for health, how to fight with the other priorities of the municipality, and then to use resources for the health and real benefit of service users.

Even though this strategy will not change things from night to day, it fosters a very important change in the minds of public managers or decision makers. Now they do not take for granted that a new contraceptive method is "the solution", but will instead be thoughtful about users and whether or not the method can be *properly* introduced. Even in Bolivia, which relies heavily on product donations, when companies now offer a new product, officials say, "Please stop, and let's think."

Maggie Diaz: I want to reiterate the real challenge of sustainability: political changes bring personnel changes. Our current working area is small. If the people involved change, the work will essentially end. I believe in these people—they really changed their way of thinking—but we need greater dissemination. We have talked about quality of care for more than ten years, and now we are seeing people take its meaning to heart, to see what free and informed choice really are. This strategy is very useful because it is a process. You need process to change attitudes—you need time.

Perspectives on Implementation of the WHO Strategic Approach to Technology Introduction in Ethiopia: Donor and Government Perspectives

THE DONOR PERSPECTIVE

*Abate Gudunffa
Program Officer and Reproductive Health Specialist
UNFPA/Ethiopia*

Donors have played an important role in the process of assessing contraceptive needs in Africa, as assessment subjects, consumers of assessment findings and recommendations, and, more recently, as funders of assessment exercises. In recent years, UNFPA has funded contraceptive needs assessments in Burkina Faso, Ethiopia, Vietnam, and, in tandem with USAID, in Zambia.

In this presentation, I will reflect on UNFPA's involvement in Ethiopia, with particular reference to our experience with the application of the assessment process inherent in the WHO Strategic Approach to Technology Introduction. I aim to answer two basic questions:

- Why is the needs assessment approach attractive from the donor's perspective?
- Why would a donor agency like UNFPA be interested in supporting a needs assessment?

UNFPA Involvement in Ethiopia

I will begin with a brief overview of UNFPA's involvement in Ethiopia. Our program began with the opening of a country office in 1973. Since then, we have implemented three large country programs, focusing on the improvement of data collection and information for decision making; capacity building and the expansion of maternal-child health/family planning services; and improvements in the quality of those services. This has entailed a total financial investment of over US \$48 million since 1981, making UNFPA Ethiopia's primary source of donor funds in the population and reproductive health field.

Of particular relevance to the issue of contraceptive needs is the fact that UNFPA remains the single largest donor of contraceptive commodities to Ethiopia. In the last four years, UNFPA assistance to contraceptive procurement in Ethiopia exceeded US \$14.5 million. We have purchased the following

contraceptives for the country program: oral contraceptives (four types); injectables (DMPA); male condoms; the Copper T IUD; NeoSampoon; and Norplant® .

The Relevance of the WHO Strategic Approach to the Ethiopian Context

In 1996-7, UNFPA decided to review certain key aspects of its support to the national contraceptive commodities procurement program. We wanted to improve our ability to forecast the quantities of contraceptives needed, and to assess the efficiency of the contraceptive logistics and distribution system.

The study carried out to address these issues was a valuable and practical exercise. It enabled us to use fairly rudimentary data on contraceptive use to develop estimates of future procurement levels, distribution requirements, and so forth. Nonetheless, our knowledge of many important issues concerning contraceptive use remained limited. For instance, we did not know what factors were influencing current use patterns (e.g., client preferences vs. provider bias). Neither did we know whether the contraceptives being procured actually responded to user needs, or whether there remained unmet needs that were not being addressed. In addition, we were not sure that the commodities we procured were being provided with appropriate quality of care.

UNFPA began preparations for the design of its next five-year country program in 1997. We had a wide array of research findings and other background material that could be used to help design the program. Yet we needed a tool that would allow us to consolidate and analyze existing data in a comprehensive manner, address the kinds of “user-issues” that fell outside the scope of studies already conducted, and identify concrete priorities for research or action that could be incorporated within the new program. We also wanted to accomplish these objectives in a way that would allow results to be perceived as country-owned—that is, we wanted an internally-driven, participatory approach.

Furthermore, our interests were not limited to contraceptive issues. Rather, we shared with the Ministry of Health (MOH) a more general interest in operationalizing an integrated approach to the management

and delivery of reproductive health services; improving quality of care at the service delivery level; and enhancing contraceptive choice. We determined that the WHO Strategic Approach—with which our Country Director already had familiarity and experience based on participation in its implementation in Vietnam—would help us to achieve these multiple objectives. We contacted WHO and the Population Council to help lay the groundwork and provide technical assistance for the national needs assessment that comprises the first step of the approach.

One of the most valuable characteristics of the strategy in general—and the needs assessment in particular—is that it is designed as a nationally-driven exercise. All meetings and planning activities, and the selection of the assessment team, were managed and coordinated by the MOH. The assessment team, half of the members of which were women, was comprised of MOH officials, donors, and health service users.

The Importance of our Findings

Even though we are still at an early stage in the WHO Strategy, the assessment findings have had a significant impact on UNFPA's activities. First of all, the findings played a critical role in the development of our 1997 Program Review and Strategy Development mission statement. In addition, one of the major recommendations of the assessment was to ensure that the expansion of Norplant[®] services—which has occurred rapidly since the method was introduced in 1993—be undertaken in a phased and controlled manner, with adequate training and appropriate logistics back-up. Concerns that Norplant[®] expansion may not have followed this path has prompted UNFPA to plan a formal evaluation of these efforts to date. We expect the results of this evaluation to define the nature of our future support for the method.

Another critical finding of the needs assessment was the limited understanding of the concept of reproductive health among policy makers, administrators and health care providers. The assessment report recommended a concerted, national effort to formulate a definition of reproductive health and a

strategy for implementation of priority interventions. Once again, this recommendation not only found its way into the design of UNFPA's country program, but plans are already underway to develop a national reproductive health strategy, building on the lessons of the needs assessment. Finally, the exercise has helped to promote the formulation of a nationally-driven, nationally-owned effort to foster improved reproductive health care.

The Benefits of the WHO Strategy

So what makes the WHO methodology attractive from a donor's perspective? For one, it consolidates and makes sense of existing health and population data and addresses critical issues ("user-issues", "system-issues") holistically, in ways that fall outside of scope of more traditional quantitative or technology-driven approaches. It allows for the development of concrete recommendations for research or action that can be incorporated within the design of donor programs while providing a context for ongoing collaboration with international NGOs. Finally, the WHO Strategic Approach also facilitates consensus-building among national and international entities in the reproductive health field, and simultaneously transfers knowledge and skills to national institutions, allowing them to assume leadership roles throughout the process.

A GOVERNMENT PERSPECTIVE

*Yohannes Tadesse
Acting Head, Family Health Department
Ministry of Health, Ethiopia*

First, I would like to thank John Skibiak of the Population Council for his assistance in preparing this presentation. I plan to explain the utility of the WHO Strategy to the Ethiopian government.

Why Use the WHO Strategy?

The multidisciplinary nature of the WHO approach, combined with its targeted planning, are two features that made it attractive to Ethiopia's MOH. Also important were the ways in which the strategy integrates technology, the concerns of users and providers, and the social, political, and economic context. Most of all, we wanted the assessment to be guided by country objectives, particularly those concerning reproductive health. For example, we wanted the assessment to feed into the development of Ethiopia's Health Sector Development Program—a 20 year effort to promote universal access to essential primary health care services by 2017. Designed to serve as a framework for technical and financial support to the health sector over the next two decades, the program is ambitious, with provisions for extending access to health care services, enhancing the quality of such services, and improving health sector management. Finally, conducting a needs assessment within the framework of the WHO Strategic Approach was also an excellent way to inform the design of UNFPA's next five year country program.

We were particularly interested in learning more about the contraceptive method mix. We had recently introduced Norplant® and had up-to-date information on its use, yet we knew very little about use of other methods, like the IUD and foaming tablets, which had long been available but did not seem to be in demand. We believed condom use was at around 7.4 percent, DMPA use at 18 percent, and oral contraceptive use at 72.3 percent. There had been a recent increase in DMPA popularity, which puzzled us; just four years ago, only 4 percent of women used this method. Over the same period, condom use had decreased to 17-18 percent. Most of all, we were interested in quality of care in the broad sense—

not just the physical characteristics of health facilities, but the wider relationship between available services and the needs of those the public health sector is supposed to serve.

Design of the Stage One Assessment

At the start of the Stage One Assessment, the MOH held an open discussion with its staff and select representatives from the National Office of Population. Following this session, we laid out a basic framework for the assessment and established a clearer sense of what we needed to learn from the exercise. Building on this, and in an effort to hear from a broader range of voices, we sponsored a planning workshop in which 55 people with varied backgrounds (medical professionals, public health specialists, social scientists, and women's health advocates) participated. We synthesized the key recommendations of this forum with previous reproductive health policy decisions that were initiated after the Cairo conference, and applied them to the assessment framework.

Ethiopia is currently undergoing both decentralization and democratization; one result of this process is regionalization of the country into 11 states. Fourteen professionals, including senior officials in the MOH, were selected to make field visits to each state. We also welcomed the technical assistance of staff from the Population Council, WHO, UNFPA, and the University of Michigan. For two weeks, the assessment team conducted interviews, group discussions, and clinic observations in all 11 administrative regions of the country. Altogether, the team met with over 600 people and visited at least 100 different facilities, including health centers, schools, hospitals, and pharmacies.

Preliminary Findings

Before the assessment, we had assumed there was a common understanding and appreciation among health care providers of the principles underlying the reproductive health approach. We discovered that while some practitioners do understand and support the concept, others are ambivalent. We need to foster a widespread understanding of the reproductive health approach among all health care providers and decision-makers. More efforts need to be devoted to assist them in planning reproductive health

strategies that better address individuals' needs. We also need to establish better linkages and collaboration among the different levels of the health system, to improve the reproductive health information system as well as insure continuity of reproductive health care by those involved in its provision.

The assessment also found that we had underestimated the extent of the problem of unsafe abortion, particularly in rural and/or Muslim areas. Finding ways to decrease the prevalence of abortion-related illness and mortality is a priority. Currently, there is no systematic or formal program in place to deal with this problem. One of our recommendations will be to reduce the prevalence of unsafe abortions using a three-pronged approach, as follows:

- intensification of related information, education and communication activities, including social mobilization efforts;
- expansion of Manual Vacuum Aspiration (MVA) services to treat the complications of unsafe abortions to all regional hospitals and selected health centers; and
- introduction of emergency contraception, with special efforts to increase awareness of this option among young people.

Looking Ahead

We have only recently completed the Stage One Assessment, yet have already learned a great deal about the reproductive health situation in Ethiopia. We look forward to moving ahead with Stages Two and Three.

DISCUSSION

Judith Bruce: One of your most striking conclusions is that 90 percent of current contraceptive use is hormonal. How might this influence the decision to move ahead with Norplant® expansion, particularly in light of the decline in what were already low levels of condom use? And when you speak about MVA, are you talking about introducing it to deal with the complications of induced clandestine abortions, or is there a major policy change looming which could make abortion safer and more widely available?

Yohannes Tadesse: We are very aware of the experiences other countries had with Norplant® expansion, and are extremely cautious about expanding provision of the method in Ethiopia. Our initial introduction was in Addis Ababa; after one year, we concluded that there were no major problems and decided to expand Norplant® services to four larger regions. We are now ready to assess this initial expansion. We also want to expand the availability of non-hormonal contraceptives. In order to do so, we need to

improve provider-client counseling and communication. We believe providers are not offering sufficient information and choice to clients and we want to change this.

It is unclear why condom use has declined; Population Services International had launched a social marketing campaign of the male condom, so we had actually expected use to increase.

Because abortion is such a delicate issue, MVA would be introduced to public hospitals to treat women who present with incomplete abortions.

Abate Gudunffa: Our data is based entirely on the public sector. Most condoms are sold in shops and are widely available, so it is possible that overall condom use is not decreasing.

Jose Barzelatto: I appreciate how delicate the abortion issue is in Ethiopia. I come from Chile where abortion was and is illegal. Women wanted smaller families, and contraception was unavailable. Maternal mortality rates were scandalous owing to unsafe abortions. It was the medical profession that brought this to the public's attention and lobbied for family planning services. The first elected president, who was Catholic, listened, and established family planning as part of the national health service. In the following two years, maternal mortality dropped in a spectacular way. Now more than ever, in the aftermath of Cairo, physicians have a responsibility to push for ways to deal with public health problems, no matter what the legal or religious biases are.

Adrienne Germain: Could you comment on the extent to which it was possible to involve women in your review process?

Yohannes Tadesse: Half of the assessment team's members were women from various institutions. Although Ethiopia does not have women's health advocacy organizations, we do have a Women's Affairs Office, and each ministry has a Women's Affairs Desk. NGOs are also increasing in number.

Jill Sheffield: You described a lack of common understanding among providers about reproductive health—I find this is a worldwide phenomenon. It seems that both the professional community and the community of health service users need better information and education. Are there plans in Ethiopia to discuss these issues more broadly, and to promote more frequent use of health facilities? This could be one of many ways to address your extremely high maternal mortality rate.

Yohannes Tadesse: The Women's Affairs Office and various Women's Affairs Desks try to disseminate information on the reproductive rights of women. We try to incorporate this information into as many settings as possible. We are, for example, revising the curriculum for physicians. In clinics, before and after working hours, we offer discussion time to help health workers improve their grasp of these issues.

Simone Diniz: In Brazil we have seen a big difference between what is written in law and what happens in practice. There is a feeling that policy advances are not real, partly because current medical training is focused on technology and not on communication. There is a provider bias towards hormonal contraception, which represents loyalty to male interests and to even bigger economic interests—despite the looming AIDS epidemic. It is also important to consider how language prevents many men and women from participating in a process such as the WHO approach. Too many of us are not comfortable with the English language; there would be better representation on evaluation teams if translators were available.

SAFE, LEGAL, AND RARE—NEGLECTED METHODS OF FERTILITY REGULATION

Obstacles to the Introduction of Female-Initiated Barrier Methods in Brazil

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Since the 1960s, Brazil has witnessed far-reaching changes in fertility patterns. In 1960, the Total Fertility Rate was 6.2 children per woman. In 1980 it was 4.5, and in 1991, 2.5. By 1996, 76 percent of women in Brazil used contraception. These changes are even more surprising when one considers that they occurred at a time when government support of family planning programs was ambiguous at best.

The following factors have influenced the transition:

- economic growth;
- urbanization;
- changing gender roles; and
- growth in mass communication, with small families becoming a cultural norm.

A Skewed Method Mix

Despite the high level of contraceptive prevalence, Brazilian women tend to rely on one of only two methods: tubal ligation (40 percent of all family planning users) and pills (20 percent). However, users receive little related support or education in the use of these methods. Barrier methods account for a maximum of 5 percent of contraceptive use. Diaphragm use statistics are not reported in Brazil's Demographic and Health Survey, indicating that it is used by less than 1 percent of women.

The government's lack of involvement in family planning has contributed to a contraceptive mix that is biased towards highly effective hormonal methods and sterilizations. Cesarean sections are paid for and tubal ligations are almost all provided during this procedure. Pills are provided by private, for-profit pharmacies.

Neglect of the diaphragm and condom in the method mix continued in the 1980s. It was thought that women could not use the diaphragm consistently. Partly as a result, the method was considered unreliable for pregnancy protection. Condoms were thought to be unpopular with men, and so were not emphasized in programs. Even the HIV epidemic seems to have had little effect on the method mix: condom use has barely risen since the 1980s, while the proportion of women relying on female sterilization increased from 26.9 percent in 1986 to 40.1 percent in 1996.

The Need for Barrier Methods: Growing HIV Risks

At the same time, it has become clear that women in Brazil are vulnerable to the AIDS epidemic. AIDS is now the leading cause of death among women of reproductive age, and the male to female ratio of AIDS cases has decreased from 28 men for every woman infected, to only three men for every woman infected. As a result, the concept of sexual negotiation and the importance of barrier methods are receiving more attention. However, strategies that blend communication and technology are not often used.

A recent study in Sao Paulo showed that condoms were generally used for contraceptive purposes only. The method is used by 16 percent of unsterilized women, but by no sterilized women. Dual method use, that is, condoms and sterilization, is extremely rare. Yet those most likely to be sterilized—married women or women in long-term partnerships—are also at high risk of contracting HIV. While there is some evidence that separated or divorced women have in some cases negotiated dual method use, married women have not been as successful.

Barriers to Barrier Method Use

One problem with barrier methods is that their use is associated with a higher pregnancy risk. Since abortion is illegal in Brazil, this increased risk of pregnancy is a burden many women are unwilling to take on. Emergency contraception could provide valuable back-up to barrier method users.

Another factor that constrains the adoption of barrier methods for HIV prevention is the fact that men and women get services from different places. Women's health care settings tend to have weak STD screening and treatment services. And overloaded public health clinics rarely take the time to teach about safer sex.

The fact that sexuality and gender issues surround the use of barrier methods also complicates their promotion and use. Limited physical access to these methods is also problematic.

Conclusion

Family planning programs should review their priorities and encourage condom use. Family planning and AIDS prevention programs—which are currently vertical—need to be more closely linked to serve the dual needs of both men and women, rather than the demand from women for family planning on the one hand, and the demand from men for STD services on the other. Our limited experience has demonstrated that it *is* possible to promote the use of barrier methods, if policy directives are clear. We need to train health workers, change logistics systems, and organize services differently. Men must be included in this new work, not just as legislators and researchers, but as participants and users.

Introducing the Female Condom in Zimbabwe

*Zorodzai Machekonoyanga
Women and Aids Network
Zimbabwe*

The Women and AIDS Network of Zimbabwe (WASN), an advocacy group, aims to reduce the prevalence of HIV and sexually transmitted infections (STIs) among women and to empower them about sexual matters. Among other projects, we are lobbying the government and other organizations in an effort to get them to view women's issues and HIV as national issues that need urgent action. Traditionally, men have been assumed to be the decision-makers in sexual relationships; we aim to change this dynamic. We have also considered the different means women could use to reduce their chances of contracting HIV. Improving access to female-controlled barrier methods was the most logical. We have thus undertaken a campaign to make the female condom widely available in Zimbabwe and to promote its use.

Reporting Of HIV Infection In Zimbabwe

Although the reported rate of women infected with HIV is high, we believe it is significantly underreported. For one, women do not seek HIV treatment as often as men (which also explains the discrepancy in reported male and female death rates from AIDS). When both partners of a couple are infected, money is more likely to be spent on treatment for the man—and these are the cases that are reported by hospitals. Perinatal transmission rates are 40 percent, suggesting far higher female infection rates than official figures indicate.

Why are Women at Heightened Risk of Contracting HIV?

There is a noticeable discrepancy in the age at which men and women are most likely to become infected. This is largely attributable to women's status as second-class citizens in Zimbabwe. Male children are more highly valued than female children, and during times of adversity—like we are experiencing now—girls and women suffer the most. Girls' education is often sacrificed so that their

brothers may attend school, and it is common for girls to be forced into early marriages to older men. Cash payments from the groom and his family may provide short-term cashflow for the bride's family—but at the expense of their daughter's health.

Female Condom Acceptability Study

There is an unquestionable need to give women a way to protect themselves against HIV infection. The female condom seemed the logical method, but we needed to know how women would feel about using it. We began by consulting with grassroots activist women nationwide. We then designed an acceptability study with the assistance of medical practitioners. The grassroots activists then interviewed women throughout Zimbabwe, even in the most remote areas.

Overall, the results of the study were favorable. In one region, 59 women enrolled, and 54 completed the two week acceptability trial. Fifty-one of the women (86 percent) said they liked the female condom very much after using it and cited a sense of safety and security as the reason. Forty-eight (81 percent) stated that they preferred it to the male condom. In most cases, both partners found that the female condom did not interfere with sexual pleasure and liked that it allowed them to extend the period of intimate contact after ejaculation. Others found the female condom more comfortable than male condoms, partly because it allows better body heat transmission. The general response from interviewees was "Where can we get more?" It seems that everyone in Zimbabwe has lost someone they love to HIV, yet information—let alone an actual means—to foster prevention has not been available.

Campaign to Bring the Female Condom to Zimbabwe

Once we established that women in Zimbabwe welcomed the female condom, we used the same grassroots network to collect signatures on a petition that demanded that the government make the female condom available at an affordable price. We sent copies to our members countrywide, translated, when necessary, into vernacular languages, and explained it to those who were unable to read. Our volunteers did a sterling job of collecting a total of 30,000 signatures from the public.

Who Signed the Petition and Why

We asked men and women who are sexually active, aged 18 to 60, to consider signing the petition. The signatories were literate and semiliterate, from rural and urban areas. Ten percent were men, 90 percent were women. They were commercial sex workers, women who are monogamous (and assume their partners are, too), single mothers, career women, and self-employed women. In other words, women and men from all walks of life.

Once we had gathered the 30,000 signatures, we presented the petition to the Deputy Speaker of Parliament (who happens to be a woman). We wanted to do this at a high-profile event and were able to capitalize on World AIDS Day, December 1, 1996. Rather than give a standard presentation filled with depressing statistics, pomp, and circumstance, we were able to do something practical, something that could have longer-lasting impact. And our goal was met: in May, 1997, the government of Zimbabwe purchased a supply of female condoms, packaged and marketed by Population Services International as the CARE brand, at US\$0.62 each, and made them available to the public at the subsidized price of three Zimbabwean Dollars for a package of two (about US\$0.30).

Introducing CARE within Relationships

Although women have reported to us that they are enthusiastic about the availability of the female condom, many also say it is a daunting task to introduce it to their partners. They report they must be tactful and strategic in their efforts to get their partner's consent. WASN continues to sponsor a series of radio phone-in shows and women call in either to share or ask about successful strategies for introducing the female condom to their sex partners. Some strategies that have been successfully employed include touting CARE's contraceptive qualities (rather than its role in preventing STIs), placing the device on the bed to initiate discussion, leaving literature about the female condom out for partner to read, and even using the device in secret by inserting it in advance of intercourse. The latter strategy is used most frequently by commercial sex workers or single women. We do suggest that women discuss with their partners the use of the female condom as an STI-HIV prevention method. Ideally, a couple should

communicate well enough to discuss the female condom's multiple benefits and experiment with it, but as sex remains a subject that "proper" women are loath to discuss, and discussing STI risks with a partner can be very difficult, other strategies are necessary.

How to Make CARE more Accessible and Increase Distribution

The cost of CARE makes it inaccessible to many Zimbabweans—even at the heavily subsidized price. If one must choose between buying a loaf of bread and buying a packet of condoms, it is really not a choice. Therefore WASN further advocates for the female condom to be distributed free, like the male condom, especially since some women are still not confident enough to purchase the female condom for fear of stigmatization.

There are other challenges as well. Despite the known dangers, older women encourage younger women to use drying agents during sex, and the lubricant in the female condom is therefore not easily accepted by some women, and presumably men. Older women also discourage female condom use because they believe it is not esthetically pleasing—they say, "A woman who's taking good care of herself cannot use that!" So although we have won the battle to make the female condom available in Zimbabwe, for many Zimbabwean women it is not an option. Our next fight is to increase its availability *and* women's ability to use it. We believe that the first battle for the female condom has been won, but the real war wages on.

DISCUSSION

Doug Huber: How many female condoms have been sold or used to date? Also, has any consideration been given to male-to-male transmission of HIV?

Zoro Machekonoyanga: We introduced CARE in May, 1997, and do not yet have figures on total sales to date. Within WASN we see only 100 condoms sold per week. However, they sell pretty quickly in pharmacies. As far as we know, we do not have a large number of homosexual relationships in Zimbabwe, so we have not specifically addressed male-to-male transmission.

Doug Huber: Is there concern about heterosexual transmission with female condom use if a prostitute does not change condoms between partners?

Zoro Machekonoyanga: We have targeted men who visit prostitutes and counseled them to help insert female condoms so they can be assured they are clean. There is awareness about this.

Jodi Jacobson: I do not remember the exact figures, but I recall from our December Working Group meeting that the female condom had well outsold PSI's projections. Sales are well ahead of what was anticipated.

Patrick Friel: When I worked on WHO's global AIDS program, the question of reuse came up often. I believe FHI has started a reuse study. It is a very important question when you talk about a device that costs the equivalent of \$0.62. The concern that was raised was that men would be infected by using a device that was already used by an infected man—even so, the prostitute is protected, and that is very important. The real issue this raises is that of promoting dual protection. This is one of the simplest and oldest methods available. I think we really need to develop a unisex condom rather than improved female condoms. We need better barrier methods.

Jim Rosen: I sense there is some criticism of the way PSI is marketing CARE in Zimbabwe. What input did WASN have in the decision to market the female condom as "CARE"? Is there ongoing dialogue about changing the marketing of the product?

Zoro Machekonoyanga: Essentially, we did all the groundwork, only to turn around and see PSI deciding the condom would be called "CARE" and be marketed as a contraceptive sheath. We were not given much of a chance to give input, though we are in constant discussion with them on how to improve the marketing. I think we need to shift some of the marketing focus to the method's disease prevention qualities.

Jose Barzelatto: Is it ethical to pre-test a product in a population that will likely be economically unable to access it? This issue has haunted me for years.

Judith Bruce: The female condom could be a useful tool to help women and providers discuss the fact that women have limited protection from disease because they cannot get men to wear condoms. It could be part of the "information mix," as well as the method mix, and could help start dialogues about power relationships. You could plausibly offer CARE for free at certain sites and build traffic for a range of different services. Has anything like this been done?

Zoro Machekonoyanga: Not yet, but it is definitely worth exploring. Cost remains an issue here. They are being imported from London at a cost, PSI pays Johnson and Johnson for packaging. If we had more money we could have a pilot project of offering it for free. With the trial group it was free. Later, when it was only offered for sale, the trial participants found it too expensive.

Diana Measham: At the December Working Group meeting, a PSI staff member explained why CARE is being marketed as a contraceptive sheath and not as a dual protection method. The decision, they claimed, was made based on research they had done that indicated that it would not be acceptable to market it as a way to protect against infection, that women would find it very difficult to negotiate use with their partners if that linkage was made. Do you have any thoughts on this? Does the information WASN collected suggest it would be acceptable to market CARE in a different way?

Zoro Machekonoyanga: Our information is that women realize they are dying from AIDS and are looking for a way to protect themselves. PSI did not want to talk about sex and infection because it is a taboo subject. But with HIV/AIDS, we have to break all the rules and taboos.

Nesha Haniff: Trials are all too often conducted on third world women. Why? The female condom is a difficult product. It is hard. It has rings in it. It is ugly. It is intrusive. Yet women are forced to use this thing because their lives are at risk. It is an enormous burden on women to ask them to use two or three methods. I think one of the reasons abortion rates are so high in the third world is that women are rejecting contraceptive technology. If they see their lives at risk they are going to want to protect

themselves. This difference is key. But the real key is getting men to wear condoms. I am sick of women constantly being the ones who have to take responsibility.

Jodi Jacobson: Is there a bias towards which methods are subsidized? Are fewer subsidies available for female condoms than for other methods?

Zoro Machekonoyanga: In Zimbabwe, all other methods are available for free from the Zimbabwe National Family Planning Council. Because the female condom is new and we do not have efficacy studies available, it is only available in the private sector.

Jodi Jacobson: Is there a perception among men that the rings in the female condom create friction that enhance male sexual pleasure? This may increase male willingness to have their partners use female condoms. And it may be part of the reason it is successful.

Zoro Machekonoyanga: Yes, there are couples who enjoy it thoroughly. Others have realized they can actually remove the inner ring, or that men can insert it. If a couple has good communication, they can remove it and have as much fun.

Judy Norsigian: There are gender sensitive men out there, in Zimbabwe and elsewhere, men who do care for their partners. What we need is an enormous public relations campaign. People need to know to try the product. Some will like it. There has been such a de-emphasis of barrier methods. Big donors fund hormonal methods, not barrier methods. Many women feel they can only negotiate a barrier method for contraceptive use. Without wider support for barrier methods, this is not likely to change.

The Role of Withdrawal in Fertility Regulation in Pakistan

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When I was first invited to present our findings on the use of withdrawal in Pakistan, I was delighted by the excellent timing. We were making plans for a national seminar to showcase the results of our research and discuss their implications. My problem at that time was—and still is—that I am unsure what these are. I welcome the opportunity to share our findings with this group, and hope that as you listen to my tale you will consider how we in Pakistan can best use them.

What Sparked our Research Interest

The story begins with the Pakistan Contraceptive Prevalence Survey of 1994-95, undertaken by the Population Council.¹ To our surprise, the survey showed that withdrawal was the most common temporary method of family planning; since previous studies had never found any substantial use of the method, we needed to confirm the survey's finding. It was confirmed by a set of community-based studies conducted in 73 villages in Punjab and Northwest Frontier provinces,² which included 3,500 respondents, and by a study of unmet need for family planning in Punjab.³ It is about to be reconfirmed by initial findings from the 1996-97 Pakistan Fertility and Family Planning Survey conducted by the National Institute of Population Studies. We wanted to know more: Why are couples using this method? What kind of demographic profile do they fit? How are they using it, and with what efficacy?

Research Design

We used the work of Rogow and Horowitz⁴ to shed light on our research questions and determine how

¹ Ministry of Population Welfare, Population Council, and United Nations Population Fund. 1998. *Pakistan Contraceptive Prevalence Survey 1994-95: Final Report*. Islamabad: Population Council.

² Ministry of Population Welfare and Population Council. 1997. "Initial performance and impact of village based family planning workers in four districts in Punjab." *Research Report no. 5*. Islamabad: Population Council.

³ Population Council. 1997. *The gap between reproductive intentions and behaviour: a study of Punjabi men and women*. Islamabad: Population Council.

⁴ Rogow, D. and S. Horowitz. 1995. "Withdrawal: a review of the literature and agenda for research." *Studies in Family Planning*

best to analyze the large-sample studies mentioned above. For example, we were able to learn the demographic, social, and economic profiles of users from detailed analysis of the Contraceptive Prevalence Survey;⁵ from the community studies we were able to follow individual segments (continuous periods of use) of withdrawal.⁶ We had individual study modules for each family planning method, which provided information about the dynamics of use and satisfaction, as well as a preliminary sense of use-effectiveness. We were able to glean information about negotiations and discussions between husbands and wives using the unmet need study.⁷ The latter also gave us a sense of the reputation of withdrawal among the general population. Finally, last spring we conducted a national survey that employed a cross-sectional approach with a contraceptive history calendar, which allowed us to obtain large-sample data on use-effectiveness and continuation.⁸ Yet many core questions remained that could only be answered through specific qualitative research into what motivated people to use withdrawal, how they knew about it, what they knew about it, what communication between spouses was like, how decisions were made, and how use of the method affected marital relations. To answer these questions, we conducted in-depth interviews among 25 men and 24 women who were current or past users of withdrawal, interviewing each respondent two or three times.⁹

History of Family Planning in Pakistan

Between the mid-sixties and 1990, Pakistan had a demographically-driven family planning program, which had essentially failed to achieve its goals. Between 1964 and 1990, the contraceptive prevalence rate (CPR) generally remained under 10 percent. By 1994-95, it had increased to 17.8 percent, and in 1996-97 it was estimated to be 23.9 percent, suggesting that family planning is finally beginning to take root in Pakistan.

26; 3:140-53.

⁵ Ministry of Population Welfare, Population Council and United Nations Population Fund, 1998, op cit.

⁶ Ministry of Population Welfare and Population Council, 1997, op cit.

⁷ Population Council, 1997, op cit.

⁸ Population Council. 1998. "The Contraceptive User Satisfaction and Longevity Study." *Research Report no. 9* (forthcoming). Islamabad: Population Council.

⁹ Ministry of Population Welfare and Population Council. 1998. "A qualitative investigation into the use of withdrawal." *Research Report no. 6*. Islamabad: Population Council

Prevalence of Withdrawal in Pakistan

In reviewing the method mix, two things are clear. First, there is a broad distribution of methods, particularly in light of the low overall CPR. There are seven methods in significant use: condoms, pills, injectables, IUDs, female sterilization, periodic abstinence, and withdrawal. Second, the procession of increase in use by method is quite orderly over time. The one notable exception is the sharp increase in the reported use of withdrawal between 1990-91,¹⁰ at 1.2 percent, and 1994-95, at 4.2 percent. Other recent studies have shown even higher levels.¹¹ The apparent sharp increase after 1990-91 is probably in part a reflection of methodological variations; the same kind of questions were asked in 1990-91 and 1994-95, but our interviewers were better trained in the latter period and were, therefore, more likely to determine when the method was being used. This is important because the majority of withdrawal users do not consider it a method, nor do they have a name for it. Furthermore, users are reluctant to talk about it with strangers. As a result, we believe that the levels of withdrawal use remain underreported, though less so than in the past.

Who Uses Withdrawal?

While the exact CPR for withdrawal eludes us, we do know that, on average, the socio-economic and demographic status of withdrawal users is similar to that of users of other temporary methods.

Withdrawal users are not stereotypical illiterate villagers who do not know any better; rather, if anything, they are disproportionately urban and educated.¹² Withdrawal users are about as aware of modern methods of family planning as other Pakistanis. Many have even used modern methods and just do not happen to be using them now. But why?

It appears that most current withdrawal users do not want to have any more children. Withdrawal, therefore, is employed to limit births. Yet even those currently using withdrawal for limiting births

¹⁰ National Institute of Population Studies and IRD/Macro International Inc. (NIPS/IRD). 1992. *Pakistan Demographic and Health Survey 1990/91*. NIPS/IRD.

¹¹ Ministry of Population Welfare, 1997, op cit.; Population Council, 1997, op cit.; Ministry of Population Welfare, Population Council, and United Nations Population Fund, 1998, op cit.

¹² Ministry of Population Welfare, Population Council, and United Nations Population Fund, 1998, op cit.

frequently report previously using it as a spacing method, and significant numbers of couples do use it for spacing, which is rarely the case with other methods in Pakistan. (Most people using any method do so to limit future births.)

Why Use Withdrawal?

Among Pakistanis who know of any other method, withdrawal enjoys the best reputation. In the unmet need survey, women and men were asked if they approve of each method, if their partner does, if they consider it expensive, if it is effective in preventing pregnancy, and if it is bad for one's health.

Withdrawal compared very favorably in every category.¹³ Particularly notable is the fact that both men and women expressed the belief that withdrawal is about as effective at preventing pregnancy as any other method, with the exception of female sterilization.

In the qualitative study, freedom from side effects was cited by both men and women as the primary reason for using withdrawal rather than other methods.¹⁴ Women in particular were unhappy with the side effects of other methods. Privacy was also found to be an important factor. The qualitative research found that individuals appreciate a method other people would not necessarily know they were using. The third main reason couples like withdrawal is convenience. They do not have to go to clinics, which may or may not be open, and they need not worry about supplies and whether they have money to pay for services. Everything they need to use the method exists between them, in the privacy of their home.

The Linguistic Challenge of Withdrawal

It is remarkable that withdrawal use is so high considering that slightly fewer than half of all women and slightly more than half of all men surveyed have ever heard of it—even when it is carefully described to them. In fact, few users have any word to describe it. There is an Arabic term—"azal"—for withdrawal, borrowed into Urdu, yet of the 49 men and women who participated in our qualitative research, exactly two had ever heard the term "azal". A few had used other words for the method; most used

cumbersome and difficult phrases, which is one of the reasons we believe we continue to underestimate total withdrawal use.

Religious Significance of Withdrawal

Because withdrawal is specifically mentioned in—and seemingly sanctioned by—a Hadith of the Prophet Mohammad, we had speculated that this could help explain its popularity. Yet only one of the 49 participants knew this, and this person holds a masters degree in Islamic studies!

Practical Use of Withdrawal

Most withdrawal users use this method exclusively, though a minority use it in conjunction with other methods (e.g., condoms). Some researchers and program managers were hopeful that withdrawal was used as a stepping stone to other methods, but this is not so. Withdrawal users are unlikely to switch to modern temporary methods of family planning, nor are they likely to seek sterilization. On the other hand, users of modern temporary methods are quite likely to switch to withdrawal, as confirmed in large-sample studies of contraceptive use history.¹⁵

Partner Relationships among Couples Using Withdrawal

Communication between partners using withdrawal seems to be strong, with both men and women reporting discussing withdrawal with their spouse. There seems to be stronger communication between husband and wife among users of withdrawal than among users of other methods. This is not too surprising: employing withdrawal requires a fundamental level of communication. Men and women both report that withdrawal is equally likely to have been initiated by the wife as by the husband. Neither women nor men gave any indications that male control over the method was an impetus to its use. Rather, we found evidence that withdrawal has some positive effects on marital relations. Several women in our small sample reported the husband's willingness to use withdrawal as a sign of his concern

¹³ Population Council, 1997, op cit.

¹⁴ National Institute of Population Studies and IRD/Macro International Inc (NIPS/IRD), 1992, op cit.

¹⁵ Ministry of Population Welfare, Population Council, and United Nations Population Fund, 1998, op cit.

for her well-being. The women in our study, and to some extent the men, see themselves as caught between the Scylla of pregnancy and the Charybdis of side effects of modern methods; use of withdrawal, including the cooperation of the woman's husband, allows them to sail smoothly between the rocks. A number of women expressed real appreciation of their husband's willingness to forego some of his satisfaction for their health and safety, and the men seemed proud of the self-control they exercise in order to use withdrawal properly. Furthermore, a number of the men expressed concern for their wives' sexual satisfaction—a concern not frequently attributed to Pakistani men—and explained that to ensure the success of the method, the wife should reach orgasm before the husband withdraws.

Satisfaction with the Method

Withdrawal users tended to be very satisfied with the method. Life-table continuation rates indicate a 36-month continuation rate of about 54 percent, which is comparable to the continuation rates for the IUD and substantially higher than those for other temporary methods in Pakistan. The fact that people tend to switch to, rather than from, withdrawal is also an indication of user satisfaction. Part of the loyalty to the method stems from a feeling of ownership. A number of respondents believed they actually invented the method, that withdrawal was *theirs*, and they were even willing to forgive its failure.

What Do Users Dislike about Withdrawal?

Husbands and wives both reported that the husband's sexual satisfaction is compromised by using withdrawal. And there is recognition that withdrawal can be difficult to practice consistently and effectively. We have done two studies that provide information about failure rates, and can estimate the failure rate for withdrawal to be about 10 percent.¹⁶ While this is relatively low by the standards of the international literature, it is by no means trivial and should not be thought of as merely a statistic; for some women, getting pregnant is simply devastating, and this needs to be taken into consideration. Couples understand that failure can occur when they do not use the method properly, but they do not recognize the possibility of the method itself failing.

Implications of our Research

What should we make of all of this? Consider that the government of Pakistan and international donors have spent millions of dollars over several decades trying to introduce modern methods in Pakistan. The Population Council has been providing technical assistance to Pakistan for the last 40 years, trying to make service delivery systems work. Yet Pakistanis are not only ignoring all of this and using a method that has nothing to do with any of these efforts, they are using it fairly effectively and quite happily.

So we have three basic options. We could try to eradicate withdrawal practices. We could, on the principle of 'if you can't beat them, join them', introduce withdrawal into the program as one more method among the lot. Or, on the principle that 'if it ain't broke, don't fix it', we could continue to ignore the existence of withdrawal altogether.

These are, of course, caricatures, but there are serious points to be made about each. While I wouldn't seriously suggest we try to stamp out withdrawal, there is a question about whether we should try to convince those couples for whom pregnancy is a particularly serious matter to switch to more effective methods. And it is also clear that attitudes toward the side effects of modern methods reflect a serious failure on the part of the program to provide accurate information, quality services, and adequate follow-up for modern methods. Turning withdrawal into a 'programmed' method is simply a question of information; there are no supplies and medical technologies involved. But that does not mean it is easy: the requisite information is very difficult to discuss in any kind of setting in Pakistan, posing a problem both for field workers and health care providers who want to discuss the method with clients. Furthermore, there is great personal ownership by couples of the method, and if it becomes a government-approved method it may well be that those who are persuaded to use it by program personnel will use it less effectively. On the other hand, do we not have an obligation to give people information about withdrawal, as part of the principle of informed choice? Fewer than half of all couples in Pakistan have ever heard of withdrawal, so if people are truly going to have 'choice,' they ought to

¹⁶ Ministry of Population Welfare and Population Council, 1997, op cit.; Ministry of Population Welfare, Population Council, and

know the method exists and be provided with the information they need to employ it.

Two other general challenges to the Pakistan program are as follows: First, how can we encourage in the general population the positive couple communication patterns we see among withdrawal users? Second, we must provide better and more complete information and counseling in support of modern methods, to reduce the excessive fear with which they are regarded.

DISCUSSION

Doug Huber: What are the failure rates of the pill in Pakistan? Could withdrawal be a backup method for other methods?

Peter Miller: I believe the failure rate for the pill is around 2 percent. The real challenge for dealing with withdrawal in any formal context in Pakistan is that there is very little interpersonal communication between providers and field workers, and their clients. In principle, yes, withdrawal could be a backup method, but that runs us into the same kinds of problems with the quality of service delivery that we see across the board.

Jim Shelton: Actually, a 10 percent failure rate for withdrawal sounds pretty good. We estimate failure rates of pill use are around 8 percent in developing countries.

Judith Bruce: Is there any relationship between age, coital frequency, and using withdrawal? People may use these rare methods when they need them. Could you test a strategy based on partner communication, information on cycle, and so on? By increasing inter-spousal communication you might not only make rare methods such as withdrawal more acceptable, but could also increase use of modern methods.

Peter Miller: No, we have not attempted to measure coital frequency. We were careful to avoid prying into those issues unless we sensed a particular client was comfortable discussing them.

We may be initiating an operations research project to look at the effect of not only more and better information, but a different way of providing information. I think the information issue cannot be overemphasized in Pakistan; it is absolutely critical, yet the system is absolutely dead-set opposed to saying anything useful to anybody. I cannot think of anything more important right now in Pakistan than information.

Lori Heise: Your executive summary states that "Correct knowledge of the fertile period was almost non-existent." It occurs to me that you might be able to have a campaign that is not directed at withdrawal per se, but is directed instead at giving correct information about when to have sex if you *want* to get pregnant. Couples could then extrapolate for themselves how to better use withdrawal—furthering their belief that they actually invented the method.

Peter Miller: Users in Pakistan generally do not know when a woman's fertile period is; conventional wisdom points to the week after a woman's menses. Withdrawal users do not make any particular

United Nations Population Fund, 1998, op cit.

connection between their use of withdrawal and the fertile period—whether they know it or not. I agree with you that people in Pakistan should know when the fertile period is. Information giving is a real challenge. There is very little communication between providers and people, and what communication does exist is not subtle. In fact, the family planning system seems opposed to providing accurate information. Nothing is more important than information in this setting, but nothing is more difficult to provide accurately.

Jodi Jacobson: The issue of men caring for their wives is particularly intriguing in this context since the Koran, from the little I know, encourages mutuality in sexual relationships, so there is actually something upon which to build concerning spousal communication. Is there any information on withdrawal use in Turkey, where formalizing withdrawal in the family planning system actually led to lower use rates? Also, is there evidence that infection rates are decreased through withdrawal use?

Peter Miller: I would be very interested to speak with Turkish colleagues and search through Turkish literature—unfortunately, there is little available in English concerning Turkish programs that is useful. I do not know about changes in infection rates.

Regina Barbosa: European studies of discordant couples show that withdrawal is somewhat effective against HIV transmission.

Margarita Diaz: We offer withdrawal in Brazil, but see a higher failure rate. How can we learn about women's sexual satisfaction with withdrawal use? Being happy with a method because it shows their partners care about them is not the same as sexual satisfaction. Specifically, in Pakistan, what is the situation with counseling, information provision, and service delivery in general? The rates of contraceptive use seem very low.

Peter Miller: The two situation analyses that have been conducted show that when there is contact between providers and clients, very little useful information is exchanged. Exit interviews with women leaving clinics post-counseling have shown that even if they have accepted a method, they know very little about that method.

Regarding sexual satisfaction, it is a part of Islamic law to provide sexual pleasure to wives. But, neither men nor women admit to women experiencing any sexual pleasure, although men often visit Hakims and homeopaths to try to increase their potency so they can better satisfy their wives. This disparity always intrigues me, though we did not explore this issue in the studies I presented today.

Anrudh Jain: When you look at failure rates, do you look at all pregnancies, whether unwanted or wanted, planned or unplanned?

Peter Miller: We discern between planned and unplanned. The pregnancies we reported were all unwanted.

Anrudh Jain: Are there any studies planned to look at the diffusion process?

Peter Miller: Given how little Pakistanis communicate outside of the couple relationship, and the fact that withdrawal has in fact been around for a very long time, studying diffusion may not be very efficient in Pakistan.

Sangeeta Pati: Regarding diffusion, we have done a poor job of training providers on the facts about natural methods. We need more research on this, but we also need to educate providers.

Judith Helzner: Did the female condom or withdrawal come up in any of the countries using the WHO assessment? Are they taken as seriously in this quality of care approach as the more “modern” and “effective” methods?

Karen Beattie: There was a study in South Africa on the female condom, and the diaphragm was studied in the Philippines, Colombia, and Turkey.

Ronnie Lovich: I am concerned about the separation between information and method mix. There is much negative information surrounding withdrawal. It seems like there is a need for reeducation among providers and family life educators that this option is better than nothing, that there is potential for effective use.

Jocelyn DeJong: I would like to see cross-country comparisons of withdrawal use throughout the Middle East. Islam is so pervasive as a value system, the culture and religion are so intertwined, there is a religious basis for mutuality, and there is a strong emphasis on the right of women to sexual fulfillment independent of reproduction. I would like to see cross-country comparisons of withdrawal use in the Middle East.

Peter Miller: We do need better information on withdrawal and periodic abstinence. There does not need to be a moral or religious distinction between withdrawal and other temporary methods, although permanent methods are considered immoral.

Lori Heise: There is tension between researchers and women’s health groups. Is a “pause” going to lead to more resistance to new and important methods, such as microbicides? In the discourse on microbicides, we need to explore whether the introduction of more choice will undermine what already exists—that is, will microbicides undermine condoms?

Jodi Jacobson: The WHO Strategy recognizes that there is a difference in the emphasis that should be placed on each method. We know the medical community really likes technology. The Strategy should find a way to address negative bias towards less technologically advanced methods.

Martha Brady: It is important to understand the program steps of a method before attempting a full-scale introduction, whether you are dealing with a microbicide product or a contraceptive method. You need to understand the system before you make an introduction.

Joanne Spicehandler: Yes, we do need to examine negative bias against a method such as a microbicide. It is essential to understand its impact on a system.

Ronnie Lovich: Is there a way to consider the demographic impact of low-technology methods, like breast-feeding and withdrawal?

Peter Miller: Even low efficacy methods have major demographic effects. Even a method with a 15 or 20 percent failure rate can still have most of the demographic effectiveness of a method with virtually no failure. In Pakistan, temporary methods currently have more effect than any other method. That is going to carry some weight with policy makers.

Jim Shelton: Provider bias really has no boundaries for methods. To me, part of our mission is to try to have a level playing field based on honest information on all available methods for providers, for consumers, and for ourselves. We still have a long way to go to get to that point.

Peter Miller: Talking with Pakistani government officials, it was interesting that there was no resistance to this at all. To my considerable surprise, I did not talk with one person who said, “Go away, this is useless.” The usual response was, “If it’s being used reasonably and effectively, why not?” This does not mean they are willing to sponsor information campaigns. But it is recognized as a reasonable method.

SHAKING UP THE METHOD MIX—STAKEHOLDERS' DEBATE

Role Play on Technology Introduction Decision-Making

The first session on February 11, the second day of the Working Group meeting, was devoted to a role play, providing a unique opportunity for participants to explore in-depth the process of country-level reproductive health (and technology introduction) decision-making.

Case studies detailing the demographic, economic, social, and political environments of two fictional developing nations, Concordia and Herestan, provided the basis for the role play (see Appendices A and B). Members of the Working Group donned the hats of potential players in national reproductive health (including contraceptive and technology introduction) planning and decision-making processes. These included a representative of a pharmaceutical company, a minister of health, the local representative of an international philanthropic foundation, a women's health advocate, a women's health care provider, a demographer, a journalist, and a community activist. Audience participation was encouraged.

The "actors" helped illuminate the multi-layered issues and competing interests that developing-country health ministries face in both their short- and long-term planning. Prioritizing health needs is often the primary challenge, especially when a genuine effort is made to incorporate the voices of health service users and service providers in addition to accommodating internal governmental demands (though it became clear that such an effort is rare). Once an agenda is set within a health ministry, advancing it can be equally difficult. Other government officials, donors, and the private sector are among the forces that wield influence in some settings, further complicating the process of moving an agenda from words to action.

For instance, the case study of Concordia sparked debate among the actors as to whether the "Goodshot Pharmaceutical Company" should introduce a new injectable to Concordia's method mix. Some women's health advocates had indeed pressured Goodshot to market its product so women would have a choice

among injectable contraceptives. Other women's health advocates expressed concern that in light of rising HIV and STI rates, improved access to barrier methods was much more important than adding a new injectable to Concordia's method mix. Neither the donor nor the demographer felt that making Goodshot's injectable widely available was a priority reproductive health issue for the public sector in Concordia; any effort to do so, they intimated, should be handled by the private sector in conjunction with a spectrum of women's health advocates. The Goodshot representative, meanwhile, indicated that his company was not convinced that Concordia would provide a good market for its injectable. Foremost in their minds was the potential backlash from the Concordian right-wing, which could result in a boycott of their many other products. Further complicating the issue, the minister of health pointed out that adding a second injectable could confuse providers. In fact, the minister was unsure whether offering any injectables would be wise—they often get held up in customs, and providers are not properly trained to administer them. Important to the tale is that most men and women of Concordia access reproductive health care through the private sector, a domain over which the government has very little control. Ultimately, no consensus was reached.

The case study of Herestan brought different issues to light. The stakeholders in this case were asked to discuss general reproductive health priorities in Herestan. The minister of health noted that Herestan had reached a critical stage with regard to the spread of HIV. If the Herestani government could mobilize resources immediately, it stood a chance of fending off an AIDS epidemic. Otherwise, Herestan might well see its infection rates skyrocket. The minister indicated that the low status of women was another big challenge he would like to see tackled—but to do anything, he first needed more donor funding. According to the international donor, however, Herestan had historically received generous reproductive health funding from many foreign donors. What Herestan really needed, in his view, was an integrated plan to increase access to methods and services and greater cooperation among government ministries. Women's health advocates stated that they would like to see expanded economic and educational opportunities for women, as well as improvements in access to and the quality of existing reproductive health services. The demographer pointed out that Herestan's population growth rate was high and

rising, and that while oral contraceptives were widely available, unmet need for contraceptives remained a problem. He suggested that the ministries of finance and education collaborate with the ministry of health to conduct a wide-reaching campaign promoting contraceptive use. Once again, no consensus was reached. Nonetheless, the role play succeeded in illustrating some of the conflicting needs and agendas of key players in such policy debates.

In the discussion that followed the role play, many Working Group members expressed how accurately the actors had depicted the frustrating scenarios which so often confound policy-making and program planning processes. Following are some of the highlights of that discussion:

Judith Bruce: What is the role of the private sector in providing information? How do we assure it is providing good information? Are there any arrangements between pharmaceutical companies and private physicians who prescribe contraceptives regarding the information they provide patients? Can the government issue guidelines to encourage the provision of accurate information? Can pharmacists provide such information? A private purchase may be the first contact many people have with a contraceptive technology, yet they receive little or no accurate information on its use.

Patrick Friel: UNFPA can help negotiate agreements with key private sector players in a country. There still seems to be great suspicion of the private sector. We should not be surprised that the private sector wants to make a profit. At the same time, multisectoral cooperation is possible.

Ruth Simmons: This role play raised all the issues that come up in the participatory process. What is a group like this to do? Sit and talk! But those concerned with quality based contraceptive introduction do more than sit and talk: they go out to the field to see what really happens.

Peter Miller: We are in a bind, and a participatory process can only help. In Herestan, the government thinks it can provide everything; there is a very strong and powerful government system in place, as well as a very traditional culture which fosters gender inequalities. Neither is responsive to user needs. It is not a good idea to disempower the government. So what can be done? In Bangladesh—for example—the government has learned that NGOs can be useful.

Jim Shelton: I'd like to comment on the phenomenon of change. I admire the WHO Task Force work, but have reservations about the expectation that changes around technology introduction will be orderly. In general, change is disorderly; disagreement is part of the process.

Diana Measham: The WHO methodology seems very public sector oriented, at a time when the private sector's role in contraceptive service provision is increasing. Does the private for-profit sector actually participate in debates around contraceptive introduction?

Ruth Simmons: The WHO approach grew out of public sector concerns, but we do take the private sector into consideration. For instance the public sector has no authority to remove high dose once-a-month injectables, but it can help to bring in Cyclofem to compete with them.

Karen Beattie: We need to remember that the private sector is very diverse.

Juan Diaz: We also need to distinguish between the private sector and real life. Real people go to pharmacies. We need to empower private sector users to make informed choices about what drugs they should or should not buy.

Judith Helzner: There are some private NGOs of value in the contraceptive introduction process, including family planning associations. PROFAMILIA Colombia has made an agreement with Schering to distribute subsidized pills. This offers Schering a toehold in the market. NGOs can also offer reproductive health programs that deal well with sex, gender, and adolescent needs.

Cynthia Steele: Voices of providers are missing in these debates. We also need to pay more attention to service delivery level supervisors, since they can be key to making changes.

Adrienne Germain: In creating a new population and health policy post-Cairo in Bangladesh, we have noted that critically important stakeholders are often not at our table—these would be consumers, advocates, service providers, and others who do not have the money, experience, or training to engage in this process. What is the experience of engaging stakeholders with different backgrounds in the implementation of the strategic approach?

Ruth Simmons: The WHO methodology is a complex approach that focuses on core strategic questions. A subject we often discuss is how we can include a broader range of voices while maintaining a focus on these strategic questions.

Maggie Diaz: This role play showed accurately what happens during real stakeholders' debates—men sit around to discuss the future of women's health, and each stakeholder has quietly vowed to protect his own interests. The two most important actors are really a woman and her provider. They must be included in these processes.

Summary: Technical Group Discussion

The afternoon session on February 11 provided an opportunity to discuss issues around technology introduction in greater depth, and to identify key areas in need of further attention.

Sustainability of the Strategic Approach

The Strategic Approach to Technology Introduction was well-received by meeting participants. Concerns were raised about its sustainability, and how to insure that the participatory process it embodies includes the broadest possible range of stakeholders, most notably those who are most likely to be overlooked at all levels—the women who use health services. Identifying and including service users and their advocates is a challenge. Many women lack not only the language skills to participate in this kind of a process, but are not comfortable doing so for personal or political reasons—or both.

Many meeting participants expressed concern that the WHO methodology take into account non-technological reproductive health concerns. Information exchange among the spectrum of decision-makers, and most notably between clients and providers, was identified as a key “non-technology” that must receive greater attention.

There was a reiteration of how flexible, by design, the WHO methodology is. There is no strict model for employing the strategic approach beyond the requirement to ask context-specific strategic questions, include participatory research conducted by a wide range of stakeholders, and respond to local circumstances.

Concern over men’s roles in reproductive health decision-making was a focal point and underlying theme of much of the dialogue. Convincing men to take some responsibility for contraceptive use is but one issue. Men also need to be more generally involved in their own reproductive health, as well as that of

their partners. While promoting condom use is a short term—albeit important—intervention and must be supported, in the longer term the power dynamic in gender relations needs to change.

This observation led to a discussion of donor results frameworks: the kind of change which needs to be fostered takes time, yet most funding is awarded in short-term cycles. The concept of “program success” needs to be modified to facilitate work on less quantifiable areas like behavior change and education. To this end, many participants agreed that education must occur at all levels—in medical schools and in clinics, among policy makers and clients. The concept of “reproductive health” remains foreign to too many people, and the quality of care available to women is compromised as a result.

Integration

The concept of integration needs to be deconstructed—it is a term that means many things to many people. Integrating STI/HIV prevention and treatment services into existing family planning programs is only one level of consideration. Others include integrating better communication strategies into reproductive health training and care; integrating the private sector into the evaluation and assessment process; and integrating awareness of how domestic violence affects contraceptive use. Better consideration should be given to the goals and objectives of integration activities, and the capacity of providers to offer integrated services. How are issues of integration best approached?

The rise of the private sector in the developing world should spur deconstructive thinking about who or what the private sector actually is. It includes pharmacies. It includes private commercial enterprises, both formal and informal. It includes private not-for-profit organizations. In many instances, the private sector is a venue for leveraging information and should be further explored as a mechanism for user education. However, as the role play brought to light, the private sector can also be an untouchable monolith through which unsafe technologies often flow.

APPENDIX A

Case Study A: Concordia

Introduction

Concordia is a geographically large country in the Southern hemisphere. Most of the population is concentrated in urban areas, but a substantial minority lives in the rural countryside. Some parts of the country are fairly inaccessible due to mountains, rivers, and a poor transportation system; indigenous groups are also isolated by language.

Economy

A developing country, Concordia has built up its manufacturing sector in the past 20 years. Noteworthy trends include the shift from subsistence agriculture to wage labor, migration from rural to urban areas in search of work, and an increase in the number of women who work outside of the home. Concordia's annual per capita income is \$532.46, but there is a considerable income gap. There are also large urban slums and a high crime rate, including a high rate of violence against women.

Fertility

The total fertility rate has dropped in the last 20 years from 4.1 to 2.9, with rural women and less educated women tending to have larger families. The contraceptive prevalence rate is approximately 68 percent.

Partnership

The average age of marriage has risen sharply; 20 years ago, it was 16 among women and 22 among men. It is now 22 among women and 25 among men. Additionally, both men and women are now likely to have several sexual partners before marriage, and age of onset of sexual activity is decreasing. Divorce is still officially unaccepted, but several small studies have noted that households headed by single women are becoming increasingly common.

Method Mix

The contraceptive method mix has changed substantially over the past 20 years. Previously, traditional methods, including abstinence and herbal pessaries, were used by the majority of couples. Now, female sterilization is rapidly becoming the most widely used method, with 28 percent of women reporting use of this method (up from 9 percent 20 years ago). The average age at sterilization is 29, down from 36 in a survey conducted 20 years ago. Vasectomy is very rare.

Hormonal methods also play an important role in the method mix. Injectables, generally dispensed by pharmacists, are used by 22 percent of family planning acceptors. Depo-Provera, a three monthly injectable, is marketed aggressively. Several years ago, a clinical introduction of Cyclofem, a monthly injectable, was undertaken. Although results showed that the method was acceptable, had high continuation rates, and was favored by local policy-makers, effective distribution channels were never found.

Oral contraceptives are largely unavailable following media stories four years ago suggesting that cancer-causing pills, rejected in northern countries, were being shipped to Concordia and other developing countries.

IUDs occupy a small niche in the capital city, but are not available in other areas. Only physicians are authorized to provide IUDs, and very few service providers have been formally trained in IUD insertion. Diaphragms and other female-controlled barrier methods are rare, and while use of condoms is fairly high among urban youth, the method is not widely used by others.

Access to Services

Most women obtain family planning services from the commercial sector (private physicians and pharmacists). However, the commercial sector is active principally in urban areas. A few NGOs exist,

including a family planning association that operates in nine cities or towns. Additionally, a small feminist reproductive health NGO operates clinics in two cities. The public sector is moribund in most parts of the country, although in some rural areas it is the primary source of contraceptive services. (The majority of the population has fairly easy access to a primary care clinic.) Services are less accessible in mountainous or isolated rural areas.

Quality of Services

There is a wide range of service quality, depending on whether services are private or public, and urban or rural. While sophisticated services such as laparoscopy are available through private practitioners in cities, rural clinics feature long waiting periods and often technically incompetent services.

Administration

The government has been pursuing a policy of decentralization of health services, and few regulations or policies are set at the central level.

Special Populations

The FPA and feminist NGO both serve adolescents, and have popular clinics for use exclusively by adolescents. (The government has no official policy related to adolescents.) The FPA has also recently opened a men's clinic, which so far is not seeing many clients. As mentioned above, women in rural areas have little access to private (commercial or NGO) providers, the main source of family planning services in Concordia. Additionally, poor women may be underserved as services are often only available in the private sector.

Abortion

Abortion is illegal in most cases, and even in cases where abortion is legal (for instance, in cases of rape or incest) most service providers will not (openly) perform abortions. However, abortion is clearly prevalent, as large numbers of women with abortion complications, generally infection, are treated in

urban emergency rooms and maternity wards. Almost half of maternal deaths are thought to be attributable to unsafe abortion. Anecdotal evidence suggests that safe abortion services are available through private physicians, but they are expensive and generally only accessible to the educated urban elite. It has been suggested that some doctors count on the provision of abortion for a significant proportion of their income.

STDs and HIV

Few studies have been conducted to measure the prevalence of STDs, including HIV. Small studies indicate that rates of gonorrhea and syphilis are increasing, while HIV rates remain low, except for high rates noted among men in the three main cities.

Media

The majority of Concordians have access to television, often through their communities. Urban dwellers congregate in "video shops" to watch popular soap operas, and in rural areas, villages often set up televisions in the central square, obtaining power from generators.

APPENDIX B

Case Study B: Herestan

Introduction

Herestan, a small, densely populated country, has recently emerged from oppressive dictatorship, border wars with its neighbor Therestan, and civil uprisings. The country is agriculturally rich and has a high annual rainfall; much transportation is by boat.

Economy

A new emphasis on integrating with the rest of the world has brought investment and tourism to Herestan; per capita income is rising, there is increasing mobility of the population, and values are changing. Timber and carpets remain important exports, but tourism is becoming an increasingly important source of foreign exchange, as is contract manufacturing, particularly of garments.

Fertility

The total fertility rate in Herestan is 4.2, and the government has a strong policy encouraging couples to have small families. Contraceptive prevalence remains low, however, at around 24 percent. Abortion is legal and widely practiced. Fertility regulation services are offered almost exclusively through the public sector.

Partnership

Increasingly, a proportion of Herestani couples are spending part of their married life apart, as more Herestani men are leaving home to work in cities or even in other countries. The average age of marriage is low for women (approximately 17) and much higher for men (28). Women are expected to bear the first child as soon as possible after marriage. There is considerable preference for sons, and a recent study found that families with girl children tend to be larger.

Method Mix

The method mix is skewed towards use of oral contraceptive pills, which are used by 60 percent of all users of modern methods. However, both clients and providers seem to have much misinformation about oral contraceptives. A recent survey found that an average of eight brands of pills were available at service delivery points. In addition, a “visiting pill” is available in pharmacies. This levonorgestrel-only pill is labeled for use after intercourse, and a recent study found that there is some confusion on the part of clients between this post-coital pill and the regular oral contraceptives, leading to some women taking their regular OCs only after intercourse. IUDs and sterilization, both male and female, are little used and fairly inaccessible. Condoms are becoming increasingly available, but female-controlled barrier methods, such as the diaphragm and female condom, are unavailable.

Access to Services

Services, both for family planning and for abortion, are provided almost exclusively through the public sector, at small general clinics located in every municipality. The government has recently instituted a cost-sharing scheme for contraceptive and reproductive health services.

Quality of Services

An assessment found that the information given to family planning clients is generally of poor quality. Service providers often supply information only on pills and condoms, even in sites where other methods are available. And, as mentioned above, information on pills is often inaccurate. In addition, many clients report perceiving service providers as rude and uncaring.

Abortion

Abortion services are widely available in the public sector and are thought to be of moderate technical quality. Repeat abortions are common. The majority of service sites use dilation and curettage. Little attention has been given to pain control or to counseling for post-abortion contraceptive uptake.

STDs and HIV

Rates of HIV are increasing rapidly, even in rural areas. Recent studies have found that rates of STDs are much higher than previous estimates, and are not confined to urban areas as thought. STD services, however, are almost all concentrated in cities.

Administration of Services

Services are almost uniformly public, and are administered from a central coordinating body.

Commodities are requested from district stores, but there are frequent stock-outs, particularly of certain brands of oral contraceptives.

Clinics are obligated to collect extensive data on family planning clients and send it to the district level every month. At the district level, the statistics are compiled and sent to the central statistics bureau of the Ministry of Health. After the statistics are received, little reporting out occurs.

Special Populations

No special services exist for adolescents, and the official family planning guidelines discourage providing methods to unmarried women. A recent study found that few women receiving abortions are given information on family planning or invited to return for services, even though the services are frequently offered in the same sites.

Media and IEC

Television and radio are still scarce. The government uses posters and billboards to disseminate messages, generally nationalistic, to the people of Herestan.

WORKING GROUP ON REPRODUCTIVE HEALTH & FAMILY PLANNING
Meeting on Innovations in Technology Introduction
February 10 & 11, 1998
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